STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265573	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Spring Care Center for Rehab and Healthcare	202 East Mill Street Humansville, MO 65674

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's family/responsible party was notified of changes in condition when staff did not document that the responsible party or emergency contact notifications for residents' change in health condition and/or new physician orders for three residents (Resident #1, #2, and #3). The facility had a census of 35. Review of the facility titled Medication Orders, dated May 2025, showed staff to notify the resident's sponsor or family of new medication order. Review showed staff did not provide a policy related notifications of resident change in condition to responsible party or family members. 1. Review of Resident #1's face sheet showed the following: -admission date of 04/04/25;-Two emergency contacts listed with name and phone number;-Diagnoses included encephalopathy (disease that affects the function or structure of your brain), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), cognitive communication deficit, and bipolar disorder (mental health condition characterized by significant shifts in mood, energy, and activity levels, ranging from extreme highs to lows). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 10/01/25, showed the following:-Moderate cognitive impairment;-Partial to moderate assistance required for toileting hygiene, dressing, personal hygiene;-Substantial to maximal assistance required for showering. Review of the resident's care plan, updated 07/23/25, showed the following:-Staff should be in contact with the resident and family at least quarterly and offer to review the plan of care;-Staff should notify the physician and family of significant weight changes. Review of the resident's nursing progress note dated 08/14/25, at 4:34 P.M., showed the resident had an event of being short of breath and unsuccessfully attempting to resolve episode with use of bilevel positive airway pressure (BIPAP - non-invasive therapy that uses a machine to deliver pressurized air through a mask or nasal plugs, making it easier to breathe) machine, the resident asked about difference of hospice and palliative care. Staff provided education. The resident at this time requested to have a palliative care consult. (Staff did not document responsible party notification).Review of the resident's October 2025 Physician Order Sheet (POS) showed an order, dated 10/10/25, for levofloxacin (antibiotic used to treat a variety of bacterial infections by killing the bacteria or preventing their growth) oral tablet 500 milligrams (mg), give one tablet by mouth one time a day for bacterial infection for four days.Review of the resident's nursing progress note dated 10/10/25, at 12:23 A.M., showed the resident returned from hospital on antibiotic therapy with no signs or symptoms of adverse reactions. Resident had no signs, symptoms, or complaints of pain or discomfort. Call light within reaction. Staff will continue to monitor. (Staff did not document responsible party notification.)Review of the resident's October 2025 POS showed the following:-An order, dated 10/11/25, for insulin lispro (rapid-acting insulin) injection, inject 4 units subcutaneously (below the skin) one time only related to type 2 diabetes mellitus;-An order, dated 10/13/25, insulin lispro injection, inject 4 units subcutaneously one time;-An order, dated 10/14/25, insulin lispro injection, inject 4 units subcutaneously one time only for blood sugar 411 mg/deciliter (dL). Review of the resident's nursing progress note dated 10/14/25, at 8:47 P.M., showed the resident had a blood sugar was 411 mg/dL. Staff received new orders from on call physician for a one-time order of four units of insulin lispro and recheck blood sugar level in two hours. Staff to call physician back if blood sugar level was over 400 mg/dL. Staff will continue to monitor. Review of the resident's medical record, dated 10/11/25 to 10/24/25, showed staff did not document responsible party notification of the blood sugar levels and insulin orders. Review of the resident's October 2025 POS showed an order, dated 10/25/25, for levofloxacin oral tablet 500 mg, give one tablet by mouth one time a day for COPD for 4 days.Review of the resident's medical records showed staff did not document responsible party notification of the new order. Review of the resident's nursing progress note dated 10/29/25, at 8:23 A.M., showed the resident called this staff in his/her room. The resident let this nurse know he/she was hearing children. This nurse then asked resident if he/she would like to go to the hospital. Resident then stated no and I think I need to be on hospice. This nurse asked resident if he/she felt okay enough right now. Resident stated, Yes I just need to talk to someone about hospice today. I need to be able to sleep and get on meds. The resident then asked this nurse to call his/her family member. This nurse let resident know he/she would talk to social services and the Director of Nursing (DON) first. Resident stated, I don't care what he/she says I need to be on hospice. This nurse then reassured the resident that he/she would talk to the DON and get it worked out. (Staff did not

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain all resident medical records according to professional standards of practice when the facility failed to document hospice evaluation and admission and ensure the record was complete and accurately documented for one resident (Resident #1). The facility had a census of 35.Review showed the facility did not provide a policy related to nursing documentation and medical records accuracy. 1. Review of Resident #1's face sheet showed the following information:-admission date of 04/04/25;-date of death of [DATE];-Diagnoses included encephalopathy (a disease that affects the function or structure of your brain), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), cognitive communication deficit, and bipolar disorder (mental health condition characterized by significant shifts in mood, energy, and activity levels, ranging from extreme highs to lows). Review of the resident's care plan, updated 07/18/25, showed the following:-Staff should monitor, record, and report presence of pain and/or intolerance during ambulation;-Staff should assess and document effectiveness of drug treatment;-Staff should document any abnormal behavior.(Staff did not care plan related to hospice services.) Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 10/01/25, showed the following:-Moderative cognitive impairment;-Used wheelchair for mobility;-Partial to moderate assistance for toileting hygiene, dressing, personal hygiene;-Substantial to maximal assistance for showering. Review of the resident's progress note dated 10/29/25, at 8:23 A.M., showed the resident called the nurse in to the room. The resident let the nurse know he/she was hearing children. This nurse then asked resident if he/she would like to go to hospital. The resident then stated no and I think I need to be on hospice. The nurse asked resident if he/she felt okay enough right now. The resident stated, Yes I just need to talk to someone about hospice today. I need to be able to sleep and get on meds. The resident then asked this nurse to call his/her family member. The nurse let the resident know he/she would talk to social services and the Director of Nursing (DON) first. The resident stated, I don't care what he/she says I need to be on hospice. The nurse then reassured the resident that he/she would talk to the DON and get it worked out.Review of the resident's October 2025 and November 2025 Physician's Order Sheet (POS) showed an order, dated 10/31/25, for Morphine Sulfate (used to treat severe pain when other medications are not effective) oral solution 10 milligram (mg)/5 milliliter (ml), 0.25 mg every two hours as needed for pain per hospice.Review of the resident's medical record, dated 10/29/25 to 11/03/25, showed staff did not document regarding a hospice referral or assessment, or the resident being placed on hospice service. The staff did not document a physician's order related to admission of hospice services. During an interview on 11/19/25, at 12:00 P.M., Certified Medication Technician (CMT) B said staff document in the resident's medical record any care and services received. There should be orders for hospice in the chart as well. During an interview on 11/16/25, at 12:30 P.M., Licensed Practical Nurse (LPN) A said nursing staff should document any change of health condition in the resident's chart. This should include information of being evaluated and admitted to hospice services. During an interview on 11/16/25, at 1:00 P.M., Director of Nursing (DON) said she was notified that the resident wanted to go on hospice services and she advised staff to start the process and contact hospice. This information should have been documented in the resident's chart. She was not able locate any hospice records. The hospice company did not leave any records. She did not find a hospice order, or any nursing documented information on hospice services. Resident charts should show the accurate and concise information related to the resident care and if it was not documented it did not happen. Care plans should be updated as soon as possible after changes in resident care needs. During an interview on 11/16/25, at 1:30 P.M., the Administrator said there should be a physician's order for hospice evaluation and treatment. The resident's medical records should show the resident was on hospice. Staff should document resident's change in health care needs in the records. The medical record should paint a clear picture of the resident's care. Complaint 2666127