

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Glendale Gardens Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 East Cherokee Springfield, MO 65809	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify all residents' families and physicians of all changes in condition and incidents when staff did not notify the physician and family of falls in a timely manner for two residents (Resident #1 and #3). The facility census was 93. Review showed the facility did not provide a policy regarding falls or physician notification. Review of the facility policy titled Charting and Documentation, undated, showed the following:-The purpose of these guidelines is to provide a complete account of the resident's care, treatment, response to care and progress; guidance to the physician in prescribing appropriate medications and treatments; assistance in the plan of care for each resident; and an information source for resident changes;-Accidents/Incidents documentation does not take the place of the Event Report Form. Documentation should include circumstances surrounding the accident or incident; where the accident or incident took place; date and time the incident occurred; name of the witness and their account of the accident or incident; resident's account of accident or incident; time the physician was notified as well as the time the physician responded; the date and time the family was notified; the condition of the resident, to include vital signs; disposition of the resident; and all pertinent observations. 1. Review of the Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/27/25; -Diagnoses included non-Hodgkin lymphoma (cancer that is in the lymphocytes (white blood cells - a component of the immune system) and osteoarthritis (joint disease that causes pain, stiffness, and loss of function). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/25, showed the resident was cognitively intact and required moderate staff assistance with dressing and shower and supervision with toileting. Review of the resident's care plan, revised on 11/05/25, showed the following:-Resident required one-to-two-person assistance with activities of daily living (ADL-basic tasks done regularly to care for the body) due to weakness;-Required one staff assistance with transfer, positioning, and hygiene;-Resident at risk for falls related to decreased mobility.Review of the resident's nursing progress note, dated 06/01/2025, showed the certified medication technician (CMT) reported the resident was on the floor. Resident reported he/she went to the restroom without a walker and on the way out lost his/her balance. Resident reported hitting right side of breast hard on the arm of a wheelchair nearby. Resident denied hitting head or pain. Resident able to move all extremities with good range of motion. Right side of breast noted to be red. Staff will monitor breast for any changes. Staff notified family of fall. Neurological assessment started. (Staff did not document notification of the resident's physician regarding the fall). Review of the resident's nursing progress note, dated 09/22/25, showed resident continued fall follow up due to a fall on 09/21/25 with no complaint of any discomfort at this time. Review of the resident's progress notes showed staff did not document a fall on 09/21/25 or family and</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 265473	Facility ID: 265473 If continuation sheet Page 1 of 11

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>physician notification of the fall. Review of the resident's nursing progress note dated 11/01/25, at 6:49 P.M., and recorded as late entry on 11/02/25 at 4:53 P.M., showed resident looked tired and reported he/she was very tired and weak. He/she slid from the recliner due to legs giving out and no energy. He/she again slid from bed, but denied falling. Resident reported sliding from the bed due to very weak legs. (Staff did not document physician or family notification of the resident's falls.) Review of the resident's nursing progress note dated 11/03/25, at 11:31 P.M., showed at 6:00 P.M. the resident fell on the way out of the bathroom. Resident was utilizing a walker and turned, lost balance, and landed on the floor. Resident found lying on his/her back. Resident complained of back pain which was not new to him/her. X-ray results negative on his/her back today before this fall. Roommate witnessed the fall. Resident able to move all extremities with no pain and denies hitting his/her head. (Staff did not document notification of the resident's physician or family of the fall.) During an observation and interview on 11/05/25 at 10:15 A.M. with resident #1 showed the resident in room sitting in a recliner with walker sitting next to resident. Resident reports he/she had four falls in the last week. During an interview on 11/05/25, at 3:45 P.M., Licensed Practical Nurse (LPN) D said the resident slipped out of the recliner and bed one night. He/she did not notify the physician because he/she did not consider sliding from the bed or a chair a fall. The resident had a fall on the way to the bathroom the day after he/she slid from the chair and bed. He/she notified the family but did not notify the physician. The resident had an x-ray to the back due to complaint of back pain before the fall. 2. Review of the Resident #3's face sheet showed the following:-admission date of 09/10/25; -Diagnoses included high blood pressure and lung cancer. Review of the resident's annual MDS, dated [DATE], showed the resident was cognitively intact and required supervision with ADL's. Resident utilized both a walker and a wheelchair. Review of the resident's care plan, revised on 09/17/25, showed the following:-Resident required one-to-two-person assistance with ADL's due to weakness;-Required one to two staff assistance with transfer and positioning;-Resident at risk for falls related to the disease process and weakness;-Staff should remind resident to be mindful of tubing as it can be a fall hazard. Review of the resident's nursing progress note dated 10/21/25, at 11:33 A.M., showed a fall reported by the nurse at shift change and happened at 5:45 A.M. Fall caused by patient trying to get a soda and fell. No abnormalities reported. (Staff did not document notification of the resident's physician or family of the fall.) 3. During an interview on 11/05/25, at 1:10 P.M., LPN C said the family and physician should be notified after a resident fall. All information should be documented in the progress note and on an event form. During an interview on 11/05/25, at 1:20 P.M., LPN G said he/she would notify the Director of Nursing (DON), physician, and family after a resident fall. All information should be documented in the progress note. The physician should be notified of any fall regardless of injuries. During an interview on 11/05/25, at 2:40 P.M., the MDS Coordinator said the nurse should assess the resident, start neurological checks, obtain vital signs, and notify the physician and family if a resident had a fall. Nurses should document in the progress note after a fall. During an interview on 11/05/25, at 3:45 P.M., LPN D said the resident's family should be notified after a fall but most of the time the resident calls the family. Night shift nurses do not usually call the physician if there are no injuries but will call the family. The facility had a policy to not call the physician if there are no injuries after a fall. During an interview on 11/05/25, at 4:15 P.M., the DON said nurses should assess a resident and notify the physician and family after a fall. Some physicians do not want to be notified of a fall during the night. Staff will notify the physician or nurse practitioner in the morning. During an interview on 11/05/25, at 5:05 P.M., the Administrator said nurses should assess the resident, notify the physician and</p> <p>(continued on next page)</p>		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family, and follow any orders after a resident fall. Physician should be notified anytime a resident sustains a fall. Complaint #2659996		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care per standard of practice when staff failed to document follow-up regarding edema (swelling/fluid retention), failed to obtain orders for the use of Tubi grips (a reuseable tubular elastic bandage used to provide support and compression,) and failed to care plan related to edema for one resident (Resident #1) and when staff failed to complete ordered daily weights and update the care plan related to edema for one resident (Resident #2). The facility census was 93. Review of the facility policy titled Physician Orders, undated, showed the following:-Current list of orders must be maintained in the clinical record of each resident to avoid confusion and errors;-Physician orders must be reviewed and renewed;-Treatment orders should specify what is done, location and frequency, and duration of the treatment. Review of the facility policy titled Care Plan Comprehensive, undated, showed the following:-An individual comprehensive care plan should include measurable goals and timeframes;-The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to the Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff);-A well-developed care plan will be oriented to preventing avoidable declines in functioning or functional levels; managing risk factors to the extent possible; applying current standards of practice in the care planning process; evaluating treatment of goals, timetables, and outcomes of care; and assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs;-The interdisciplinary care team is responsible for reviewing and updating the care plan when a significant change has occurred, quarterly, and when changes that impact resident care occur. 1. Review of the Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/27/25; -Diagnoses included non-Hodgkin lymphoma (cancer that is in the lymphocytes (white blood cells - a component of the immune system), varicose veins of lower extremities (swollen, and twisted veins), high blood pressure, and cardiovascular disease (group of diseases that affect the heart and blood vessels). Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Required moderate staff assistance with dressing and shower and supervision with toileting;-Utilized a walker.Review of the resident's nursing progress note, dated 04/01/25, showed resident had some swelling to feet, ankles, and legs. Staff contacted the physician contacted and nurse practitioner (NP) will look at tomorrow. Review of the resident's progress notes showed staff did not document monitoring or the resident swelling or physician/NP response to swelling. Observation and interview on 11/05/25, at 10:15 A.M., showed the resident sitting in a recliner with Tubi grips in place to both lower extremities. He/she reported swelling to the legs on and off. Observation and interview on 11/05/25, at 4:05 P.M., showed the resident observed sitting in a recliner wearing Tubi grips on both legs. Resident reported the certified nurse assistant (CNA) applied the Tubi grips in the morning and removed them at night. Resident reported that he/she also applied them at times. Review of the resident's care plan, revised on 11/05/25, showed the following:-Resident required one-to-two-person assistance with activities of daily living (ADL-basic tasks done regularly to care for the body) due to weakness;-Required one staff assistance with transfer, positioning, and hygiene.(Staff did not care plan related to the use of Tubi grips.) Review of resident's current Physician Order Sheet (POS) showed staff did not document an order for use of Tubi grips.During an interview on 11/05/25, at 3:35 P.M., Certified Nurse Aide (CNA) A said the resident wore Tubi grips. The CNA that gets him/her up in the morning puts them on and they are removed at night. During an interview on 11/05/25, at 3:45 P.M., Licensed Practical Nurse (LPN) D the resident does not wear Tubi grips and does</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not have an order. During interviews on 11/05/25, at 2:40 P.M. and 3:40 P.M., the MDS Coordinator said he/she was unsure if the resident wore Tubi grips, but the resident does not have an order in the chart. During an interview on 11/05/25, at 4:15 P.M., the Director of Nursing (DON) said the resident does not have an order for Tubi grips to be applied. 2. Review of the Resident #2's face sheet showed the following:-admission date of 05/13/24;-Diagnoses included edema, high blood pressure, and chronic respiratory failure (condition where the lungs are unable to exchange oxygen and carbon dioxide between the body and the environment). Review of the resident's care plan, revised on 06/13/24, showed the following:-Required one staff assistance with ADL's due to weakness;-Monitor weights per physician orders. Notify physician and responsible party of significant weight changes. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Dependent on staff for transfers, mobility, dressing, and showering;-Wheelchair used for mobility;-Resident taking a diuretic. Review of resident's current POS showed the following:-An order, dated 03/11/25, for fluid restriction of 1500 milliliters (ml) in 24 hours for a diagnosis of hyposmolality (condition where there is an excess of water in relation to the amount of sodium in the body); -An order, dated 03/11/25, for Tubi grips size F in morning and off in the evening;-An order, dated 05/16/25, for daily weight check and notify provider for a weight gain of 3 pounds in one day or 5 pounds in a week;-An order, dated 06/15/25, for Lasix (used to treat edema) 20 milligram (mg) tablet take two tablets daily.Review of the resident's care plan, revised on 06/13/24, showed staff did not update the care plan to reflect the new orders including fluid restriction, Tubi grips, and Lasix. Review of resident's September 2025 Medication Administration Report (MAR) showed the following:-An order, dated 05/16/25, for a daily weight check - notify provider of weight gain of 3 pounds in one day or 5 pounds in a week;-On 09/01/25, weight of 189.8 pounds;-On 09/02/25, weight of 190.2 pounds;-On 09/03/25, staff did not document a weight or refusal;-On 09/04/25, staff did not document a weight or refusal;-On 09/05/25, weight of 191.3 pounds;-On 09/06/25 - staff did not document a weight or refusal;-On 09/07/25, resident refused;-On 09/08/25, resident refused;-On 09/09/25, weight of 190.2 pounds;-On 09/10/25, resident refused;-On 09/11/25, staff did not document a weight or refusal;-On 09/12/25, resident refused;-On 09/13/25, staff did not document a weight or refusal;-On 09/14/25, staff did not document a weight or refusal;-On 09/15/25, staff did not document a weight or refusal;-On 09/16/25, staff did not document a weight or refusal;-On 09/17/25, resident refused;-On 09/18/25, staff did not document a weight or refusal;-On 09/19/25 - staff did not document a weight or refusal;-On 09/20/25, weight of 194.2 pounds;-On 09/21/25, weight of 194 pounds;-On 09/22/25, weight of 193 pounds;-On 09/23/25, staff did not document a weight or refusal;-On 09/24/25, weight of 149 pounds. Staff did not document recheck of weight or documentation of physician notification;-On 09/25/25, weight of 194 pounds;-On 09/26/25, weight of 192 pounds;-On 09/27/25, weight of 192 pounds;-On 09/28/25, weight of 192 pounds;-On 09/29/25, staff did not document a weight or refusal;-On 09/30/25, staff did not document a weight or refusal. Review of resident's October 2025 MAR showed the following:-An order, dated 05/16/25, for a daily weight check and notify provider of weight gain of 3 pounds in one day or 5 pounds in a week;-On 10/01/25, staff did not document a weight or refusal;-On 10/02/25, weight of 193 pounds;-On 10/03/25, weight of 193 pounds;-On 10/04/25, staff did not document a weight or refusal;-On 10/05/25, staff did not document a weight or refusal;-On 10/06/25, resident refused;-On 10/07/25, staff did not document a weight or refusal;-On 10/08/25, weight of 196.4 pounds;-On 10/09/25, staff did not document a weight or refusal;-On 10/10/25, resident refused;-On 10/11/25, staff did not document a weight or refusal;-On 10/12/25, resident refused;-On 10/13/25, staff did not document a weight or refusal;-On 10/14/25, staff did not document a weight or refusal;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 10/15/25, staff did not document a weight or refusal; -On 10/16/25, staff did not document a weight or refusal; -On 10/17/25, resident refused; -On 10/18/25, staff did not document a weight or refusal; -On 10/19/25, staff did not document a weight or refusal; -On 10/20/25, resident refused; -On 10/21/25, staff did not document a weight or refusal; -On 10/22/25, staff did not document a weight or refusal; -On 10/23/25, weight of 195.6 pounds; -On 10/24/25, staff did not document a weight or refusal; -On 10/25/25, weight of 195 pounds; -On 10/26/25, weight of 194 pounds; -On 10/27/25, staff did not document a weight or refusal; -On 10/28/25, staff did not document a weight or refusal; -On 10/29/25, staff did not document a weight or refusal; -On 10/30/25, staff did not document a weight or refusal; -On 10/31/25, staff did not document a weight or refusal. Observation and interview on 11/05/25, at 12:35 P.M., showed the resident sat in a wheelchair wearing Tubi grips to both lower extremities. The resident reported he/she needed tighter Tubi grips due to leg swelling. The resident said he/she had a hard time walking due to his/her legs being so swollen. Resident thinks he/she should be weighted daily but staff are not doing it. He/she reported weight gain since admitted to the facility. During an interview on 11/05/25, at 3:35 P.M., CNA A said the resident gets weighted by the CNA's but he/she was unsure if it is done daily. The resident complained about having trouble walking with edema to legs. He/she wears Tubi grips and elevated legs. Resident reported having trouble wearing shoes due to swelling. During an interview on 11/05/25, at 3:45 P.M., LPN D said the resident is on daily weights and fluid restriction due to edema. During interviews on 11/05/25, at 2:40 P.M. and 3:40 P.M., the MDS Coordinator said the resident had edema that comes and goes. During an interview on 11/05/25, at 4:15 P.M., the DON said the resident had an order for daily weights. 3. During an interview on 11/05/25, at 12:45 P.M., CNA B said he/she would report a resident with new or increased leg swelling to the charge nurse. During an interview on 11/05/25, at 3:30 P.M., LPN C said the following:-He/she would contact the physician for any new onset or worsening of edema;-Residents should have a physician order for Tubi grips;-Tubi grips and edema should be included in the care plan;-CNA's are responsible for obtaining resident weights;-Weights should be obtained daily if a resident has an order. During an interview on 11/05/25, at 3:35 P.M., CNA A said the charge nurse tells the CNA's which residents wear Tubi grips. The CNA's are responsible for putting Tubi grips on residents. Tubi grips should be included in the care plan. Day shift CNA's should complete daily weight by 10:00 A.M The charge nurse provides a list with residents that need to be weighed in the morning. During an interview on 11/05/25, at 3:45 P.M., LPN D said a resident should have an order to use Tubi grips. The order should include the size and when to wear. A resident with edema or Tubi grip use should have the information included on the care plan. The morning aides complete daily weights. The nurse provides the CNA's with a list of weights to be done every day. During an interview on 11/05/25, at 4:00 P.M., Certified Medication Technician (CMT) E said Tubi grips require a physician order. He/she does not apply Tubi grip. Tubi grips and edema should be included on the care plan. Daily weights are completed by day shift CNA's. During interviews on 11/05/25, at 2:40 P.M. and 3:40 P.M., the MDS Coordinator said he/she updates the care plan based upon information obtained from nurses and in the morning meetings. Edema and Tubi grips should be included on residents' care plans. Tubi grips should have an order. During an interview on 11/05/25, at 4:15 P.M., the DON said edema, Lasix use, and Tubi grips should be included on the care plan. Care plan changes are discussed in stand-up meeting daily with the DON, Assistant Director of Nursing (ADON), and the MDS Coordinator. New orders and progress notes are reviewed for the last 24 hours for updates. The nurse and CNA's are responsible for daily weights. The CNA's are responsible for completing monthly weights. The charge nurse should make a list of daily weights and provide it to the aides. During an interview on 11/05/25, at</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5:05 P.M., the Administrator said staff should follow physician orders for daily weights. Tubi grips should have an order and be included on the care plan. Edema should be included on a resident's care plan.</p> <p>Complaint #2659996</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure an environment as free from accident hazards as possible when staff failed to analyze and identify the risks for falls, failed to implement new intervention to prevent future falls, and failed to care plan regarding new falls for three residents (Resident #1, #3, and #4) that sustained falls. The facility census was 93. Review showed the facility did not provide a policy regarding falls. Review of the facility policy titled Care Plan Comprehensive, undated, showed the following:-An individual comprehensive care plan should include measurable goals and timeframes;-The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to the Minimum Data Sheet (MDS - a federally mandated assessment instrument completed by facility staff);-A well-developed care plan will be oriented to preventing avoidable declines in functioning or functional levels; managing risk factors to the extent possible; applying current standards of practice in the care planning process; evaluating treatment of goals, timetables, and outcomes of care; and assessing and planning for care to meet the resident's medical, nursing, mental, and psychosocial needs.-The interdisciplinary care team is responsible for reviewing and updating the care plan when a significant change has occurred, quarterly, and when changes that impact resident care occur. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 03/27/25; -Diagnoses included non-Hodgkin lymphoma (cancer that is in the lymphocytes (white blood cells - a component of the immune system) and osteoarthritis (joint disease that causes pain, stiffness, and loss of function). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 10/01/25, showed the resident was cognitively intact and required moderate staff assistance with dressing and shower and supervision with toileting.Review of the resident's care plan, revised on 04/04/25, showed the following:-Resident at risk for falls related to decreased mobility and disease process;-Assess comfort and provide interventions during periods of restlessness;-Assist to the restroom before and after meals, bedtime, and as needed;-Assure resident wears eyeglasses;-Call light and personal items within reach;-Encourage resident to use environmental devices as needed;-Ensure proper footwear;-Bed in low position;-Obtain physical therapy consult as needed. Review of the resident's nursing progress note dated 05/07/25, at 1:00 A.M. showed the resident had an unwitnessed fall in the restroom while a certified nurse aide (CAN) was in the room. The CNA turned to obtain supplies for the resident and resident fell toward the right and hit his/her head on the wall next to the shower. Resident remained conscious and was able to follow commands. No red drainage noted. No bruise noted on head. Turned resident over to back and range of motion performed on right arm without difficulty. Faint lavender bruise noted on right side. Assisted up to toilet with one person assist. Resident complained of headache, rated at a 10 out of 10 on pain scale and pain medication administered. Vital signs and neurological monitoring started. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 05/07/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note, dated 06/01/25, showed the certified medication technician (CMT) reported the resident was on the floor. Resident reported he/she went to the restroom without a walker and on the way out lost his/her balance. Resident reported hitting right side of breast hard on the arm of a wheelchair nearby. Resident denied hitting head or pain. Resident able to move all extremities with good range of motion. Right side of</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265473	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Glendale Gardens Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 East Cherokee Springfield, MO 65809	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>breast noted to be red. Will monitor breast for any changes. Family notified of fall. Neurological assessment started. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 06/01/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note, dated 09/22/25, showed resident continued fall follow up due to a fall on 09/21/25 with no complaint of any discomfort at this time. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 09/21/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note dated 11/01/25, at 6:49 P.M., showed resident looked tired and reported he/she was very tired and weak. He/she slid from the recliner due to legs giving out and no energy. He/she again slid from bed but denies falling. Resident reported sliding from the bed due to very weak legs. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 11/01/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing note dated 11/02/25, at 1:12 P.M. showed a late entry indicating a report from the CNA this morning that the resident slipped on the floor while standing and landed on his/her back. Nurse checked resident and no injury or bruise noted. Resident denied any pain and stated his/her legs gave out and became very weak. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 11/02/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of the resident's nursing progress note dated 11/03/25, at 11:31 P.M., showed at 6:00 P.M. the resident fell on the way out of the bathroom. Resident was utilizing a walker and turned, lost balance, and landed on the floor. Resident found lying on his/her back. Resident complained of back pain which is not new to him/her. X-ray results negative on his/her back today before this fall. Roommate witnessed the fall. Resident able to move all extremities with no pain and denies hitting his/her head. Review of the resident care plan, revised 11/05/25, showed staff did not update the care plan with the fall on 11/03/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. 2. Review of the resident #3's face sheet showed the following:-admission date of 09/10/25; -Diagnoses included high blood pressure and lung cancer. Review of the resident's annual MDS, dated [DATE], showed the resident was cognitively intact and required supervision with ADL's. Resident utilized both a walker and a wheelchair. Review of the resident's care plan, revised on 09/17/25, showed the following:-Resident required one-to-two-person assistance with ADL's due to weakness;-Required one to two staff assistance with transfer and positioning;-Resident at risk for falls related to the disease process and weakness;-Staff should remind resident to be mindful of tubing as it can be a fall hazard;-Assess and treat orthostatic hypertension;-Implement exercise program for strength, balance, and gait;-Staff supervision based on resident need;-Offer comprehensive medication review;-Provide toileting interventions based on needs. Review of the resident's nursing progress note dated 10/06/25, at 12:30 A.M., showed resident turned on the call light and reported he/she was reaching for a pen on the floor and rolled out of bed. Resident sitting up with head above mattress. No marks seen on head, hand grip and feet</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>push pulls equally strong. Resident helped to her feet without difficulty. Neurological assessment and vital signs started. Review of the resident current care plan showed staff did not update the care plan with the fall 10/06/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. Review of a nursing progress note dated 10/21/25, at 11:33 A.M., showed a fall reported by the nurse at shift change and happened at 5:45 A.M. Fall caused by patient trying to get a soda and fell. No abnormalities reported. Review of the resident current care plan showed staff did not update the care plan with the fall on 10/21/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. 3. Review of the resident #3's face sheet showed the following:-admission date of 11/12/24; -Diagnoses included chronic obstructive pulmonary disease (COPD- group of lung diseases that cause persistent airflow obstruction and breathing problems) and heart failure. Review of the resident's annual MDS, dated [DATE], showed the resident was cognitively intact and required supervision with ADL's. Resident utilized both a walker and a wheelchair. Review of the resident's care plan, revised on 12/13/24, showed the following:-Resident at risk for falls related to the weakness, gait and balance concerns, and tethering of oxygen tubing;-Implement exercise program for strength, gait, and balance;-Increased staff supervision based on resident need;-Order comprehensive medication review;-Provide individualized toileting interventions. Review of the resident's nursing progress note dated 06/03/25, at 7:00 P.M., showed the resident found lying in the bathroom by the CNA. Resident stated he/she fell due to being lightheaded and hit head on the toilet paper holder. Resident left ankle was underneath him/her when fell. Head to toe assessment completed. Resident reported having a lot of pain. Scheduled pain medication is due. Family, nurse practitioner, and DON notified. X-ray is pending. Area wrapped, elevated, and ice applied. Review of the resident current care plan, updated 09/29/25, showed staff did not update the care plan with the fall 16/03/25 or any new interventions to prevent future falls. Review of the resident's record showed staff did not document an investigation into the fall, the cause of the fall, and any new interventions to prevent future falls. 4. During an interview on 11/05/25, at 12:45 P.M., CNA F said a resident care plan should include actual falls or if a resident is at risk for falls. Interventions for falls could include clear area or path for resident and ensure use of grippy socks. During an interview on 11/05/25, at 12:45 P.M., CNA B said he/she would check on the resident, call for help, and tell the nurse right away if a resident had a fall. Fall interventions could include call light within reach, bed rails, and keeping bed in a low position. During an interview on 11/05/25, at 3:35 P.M., CNA A said falls should be included in the care plan and interventions should be included after falls. Fall interventions could include grippy socks, bed alarms, call lights within reach, and ensuring use of adaptive equipment. During an interview on 11/05/25, at 1:10 P.M., Licensed Practical Nurse (LPN) C said new interventions should be included on the fall event form. During an interview on 11/05/25, at 1:20 P.M., LPN G said any new interventions should be entered in the event form. Falls should be included on a resident care plan and reviewed and updated after a fall. During an interview on 11/05/25, at 3:45 P.M., LPN D said residents at risk for falls should have it included in the care plan. He/she did not know if the care plan should be updated or reviewed after a fall. Fall interventions include bed in the lowest position and call light within reach. During an interview on 11/05/25, at 2:40 P.M., the MDS Coordinator said falls should be included in the care plan and have a template to include it. Falls are reviewed in morning meeting and new interventions are implemented and should be included in the care plan. He/she updates the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>care plan based upon information obtained from nurses and in the morning meetings. Interventions for falls could include use of grippy socks and keeping the bed in a low position. During an interview on 11/05/25, at 4:15 P.M., the Director of Nursing (DON) said care plans should be updated after a fall if a new intervention is needed. Care plan changes are discussed in stand-up meeting daily with the DON, Assistant Director of Nursing (ADON), and the MDS Coordinator. New orders and progress notes are reviewed for the last 24 hours for updates. During an interview on 11/05/25, at 5:05 P.M., the Administrator said falls and prevention are discussed in the morning stand up meeting. Care plans should be updated with any interventions that apply to a fall and what the fall was related to. Complaint #2659996</p>		