

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Woodland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 East Valley Watermill Road Springfield, MO 65803	

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)
<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>Based on Interview and record review, the facility failed to ensure all residents with a history of prior trauma received appropriate treatment and services to attain the highest practical psychosocial well-being when staff failed to care plan triggers and failed to provide care in a manner that was responsive to triggers caused by a history of post-traumatic stress disorder (PTSD - a mental health condition that can develop after a person has experienced or witnessed a traumatic event) for one resident (Resident #1). Facility census was 81.</p> <p>Review of the facility policy titled Dignity and Quality of Life, undated, showed the following:</p> <ul style="list-style-type: none"> -The facility will promote care for the residents in a manner and an environment that maintains the resident's dignity, quality of life, and respect in full recognition of his/her individuality. The facility will respect and promote the rights of the resident to exercise his/her autonomy regarding what he resident considers important facets of his/her life. The facility staff will provide services in a manner which enhances/maintains a dignified existence for the residents; -Staff must carry out activities in a manner which assist the residents to maintain and enhance his/her self-esteem and self-worth; -The facility best practice guide for all facility staff members who will care for the residents in the manner in which/ he/she would expect to be treated or would expect loved ones to be treated; -Respecting resident social status, speaking respectfully, listening carefully, and always treating residents with respect; -Staff members should respond in a dignified manner to residents with cognitive impairments, such as not contradicting what a resident is saying and addressing what the resident are trying to express behind their behavior. <p>Review showed the facility did not provide a policy regarding PTSD or trauma based care.</p> <p>1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:</p> <ul style="list-style-type: none"> -admission date of 01/09/25; <p>(continued on next page)</p>

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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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included complete traumatic amputation at level between right hip and knee, complete traumatic amputation at level between left hip and knee, major depressive disorder, generalized anxiety disorder, PTSD, and insomnia.</p> <p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/04/25, showed the following:</p> <ul style="list-style-type: none"> -The resident was cognitively intact; -The resident had trouble falling asleep or staying sleep for 12 to 14 days of the review period (nearly every day); -The resident was dependent on staff for transfers to get from the bed to the wheelchair. <p>Review of the resident's nurse's note dated 01/09/25, at 3:32 P.M., showed the Social Services Designee (SSD) noted the resident admitted to the facility for a therapy stay after an amputation. The resident had PTSD and preferred for his/her door to be left open when he/she was alone in his/her room and would like a light left on at night.</p> <p>Review of the resident's care plan, dated 01/24/25 and revised 03/17/25, showed the following:</p> <ul style="list-style-type: none"> -The resident has experiences traumatic events in the past, that currently affects their mental and psych-social well-being. The resident has a diagnosis of PTSD due to those traumatic events; -Interventions will minimize exposure to trauma triggers and promote de-escalation should triggering occur; -Allow resident to share thoughts and feelings. Offer support through listening one-on-one; -Consult with pastoral care if the resident approves; -Include the resident/family/representative with the plan of care; -Provide a calm environment; -Refer to social services or counseling as needed; -The resident had a recent above the knee amputation; -The resident will be monitored for withdrawn behavior, negative self-talk, or over concern with actual and preserved changed due to amputation: -The resident will be encouraged to express fears, negative feelings, and grief over the loss of the lower extremity; -The resident will referral for psychologist if needed for the resident to voice his/her feelings related to amputation and to learn positive coping behaviors. <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(Staff did not care plan related to resident specific triggers related to prior PTSD and trauma history.)</p> <p>Review of the resident's care plan, dated 03/26/25, showed the following:</p> <ul style="list-style-type: none"> -The resident has an amputation above the right knee due to vascular insufficiency; -The resident will have an acceptable level of comfort and have well-controlled phantom pain through the review date; -Staff will complete pain assessment every shift and as needed and to administer analgesics as ordered from the physician. <p>(Staff did not care plan related to resident specific triggers related to prior PTSD and trauma history.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <ul style="list-style-type: none"> -On 03/30/25, at 5:31 A.M., Registered Nurse (RN) A noted prior to recent surgery resident would be up and down all night long from bed to wheelchair. Now that resident was a double amputee and required a Hoyer lift (mechanical lift for non-weight bearing residents) for transfers, he/she still wanted to be up and down throughout the night. -On 03/31/25, at 6:14 A.M., RN A noted the resident refused to go to bed and stayed up in his/her wheelchair the entire night. The resident expected staff to get him/her up and down multiple times throughout the night. Now the resident was a double amputee and required a Hoyer lift. The resident had been educated that it was not possible to do this. Resident had also been educated on the importance of getting out of his/her wheelchair and into bed in order to help alleviate the risk of developing pressure ulcers to his/her buttocks. Despite this resident was still refusing to go to bed. -On 04/07/25, at 10:40 A.M., RN A noted the resident continued to stay up in his/her wheelchair all night rather than going to bed. The resident was a Hoyer lift for transfers and said that unless staff will get him/her up immediately upon request he/she will just stay up in her wheelchair. Educated resident that there must be two staff present with all Hoyer transfers and that at night there was just usually one certified nurse aide (CNA) per wing and that a CNA from another wing would have to be called to assist, so therefore staff can't guarantee that he/she would not have to wait a short time. Resident said he/she won't go to bed and will just stay up in his/her wheelchair. The resident has been educated multiple times by multiple staff that he/she needs to go to bed to help alleviate pressure to his/her buttocks and that staying up in his/her wheelchair all day and night is putting him/her at risk of pressure wounds. Resident still refused to allow staff to put him/her to bed. <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she said that the staff may not be able to get the resident out of bed multiple times because he/she used to get up and down around six to seven times prior to his/her most recent surgery, however, that is not the facility policy;</p> <p>-The resident can get up as much as they want;</p> <p>-He/she had never refused to get the resident out bed;</p> <p>-He/she was aware that the resident had PTSD and was familiar with PTSD, but did not believe that PTSD and possible triggers had anything to do with the resident's behaviors and desire to get up as soon as possible after waking up.</p> <p>During an interview on 04/24/25, at 1:51 A.M., CNA C said the following:</p> <p>-The resident gets very anxious and will yell out because he/she was panicking if he/she had to wait to long for assistance to get out of bed;</p> <p>-If the staff go in and explain to him/her that they are just getting the lift and will return he/she does do a bit better;</p> <p>-The resident said it makes him/her feel trapped when he/she is stuck in the bed and awake. It was easier for him/her prior to his/her most recent amputation about a month ago because now he/she required assistance, and he/she used to get up on his/her own;</p> <p>-The resident did have a strong reaction to certain triggers and he/she tried to make sure he/she was responsive to that;</p> <p>-The resident slept from 10:00 P.M. to around 12:30 A.M. He/she got him/her up and it was not an issue;</p> <p>-The residents have the right to get up when they want to and they should not be told that they cannot.</p> <p>During an interview on 04/24/25 at 2:03 A.M., RN D said the following:</p> <p>-The residents have the right to get up out of bed as much as they want and when they desire. The staff should assist them as timely as possible;</p> <p>-Staff should not tell resident's that if they lay down they will not be able to get them back up.</p> <p>During an interview on 04/24/25. at 2:15 A.M., CNA E said the following:</p> <p>-He/she is aware that the resident has PTSD and had triggers such as keeping the door open and getting out of bed as soon as possible after waking up;</p> <p>-Residents have the right to get up whenever they would like;</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The staff should not tell a resident that they will not be able to get them up. Due to the resident's PTSD this is triggering for him/her and every resident has the right to get out of bed when they want to;</p> <p>-The resident generally slept about three to four hours and then got up and was up for the rest of the morning;</p> <p>-He/she had worked the overnight shift on the resident's hall and had no issues because the resident was gotten up timely. The resident was willing to wait a short amount of time for staff to come get him/her up.</p> <p>During an interview on 4/24/25, at 12:42 P.M., the SSD said the following:</p> <p>-He/she was told the resident was having behaviors. He/she went to speak with him/her and filed a grievance on his/her behalf. The DON and ADON were responsible for instructing the staff;</p> <p>-The resident specifically said that RN A told him/her that the staff would not be able to get him/her up;</p> <p>-The resident was diagnosed with PTSD and that can make a person act out due to triggers. Staff should be aware of the resident's triggers;</p> <p>-It was not appropriate to tell a resident that staff cannot get them up multiple times in a night. Due to the resident's past trauma that could be very triggering for them. He/she could see how it could cause the resident to have behaviors or not want to go to bed out of fear that the staff might not get them back up;</p> <p>-If a nurse was available then they should assist the CNA's with care so the resident does not have to wait longer;</p> <p>-The resident specifically said RN A was rude and hateful to him/her;</p> <p>-He/she thought trauma informed care would be on the care plan with known triggers.</p> <p>During an interview on 04/24/25, at 2:41 P.M., the ADON said the following:</p> <p>-The resident had PTSD with specific triggers that the staff should be aware of. The resident preferred to have the light left on and the door left open;</p> <p>-He/she was not aware of the nurses note that was written by RN A. It is not appropriate to tell any resident that staff may not be able to get them out of bed multiple times in a night;</p> <p>-If he/she had been aware of the note, he/she would have immediately educated the nurse that it was not appropriate an every resident has the right to get out of bed as much as they want to;</p> <p>-He/she was not aware of the resident requesting to get up multiple times in a night. He/she was not sure why staff would say that to the resident;</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265749	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2025
NAME OF PROVIDER OR SUPPLIER Woodland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 East Valley Watermill Road Springfield, MO 65803	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she felt that a staff member saying that to the resident could be triggering for him/her due to his/her diagnosis of PTSD. It could cause him/her not to want to lay down at night due to being worried that staff might not get her back up. The resident appeared to be very triggered by that;</p> <p>-The resident generally slept around four hours and then he/she gets up and is up for the rest of the morning per his/her choice;</p> <p>-He/she was not aware of any specific education given to RN A.</p> <p>During an interview on 04/24/25, at 2:59 P.M., the DON said the following:</p> <p>-He/she felt it is was unacceptable for staff to say that it might not be possible to get the resident up multiple times in a night to a resident. They can tell them it might take longer to get to them;</p> <p>-He/she was not aware of all of the resident's specific triggers due to their PTSD;</p> <p>-It could be triggering for the resident to feel like they are stuck in bed;</p> <p>-There was no excuse for a nurse not assisting a CNA with a transfer if they are available;</p> <p>-RN A said there was not enough staff when asked why he/she said the staff may not be able to get the resident up multiple times in a night. However, there was plenty of staff. It was no excuse to say that to a resident.</p> <p>During an interview on 04/24/25, at 4:28 P.M., the Administrator said the following:</p> <p>-He/she did not understand why RN A would document that he/she told the resident something about not being able to get the resident up. The staff should get them up and not argue with them;</p> <p>-It was not appropriate to say that to any resident;</p> <p>-He/she was not aware of the note written by RN A on 03/31/25 the investigator came onsite;</p> <p>-He/she did not know the specific details of the resident's past trauma but was aware that he/she has PTSD;</p> <p>-The staff should be aware of the resident's triggers and it should probably be on the resident's care plan;</p> <p>-He/she felt that staff was aware of some of the resident's triggers;</p> <p>-He/she would expect a nurse to assist the CNA if their partner is on lunch;</p> <p>-He/she was not aware of the resident having issues with RN A.</p> <p>MO00252465, MO00252927</p>		