STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265157	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Rehabilitation & Health Care Center	2800 South Fort Avenue 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a pain management program that managed resident pain effectively when staff failed to address one resident's (Resident #1) on-going pain and when staff failed to address one resident's (Resident #2) behavioral indications of pain. The facility census was 121.Review of the facility policy Pain-Clinical Protocol, dated 2001, showed the following:-The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain such as degenerative joint disease, rheumatoid arthritis, osteoporosis, post-stroke syndromes;-The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain;-The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity;-Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level;-The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated such as wound care, ambulation, or repositioning;-The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life;-Staff will reassess the individual's pain at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain. Review should include frequency, duration and intensity of pain, ability to perform activities of daily living, sleep patter, mood, behavior, and participation in activities;-The staff will evaluate and report the resident's use of standing and PRN analgesics: depending on the characteristics of pain, the physician may start with PRN doses or supplement standing doses with PRN doses for breakthrough pain. If there are more than occasional analgesic requests, the physician will consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the standing dose of an existing analgesic, switching to another analgesic, and/or adding nonpharmacological measures.1. Review of Resident #1's face sheet (admission information at a glance) showed the following:-admission date of 11/18/24;-Diagnoses included rheumatoid arthritis (a chronic inflammatory disorder which causes joint pain, swelling, and stiffness and inflammation in other parts of the body) with rheumatoid factor of multiple sites without organ or systems involvement, neuralgia (pain caused by damaged or irritated nerves and causes sensitivity of the skin, numbness, tingling, or other unpleasant sensations), and neuritis (inflammation of one or more peripheral nerves that can cause pain, numbness, tingling, or weakness in the area). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 5/28/25, showed the following:-Cognitive skills were intact and made decisions;-On scheduled pain medication and received as needed (PRN) pain medication;-Had frequent pain that affected sleep and interfered with day to day activities;-A numeric pain level of 6 (indicating moderate pain);(Staff did not assess for indicators of pain such as non-verbal sounds such as crying, gasping, moaning, or groaning, whining, vocal complaints such as that hurts, ouch, stop, facial expressions such as grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw, protective body movements or postures such as bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement. Staff did not assess for indicator of pain or possible pain in the last 5 days such as indicators of pain observed 1 to 2 days, 3 to 4 days, or observed daily.)Review of the resident's pain assessment, dated 05/28/25, showed the following:-Received scheduled pain medications and had received medications in the past five days;-The resident received PRN pain medications or was offered and/or declined pain medications in the past 5 days;-Had not received any non-medication intervention for pain in the last 5 days;-Had frequent pain in the past 5 days;-Had not limited participation in rehabilitation therapy sessions in past 5 days because it did not apply;-Had pain which frequently limited day-to-day activities;-Pain intensity 6 (0-10 pain scale) over the past 5 days;(Staff did not assess the intensity (mild, moderate, severe, very severe, horrible, unable to answer, not assessed) of the resident's worst pain over the last 5 days. The staff assessment for pain was not conducted.)Review of the resident's care plan, revised 05/29/25, showed the following:-Resident had chronic pain related to rheumatoid arthritis (RA);-Pain will be managed at resident's tolerable level;-Administer medications as ordered and assess effectiveness, assess for pain, and intervene as indicated including non-pharmacological interventions to manage pain and assisting with positioning for comfort.Review of the resident's current Physician Orders showed the following:-An order, dated 01/14/25, for gabapentin (for