STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265731	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Square Nursing and Rehab	1502 West Edgewood Springfield, MO 65807

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to protect the resident's right to be free from verbal and emotional abuse when one staff member (Certified Nurse Aide (CNA) B) spoke to one resident (Resident #1) in an aggressive manner, continued care when the resident said it hurt, and degraded the resident by telling the resident they would have to use a bed pan. The facility census was 89.Review of the facility's policy titled, Report Abuse, not dated, showed the following: -The facility will not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the residents, family members, other residents, etc.-Abuse is defined as the willful infliction of injury; unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.Review of the facility's policy titled, Preventing Resident Abuse, not dated, showed preventing resident abuse was a primary concern for the facility. It was the facility's goal to achieve and maintain an abuse-free environment.1. Review of Resident #1's face sheet (resident's information at a quick glance) showed the following: -admission date of 09/04/25;-Diagnoses included thoracic spondylosis without myelopathy or radiculopathy (refers to degenerative wear and tear of the spine in the mid-back (thoracic) region), hyperlipidemia (high levels of fat in blood), and osteoporosis (a common disease characterized by, or causing, low bone mass and structural deterioration, making bones fragile and prone to fracture).Review of the resident's quarterly Minimum Data Set (MDS - federally mandated assessment completed by facility staff), dated 12/11/25, showed the following: -The resident was cognitively intact;-The resident required partial to moderate assistance with toileting, hygiene, lying to sitting, sitting to lying, sit to stand, bed to chair transfer and toilet transfer;-The resident received scheduled pain medication and as needed pain medication.Review of the resident's care plan, reviewed on 12/24/25, showed the following: -The resident was totally dependent on one staff for toilet use;-The resident required moderate assist by one staff to move between surfaces;-Encourage the resident to use call light.Review of the resident's medical record showed staff documented the following: -On 01/11/26, at 12:46 P.M., the resident's family presented to nurses' station and informed charge nurse (Registered Nurse (RN) F) that resident reported to them that a certified nurse aide (CNA) was rough and rude while providing care to the resident during the night. The RN went to room to interview resident upon family's report. The RN notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) of report and interview;-On 01/12/26, at 3:38 A.M., Licensed Practical Nurse (LPN) H was notified by CNA B that the resident had complaints of pain when ambulating to toilet. The resident had persistent and chronic pain. It was reported that the bed pan was offered and refused by resident. The resident did not request any as needed pain medication. Resident usually, will take one pain medication overnight.Review of a written statement, dated 01/11/26, showed the resident told RN F and LPN J the (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: -Between 2:00 A.M. and 2:30 A.M. in the morning, the resident pushed his/her call light to use the bathroom;-When CNA B answered call light, CNA B said he/she was training CNA E who was with him/her;-CNA B was very loud and rude and said if the resident didn't learn to transfer his/herself that he/she would be putting the resident on the bed pan;-The resident said he/she wouldn't use the bed pan;-CNA B was between the resident and resident roommate's bed, squatted down yelling at him/her;-The resident said that CNA B was rough with him/her and just flopped the resident in his/her chair;-The resident told CNA B that he/she was hurting the resident. CNA B did not stop or check to see why the resident was hurting. The resident kept telling CNA B his/her foot was caught and the CNA B continued to move the resident;-When CNA B put the resident back in bed, CNA B was still rough and rude at that time;-The resident stated after that he/she heard other residents yelling you are hurting me;-The resident was asked if he/she was fearful and the resident replied, he/she wouldn't say fearful but cautious;-The resident did not want CNA B back in his/her room.During an interview on 01/13/26, at 8:02 A.M., the resident said the following:-About 2:30 A.M., on 01/11/26, the resident pushed her call light for assistance to use the restroom;-CNA B responded to the room with CNA E;-CNA E stayed at the door to the resident's room;-CNA B was rough with the resident while assisting the resident out of bed and into his/her wheelchair;-CNA B brought the resident back to bed after using the restroom;-While CNA B was transferring the resident back to bed, the resident's left leg got caught in the wheelchair;-The resident told CNA B that he/she was hurting his/her leg and to please be careful;-CNA B continued jerking on the resident and the resident told CNA B, please you're hurting me, my foot is caught in the wheelchair;-After the resident was back in bed, CNA B squatted down between the resident's bed and his/her roommate's bed, got in the resident's face, and said to the resident, if you don't transfer on your own, I will put you on a bed pan;-The resident replied to CNA B, you won't find me on your bed pan;-CNA E who was still standing at the door said to CNA B, I think we better get out of here;-The resident said that he/she was very quiet the rest of the night, scared to death to ring her call light, and scared that CNA B would come back to the resident's room;-The resident said he/she needed to use the bathroom later that night but did not use his/her call light again until the day shift came on;-The resident reported the incident that day to his/her family and CNA C;-The resident said she had a good cry that night. He/she was mad, felt disrespected, and like that CNA B did not care;-He/she had anxiety the following evening in anticipation that CNA B would be back to work that night;-RN F took the resident's statement about the incident;-The resident said while lying in bed after the incident, he/she heard a female resident say, you are hurting me and a male resident say, that hurts;-The resident said that he/she was worried that CNA B had the code to the door and could get back into the facility.During an interview on 01/13/26, at 8:43 A.M., Resident #2 said the following:-The resident was awake when Resident #1 pushed his/her call light;-CNA B came into the room and Resident #2 heard banging while CNA B was transferring Resident #1 to the wheelchair;-CNA B threw Resident #1's pillows in the chair and grabbed the covers on Resident #1's bed and yanked them back;-CNA B was trying to transfer Resident #1 from behind to put him/her back in bed;-Resident #2 turned his/her head for a while to avoid getting upset with how CNA B was treating Resident #1;-Resident #2 did not hear Resident #1 say anything but could tell by the look on Resident #1's face that Resident #1 was in pain;-Resident #2 saw CNA B squat down between the resident's beds but did not hear what CNA B said to Resident #1.Review of a written statement, not dated, showed CNA B noted the following:-On Saturday, 01/10/26, at approximately 10:15 P.M., CNA B assisted the resident to the restroom;-The resident complained of pain while CNA B was tried to help the resident move his/her feet over the edge of the bed to help him/her sit up to transfer from bed to the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chair;-While transferring the resident, he/she said several times within each transfer that it was hurting him/her;-CNA B helped him/her from the chair back into the bed where the resident's right foot got caught under the wheelchair;-CNA B tried to help the resident get his/her foot uncaught by lifting the wheelchair. The resident proceeded to complain of pain which CNA B understood, but also advised the resident that for his/her safety concerns and not wanting to inflict pain onto him/her since he/she was unable to help stand or pivot that it would be best to use another option such as the bed pan to ensure his/her safety;-The resident told CNA B that suggesting the bed pan was unnecessary and that he/she wasn't going to use it;-CNA B reported this situation to the nurse.During an interview on 01/15/26, at 3:02 P.M., CNA B said the following: -Resident #1 pushed his/her call light around 10:15 P.M., on 1/10/26, the resident needed assistance using the restroom;-While CNA B was moving the resident's feet around the bed the resident said that hurt, be slower;-CNA B said that the resident was not helping with the transfer, CNA B was lifting the resident up and putting him/her in the wheelchair;-The resident exerts all her energy during the day and during the night the resident is not able to assist with his/her transfers;-While assisting the resident back to bed the resident was complaining of pain;-CNA B suggested to the resident that because of his/her pain it might be better if the resident used a bed pan;-The resident said he/she would not use a bed pan;-The resident's foot got caught in the wheel of the wheelchair and CNA B got the residents foot unstuck;-CNA B reported to LPN H that the resident was unable to assist with the transfer and CNA B offered the resident a bed pan.During an interview on 01/14/26, at 12:34 P.M., CNA E said the following: -On 1/10/26, CNA E was shadowing CNA B on the overnight shift;-The resident had used the call light to call for assistance;-CNA B went into the resident's room while CNA E stood at the resident's door;-CNA B was rude to the resident and was being aggressive with the resident;-While CNA B was transferring the resident back into bed the resident said you are hurting me;-The resident's leg had gotten caught under the arm of the wheelchair;-CNA B continued to transfer the resident to the bed;-Once the resident was in bed, CNA B got in the resident's face and said if you don't like the way I transfer you then you can use the bed pan;-The resident told CNA B that he/she would not use a bed pan;-CNA B was arguing with the resident about using the bed pan;-CNA E could tell the resident was upset and told CNA B I think we need to go;-CNA E said that CNA B's aggression and rudeness with the resident made him/her uncomfortable;-CNA B left the resident's room and told LPN H that if the resident did not like the way CNA B transferred him/her then he/she could start using the bed pan.During an interview on 01/13/26, at 5:33 A.M., CNA A said the resident told him/her that CNA B was rude to him/her and told the resident he/she would have to use the bed pan if he/she did not get up on her own.During interviews on 01/13/26, at 5:41 A.M. and 12:52 P.M., CNA C said the following: -The resident said that the overnight aide (CNA B) had been rough and hateful with him/her;-CNA B told the resident if you can't get out of bed then you will start using the bed pan;-The resident told CNA B he/she would not use a bed pan and would use the toilet;-On 1/11/26, the resident told CNA C that he/she needed to use the restroom overnight on 01/10/26 and pushed his/her call light;-CNA B came in and told the resident that he/she could use a bed pan;-The resident told CNA B that he/she can get out of bed;-The resident said that CNA B hurt his/her leg while transferring the resident back to bed;-He/she had never seen the resident so upset before this incident;-The resident told CNA C that he/she did not want CNA B back in the resident's room.During an interview on 01/13/26, at 6:11 A.M., CNA D said the resident told him/her that CNA B was trying to make the resident use a bed pan.During an interview on 01/15/26, at 9:54 A.M., LPN J said the following: -On 11/11/26, RN F asked LPN J to be a witness while RN F interviewed the resident;-The resident said he/she pushed his/her call light for assistance using (continued on next page)

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