STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265814	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Villa	1100 East Montclair 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, the facility failed ensure resident representatives were notified of changes in condition in a timely fashion when staff failed to document contact of one resident's (Resident #1) responsible party regarding changes in the resident's health condition. The facility census was 122.Review of the facility provided policy titled, Change in Condition of a Resident, dated 05/15/28, showed the following: -The facility is committed to timely recognition and response to significant changes in a resident's condition. This includes medical evaluation, appropriate interventions, family/representative and physician notifications, interdisciplinary collaboration, and updating the care plan and assessments as necessary to ensure the resident receives person-centered, high-quality care.-The resident's representative must be notified promptly, within 24 hours of the change in condition;-Documentation of notification must be in the medical record;-All assessments, physician communications, family notification, interdisciplinary meetings, and care plan updates must be documented in the medical record.1. Review of Resident #1's face sheet (a brief information sheet about the resident) showed the following:-admission date of 08/06/24;-Diagnoses included heart failure (severe failure of the heart to function properly, especially as a cause of death), Alzheimer's disease (a progressive brain disorder that causes memory loss, cognitive decline, and changes in behavior and personality), and chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood);-Three emergency contacts were listed for the resident, including his/her Durable Power of Attorney (DPOA).Review of the resident's nursing progress notes showed the following:-On 05/12/25, at 4:33 A.M., staff documented a new order received from physician for vitamin D3 2000 international units (IU) oral capsule liquid filled, administer two capsules daily; complete blood cell count lab (CBC - blood test measures various components of the blood), comprehensive metabolic panel (CMP - blood test measuring 14 substances), magnesium lab (MG - blood test measures the amount of the essential mineral magnesium in the blood to diagnose deficiencies or imbalances that can affect muscle, nerve, heart, and bone function), brain natriuretic peptide lab (BNP - blood test that measures levels of BNP hormone, which the heart releases when it's under pressure or strained, especially in heart failure) every month, and discontinue Spironolactone (used to treat high blood pressure). Staff notified the lab and the pharmacy of the changes/orders. (Staff did not document notification or attempted notification of the resident's representatives or DPOA.);-On 07/04/25, at 2:30 A.M., staff noted a new order received from physician for CMP, BNP, Vitamin D, Vitamin B12, and CBC with differential labs to be drawn on 07/07/25 with daily blood pressure checks, weekly weight, and ferrous sulfate (salt of iron used as dietary supplement) 65 milligrams (mg) every other day. Staff notified the lab and pharmacy of the changes/orders. (Staff did not document notification or attempted notification of the resident's representatives or DPOA.)-On 07/08/25, at 6:14 P.M., staff noted critical lab communication. The lab called and notified staff of a critical BNP of 529 (normal less than 100 picograms per milliliter (pg/ml)). The nurse notified the nurse practitioner (NP). The NP said he/she was not worried as he/she had seen the resident in the past week and to monitor the resident for signs and symptoms of fluid overload. The NP would see the resident this week on his/her rounds. The nurse assessed the resident, 2+ pitting edema (type of swelling where a 3 to 4 millimeter (mm) deep indentation appears after pressing on the affected area) was present. Resident usually had some edema. Resident showed no signs or symptoms of shortness of breath or fatigue, and he/she had just walked down from dinner. Resident's vital signs were stable and within normal limits. The resident's lungs were clear to auscultation. Will report and continue to monitor. (Staff did not document notification or attempted notification of the resident's representatives or DPOA.)Review of the resident's care plan, last reviewed on 07/09/25, showed the following:-Resident had dementia, if noted to have increased confusion or difficulty regarding cares, refer to advance directive paperwork;-Resident had an active DPOA;-Resident may need assistance with end-of-life issues, related to hospice;-Staff should allow the resident's family and resident to vent, as needed with staff and to be available to listen to family and resident's feelings;-Resident was at risk for inadequate nutrition, with nutritional status, related to fluctuating intake and disease process. Staff should communicate with the resident's family regarding any food and weight issues;-The resident was at risk for falls, walking independently, medication regimen, occasional weakness and disease processes. Staff should notify my family and doctor, and complete documentation as per facility protocol.Review of the resident's nursing progress note dated 07/12/25, at 3:28 P.M., showed the resident was having shortness of breath with accessory muscle breathing (using muscles other than those typically used for breathing to take in and

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents' right to free from misappropriation was protected when medication of three residents (Resident #1, Resident #2, and Resident #3) went missing and were unaccounted for while in the possession of the facility. The facility had a census of 110. Review of the facility provided document titled, The National Consumer Voice Fact Sheet: Abuse, Neglect, Exploitation, and Misappropriation of Property, showed federal law gave each nursing home resident the right to quality care and quality of life. This included freedom from neglect, abuse, exploitation, and misappropriation of property. Review of the facility's Abuse Prohibition Protocol Manual: Identification, undated, showed the following: -It is the policy of the facility to identify, correct, and intervene in situations in which physical and mental abuse, neglect, adverse events, exploitation, mistreatment, involuntary seclusion, and/or misappropriation of resident's property may occur; -Monitoring for indicators of abuse, mistreatment, exploitation, neglect, misappropriation will be conducted by all staff and reported immediately to the Administrator and/or Director of Nursing (DON). Staff will intervene appropriately. 1. Review of the facility's completed investigation, dated 06/05/25, showed the following: -On 05/28/25, at 12:00 A.M., a nurse reported the DON that he/she suspected a certified medication tech (CMT) had popped bills out of a card, tore the top off, and put the pills in a pocket; -On 05/29/25, at 9:30 A.M., a nurse reported finding three labels for three medication cards containing gabapentin (medication used to treat nerve pain and seizures) in the shred bin. The cards belonged to Resident #1, Resident #2, and Resident #3; -The audit showed approximately 60 gabapentin were missing. 2. Review of Resident #1's face sheet showed the following: -admission date of 08/15/24; -Diagnoses included pain. Review of the resident's pain care plan, dated 08/15/24, showed the following: -Resident was at risk for altered comfort related to weakness, impaired mobility, and disease processes; -Staff to observe resident for effective pain management; (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff to assess the resident routinely for the presence of pain and document the onset, location, quality, and intensity of the pain; -Staff to consider the type and source of pain when selecting relief strategies; -Staff to administer pain medications as ordered. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 05/12/25, showed the following: -Resident had moderately impaired cognitive skills; -Staff administered scheduled pain medication. Review of the resident's most recent Physician Order Sheet (POS) showed the following: -An order, dated 08/22/24, for staff to assess the resident's pain weekly using a pain scale of 0 to 10; -An order, dated 09/26/24, for gabapentin 300 milligram (mg) oral capsule twice a day. Review of the pharmacy proof of delivery packing slip, dated 05/16/25, showed the pharmacy delivered two cards of the resident's 30 gabapentin 300 mg (60 total tablets). Review of the resident's May 2025 medication administration history showed the following: -An order, dated 9/26/24, for staff to administer gabapentin 300 mg orally twice a day (once between 6:00 A. M. and 10:00 A.M. and and once between 6:00 P.M. and 10:00 P.M.) for diagnoses of neuralgia (nerve pain) and neuritis (nerve inflammation); -Beginning 05/19/25, staff documented the medication was not given because the resident was in the hospital. During an interview on 06/03/25, at 12:05 P.M., the DON said the following: -Staff found a gabapentin label for the resident in the shred bin; -The resident was in the hospital at the time of the discovery; -On 05/16/25, the pharmacy filled a card of 30 gabapentin pills and the resident should have had 25 pills left when he/she went to the hospital on [DATE]. Staff could not locate any gabapentin for the resident. 3. Review of Resident #2's face sheet showed the following: -admission date of 03/18/25; -Diagnoses included pain. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's admission MDS, dated [DATE], showed the following: -Resident had moderately impaired cognitive skills; -Staff administered scheduled and as needed pain medication to the resident; -Indicators of pain in the last five days included, non-verbal sounds, facial expressions, and protective body movements. Review of the resident's current physician orders showed: -An order, dated 03/18/25, for gabapentin 800 mg, three times a day; -An order, dated 03/25/25, for pain assessment every week (scale 0 to 10). Review of the resident's pain care plan, dated 03/31/25, showed the following: -Resident was at risk for altered comfort related to weakness, impaired mobility, and disease processes; -Staff to observe resident for effective pain management; -Staff to assess the resident routinely for the presence of pain and document the onset, location, quality, and intensity of the pain; -Staff to consider the type and source of pain when selecting relief strategies; -Staff to administer pain medications as ordered. Review of the pharmacy proof of delivery packing slip, dated 05/06/25, showed the pharmacy delivered three cards of the resident's 30 gabapentin 800 mg (90 total tablets). Review of the resident's May 2025 medication administration history showed: -An order, dated 03/18/25, for staff to administer gabapentin 800 mg orally three times a day (once between 6:00 A.M. and 10:00 A.M., once between 12:00 P.M. and 4:00 P.M., and once between 6:00 P.M. and 10:00 P.M.) for diagnosis of generalized muscle weakness. -Staff initialed administration of doses of the medication from 05/01/25 to 05/31/25, with the following exceptions: During an interview on 06/03/25, at 12:05 P.M., the DON said the following: -Staff found a gabapentin label for the resident in the shred bin; -The resident currently resided at the facility; (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/06/25, the pharmacy filled three cards of 30 gabapentin pills and the resident should have had 55 pills remaining, but staff could only locate 30 pills of gabapentin for the resident. 4. Review of Resident #3's face sheet showed: -admission date of 03/03/22; -Diagnoses included spinal muscular atrophy (causes progressive muscle weakness and wasting), contractures (shortening, hardening or muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of both hands, and muscle weakness. Review of the resident's pain care plan, dated 03/31/22, showed the following: -Resident was at risk for altered comfort related to weakness, impaired mobility, and disease processes; -Staff to observe resident for effective pain management through next review; -Staff to assess the resident routinely for the presence of pain, document the onset, location, quality, and intensity of the pain; -Staff to consider the type and source of pain when selecting relief strategies; -Staff to administer pain medications as ordered. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Resident had moderate cognitive impairment; -Staff administered scheduled and as needed pain medications for occasional pain. Review of the resident's current physician orders showed the following: -An order, dated 10/18/23, for gabapentin 600 mg, three times a day; -An order, dated 10/25/23, for pain assessment every week (scale 0 to 10). Review of the pharmacy proof of delivery packing slip, dated 05/19/25 showed the pharmacy delivered three cards of the resident's 30 Gabapentin 600 mg (90 tablets total). Review of the resident's May 2025 medication administration history showed the following: -An order, dated 10/18/23, for staff to administer gabapentin 600 mg orally three times a day (once between 6:00 A.M. and 10:00 A.M., once between 12:00 P.M. and 4:00 P.M., and once between 6:00 P.M. and 10:00 P.M.) for diagnosis of chronic pain syndrome. During an interview on 06/03/25, at 12:05 P.M., the DON said the following: (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff found a gabapentin label for the resident in the shred bin; -The resident currently resided at the facility; -On 05/18/25, the pharmacy filled three cards of 30 gabapentin pills (90 pills) and the resident should have had approximately 60 pills left. but staff could only locate 30 pills of gabapentin for the resident. 5. During an interview on 06/05/25, at 9:35 A.M., Licensed Practical Nurse (LPN) D said the following: -On the night of 05/28/25, while working with CMT C, the LPN heard multiple popping noises, at least 8 times. The LPN turned around saw the CMT tear off the top portion of a pill card and toss it into the shred box. The LPN saw the CMT placed his/her hand into the front pocket of his/her backpack and appeared to drop something into the pocket; -The LPN called the DON and the DON told the nurse to confront CMT C. The LPN left the nurse's station to get the other nurse and when the two nurses returned to the area, the CMT had left the building. This occurred at the end of the CMT's shift. -The LPN checked the shred bin and found resident medication card prescription labels for gabapentin. During an interview on 05/30/25, at 11:00 A.M., Licensed Practical Nurse (LPN) A said the following: -Only nurses and CMTs had access to the resident medications; -Medications are kept locked in the medication cart or locked in the medication room. During an interview on 05/30/25, at 11:53 A.M., CMT B said the following: -In the past, when a nurse or CMT used the last of a resident medication, he/she was supposed to tear the label off the medication and place the label in the shred box before disposing of the empty card to protect the resident's health information; -If he/she suspected a staff member of taking resident medications, he/she would immediately notify his/her charge nurse; -Staff administered resident medications as ordered; -On 05/29/25, he/she arrived for work and LPN D said he/she saw CMT C pop resident medication out of a bubble pack card and place the medication in the CMT's backpack; -The LPN said he/she notified the DON of the situation; -LPN D went to get another nurse before confronting the CMT and by the time he/she returned to the unit, the CMT had left the facility; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurses opened the locked shred box to look for medication labels; -Nurses found a label for Resident #1's gabapentin, but the resident was in the hospital and should not have been out of gabapentin; -Nurses found a label for Resident #2's gabapentin, but this resident should not have been out of his/her supply of the medication. During interviews on 05/30/25, at 12:56 P.M. and at 2:55 P.M., and on 06/03/25, at 3:56 PM., the DON said the following: -On Wednesday night (05/28/25), the LPN D called the DON and reported he/she thought CMT C had taken some pills from the medication room and placed these pills into his/her backpack; -LPN D also reported he/she saw CMT C throw some medication labels from bubble packs into the shred bin; -The DON instructed the LPN to ask the CMT about the medication and ask to check his/her back pack; -The LPN went to get another nurse as a witness and while gone to do so, CMT C left the facility; -The next morning nurses discovered three residents with missing cards of gabapentin. They were Resident #1, Resident #2, and Resident #3; -The facility CMTs generally order the resident medications; -If staff discover or someone makes an allegation of misappropriation of resident medication, staff should immediately go to the charge nurse or to the DON; -The nurse should immediately report all allegations or misappropriation to the DON; -As the DON, he/she would notify the Administrator of the allegation; -For allegations of misappropriation, staff notifies the Department of Health and Senior Services (DHSS), the facility notifies the resident and/or responsible party, the resident physician, assess the resident for pain or signs/symptoms of oversedation, and submit a completed investigation to DHSS within 5 days. During an interview on 06/03/25, at approximately 4:05 P.M., the Administrator said the following: -No staff were allowed to take any resident medications; -The LPN who observed the issue immediately called the DON and the DON notified DHSS within 24 hours. MO00254977

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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	Based on record review and interviews, the failed to provide care per standard of practice when staff failed to document continued monitoring and assessment on one resident (Resident #1) with an ongoing change of condition resulting in new medication orders and a follow-up x-ray. The facility census was 122.Review of the facility policy titled, Change in Condition of a Resident, dated 05/15/28,showed the following:-The facility is committed to timely recognition and response to significant changes in a resident's condition. This includes medical evaluation, appropriate interventions, family/representative and physician notifications, interdisciplinary collaboration, and updating the care plan and assessments as necessary to ensure the resident receives person-centered, high-quality care;-Nursing staff must immediately report and document any suspected significant changes in the resident's status;-A licensed nurse must promptly assess the resident, document findings in the medical record, and notify the physician or nurse practitioner immediately, or within 24 hours;-All assessments, physician communications, family notification, interdisciplinary meetings, and care plan updates must be documented in the medical record.Review showed the facility did not provide a policy related to nursing staff documentation.1. Review of Resident #1's face sheet (a brief information sheet about the resident), showed the following:-admission date of 08/06/24;-Diagnosis included heart failure (severe failure of the heart to function properly, especially as a cause of death), Alzheimer's disease (a progressive brain disorder that causes memory loss, cognitive decline, and changes in behavior and personality), and chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood).Review of the resident's care plan, date 07/09/25, showed the following:-Resident had dementia, if noted to have increased confusion or difficulty regarding cares, refer to advance directive paperwork;-Resident may need assistance with end-of-life issues, related to hospice;-Staff should allow the resident's family and resident to vent, as needed with staff and to be available to listen to family and resident's feelings;-Resident was at risk for inadequate nutrition, with nutritional status, related to fluctuating intake and disease process;-The resident was at risk for falls, walking independently, medication regimen, occasional weakness and disease processes. Staff should notify my family and doctor, and complete documentation as per facility protocol.Review of the resident's nursing progress note dated 07/12/25, at 3:28 P.M., showed the resident was having shortness of breath with accessory muscle breathing (using muscles other than those typically used for breathing to take in and expel air) noted. Oxygen level (O2) would go to 88% and then go back down to 81% (normal greater than 90%). Staff notified the on-call physician. The physician ordered a chest x-ray, DuoNeb treatment (brand named for inhaled solution with two active ingredients work together to relax and open the airways and increase airflow to the lungs), and to titrate oxygen to keep pulse oximetry (non-invasive medical procedure that measures the percentage of oxygen in the blood (oxygen saturation)) at greater than 90. Resident being checked on about every 15 to 30 minutes. Staff will continue to monitor.Review of the resident's July 2025 Physician Orders Sheet (POS) showed an order, dated 07/12/25 (with discontinued date of 07/17/25), for ipratropium-albuterol solution (used to treat breathing difficulty) for nebulization, 0.5 milligram (mg) - 3 mg administer twice per day for shortness of breath.Review of the resident's chest x-ray report dated 07/13/25, at 11:52 A.M., showed findings consistent with congestive heart failure (CHF - chronic condition where the heart muscle is weakened and cannot pump blood effectively, leads to a buildup of fluid in the lungs, legs, and other parts of the bod) and pulmonary edema (condition where excess fluid accumulates in the lungs) without focal consolidation (localized area in the lung where the normally air-filled sacs are filled with fluid, pus, blood, or other cells instead of air). Follow up exam can be obtained to evaluate for interval improvement.Review of the resident's July 2025 POS showed the following:-An order, dated 07/13/25 (with discontinued date of 07/13/25), for Lasix (powerful diuretic (water pill) used to treat fluid retention (edema) and high blood pressure) tablet, 40 mg administered one time for diagnosis of heart failure;-An order, dated 07/13/25 (with discontinued date of 07/14/25), for Lasix tablet 20 mg, administer once a day for diagnosis of shortness of breath;-An order, dated 07/13/25 (with discontinued date of 07/13/25), for potassium chloride capsule (used to treat or prevent low blood potassium levels), 20 milliequivalent (mEq), administer one time for diagnosis shortness of breath;-An order, dated 07/13/25 (with discontinued date of 07/21/25), for potassium chloride capsule, extended release, 10 mEq, administer once per day for diagnosis shortness of breath;-An order, dated 07/14/25, for Lasix tablet 20 mg, administer once per day for diagnosis of heart failure;-An order, dated 07/21/25, for Geri-Tussin (guaifenesin - expectorant that works by thinning and loosening mucus in the chest