

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Big Spring Care Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document notification of the responsible party or emergency contact of the resident's change in health condition, transfer to the hospital, and/or death of three residents (Resident #1, #2, and #3). The facility had a census of 42. Review of the facility provided policy, Notification of Changes, dated [DATE], showed the following:-The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notified, consistent with his or her authority, the resident's representative when there is a change requiring notification;-Circumstances requiring notification include accidents resulting in injury or potential to require physician intervention; significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, or mental or psychosocial status; -Circumstances that require a need to alter treatment may include new treatment or discontinuation of current treatment; a transfer or discharge of the resident from the facility; or a change in resident rights;-For competent individuals, the facility must still contact the resident's physician and notify resident's representative. A family that wishes to be informed would designate a member to receive calls. When a resident is mentally competent, such a designated family member should be notified of significant changes in resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident;-For resident incapable of making decisions, the representative would make any decisions that have to be made; the resident should still be told what is happening to him or her; and staff to contact information of the resident's legal representative or family member must be recorded and periodically updated. 1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following: -admission date of [DATE];-Transferred to the hospital on [DATE];-An emergency contact listed with name and phone number;-Diagnoses included nontraumatic intracerebral hemorrhage (sudden, spontaneous bleed inside the brain tissue that is not caused by an injury or a head accident), atherosclerotic heart disease (condition where fatty plaque builds up inside the heart's arteries, leading to narrowed blood vessels, reduced blood flow, and serious risks like heart attacks), hypertension (high blood pressure), shortness of breath. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated [DATE], showed the resident was cognitively intact. Review of the resident's care plan, updated [DATE], showed the resident's designated contact is a family member. Review of the resident's nursing progress notes showed staff the following:-On [DATE], at 7:10 P.M., the nurse was notified by staff that the resident was not his/her usual self. The nurse spoke with resident who reported: I am very confused, I don't know what time of day it is. Vitals taken blood pressure (BP) 92/59 millimeters of Mercury (mm/Hg) (normal 120/80 mm/Hg), pulse 81 beat per minute (bpm) (normal 60 to 100 bpm), temperature 97.9 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265573 If continuation sheet Page 1 of 5

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	degrees Fahrenheit (F) (normal 98.6 F), respirations 20 per minute (normal 12 to 20), and blood oxygen level of 83% on room air (normal above 90%). The resident denied shortness of breath or any new or increased pain. A call was placed to the physician who requested the resident be placed on 2 liters (L) oxygen (O2) via nasal cannula (NC - lightweight, flexible medical device used to deliver supplemental oxygen directly into your nostrils) and monitor. Staff should call the physician if there was a change. The resident was started on oxygen;-On [DATE], at 6:30 A.M., the Director of Nursing (DON) entered the resident's room and believed the resident to be sleeping. The DON called out the resident's name and he/she did not wake. This was not unusual. The DON tested the resident's blood sugar with the stick, and the resident did not wake. The DON continued to call the resident's name and sternum rub (involves making a closed fist and grinding the knuckles vigorously against the center of the person's chest to elicit a pain response) was performed with no response. The resident's pulse was checked with none felt. The DON called 911 and requested help from housekeeping to move the resident to the floor. Once on the floor, the resident began agonal breathing (abnormal, reflexive pattern of gasping and labored breathing that occurs when the brain is deprived of oxygen), and cardiopulmonary resuscitation (CPR - life-saving emergency procedure used when someone's breathing or heartbeat has stopped, combining chest compressions and rescue breaths to keep blood flowing to vital organs) was initiated. Housekeeping called for more help. Once additional staff arrived, the DON switched out with another staff member. The DON became the timekeeper, suctioning, and airway while keeping count of compressions and quality and had other staff rotate out for compressions. After seven rounds of compressions, emergency medical services (EMS) arrived. An airway was placed following placement of automatic external defibrillator (AED - portable medical device used to check the heart rhythm and give an electric shock if needed to restart a normal heartbeat) pads and another round of chest compressions and a pulse was found. The resident was moved to a gurney by EMS and staff and left the building at 7:15 A.M.;-On [DATE], at 12:21 P.M., a late entry, staff spoke with resident's family member. The family member had been informed by the hospital of the resident's condition.(Staff did not document notification of the resident's emergency contact or family of the resident's change of health condition or transfer to the hospital.) During an interview on [DATE], at 2:00 P.M., the Director of Nursing (DON) said the following:-The resident coded (a sudden, life-threatening crisis, meaning their heart or breathing has stopped and they need immediate resuscitation) while she was on shift;-The DON followed the ambulance to the emergency room (ER);-The DON did not call the family. The family called the facility after they were notified by the hospital. 2. Review of Resident #2's face sheet showed the following: -admission date of [DATE];-An emergency contact listed with name and phone number;-Diagnoses included Type 1 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)) with hyperglycemia (high blood sugar levels), stage 4 pressure ulcer (severe injury featuring full-thickness skin and tissue loss with directly exposed bone, muscle, tendon, or cartilage) of sacral region (area at the base of the spine, just below lower back and above the tailbone), nontraumatic intracranial hemorrhage. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of the resident's care plan, updated [DATE], showed the resident's designated contact was a family member. Review of the resident's nursing progress notes showed staff documented the following: -On [DATE], at 9:22 A.M., the resident was uncooperative with care today. He/She was asking to just die. He/She refused morphine (used to relieve severe pain) unless nurse was going to give him/her enough to kill him/her. He/She was asking to go home. The resident refused treatments and medications on this shift;-On [DATE], at 4:51 P.M., the resident continued to refuse cares and treatments, and has also been refusing scheduled morphine;-On [DATE], at 4:47 (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P.M., resident passed away at 4:30 P.M. Hospice was contacted and confirmed death at 4:45 P.M. Hospice helped with paperwork and clean up.(Staff did not document of family or emergency contact notification of the health change and death.) During an interview on [DATE], at 2:00 P.M., the DON said the resident's emergency contact should have been notified of their death and the information should have been documented. 3. Review of Resident #3's face sheet showed the following: -admission date of [DATE];-Two emergency contacts listed with name and phone number;-Diagnoses included local infection of the skin and subcutaneous tissue (deepest layer of the skin), necrotizing fasciitis (rare but severe bacterial infection that destroys the tissue beneath the skin, including fat and the fascia (the connective tissue covering muscles)), cellulitis bilateral lower limb (common, potentially serious bacterial skin infection causing redness, swelling, and pain). Review of the resident's comprehensive MDS, dated [DATE], showed the resident was cognitively intact. Review of the resident's care plan, updated [DATE], showed the following:-Staff should encourage resident and family to express, verbalize desires or wishes, regarding personal decisions for care and/or treatment;-Notify physician and responsible party of any changes in condition. Review of the resident's nursing progress note, dated [DATE], showed staff the following:-At 7:56 A.M., the resident's wounds were assessed;-The physician was contacted due to the resident's wounds declining, as the wounds were producing thick yellow/ green drainage;-The physician ordered the resident be sent to the hospital for further evaluation with the start of antibiotics possibly through peripherally inserted central catheter line (PICC - long, thin, flexible tube put into a vein in the arm to deliver long-term medicines);-Resident notified of physician order.(Staff did not document family or emergency contact notification of change of health or transfer to the hospital.) During an interview on [DATE], at 2:00 P.M., the DON said the resident's emergency contact should have been notified of transfer to the hospital and the information should have been documented. 4. During an interview on [DATE], at 11:30 A.M., Licensed Practical Nurse (LPN) A said the following:-If a resident has a change of condition, is transferred to the hospital, or passes away at the facility, he/she would notify the resident's responsible party;-If the resident was their own self responsible party, he/she would not necessarily notify the family; -The nurse should document any notification to residents or their family. During an interview on [DATE], at 1:45 P.M., the SSD said the following:-The nurse on duty should contact the resident's family or emergency contact of changes in health condition, transfer to the hospital, and/or death at the facility;-If the resident is their own self-responsible party, sometimes the resident does not want their family to be contacted unless they go to the hospital;-All information involving contacting the family or not contacting the family should be documented. During an interview on [DATE], at 2:00 P.M., the DON said the following:-The nursing staff should notify the on-call manager if a resident has a change in health condition;-The nurse should contact the resident's family or emergency contact of changes in health condition, transfers to the hospital, or death at the facility;-If a resident is their own self-responsible party, sometimes they do not want their family contacted unless they are sent to the hospital;-All information regarding family contacts or not contacting the family, should be documented. During an interview on [DATE], at 3:15 P.M., the Administrator said the following:-Nursing staff should notify a resident's family or emergency contact for all changes of health, transfers to the hospital, or death;-Notifications should be documented in the resident's chart;-If the resident is their own person and does not want family notified that information should be documented. Complaint #3053715		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to have process in place to ensure resident's received cardiopulmonary resuscitation (CPR - life-saving emergency procedure used when someone's breathing or heartbeat has stopped, combining chest compressions and rescue breaths to keep blood flowing to vital organs) per standard of practice when two of the four staff who performed CPR were not certified in CPR (official credential proving that you have completed a formal training course and know how to perform CPR, use an AED (automated external defibrillator), and manage choking or breathing emergencies), for one resident (Resident #1) prior to Emergency Medical Services arrival. The facility had a census of 42. Review of the facility policy titled Cardiopulmonary Resuscitation (CPR), dated [DATE], showed the following: -If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services in accordance with the resident's advance directives; -CPR certified staff will be available at all times; -CPR certified staff will maintain current CPR certification for healthcare providers through a CPR provider whose training includes a hands-on session either in a physical or virtual instructor-led setting in accordance with accepted national standards. 1. Review of Resident #1's face sheet (brief information sheet about the resident) showed the following: -admission date of [DATE]; -Full code status (wished to receive CPR if heart beats or breathing stopped); -Diagnoses included nontraumatic intracerebral hemorrhage (sudden, spontaneous bleed inside the brain tissue that is not caused by an injury or a head accident), atherosclerotic heart disease (condition where fatty plaque builds up inside the heart's arteries, leading to narrowed blood vessels, reduced blood flow, and serious risks like heart attacks), hypertension (high blood pressure), and shortness of breath. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated [DATE], showed the resident was cognitively intact. Review of the resident's care plan, updated [DATE], showed the following: -Full code status; -Staff should communicate code status to all care team members; -Staff should maintain readiness for emergency response. Review of the resident's nursing progress notes, dated [DATE], showed the following: -At 6:30 A.M., the Director of Nursing (DON) entered the room and the resident appeared to be sleeping; -The DON said the resident's name and he/she did not wake; -The DON checked the resident's blood sugar and he/she still did not wake; -The DON continued to say the resident's name and perform a sternum rub (involves making a closed fist and grinding the knuckles vigorously against the center of the person's chest to elicit a pain response) with no response; -The DON checked the resident's pulse, and no pulse was felt; -The DON called 911 and requested help from housekeeping to move the resident to the floor; -Once the resident was moved to the floor, he/she began agonal breathing (abnormal, reflexive pattern of gasping and labored breathing that occurs when the brain is deprived of oxygen); -The DON initiated CPR; -Housekeeping staff obtained additional staff assistance; -Another staff took over CPR; -After 7 rounds of compressions, emergency medical services (EMS) arrived; -An airway was placed following placement of automatic external defibrillator (AED - portable medical device used to check the heart rhythm and give an electric shock if needed to restart a normal heartbeat) pads and another round of chest compressions and a pulse was found; -The resident was moved to a gurney by EMS and staff and left the building at 7:15 A.M. Review of the facility's CPR certificates showed the following: -CPR certification for the DON, dated [DATE], with expiration [DATE]; -CPR certification for transportation staff, dated [DATE], with expiration [DATE]; -No CPR certificate provided or located (continued on next page)		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Certified Nursing Assistant (CNA) E or CNA F who provided CPR to the resident. During an interview on [DATE], at 12:10 P.M., Certified Medication Technician (CMT) B said his/her CPR certificate had lapsed and was not certified at this time. He/She would not feel comfortable providing CPR without attending recertification classes. During an interview on [DATE], at 1:30 P.M., CNA C said he/she was not currently CPR certified. He/She would feel uncomfortable performing CPR, but would perform CPR if there was no one else CPR certified. During an interview on [DATE], at 2:45 P.M., CNA F said the following: -He/She was not CPR certified;-He/She told the DON that he/she was not CPR certified prior to assisting with chest compressions on the resident;-He/She was not comfortable with the CPR process but felt he/she had no choice as he/she had to follow the DON's orders. During an interview on [DATE], at 3:30 P.M., CNA E said the following: -He/She was not CPR certified;-He/She told the DON on [DATE] that he/she was not CPR certified;-He/She was told he/she had to assist with CPR on the resident;-He/she was uncomfortable assisting with chest compressions since he/she had not been trained. During an interview on [DATE], at 2:05 P.M., the DON said the following:-The staff who assisted her with performing CPR were transportation, CNA E, and CNA F;-She initiated CPR and once additional staff arrived, she maintained the resident's airway, compression count, and monitored staff providing CPR;-She was unaware that all staff were required to be CPR certified in order to provide CPR. During an interview on [DATE], at 3:15 P.M., Administrator said that he was not aware that all staff performing CPR had to be certified.		