STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265749	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure all alleged violations of possible abuse were reported immediately, but not later than two hours after the allegation was made, to the State Survey Agency (SSA - Department of Health and Senior Services (DHSS)) when the facility failed to report an allegation of resident-to-resident abuse involving two residents (Resident #1 and Resident #2). Four residents were sampled out of a facility census of 89.Review of the facility policy and procedure titled, Abuse and Neglect, revised 07/21/25, showed the following information:-Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish; -All allegations of abuse must be reported immediately to the Administrator, Director of Nursing (DON), and other officials according to state law;-The Administrator or DON immediately reports his/her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility, the residents representative, the facility medical director, and local law enforcement officials;-Immediately is defined as within two hours of an allegation involving abuse.1. Review of the Resident #1's face sheet (brief look at resident information) showed the following information:-admission date of 04/13/20;-Diagnoses included dementia, post-traumatic stress disorder (PTSD- a mental health condition triggered by experiencing or witnessing a terrifying, shocking, or life-threatening event), and major depressive disorder. Review of the resident's care plan, revised 08/19/25, showed the following;-The resident had experienced a traumatic event effecting psychosocial well-being;-Staff to provide a calm environment and offer support and listening;-Staff to encourage the resident to verbalize feelings, concerns, and fears.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 10/15/25, showed the following information:-Intact cognition;-No behaviors or wandering documented;-Independent with dressing, bathing, and mobility.Review of the resident's progress note dated 12/27/25, at 10:40 P.M., showed the following:-Another resident (Resident #2) entered the resident's room;-The resident met Resident # 2 at the door and asked him/her to leave. Resident # 2 grabbed Resident #1's right forearm. Resident #1 asked Resident #2 to let go and he/she did;-The writer (Licensed Practical Nurse (LPN) A) intervened, removed Resident #2 from the room. Resident #1 was assessed for injury with no injuries seen at the time of assessment;-Staff notified administrator.(Staff did not document notification of DHSS.)Review of the resident's progress note dated 12/28/25, at 1:55 P.M., showed LPN B documented the following:-The resident was assessed for follow-up from an altercation with another resident;-He/she said that his/her right forearm was grabbed and there is one small, round, light purple bruise, approximately 0.8 centimeters (cm) seen to the forearm;-No additional redness or edema (swelling) seen;-Vital signs were stable with no complaints of pain. (Staff did not document notification of the DHSS.)Review of the resident's progress note dated 12/29/25, at 3:48 P.M., showed the Social Services Director (SSD) documented the following:-The resident came to the office wanting to speak with her and the Administrator;-The resident told her and the Administrator about the incident with another resident entering his/her room and throwing him/her around by the arm;-The incident was observed by staff and charted that Resident #2 was in the doorway, not in the resident's room;-The Administrator tried to explain to him/her that he/she needed to push the call light and ask the staff for assistance in these situations. Afterwards, the resident began yelling and requested that something be done about Resident #2;-SSD explained to the resident that he/she could not come into the office and yell at her and the Administrator and expect them to move Resident #2 out;-SSD offered the resident to find an alternative facility; -The resident threatened to notify SSA;-The Administrator assessed the residents arm and did not see any injuries at that time.(Staff did not document notification of DHSS of the abuse allegation.) Review of the resident's care plan, revised 12/29/25, showed staff added aggressive behavior and the resident would not approach any resident in a negative manner.Review of DHSS records showed the facility did not self-report the altercation/abuse allegation involving Resident #1 and Resident #2. During observation and interview on 12/30/25, at 11:26 A.M., the resident said the following: -On 12/27/25, he/she was sitting in his/her recliner in his/her room with the door shut. Suddenly, Resident #2 opened his/her door and attempted to enter his/her room;-Resident #1 began yelling at Resident #2 what do you want and get out of here;-Resident #2 grabbed his/her right forearm. He/she asked him/her to let go, to which he/she did. At that time LPN A was present and re-directed Resident #2 away from his/her room;-Observation showed the resident had slight yellow discoloration, approximately dime size, to his/her right forearm;-He/she did report the incident to the Administrator and SSD. He/she had plans of filing a

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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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standard, physician's order, and resident's preference when the facility failed to order or provide a drop arm commode for one resident (Resident #3), which would increase his/her independence. The facility census was 89. Record review showed the facility did not provide a policy regarding the process of ordering durable medical equipment or the process of handwritten physician orders. 1. Review of Resident #3's face sheet (gives basic profile information) showed the following information: -admission date of 01/09/25 with the last return on 03/25/25;-Diagnoses included complete traumatic (emotional stress) amputation (the surgical removal of a body part) at level between right hip and knee, complete traumatic amputation at level between left hip and knee, absence of left leg above the knee, long-term kidney disease, urinary retention (the inability to completely empty your bladder), severe obesity, major depressive disorder (a serious mood disorder causing sadness, loss of interest, tiredness, sleep and appetite changes, and suicidal thoughts), anxiety (a condition that causes one to worry), and long-term post-traumatic stress disorder (a mental health condition that is developed after experiencing or witnessing an unpleasant event). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/25/25, showed the following information:-Cognitively intact;-Used a motorized and manual wheelchair independently;-Independent with toileting hygiene;-Setup or clean-up assistance for shower/bathing;-Independent with personal hygiene, rolling left and right, going from sit to lying and lying to sitting on side of bed;-Supervision or touch assistance for chair/bed-to-chair transfer, and tub/shower transfers;-At risk of pressure ulcers/injuries.Review of the resident's care plan, last updated 12/26/25, showed the following:-The resident had bladder/urinary incontinence;-He/She will remain free of skin breakdown due to incontinence and brief use;-Had a right above the knee amputation;-Had a left above the knee amputation;-He/She had potential/actual skin impairment to skin integrity related to poor safety awareness, impaired mobility, weakness, and bowel incontinence;-Educate resident/family/caregivers of causative factors and measures to prevent skin injury;-Identify and document potential causative factors for potential/actual skin impairment and eliminate/resolve where possible. Review the resident's Physical Therapy Department record showed no progress notes or records were available. There was a copy of a handwritten physician's order, dated 10/28/25, for may have heavy duty bedside commode with a drop arm to assist with mobility from bed to commode secondary to bilateral (both) amputations. Review of the resident's Physician Order Sheet (POS), dated 10/01/25 through 12/30/25, showed the following:-An order, dated 08/19/25 with a discontinuation date of 12/24/25, for a Hoyer lift (mechanical lift used for non-weight bearing residents) for transfers as needed;-An order, dated 08/19/25, for a sliding board for transfers as needed.(Staff did not have a documented order for the beside commode.) Review of the resident's progress notes, dated 10/13/25 through 12/30/25, showed a nurse's note on 12/27/25, at 3:13 P.M., stating the resident was incontinent of bowel and bladder and wanted to utilize a commode as soon as possible, but he/she needed to be trained by therapy. He/She wore incontinent briefs and needed assistance from staff with changing soiled briefs.Review of the resident's record showed staff did not document follow-up regarding obtaining the bedside commode for the resident. During an interview on 12/30/25, at 12:00 P.M., the resident said the following:-In August of 2025, the Director of Rehab (DOR) asked the facility physician to order a bedside commode for him/her;-In September 2025 or October of 2025, the facility physician gave an order for the facility to order the commode;-The resident asked the social worker about the commode a couple of weeks ago and the social worker informed him/her that he/she she had not had time to order it because he/she had other things to do;-The staff at the facility expect him/her to go to the bathroom in a brief and that made him/her feel embarrassed;-If he/she had a bedside commode it would give him/her more independence and he/she would not have to rely on staff to assist him/her to the bathroom;-He/She used a sliding board to transfer with supervision/minimal help;-The therapy department would need to teach him/her how to use the commode before he/she could use it;-Without a commode, he/she would need to continue using briefs because he/she could not get into the bathroom due to having both legs amputated;-He/She would prefer to use a commode. During an interview on 12/30/25, at 1:20 P.M., Licensed Practical Nurse (LPN) B said the following:-He/She was not aware of the resident requesting a commode;-If a resident wanted a commode the process would be to check with therapy to make sure he/she could use it safely, and

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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. (continued on next page)

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F 0689 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 ensure all residents were kept as free from accident hazards as possible when staff failed to [NAME] steps to prevent future burns and failed to update the care plan regarding a burn for one resident (Resident #3) who suffered burns after spiling hot soup on him/herself. The facility census was 89.Review showed the facility did not provide a policy related to resident use of microwaves. 1. Review of Resident #3's face sheet (gives basic profile information) showed the following information:-admission date of 01/09/25 with the last return on 03/25/25;-Diagnoses included complete traumatic (emotional stress) amputation (the surgical removal of a body part) at level between right hip and knee, complete traumatic amputation at level between left hip and knee, absence of left leg above the knee, long-term kidney disease, major depressive disorder (a serious mood disorder causing sadness, loss of interest, tiredness, sleep and appetite changes, and suicidal thoughts), anxiety (a condition that causes one to worry), long-term post-traumatic stress disorder (a mental health condition that is developed after experiencing or witnessing an unpleasant event), and peripheral vascular disease (a circulatory problem where narrowed blood vessels outside the heart and brain reduce blood flow to the limbs). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/25/25, showed the following information:-Cognitively intact;-Uses a motorized and manual wheelchair independently;-Supervision or touch assistance for chair/bed-to-chair transfer, tub/shower transfers;-At risk of pressure ulcers/injuries. Review of the resident's care plan, last updated 12/26/25, showed the following:-Regular textured diet with thin liquids;-Staff will monitor diet at each meal;-Has a right above the knee amputation;-Has a left above the knee amputation;-He/She had potential/actual skin impairment to skin integrity related to poor safety awareness, impaired mobility, weakness, and bowel incontinence;-Educate resident/family/caregivers of causative factors and measures to prevent skin injury;-Follow facility protocol for treatment of injury;-Identify and document potential causative factors for potential/actual skin impairment and eliminate/resolve where possible;-Monitor/document location, size, and treatment of skin injury and report abnormalities;(Staff did not care plan related to hot liquids or a hot liquid injury or being.) Review of the resident's progress notes showed the following:-A dietary note dated 12/15/25, at 11:21 A.M., stating the resident was independent at meals, ate breakfast in main dining room, and lunch and dinner in his/her room. Resident was on a regular no-added salt diet;-A nurse's note dated 12/18/25, at 5:33 P.M., showed the resident was in wheelchair with a bowl of hot tomato soup. While transporting the tomato soup to his/her room, he/she ran into the door and the tomato soup landed on the resident. Resident to room, undressed, and cool cloths applied to area;-A nurse's note dated 12/18/25, at 5:45 P.M., stated the resident informed the nurse he/she would notify his/her family;-A nurse's note dated 12/18/25, at 6:00 P.M., stating the nurse spoke with on-call physician staff, explained the situation of tomato soup being spilled on the resident, cool cloths applied immediately, and changed out three times. Reddened area was disappearing, and the resident did not have any complaints of pain. Physician instructed to leave open to air, with no treatment. Review of the resident's weekly skin assessment, dated 12/18/25, showed resident poured hot soup on himself/herself, placed cold compress over his/her front multiple times, and cleared up small red area under left breast. Review of the resident's progress note dated 12/20/25, at 7:15 P. M., showed staff notified nurse practitioner on-call for physician of the area on the resident's abdomen where the hot tomato soup was spilled Thursday night was red initially, but now there were multiple areas that had fluid filled blisters, and some blisters had popped. Treatment order received for the burned areas that were obtained from the hot soup spilling on the resident on Thursday. Staff to cleanse areas to abdomen with wound cleanser daily, pat dry, apply Vaseline gauze to the areas of concern, and then cover with Telfa (a sterile wound dressing) or ABD (thick absorbent gauze pad for heavy-draining wounds) dressings daily until healed. Review of the resident's Physician Order Sheet (POS), dated 10/01/25 through 12/30/25 showed the following:-An order, dated 12/20/25 with a discontinuation date of 12/24/25, to cleanse multiple popped blistered areas to abdomen daily with wound cleanser, pat dry, apply Vaseline gauze to the areas, and cover with Telfa dressing daily until healed. Monitor for signs and symptoms of infection and notify provider for any abnormalities, once a day;-An order, dated 12/24/25, to cleanse right lower abdomen blistered area and apply skin prep once a day until healed. Review of the resident's Wound Summary Report showed the following:-A burn to the left chest, identified on 12/24/25, with an Initial measurement of 1 centimeter (cm) in