STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265799	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighborhoods at Quail Creek, The	1514 West Lark Springfield, MO 65810

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide residents with a complete and fully functional call light system when the facility failed to have a process in place to notify staff of call light notifications when call light pagers where not functioning, when the nursing station notification terminal was not receiving notifications, and when the system would reset a call light without it being answered by staff for four residents (Resident #16, #107, #115, and #62). The census was 96.Review of the facility policy titled, Call Lights: Accessibility and Timely Response, undated, showed the following:-This policy is to assure the facility is adequately equipped with a call light at each resident's bed;-Call lights will relay directly to staff or a centralized location to ensure appropriate response;-Staff will be educated on the proper use of the call system including how the system works;-Staff will ensure the call light is within reach of the resident;-Staff will report problems with the call system immediately to the supervisor or maintenance director and provide immediate or alternative solutions until the problem can be remedied;-Ensure the call light alerts staff directly or goes to a centralized location;-All staff who see or hear an activated call light are responsible for responding. 1. Review of Resident #16's face sheet (brief information sheet about resident) showed the following: -admission date of [DATE];-Diagnoses included chronic kidney disease (a progressive disease where damaged kidneys lose their ability to filter waste and fluid from the blood), protein calorie malnutrition (lack of protein intake or absorption by the body), and major depression disorder (a serious mood disorder characterized by persistent sadness, loss of interest, and low energy). Review of the resident's admission Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated [DATE], showed the resident is cognitively intact with no memory issues. Review of resident care plan (facility document used to guide daily care of residents based on needs and preferences), dated [DATE], showed the resident needed assistance with all activities of daily living (ADL) including dressing, transferring, bathing due to lower body weakness. Observation and interview on [DATE], at 10:00 A.M., showed the following: -Resident sat in wheelchair in the center of the room with his/her head down and call light laying on the bed;-Resident said he/she felt angry and frustrated because he/she liked to get up around 6:00 A.M., -He/she pressed the call light at 6:00 A.M. and no staff responded until after 9:30 A.M.,-He/she was still waiting for staff to take him/her to breakfast. Review of the facility call light report showed the following:-On [DATE] the resident pressed the call light at 2:53 P.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 6:31 A.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 9:31 P.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 6:27 A.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 10:16 A.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 11:48 A.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 1:22 P.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 1:58 P.M., the call light alerted staff seven times and was not answered;-On [DATE] 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident pressed the call light at 3:09 P.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 4:18 P.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 6:17 P.M., the call light alerted staff seven times and was not answered;-On [DATE] the resident pressed the call light at 2:36 P.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 4:30 P.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 10:14 A.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 6:27 A.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 7:16 A.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 7:07 A.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 9:03 A.M., the call light alerted staff seven times and was not answered;-On [DATE], the resident pressed the call light at 6:07 A.M., the call light alerted staff seven times and was not answered. During an interview on [DATE], at 12:16 P.M., Licensed Practical Nurse (LPN) F said the following:-He/she was not aware of the resident's call light not working;-The resident would report if his/her call light was not working. During an interview on [DATE], at 10:55 A.M., the Social Worker said the following:-He/she spoke with the resident after viewing their call light log and the resident was given a bell at that time;-He/she believed the resident's call light was not functioning properly;-The resident did not inform staff that his/her call light was not working;-Nursing staff said the resident would come get them if they were needed;-He/she did not know the resident's call light was not working;-The call light will alert seven time and then reset. It would have to be pushed again for it to alert staff again. 2. Review of Resident #107's face sheet showed the following information:-admission date of [DATE];-Diagnoses included bilateral below the knee amputations and chronic peripheral venous insufficiency (narrowing of blood vessels in the arms and legs affecting blood circulation). Review of the resident's admission MDS, dated [DATE], showed the following information:-Cognitively intact;-Dependent on staff for transfers from bed to chair;-Required maximal assistance for toileting and showering needs. Review of the resident's care plan, revised [DATE], showed the following information:-Ensure call light is available;-Provide resident with supportive care and services. Review of the resident's call light log, dated [DATE] through [DATE], showed the following information:-On [DATE], at 7:55 A.M., the call announced seven times from 7:55 A.M. until 8:30 A.M. Staff never responded to the alert;-On [DATE], at 8:55 A.M., the call announced seven times from 8:55 A.M. until 9:40 A.M. Staff never responded to the alert;-On [DATE], at 7:04 A.M., the call announced seven times from 7:04 A.M. until 7:49 A.M. Staff never responded to the alert;-On [DATE], at 5:13 A.M., the call announced seven times from 5:13 A.M. until 5:58 A.M. Staff never responded to the alert;-On [DATE], at 12:21 A.M., the call announced seven times from 12:21 A.M. until 1:06 A.M. Staff never responded to the alert;-On [DATE], at 8:04 A.M., the call announced seven times from 8:04 A.M. until 8:49 A.M. Staff never responded to the alert; -On [DATE], at 8:52 A.M., the call announced seven times from 8:52 A.M. until 9:37 A.M. Staff never responded to the alert; -On [DATE], at 4:08 P.M., the call announced seven times from 4:08 P.M. until 4:53 P.M. Staff never responded to the alert; -On [DATE], at 5:52 P.M., the call announced seven times from 5:52 P.M. until 6:37 P.M. Staff never responded to the alert. During an interview on [DATE], at 2:30 P.M., the resident said the following information:-Call lights rarely get answered;-He/she said it normally takes over an hour to get his/her call light answered;-He/she has waited as long as four hours causing him/her to urinate and defecate on him/herself;-He/she cannot get out of bed or chair without assistance from staff;-Staff told the resident that sometimes their pagers don't work properly. 3. Review of Resident #115's face sheet showed the following information:-admission date of [DATE];-Diagnoses included bone cancer, kidney disease and colostomy (a surgical procedure that creates a new path for waste to leave the body). Review of the resident's admission MDS, dated [DATE], showed the following information:-Cognitively (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed staff failed to respond to the resident's call light on the following dates and times:-On [DATE], at 3:46 P.M.;-On [DATE], at 5:40 P.M. Review of grievance forms, dated [DATE], showed the following:-The resident filed a grievance on [DATE], regarding call lights not answered timely;-Social services notified, call light report ran and was discussed with the resident, and staff were reeducated on response times. During an interview on [DATE], at 2:11 P.M., the resident said call lights take an hour on average to be answered, and he/she has waited as long as two to three hours causing the resident to have accidents of both bladder and bowel. 5. During an interview on [DATE], at 8:30 P.M., Certified Nurse Assistant (CNA) J said the following:-Staff use a pager system. Sometimes it worked and sometimes it did not; -The resident had to tell the staff if their call light was not working. During an interview on [DATE], at 8:40 P.M., CNA I said the following:-The only way to turn off a call light was to hit the button in the room;-The resident had to tell the staff if a light was not working;-He/she will check on that resident more often if their light was not working. During an interview on [DATE], at 8:55 P.M., CNA H said the following:-Sometimes the pagers for the call lights do not work;-They only know if a call light was not working if the resident told them;-They will report non-working call light to the charge nurse or maintenance. During an interview on [DATE], at 9:00 A.M., CNA E said;-All call lights should be answered in five minutes;-He/she was not aware of any call lights not working;-Residents would report to staff if their light was not working; -Faulty lights were reported to the charge nurse or maintenance department. During an interview on [DATE], at 1:45 P.M., CNA M said the following:-There are issues with the call lights sometimes;-On [DATE] his/her pager didn't work;-He/she had to ask the Director of Nursing (DON) for another pager because nothing was working on the one he/she had;-The only way to know if the pager wasn't working was to investigate when a resident said no one was answering their call light. If it doesn't show up on the pager, staff know that it isn't working properly;-Staff then notify maintenance, and he/she will reset the system;-After maintenance resets it, it will go back to working;-He/she was not sure why it goes down. During an interview on [DATE], at 9:00 P.M., LPN G said the following:-He/she was not aware of any call lights not working;-Staff could check if a call light was on, on the computer, when it was working;-He/she did not carry a pager;-He/she had heard complaints from residents about having to wait a long time for their call light to be answered. During an interview on [DATE], at 12:16 P.M., LPN F said;-The call lights have been malfunctioning more often since the storms earlier that month;-Residents would have to report to staff if a call light was not working;-Staff would leave a resident's door open and provide more frequent checks if the system was not working. During an interview on [DATE], at 1:50 P.M., LPN N said the following information:-Sometimes the CNA's say their pager isn't working and the nurse will notify maintenance;-Maintenance will reset the system;-He/she did not typically carry a pager;-He/she just relied on the CNA staff to let him/her know if the pages were not working. During an interview on [DATE], at 9:10 A.M., Registered Nurse (RN) B said the following: -He/she had not heard complaints from residents concerning call lights, but he/she did not work the floor often;-Staff report to the charge nurse if a call light was not working;-Staff can reset the light by unplugging it and plugging it back in. During an interview on [DATE], at 6:35 A.M., RN P said the following:-He/she would expect the call light to always be within reach of the resident;-He/she would expect staff to answer call lights timely, within five to 10 minutes depending on what is going on in the facility at the time. During an interview and observation on [DATE], at 1:55 P.M., RN O said the following:-Residents should always have their call light within reach;-Nurses have an icon on their computers at the nurses' station, to be able to see if call lights are going off;-He/she pulled up the app on his/her computer at the nurses' station, and in a large red box with black letters it said test system not found;- It is iffy if it works. Sometimes the app works and sometimes it doesn't work;-The nurses' pagers will cycle through four times, alerting five minutes apart, then it will alert the DON or Assistant Director of Nursing (ADON) and they will call and let staff know to answer the call light;-He/she never knows if its working of it it's not working;-Administration wants nurses to carry a pager, but they usually don't have any extra pagers. During an interview on (continued on next page)

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