STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265664	A. BUILDING 01 B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATION	3550 EAST BATTLEFIELD SPRINGFIELD, MO 65809

(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) COMPLETION DATE
E 000	Initial Comments The Emergency Preparedness portion of the survey did not result in any citations.	E 000		
K 000	INITIAL COMMENTS 42 CFR 483.90 (a) The facility does not meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association and related reference documents.	K 000		
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 9/4/24

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days fol ow ng 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265664	A. BUILDING **01** B. WING _____	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATION	**3550 EAST BATTLEFIELD** **SPRINGFIELD, MO 65809**

(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) COMPLETION DATE
K 161	Continued From page 1 non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain the integrity of the building construction by failing to maintain the one-hour fire rating of the ceilings when the building had unsealed penetrations between the attic and areas below. This deficient practice had the potential to affect all residents, staff, and visitors in these areas in the event of a fire by allowing smoke to pass between the attic and the area below, including some resident-use areas. The failure had the potential to affect three of ten smoke compartments. The facility has a capacity of 120 and had a census of 101 at the time of the survey. Review of the Department of Health and Senior Services (DHSS) database showed the facility has been licensed and certified as a Type V (111) constructed building, which indicates the building is wood construction and has one-hour fire-rated ceilings. Review showed the facility did not provide a policy on maintaining one-hour fire rating of the	K 161		

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	265664	A. BUILDING **01** B. WING _____	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATION	**3550 EAST BATTLEFIELD** **SPRINGFIELD, MO 65809**

(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) COMPLETION DATE
K 161	Continued From page 2 ceilings. 1. Observations on 07/23/24, starting at 8:30 A.M., showed the following: -In the utility room inside the kitchen, some drywall around an exhaust duct was falling down, which exposed a hole about 1/4 inch wide around the circumference of the duct. In the same room, a drywall patch in the ceiling had started to fall down, which exposed a hole about 1 inch by 15 inches; -In the riser room on the 400 hall, there was a hole cut out of the ceiling measuring approximately 1 foot by 1 foot. Two HVAC (heating, ventilation, and air conditioning) units were located in this room was well; -In the hallway just outside the laundry room entrance there was a sprinkler head off-center which exposed a hole approximately 1/4 inch wide around the circumference of the escutcheon (a decorative ring around a sprinkler head which seals the area so there are no holes in the ceiling); -In 'B' closet of resident room 301, the sprinkler drain/low point pipe had come down from the ceiling, which exposed a hole approximately 1/4 inch wide around the circumference of the pipe; -In the clean utility room on 400 hall, the escutcheon around the sprinkler pipe was completely missing. This resulted in a gap measuring 1/4 to 1/2 inch in the ceiling around the pipe. During an interview on 07/24/24, at 1:55 P.M., the Maintenance Director said sprinkler heads (including the area around the escutcheons and pipes) were checked by himself about once per month during a monthly walk-through of the	K 161		

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	265664	A. BUILDING 01 B. WING _____	07/30/2024

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JAMES RIVER NURSING AND REHABILITATION	3550 EAST BATTLEFIELD SPRINGFIELD, MO 65809

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K 161	Continued From page 3 building. He said these checks are not documented. He didn't know of any holes in the ceiling, including any holes around sprinkler escutcheons. During an interview on 07/24/24, at 3:00 P.M., the Administrator said she did not know of any unsealed penetrations from the ground floor into the attic area above. The holes should always be fully sealed. Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5	K 161		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors that led to the outside, but not to a public way, had "No Exit" signs posted on them. This deficient practice had the potential to affect all residents, staff and visitors who might mistake the door for an external exit in case of a fire or other need to evacuate the building. The	K 293		

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	265664	A. BUILDING **01** B. WING _____	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATION	**3550 EAST BATTLEFIELD** **SPRINGFIELD, MO 65809**

(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) COMPLETION DATE
K 293	Continued From page 4 facility has a capacity of 120 and had a census of 101 at the time of the survey. Review showed the facility did not provide a policy related to exterior doors and exit signage. 1. Observations on 07/23/24, starting at 8:30 A.M., showed a door off the main (front) lobby which led to an interior courtyard. The courtyard was completely surrounded by walls of the facility. The door was unsecured (unlocked) from the interior, which allowed anyone to freely access to the courtyard. The door did not have any signage indicating it was not an emergency exit. During an interview on 07/24/24, at 1:55 P.M., the Maintenance Director said the door off the main (front) lobby which led to an interior courtyard did not have any signage indicating it was not an emergency exit. He said the glass on the door was broken by a lawnmower about one year ago and there has not been a sign on it since at least that time. He didn't know there should be a sign of "No Exit," or similar on the door. During an interview on 07/24/24, at 3:00 P.M., the Administrator confirmed that the door off the main lobby which led to an interior courtyard did not have any signage indicating it was not an emergency exit. She didn't realize the door did not have appropriate signage. NFPA 101 (2012 ed.) 7.10.8.3.1 Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that is it likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT.	K 293		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATION	**3550 EAST BATTLEFIELD** **SPRINGFIELD, MO 65809**

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K 372	Continued From page 5	K 372		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to maintain the smoke resistive properties of the Smoke Barrier Walls (SBW - a continuous barrier from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof). This deficient practice had the potential to affect all residents, staff and visitors on the affected halls in the event of a fire in the facility by allowing the passage of smoke from the compartment affected by the fire to the adjoining unaffected compartments. The failure had the potential to affect two of ten smoke compartments. The facility has a capacity of 120 and had a census of 101 at the time of the survey. Review showed the facility did not provide a policy related checking the smoke barrier walls.	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265664	A. BUILDING **01** B. WING _____	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATION	**3550 EAST BATTLEFIELD** **SPRINGFIELD, MO 65809**

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K 372	Continued From page 6 1. Observations on 07/24/24, starting at 10:00 A.M., showed the following in the attic area above the first floor: -Above the assisted dining room (close to resident room 322), the SBW was unsealed at the top of the wall (at the roof deck) measuring about 1/2 inch wide, and for the length of the roof. There were also unsealed gaps around a support four beam/rafter, measuring approximately 1/2 inch around each beam. During an interview on 07/24/24, at 1:55 P.M., the Maintenance Director said he did not know of the holes or gaps in the SBWs. He has never checked the walls in the attic since he started a couple months ago and was not sure how often they should be checked. During an interview on 07/24/24, at 3:00 P.M., the Administrator said all penetrations in smoke barrier walls should be fully sealed by a fire-rated product. It is the responsibility of the Maintenance Director to ensure there are no gaps or holes in the smoke barriers, and all walls should be checked at least yearly. NFPA 101, 2012 edition: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5 Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 7 19.3.7.3, 8.6.7.1(1)	K 372		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17645	A. BUILDING: 01 B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER NURSING AND REHABILITATIOI	3550 EAST BATTLEFIELD SPRINGFIELD, MO 65809

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A2054	19 CSR 30-85.022(29) Smoke Section Walls/Doors Each smoke section shall be separated by one-(1-) hour fire-rated walls that are continuous from outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. All doors in this wall shall be at least twenty- (20-) minute fire rated or its equivalent, self-closing, and may be held open only if the door closes automatically upon activation of the fire alarm system. II This regulation is not met as evidenced by: 1. Please refer to K372.	A2054		
A3001	19 CSR 30-85.032(2) Substantially Constructed/Maintained The building shall be substantially constructed and shall be maintained in good repair. New facilities shall comply with the requirements in accordance with the provisions found in 19 CSR 30-85.012. Existing licensed facilities shall meet and maintain the facility's physical plant in accordance with the construction standards in effect at the time of initial licensing, unless there is a specific rule governing the subject cited in this section or in 19 CSR 30-85.022, except that those facilities licensed between 1957 and 1965 shall not increase the capacity of any room or the total capacity of the facility without meeting new construction requirements. Existing licensed facilities with plans approved after April 8, 1972 and prior to January 1, 1999, shall comply as Existing Health Care Occupancies with NFPA 101, 2000 edition. Facilities whose physical plant requirement plans are approved on or after January 1, 1999, shall comply as New Health Care Occupancies with NFPA 101, 2000 edition.	A3001		

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A3001	Continued From page 1 II/III This regulation is not met as evidenced by: Class II* 1. Please refer to K161. *The higher level merited due to the extent of the violation and impact when combined with other deficiencies.	A3001		

PLAN OF CORRECTION		
Provider/Supplier Name:	James River Nursing and Rehab	
Street Address, City, Zip:	3550 E. Battlefield Rd Springfield MO 65809	
Date of Survey:	7/30/2024	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		265664

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE

K 161	1. Drywall in utility room in kitchen, hole in ceiling of riser room on 400 hall, sprinkler drain/ low point pipe in B closet in room 301, sprinkler head outside of laundry room, and escutcheon around sprinkler head in clean utility room will be repaired/replaced by 9/10/24 by contractor. 2. All ceilings inspected by maintenance director to ensure all smoke barriers are intact. No other areas noted. 3. Education completed with maintenance director by 9/2/24 by Administrator to ensure there are no penetrations in smoke barriers. 4. Maintenance Director or designee to audit 3 smoke barriers weekly x6 weeks. 5. Results of audits to be brought to QA Committee monthly x2 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QA Committee recommendations.	9/13/24
K 293	1. A "Not an Exit" sign placed on door of interior courtyard located off the main lobby on 7/24/24 by the Maintenance Director. 2. All other doors leading to interior courtyards inspected to ensure appropriate signage is in place. No negative findings noted. 3. Education provided with maintenance director by 9/2/24 by Administrator to ensure all doors leading to interior courtyards have appropriate signage.	9/13/24

	4. Maintenance Director to visualize interior doors for integrity of signage weekly x6 weeks. 5. Results of audits to be brought to QA Committee monthly x2 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QA Committee recommendations.	
K 372	1. Contractor has been scheduled for installation of fire caulk at the top of the attic firewall and around support beam/rafter above resident room 322. 2. All residents have the potential to be affected. 3. Maintenance Director educated by 9/2/24 by Administrator to ensure there should be no gaps around smoke barrier walls and ensure frequency of inspections per preventative maintenance guide. 4. Maintenance Director to audit smoke barrier penetration weekly x6 weeks. 5. Results of audits to be brought to QA Committee monthly x2 months to identify trends and to make recommendations. If issues/trends are identified, then will continue audits based on QA Committee recommendations.	9/13/24
A 2054	Please refer to K 372	9/13/24
A 3001	Please refer to K 161	9/13/24

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.