STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265577	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshfield Care Center for Rehab and Healthcare	800 South White Oak Marshfield, MO 65706

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 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. (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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F 0678 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 observation, interview, and record review, the facility failed to maintain a procedure to document a resident's choices regarding advanced directives (a written instruction, such as a living will, or power of attorney, recognized under state law, relating to the provision of heath care when the individual is incapacitated), when the facility failed to clearly document code status (refers to the level of medical interventions a person wishes to have started if their heart or breathing stops) in one resident's (Resident #1) chart out of 7 sampled residents resulting in staff being unable to locate the resident's code status in an emergency. The facility census was 42.Review of the facility policy tiled Communication of Code Status, revised on [DATE], showed the following information:-The facility will follow policy regarding a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive;-When an order is written pertaining to a resident's presence or absence of an advance directive, the directions will be clearly documented in designated sections of the medical record;-The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record;-The designated sections of the medical record may include face sheet, physician orders, care plan, and advanced directives;-In the absence of an advance directive or further direction from the physician, the default direction will be full code (resident wishes to receive cardiopulmonary resuscitation (CPR) if their heart or breathing stops);-The Social Services Director (SSD) will maintain a list of residents who have an advance directive on file;-The resident's code status will be reviewed at least quarterly and documented in the medical record. 1. Review of the Resident #1's face sheet, showed the following information:-admission date of [DATE];-No code status listed;-Diagnoses included pleural effusion (an abnormal accumulation of fluid in the pleural space, the thin membrane that lines the lungs and chest wall), high blood pressure, diabetes, and pneumonia (an infection of the lungs that causes inflammation of the air sacs).Review of the resident's admission baseline care plan, dated [DATE], showed the resident was a full code and required cardiopulmonary resuscitation (CPR- refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased) if his/her heart or breathing stopped.Review of the resident's POS, dated [DATE] through [DATE], showed the resident did not have an order regarding code status entered. Review of the resident's progress note dated [DATE], at 5:25 A.M., showed Licensed Practical Nurse (LPN) A noted the following:-LPN A was called into the resident's room when staff members reported that the resident was holding his/her hand and said help. After saying help, the resident went limp and unresponsive, without breathes;-LPN A found the resident to be unresponsive and without pulse. LPN A was unable to identify code status, so he/she began CPR;-Emergency Medical Services (EMS) arrived at 5:35 A.M. and LPN A continued to participate in CPR with EMS until they left with the resident at 6:03 A.M.;-Staff notified the resident's next of kin and physician.Review of the resident's care plan, dated [DATE], showed the resident's code status was added with the additional information:-Full code;-Place a copy of code status in the front of his/her chart. Ensure that family and physician has signed the status.During an interview on [DATE], at 12:38 P.M., Nursing Assistant (NA) B said the following:-Resident code statuses should be found in the resident's chart, on their door, and in the code status book that is located at the nurses' station;-He/she went into the resident's room to check on him/her and noticed the resident was unresponsive. At that time NA C went and got LPN A;-Three minutes later, LPN A entered the room and told NA B that he/she did not know what to do that he/she could not find the resident's code status;-NA B suggested they begin CPR. LPN A left the resident's room again to return approximately three minutes later and instructed that NA B, NA C, and him/herself would be starting CPR;-The Social Services Director (SSD) generally updates the resident's code status in all the locations. However, he/she does not believe there is someone hired in that position at this time, so it hasn't been getting done.During an interview on [DATE], at 12:45 P.M., NA C said the residents' code statuses should be found in the resident's chart, on their doors, and in the code status book that is located at the nurse's station. All the information should match.During observation and interview on [DATE], at 1:20 P.M., LPN D said the following:-Code status should be found in the resident's chart, including the care plan, face sheet, and physician orders;-Code status should also be found in the code status book that can be found in the nurses' station, and on the resident's name tag outside of their room. If the name tag is blue, that means full code (CPR). If the name tag is white, that means no code (no CPR);-The nurse admitting the resident is who is responsible for putting the orders into the resident's chart

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure that all residents received treatment and care in accordance with professional standards of practice when the facility staff failed to notify family and physician of fall with possible injury in a timely fashion, when staff failed to complete and document initial assessment and ongoing fall monitoring, including neurological checks (evaluates the nervous system), for one resident (Resident #2), who suffered a fall resulting in a fracture, out of 7 sampled residents. The facility census was 42.Review showed the facility did not provide a policy and procedure related to falls, fall documentation, and/or fall notifications. 1. Review of the Resident #2's face sheet (brief look at resident information) showed the following information:-admission date of 10/25/22;-Diagnoses included Alzheimer's disease, muscle weakness, high blood pressure, and respiratory failure.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 07/24/25, showed the following information:-Intact cognition;-No impairment of extremities;-Required the use of a walker and supervision from staff for toileting and mobility.Review of the resident's care plan, revised 09/11/25, showed the following:-At risk for falling related to unsteady balance;-Encourage the resident to request assistance with transfers, provide assistance with his/her walker, and ensure that he/she has properly fitted shoes;-Fall on 09/09/25. Please make sure the resident's bathroom is clean and the floor is dry. The physician requested scan for possible fracture to hip and the resident was sent to the Emergency Department (ED) per request.Review of the resident's progress note dated 09/10/25, at 3:15 A.M., showed Licensed Practical Nurse (LPN) A documented the following:-Staff alerted LPN A to the resident's room after hearing help from down the hall. The resident was observed to be laying on his/her left side, resting upon his/her left hip;-The resident's walker was seen several feet away from him/her;-The resident said he/she was trying to go to the bathroom and his/her walker got away from him/her and he/she just fell over;-The resident complained of pain and discomfort to the left hip. The resident was assessed after rolling onto his/her back. The resident remained guarded but was able to lift his/her left leg when instructed to pull it in toward him/her;-No abduction (movement from midline) was seen;-Staff placed a gait belt on the resident and assisted him/her to his/her feet. The resident remained guarded to the left leg and was fearful to put pressure onto the left foot;-The resident was able to hold onto his/her walker with staff holding him/her with the gait belt;-Two staff ambulated the resident back into his/her bed and LPN provided an as needed pain mediation;-Staff notified the physician.(Staff did not document notification of the resident's next of kin regarding the fall with possible injury. The nurse did not document a full assessment including base-line neuro-checks after the fall.)Review of the resident's progress note dated 09/10/25, at 6:32 P.M., showed LPN D noted the following:-The resident was transferred to the hospital via Emergency Medical Services (EMS) around 6:15 P.M.;-The resident had a fall around 3:00 A.M. and injured his/her left hip;-Immediate X-ray was ordered and performed on this shift. The results came back as showing a possible acute fracture to the left superior pubic root (the left upper portion of the pubic bone);-Staff notified provider and Assistant Director of Nursing (ADON) of the results;-The resident was transferred to the hospital for further testing and to prevent further injury;-Staff notified the resident's next of kin.Review of the resident's progress notes showed staff did not document monitoring of the resident between the fall and being sent to the ED. Review of the resident's hospital progress note, dated 09/13/25, showed the following information:-The resident admitted to the hospital after a ground level fall resulting in left hip pain and inability to bear weight;-On admission, imaging revealed a diagnosis of closed fracture of multiple left pubic rami (a break in one of the bones that make up the front part of the pelvis) and sacral fracture (a break in the sacrum, a triangular shaped bone at the bottom of the spine that forms the back of the pelvis). During an interview on 10/14/25, at 12:38 P.M., Nursing Assistant (NA) B said the following:-The resident fell in the floor on 09/10/25, at approximately 3:00 A.M.;-He/she was present for the incident, and recalled the resident continuously stating he/she could not walk and was in pain;-When LPN A entered the room. He/she did not obtain any vital signs or neurological checks;-LPN A insisted the resident was fine, and instructed him/her and NA C to get the resident up off the floor;-NA B and NA C did as they were told and during the transfer it took the both of them with a gait belt and a walker to assist the resident back into bed. Previously the resident was independent with mobility;-The resident continuously pointed at his/her pelvic area and yelled out with pain;-The expected process for falls was to get the charge nurse and get a set of vital signs. The charge nurse would assess the resident for injury and call the physician and the resident's family. The charge nurse would also document