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	07/10/2025

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. 1.Please refer to event ID HP9H-H2, exit date 09/04/25, for citation details. Complaint #2572449 and #2586807

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 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. Deficiency Text Not Available

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to document regarding identification of potential pressure ulcers, failed to document timely assessment and tracking for potential pressure ulcers, and failed to care plan regarding newly identified possible pressure ulcers. The facility census was 116. Review of the facility policy titled Wound Care and Treatment, undated, showed prevention strategies include on-going skin assessment with weekly documentation of status, minimize dry skin by applying lotion, avoid massage, minimize friction and sheer through proper positioning, transferring, and turning, and develop and implement a method of communication position changing. Review of the facility policy titled Care Area Assessments, dated March 2015, showed the following: -Care area assessments (CAA's) will be used to help analyze data obtained from the MDS and to develop individualized care plans;-CAA's are the link between assessment and care planning;-Triggered care areas will be evaluated by the interdisciplinary team to determine the underlying causes, potential consequences and relationships to other triggered care areas;-Review the triggered CAA's by doing an in-depth, resident-specific assessment of the triggered condition, which includes history taking, physical assessment, gathering of relevant information such as labs or tests and sequencing of clinically significant events;-The problem shall be defined by identifying the implications of the problem and the relationships between risk factors, triggers and problems;-Decisions about the care plan are made;-Document interventions on the care plan. Review showed the facility did not provide a policy regarding assessment of skin and wounds and documentation protocol of those wounds. 1. Review of Resident #1's face sheet (a brief look at the residents personal, incoming information) showed the following: -admission date of 03/02/22;-Diagnoses included Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement, but also involves non-motor symptoms), dementia (a general term for a decline in mental ability severe enough to interfere with daily life) and palliative care (specialized medical care focused on improving the quality of life for individuals with serious illnesses, like cancer, by managing symptoms and side effects of treatment). Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 05/22/25, showed the following: -Cognitively impaired;-Dependent on staff assistance for all activities of daily living (ADL- to include dressing, bathing, transfers, and mobility). Review of the resident's care plan, dated 03/02/22, showed the following: -At risk for skin breakdown, with contractures, impaired mobility, incontinence, and disease processes;-Goal to be free from skin breakdown;-Apply moisture barrier as appropriate;-Check positioning in wheelchair and bed regularly;-Clean and dry skin after each incontinent episode;-During staff assisted showers, note and report any areas of redness/breakdown to the skin. Review of the resident's Physician Order Sheet (POS), dated 06/01/25 through 07/10/25, showed an order, dated 03/14/25, to apply barrier cream to left glute (buttock) two times a day (BID). Review of the resident's shower sheet, dated 06/06/25, showed the resident had redness to bilateral (both) buttocks and the peri-area. Review of the resident's progress notes, dated 06/06/25 through 06/11/25, showed staff did not document regarding the identified redness to the resident's buttocks. Review of the resident's POS dated 06/01/25 through 07/10/25, showed no new physician orders for the identified redness to the resident's buttocks. Review of the resident's care plan showed staff did not update the care plan regarding the identified redness to the resident's buttocks and any new treatments or interventions. Review of the resident's hospice shower sheet, dated 06/30/25, showed the resident had a small open area to the left buttock. Review of the resident's progress notes, dated 06/30/25, showed the resident had a small open area to the coccyx (a small triangular bone at the base of the spinal column). Hospice was notified. Review of the resident's weekly skin assessments showed staff had not completed a skin assessment completed since December 2024. Review of the resident's wound management log, dated 06/30/25, showed staff did not document regarding the discovered wound. Review of the resident's POS, dated 06/30/25 through 07/07/25, showed no new orders for the resident's open area. Review of the resident's progress notes, late entry dated on 07/10/25, at 9:56 A. M., for 07/06/25, at 9:56 A.M., showed the Director of Nursing (DON) observed the resident's area of concern to the right buttock, physician was notified, and new orders were placed. Hospice aware. Review of the resident's wound management log, dated 07/07/25, showed the resident had a stage two (an open wound that involves partial-thickness skin loss, affecting the epidermis and dermis) pressure ulcer to the left buttock, measuring 0.4 centimeter (cm) by 0.4 cm with a 0.1 cm depth. Peri-wound was pink/red and blanchable (skin that turns pale or white when pressed on and then quickly returns to normal when pressure