STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265664	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, staff failed to ensure an environment free of accident hazards when staff failed to consistently implement fall preventions interventions for one resident (Resident #23) with a recent fall. The facility census was 100.Review of facility policy titled, Falls-Clinical Protocol, dated March 2018, showed the following information:-After first fall the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling;-Staff and physicians will identify pertinent interventions;-If underlying causes cannot be readily identified or corrected staff will try various interventions; -The staff and physicians will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. Review of a facility's policy, Hazardous Areas, Devices, and Equipment, dated June 2017, showed the following:-A hazard is defined as anything in the environment that has the potential to cause injury;-All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible;-Assessment and analysis of hazardous areas and equipment will include resident-specific information including identification of vulnerable residents;-Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous;-Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities, mood, and health treatments (e.g., medications);-Resident vulnerability to hazards may change over time. Ongoing assessment helps identify when elements in the environment pose hazards to a particular resident;-Improper or inappropriate use of equipment and devices will be identified as part of the hazard assessment and analysis;-Resident-specific interventions may include changes to the plan of care and/or increased supervision; 1. Review of Resident #23's face sheet (basic information sheet) showed the following:-admission date of 05/20/26;-Diagnoses included unspecified dementia without behaviors, anxiety, rhabdomyolysis (the rapid breakdown of muscle tissues) and spinal stenosis with claudication (narrowing of the spinal canal creating numbness and tingling and limited range of motion in lower extremities).Review of the resident's Minimum Data Sheet (MDS- a federally mandated assessment tool completed by facility staff), dated 05/29/26, showed the following:-The resident had severe cognitive impairment;-The resident had impairment of both sides of the upper and lower extremities;-The resident was maximum assist and dependent on staff for personal cares, bed mobility, and transfers. Review of the resident's fall event, dated 06/11/26, showed the following:-A fall was noted on 06/11/26 at approximately 8:00 A.M.;-The fall was unwitnessed;-Resident was restless that morning, attempting to stand from wheelchair twice. Nurse attempted redirection;-Resident was requesting to lay down;-Shower aide found resident on floor in common area. Resident fell from wheelchair attempting to stand;-Resident fell onto left arm near fish tank with forehead down on the ground;-Fall resulted in skin tear to forearm, bruising around eye, and hematoma (a closed wound where blood collects and fills a space inside the body because it cannot flow or drain out) to forehead;-Staff notified family and physician. Intervention in place to lay resident down after meals. Review of resident's care plan, dated 06/17/26, showed the following:-The resident had (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired mobility requiring dependence on staff for all activities of daily living (ADLs- activities related to personal cares including bathing, showering, dressing, getting in and out of bed or a chair, walking, toileting, and eating);-High risk for falls;-Keep call light in reach;-Lay resident down after meals.Observation on 06/16/26, at 8:02 A.M., showed the resident wheeled by staff into the sunroom and placed in front of a television. The staff member left the sunroom, leaving no staff present to supervise the resident.Observation on 06/16/26, at 9:14 A.M., showed the following:-The resident sat in his/her wheelchair in the hallway saying, I want out of here, (motioning to the wheelchair);-No staff at nursing station or near the resident;-Visible bruise to left eye and forehead. Observation on 06/17/26, at 8:30 A.M., showed the following;-The resident #23 sitting in wheelchair in sunroom stating, I'm sick of sitting here;-No staff present in sunroom. Observation on 06/17/26, at 10:53 A.M., showed the following: -The resident in bed with eyes closed;-Call light on bookshelf approximately three feet away;-Resident's door partially shut. During an Interview on 06/17/26, at 9:00A.M., Certified Nurse Aide (CNA) M said the following: -The resident liked to try and get up from wheelchair and attempt to walk. He/she liked to get close to the television;-The resident was not able to ambulate on own;-If a resident fell he/she notified the nurse right away. They would implement two hour checks;-If a resident was a high fall risk, they will have a leaf symbol on their door tag;-He/She would implement two-person lifts and make sure call light is within reach;-The resident can use the call light and they should be putting him/her to bed after eating, then getting him/her back up. During an interview on 06/17/26, at 9:04 A.M. and 10:10 A.M., CNA N said the following:-If a resident was a high fall risk, staff should set eyes on them every 15 minutes;-Interventions would be not leaving resident alone, or unattended and make sure they had a call light when in bed;-The resident tries to get out of the wheelchair a lot;-When he/she sees the resident climbing out of his/her chair staff should sit him/her back down;-Fall risk leaf icon are on the resident's door;-Fall interventions for residents are usually told to her/him by the nurse;-He/she was not aware of an interventions to lay the resident down after meals. During an interview on 06/17/26, at 12:01P.M., Registered Nurse (RN) I said the following:-The resident had a previous fall;-He/she attempted to stand up from his/her wheelchair; -The resident should go back to bed after eating;-Fall interventions depend on fall frequency, with observation of the resident's behaviors to identify risk as well as their cognition level;-Fall interventions are found in resident's care plan. During an interview on 06/18/26, at 2:21P.M., the Assistant Director of Nursing (ADON) said:-He/she expected staff to follow the care plan for interventions;-He/she expected staff to provide basic interventions immediately. During an interview on 06/18/26, at 4:06 P.M., the Director of Nursing (DON) said the following: -The resident was considered a high fall risk due to previous fall at facility. He/she attempted to stand from his/her wheelchair often;-Recent fall interventions have been implemented;-Interdisciplinary Team (IDT) met weekly to go over recent falls and decide on interventions; -He/she expect staff to know fall interventions for the residents;-He/she was responsible for evaluating the interventions and ensuring follow-through;-He/she expected staff to make rounds to ensure patient safety including ensuring call lights are in reach;-If a resident had an intervention to lay a resident down after a meal, he/she expected staff to attempt to do that, unless residents' are refusing;-If resident refused, he/she expected staff to document a refusal. During an interview on 06/18/26, at 3:15 P.M., the Administrator said the following: -She expected staff to communicate and follow the care plan for interventions regarding falls;-She expected staff to keep call lights within reach. Complaint #2980691