| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 28295 | A. BUILDING: _____ B. WING _____ | C 12/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDARHURST OF SPRINGFIELD | 1146 EAST LAKEWOOD STREET SPRINGFIELD, MO 65810 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| A8023 | 19 CSR 30-88.010(23) Develop/Implement A/N Policies<br><br>The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III<br><br>This regulation is not met as evidenced by:<br>Class II*<br><br>Based on interview and record review, the facility failed to fully implement their abuse policy when one staff member (Resident Assistant (RA) C) failed to report two allegations of possible employee to resident physical abuse involving two residents (Resident #2 and #3) to facility management. The facility census was 53.<br><br>Review of the facility policy titled "Abuse, Neglect, and Exploitation Prevention, Prohibition, and Investigation Policy and Procedures," updated 03/14/22, showed the following:<br>-If abuse is suspected, ensure the safety of the resident by separating the resident and the person allegedly abusing the resident. Any suspected employees are suspended during the investigation;<br>-Determine if the resident is safe and if they require medical treatment or supportive services;<br>-Immediately report the alleged abuse to your supervisor and Executive Director or designee per State guidelines;<br>-The State agency will be notified by the | A8023 | | |

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| A8023 | Continued From page 1<br>Executive Director or designee per State guidelines.<br><br>1. During an interview on 12/30/25, at 2:30 P.M., RA C said the following:<br>-RA D was "aggressive" with residents;<br>-RA D turned Resident #2 and Resident #3 by their wrists and ankles when assisting them with repositioning;<br>-Staff were supposed to reposition/turn residents with a hand on the back of the shoulder and back of the leg, not by the wrists or ankles;<br>-Resident #2 and Resident #3 had bruises on their wrists and ankles at the end of the shift;<br>-This happened about two weeks ago, and he/she only witnessed this one time;<br>-It was facility policy to report employee to resident abuse to the supervisor on duty;<br>-He/She did not report the abuse as he/she got busy with other things and then it was shift change;<br>-He/She should have reported this incident to the supervisor on duty.<br><br>2. Review of Resident #2's face sheet (basic medical information) showed the following:<br>-Admission date 08/14/25;<br>-Diagnoses included unspecified dememtia (cognitive decline that is severe enough to impact daily life but does not fit neatly info a specific dementia type) and anxiety.<br><br>Review of the resident's nurses' notes, dated 10/01/25 to 12/31/25, showed staff did not document regarding the allegation of employee to resident abuse.<br><br>3. Review of Resident #3's face sheet showed the following:<br>-Admission date of 10/24/25; | A8023 | | |

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| A8023 | Continued From page 2<br>-Diagnoses included Alzheimer's disease (a progressive brain disorder that slowly damages memory, thinking, and reasoning skills).<br><br>Review of the resident's nurses' notes, dated 10/01/25 to 12/31/25, showed staff did not document regarding the allegation of employee to resident abuse.<br><br>4. During an interview on 12/30/25, at 2:54 P.M., RA E said the following:<br>-It is facility policy to move/reposition residents with one hand behind the shoulder and one hand behind the knee;<br>-It is facility policy was to report any suspected abuse of a resident to the supervisor on duty.<br><br>During an interview on 12/30/25, at 3:33 P.M., RA D said the following:<br>-Residents are to be moved or repositioned with one hand behind the shoulder and one hand behind the knee;<br>-It was facility policy to report any suspected abuse of a resident to the supervisor on duty.<br><br>During an interview on 12/31/25, at 10:08 A.M., Level One Medication Aide (LIMA) F said the following:<br>-The appropriate way to turn or reposition a resident is by the back of the shoulder and leg;<br>-It was facility policy to report any suspected abuse of a resident to the supervisor on duty.<br><br>During an interview on 12/31/25, at 10:40 A.M., LIMA G said the following:<br>-He/She was a charge, which means he/she was a supervisor;<br>-It is facility policy for staff to report any suspected abuse of a resident to him/her and he/she calls the Director of Nursing (DON). | A8023 | | |

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| A8023 | Continued From page 3<br><br>During an interview on 12/30/25, at 2:45 P.M., the Director of Nursing (DON) said the following:<br>-RA C did not report the suspected abuse of Resident #2 and #3 to his/her supervisor;<br>-All staff are trained on reporting abuse when they are hired and periodically thereafter.<br><br>During an interview on 12/31/25, at 1:40 P.M., the Executive Director said the following:<br>-RA C did not report the suspected abuse of Resident #2 and #3 to anyone else in the facility to his/her knowledge.<br><br>*The higher classification merited due to the extent of the violation.<br><br>MO00260001 | A8023 | | |
| A8030 | 19 CSR 30-88.010(29) Dignity/Privacy<br><br>Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III<br><br>This regulation is not met as evidenced by:<br>Class II*<br><br>Based on interview, record review, and observation, the facility failed to ensure all residents were treated with dignity and respect at | A8030 | | |

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| A8030 | Continued From page 4 | A8030 | | |

all times when one staff (Resident Assistant (RA) A) raised his/her voice, spoke in a demeaning way, and showed impatience to one resident (Resident #1).The facility census was 53.

Review of the facility "Resident and Family Handbook," updated 02/15/23, showed the following:
-Each of the residents deserves care and attention with all of the dignity, independence, and support that our team can offer;
-Every resident has certain rights, including a right to a dignified existence and to be treated with respect.

1. Review of Resident #1's face sheet (basic medical information sheet) showed the following:
-Admission date of 09/30/25;
-Diagnoses included vascular dementia (occurs when damaged blood vessels reduce blood flow and oxygen to the brain, impairing thinking, memory, and judgment.

Review of the resident's Community Based Assessment (CBA - form that determines an individual's specific needs for care and support before admission and periodically after), dated 09/26/25, showed the following:
-Needed some assistance in with mobility and used a walker;
-Some memory lapse in the areas of orientation to date, day, and place, memory recall, and judgment;
-Some memory lapse in the area of wandering or confusion.

Review of the resident's Individual Service Plan (ISP - a document outlining a resident's needs and preferences, services to be provided, and goals expected by the resident or resident's legal

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| A8030 | Continued From page 5<br>representative in partnership with the facility), dated 11/17/25, showed the following:<br>-Sleep disturbances, intermittent confusion, and disorientation to time and place;<br>-Mobile with walker;<br>-Needs frequent redirection;<br>-Needs to be approached in a calm and gentle manner, using positive body language and facial expressions;<br>-Needs to be engaged in small talk prior to a direction given to reduce anxiety and build rapport;<br>-If upset, needs to be redirected to an activity or a conversation of interest to the resident.<br><br>Review of a facility investigation, dated 01/02/26, showed the following:<br>-On 12/29/25, while investigating a resident-to-resident altercation, the Director of Nursing (DON) observed RA A (on video) push away the resident's hands after the resident grabbed RA A;<br>-The DON also heard RA A talk to the resident disrespectfully by yelling at and scolding the resident saying "do not put your hands on me;"<br>-RA A intervened during the resident-to-resident altercation and yelled at the resident in a disrespectful tone and scolded the resident, saying "She is not your thing, and you do not get to slap her."<br><br>Review of the camera video on 12/30/25, at 9:45 A.M., for the 12/29/25 incident showed the following:<br>-Video began at 6:05 P.M. on 12/29/25;<br>-The resident was standing in front of RA B and blocking his/her way to move residents out of the dining room;<br>-The resident hit RA B on the back as RA B went around him/her; | A8030 | | |

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| A8030 | Continued From page 6<br><br>-RA B kept walking to the dining room;<br>-The resident sat on a chair near the dining room and RA A came over to him/her and said "(name) this is why no one wants to (the rest of the sentence was inaudible);"<br>-RA A told the resident "you need your walker, you almost fell" in a scolding tone;<br>-Later in the video, the resident slapped another resident on the hand;<br>-RA A was on the other side of the welcome area by the dining room;<br>-RA A yelled "hey" and came across the room to the resident and said "she is not your kid you do not get to slap her," in a scolding tone;<br>-RA A appeared to be frustrated based on his/her body language and facial expressions. RA A got very close to the resident when addressing him/her with a tense expression on the RA's face.<br><br>Review of RA A's written statement, dated 12/29/25, showed the following:<br>-The resident was chasing after another staff member, trying to put his/her hands on the staff member;<br>-The RA interfered and got the resident sat down;<br>-The RA kept getting onto the resident as the resident was not being very nice;<br>-The resident put his/her hands on the RA more than once that day;<br>-The RA said he/she did slightly raise his/her voice because there was a lot going on;<br>-When the resident would not move, the RA said he/she "one armed" him/her and took him/her where the RA needed to be;<br>-The RA saw and heard the resident slap the other resident, so the RA instinctively shouted "hey" and removed the resident from the other resident and sat him/her in a chair.<br><br>During an interview on 12/31/25, at 11:20 A.M., | A8030 | | |

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| A8030 | Continued From page 7<br><br>RA A said the following:<br>-He/She was working the evening of 12/29/25;<br>-The staff was trying to bring residents out of the dining room;<br>-The resident had been agitated during the shift and was following residents and staff around and had already put his/her hands on staff a few times;<br>-The resident came up to him/her and grabbed his/her upper body by the shoulders;<br>-He/She removed the resident's hands by holding them, bringing them down, and then walked away;<br>-A bit later, he/she saw the resident slap the hand of another resident;<br>-He/She raised his/her voice and said "hey, she is not your kid, you can't discipline her;"<br>-He/She had to "get onto" the resident a few times during the shift;<br>-Level I Medication Aide (LIMA) G talked to him/her and he/she decided he/she should stay away from the resident the rest of the shift;<br>-He/She was flustered by the resident's behavior.<br><br>During an interview on 12/31/25, at 10:40 A.M., LIMA G said the following:<br>-He/She was a charge LIMA, and was the supervisor on shift on 12/29/25;<br>-He/She did not see RA A push the resident's hands down. He/she was in the office on a phone call;<br>-When he/she returned to the front desk, he/she saw RA A give the resident his/her walker and yell at the resident "you need to stop following me and yelling at me" in the resident's face;<br>-He/She did see the resident slap the hand of another resident;<br>-RA A was across the front area when this happened, at least 20 feet from where the incident occurred; | A8030 | | |

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| A8030 | Continued From page 8<br>-RA A yelled "hey, no (resident name) no" and came across the room to the resident;<br>-RA A said in a loud voice "she is not your child, and you do not get to slap her;"<br>-He/She took RA A in the medication room to talk privately and told RA A to let other aides deal with the resident the rest of the shift;<br>-He/She felt RA A became easily frustrated with residents and raised his/her voice;<br>-RA A's behavior was not appropriate.<br><br>During an interview on 12/31/25, at 11:44 A.M., RA B said the following:<br>-He/She was working on 12/29/25 with RA A;<br>-When he/she was trying to go back to the dining room to move residents out the resident stepped in front of him/her and said "what are you going to do" in an agitated manner;<br>-He/She told the resident that he/she was trying to work and get residents out of the dining area;<br>-He/She stepped around the resident without touching him/her and the resident hit him/her in the back;<br>-He/She kept going to the dining room and the resident sat down in a chair outside the dining area;<br>-A bit later, the resident hit another resident on the hand, and he/she heard RA A say "hey" and came across the room to address the situation;<br>-He/She heard RA A tell the resident that he/she does not get to hit other residents;<br>-He/She feels that RA talks sternly to the residents;<br>-He/She was trained on handling challenging behaviors and knows staff needs to remain calm and respectful;<br>-He/She feels more hands-on training is needed for dealing with challenging behaviors.<br><br>During an interview on 12/31/25, at 10:08 A.M.., | A8030 | | |

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| A8030 | Continued From page 9<br><br>LIMA F said the following:<br>-He/She worked both as a LIMA and a shower aide;<br>-RA A will say things like "I'll get to you in a minute, I am busy" and will roll his/her eyes;<br>-The LIMA did not report RA A's actions to management.<br><br>During an interview on 12/30/25, at 9:20 A.M., the Director of Nursing (DON) said the following:<br>-All employees are trained on treating residents with dignity and respect and handling challenging behaviors when they are hired and on an ongoing basis;<br>-After viewing the video and investigating, he/she feels that RA A communicated inappropriately with the resident by raising his/her voice and talking to the resident in a scolding manner;<br>-The RA did not treat the resident in a dignified manner.<br><br>During an interview on 12/31/25, at 1:40 P.M., the Executive Director said the following:<br>-He/She viewed the video footage of RA A's interactions with the resident;<br>-RA A did not treat the resident appropriately and the interactions were not in line with the company's policy or training;<br>-RA A did not stay calm or respectful and communicated inappropriately to the resident.<br><br>*The higher classification merited due to the extent of the violation, the effect on the resident, and the impact when combined with other deficiencies.<br><br>MO00259992 | A8030 | | |

# PLAN OF CORRECTION

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| **Provider/Supplier Name:** | Cedarhurst of Springfield Missouri |
| **Street Address, City, Zip:** | 1146 E Lakewood St, Springfield Mo 65810 |
| **Date of Survey:** | 12/31/2025 |

| PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | |
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| | The community will provide protective oversight 24 hours a day. | |
| | | |
| | Deficiency A8023 has the potential to affect all residents in the community. | |
| | | |
| A8023 | • All staff will receive upon hire abuse and neglect identification and reporting training. All current staff have received training on abuse and neglect reporting. Additional training regarding notification of concerns related to any abuse or neglect and immediately reporting to Executive Director (ED) and or (DON) Director of Nurses will be completed quarterly.<br>• Training was provided to all staff on Validation Therapy during monthly all staff in-service on 01/13/2026.<br>• Relias training Abuse: Preventing, Recognizing and Reporting was assigned on 12/31/25. Date of completion 1/13/2026<br>• Relias training Dementia Care: Challenging Behaviors and Direct Care Staff was assigned on12/31/25. Additional training will be done quarterly.<br>• Training was provided to all staff on Resident Rights, Core Values/Dignity and Respect and Abuse and Neglect reporting during monthly all staff in-service on 02/10/2026. | 01/13/2026<br>02/10/2026 |
| | | |
| A8030 | The community will provide protective oversight 24 hours a day. | |
| | | |
| | Deficiency A8030 has the potential to affect all residents in the community. | |
| | | |
| | Employee (RA A) was immediately suspended and then terminated as result of the investigation. | |
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| | • All staff will receive upon hire abuse and neglect identification and reporting training. All current staff have received training on abuse and neglect reporting. Additional training regarding notification of concerns related to any abuse or neglect and immediately reporting to Executive Director (ED) and or (DON) Director of Nurses will be completed quarterly.<br>• Training was provided to all staff on Validation Therapy during monthly all staff in-service on 01/13/2026.<br>• Relias training Abuse: Preventing, Recognizing and Reporting was assigned on 12/31/25. To be completed by 1/13/26<br>• Relias training Dementia Care: Challenging Behaviors and Direct Care Staff was assigned on12/31/25.<br>• Training was provided to all staff on Resident Rights, Core Values/Dignity and Respect and Abuse and Neglect reporting during monthly all staff in-service on 02/10/2026. Additional training quarterly. | 01/13/2026<br>02/10/2026 |
| | | |

**The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.**