

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 11/29/2025
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)		
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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

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 11/29/2025
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were treated with dignity and respect when one staff (Certified Nurse Aide (CNA) A) spoke disrespectfully and did not honor the resident's sleeping preferences for one resident (Resident #1) in a selected sample of four residents. The facility census was 89. Review of the facility's Dignity and Quality of Life Policy, updated 02/13/25, included the following information:-The facility will promote care for the residents in a manner and in an environment that maintains and enhances each resident's dignity, quality of life and respect in full recognition of his or her individuality. Facility staff will respect and promote the rights of the resident to exercise his or her autonomy regarding what the resident considers important facets of his or her life. The facility staff will provide services in a manner which enhances/maintains a dignified existence for our residents;-Staff must carry out activities in a manner which assist the residents to maintain and enhance his/her self-esteem and self-worth;-Maintaining a resident's dignity includes the respecting resident social status, speaking respectfully, listening carefully, and always treating residents with respect.-Respect residents by speaking respectfully. 1. Review of Resident #1's face sheet (a document that contains a summary of a resident's personal and demographic information) showed the resident admitted to the facility on [DATE]. His/her diagnoses included diabetes, heart failure, severe obesity, anxiety disorder, and depression. Review of the resident's Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff), dated 9/20/25, showed the following:-No cognitive impairment;-Dependent on staff for transfers, bed mobility and toilet use. Review of the resident's care plan, last reviewed 09/22/25, showed the following information:-Honor resident's lifestyle and customary routines;-Allow resident to establish or maintain personal sleeping patterns;-Respect resident's preferences at all times. Review of a statement dated 11/29/25, at 7:25 A.M., showed an anonymous individual said the resident asked to go to the bathroom and CNA A went into the resident's room and said I am not about to help the resident. He/she got my back hurting from last night. CNA A also slammed the door when he/she left the room. During an interview on 11/29/25, at 3:20 P.M., the resident said the following:-Last night (11/28/25), CNA A and CNA B entered his/her room to assist him/her to bed from his/her recliner;-CNA A said that he/she was not going to hurt his/her back on the resident;-This was not the first time the CNA made this type of comment regarding the resident hurting the aide's back;-The CNA eventually helps the resident each time he/she makes these comments, but he/she is very vocal about it;-When the CNA says this, it hurts the resident's feelings.-When he/she reached the bed, he/she sat down quickly, which apparently upset CNA A because he/she stormed out of the room;-CNA A was disrespectful and rude, The resident did not know why he/she acted that way. The resident tried to get along with everyone;-The resident had told other staff about CNA A's demeanor towards him/her, and they told the resident he/she should tell administration, but the resident did not want to get anyone into trouble. During an interview on 11/29/25, at 3:35 P.M., CNA C said the following:-The resident had told him/her that CNA A was disrespectful when the CNA did not allow the resident to wear an incontinent brief to bed; -CNA A told the resident that it was healthier for him/her to sleep without a brief. The resident was upset because he/she wanted to wear an incontinent brief, but he/she did not want to tell anyone because he/she was afraid of retaliation from CNA A;-CNA C said it appeared as though the night shift staff did not provide incontinent care to the resident all night and he/she told the nurse about the lack of care provided by CNA A. During an interview on 11/29/25, at 3:55 P.M., CNA D said the following:-There were some issues with night shift staff, specifically CNA A, not wanting or allowing the resident to sleep with an incontinent brief;-CNA A told the resident that it was better for him/her to sleep without anything covering his/her bottom, but the resident wanted to sleep in a brief;-The resident told CNA D that sleeping without a brief made him/her feel like he/she did not matter, like staff did not care, and it made him/her feel bad. During interviews on 11/29/25, at 3:45 P.M. and 5:25 P.M., the resident said the following:-He/she wanted to wear a brief to bed but CNA A told him/her it was better to not wear anything to bed;-The resident did not want to cause trouble, but he/she hated incontinence and many times the aides at night either did not change him/her often or sometimes they did not come in at all;-The resident sighed and said he/she guessed that CNA A let him/her decide if he/she wore a brief or not but really CNA A would just keep at him/her until the resident relented and because the resident just wanted to get along with everyone, he/she did not argue. -The resident said no other staff really had an issue with cleaning him/her, only CNA A. During an interview</p>		