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	12/11/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review , the facility failed to provide care per standards of practice when staff failed to promptly assess one resident (Resident #2) after a change in condition. The census was 123.Review of the facility's policy named, Event Investigation, undated, showed the following:-Purpose to investigate the cause of all marks, discolorations, skin breaks and injuries which have not been witnessed and to identify any injuries after a resident sustains an event;-Handle resident gently, examine the entire skin surface, interview the resident to determine cause of any conditions identified, interview any witnesses to determine cause of any conditions identified, measure vital signs, assess pain, identify all skin discolorations, redness, swelling, edema (swelling), tenderness, breaks, or changes in temperature, measure the size, depth, color and location of any skin conditions identified, palpate peripheral pulses, gently perform passive and active range of motion of all joints, assess any change in mental and cognitive status through observation and interview of the resident, observe and assess all neurological signs, notify the resident's attending physician of a change of condition or any concerns that have been identified,notify the resident's representative of a change of condition or any concerns that have been identified, attempt to determine the cause of any conditions identified, implement preventive measures as appropriate, if resident abuse is suspected, proceed with abuse investigation;-Complete a Report of Event Form as soon as possible whenever there is an unusual, unexpected and/or unintended event that is not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a resident or visitor;-Examples of when a form should be completed include allegation or known abuse of a resident by a staff member, visitor or resident, fracture/dislocation of unknown origin, bruise/skin tear of unknown origin, elopement from the facility, equipment malfunction, fall or person found on the floor, burn/scald from hot beverage or hot water temperature, occurrence involving medication, self-inflicted injury, suicide or attempted suicide, and damaged or lost personal property;-Any staff member who discovers, witnesses or is involved in an event should immediately report the event to the nurse in charge. The charge nurse is responsible for completion of the Report of Event form and forwarding to the Director of Nursing (DON) as soon as possible. Events resulting in injury, life-threatening nature and/or allegation of or known abuse/neglect, the charge nurse will notify the DON and Administrator immediately. Upon notification of an event resulting in hospitalization or need to notify outside agency, the Administrator will notify the Quality Assurance Nurse Consultant and Director of Operations immediately;-The following should be completed on the form facility name; who the event involved; person's by name; date and time of the event; description of the event; witness names and contact information; primary diagnoses; cognitive status; exact location of event; equipment involved; type of event; observations; exact location of the injury and measurement ; vital signs; mental/neuro status - after the event; range of motion; complaint of pain; first (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aid given; what was done immediately to prevent event from happening again; nurse completing report and date with nurse signature with date;-Follow up section to be - These questions are to be completed by the DON to ensure an entry was made in the nurses' notes regarding the event, the event was logged for tracking/trending purposes, the facility's investigation was completed to determine causal factors of the event and to determine changes in resident plan of care or facility practice to reduce the likelihood of recurrence, the plan of care was revised, 72 hour monitoring initiated in nurses' notes and any further comments. If any of the questions are answered no there must be further explanation of why;-Administrative action taken, to be completed by the Administrator after review of the event report and investigation findings. Provide information regarding any further administrative action including but not limited to personnel action or policy revision. 1. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 07/31/24;-Diagnoses included chronic kidney disease - stage 5 (end-stage kidney disease - when the kidneys have failed or have very low function), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), and mood disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 08/17/25, showed the following:-Resident had mild cognitive impairment;-The resident required set-up or clean up assistance for oral hygiene;-The resident required substantial/maximal assistance for transfers and used a wheelchair. Review of the resident's care plan, dated 07/31/24, showed the resident required dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally) three times per week. The resident was at risk of fluid volume excess and or/depletion.Review of the resident's hospital records showed the following:-The resident admitted to the hospital on [DATE];-The resident arrived at the hospital by emergency medical services from a dialysis clinic after he/she was dropped off by transport. They found him/her to have altered mental status. He/she was normally oriented to person, place, time, and situation but was only oriented to person;-The resident was diagnosed with metabolic encephalopathy and hypoglycemia (low blood sugare);-The resident returned to the facility on [DATE]. Review of the resident's records showed staff did not document regarding the resident's change in condition or transfer to the hospital on [DATE]. Review of the resident's progress note dated 11/01/25, at 6:15 P.M., showed License Practical Nurse (LPN) I noted the resident readmitted from the hospital for acute encephalopathy. During an interview on 10/29/25, at 11:12 A.M., Certified Nursing Aide (CNA) J said the following:-On 10/27/25, he/she transported the resident to dialysis;-He/she helped CNA K get the resident ready for the appointment around 10:15 A.M. to 10:30 A.M., ;-He/she noticed that the resident was not acting like his/her normal self. The resident kept dropping (3 times) his/her toothbrush while trying to brush his/her teeth and couldn't lean forward to spit in the skin and spit on him/herself. The resident seemed a little incoherent and was mumbling. This was not normal for the resident, and he/she felt it was a change in condition;-Generally, the resident can brush teeth with just a little set-up help and can converse;-He/she was concerned about the resident and checked the resident's vital signs;-He/she then reported to the LPN I that the resident was talking nonsense and was not acting like herself. He also told the nurse that she was kept dropping his/her toothbrush and what the vital signs were;-The nurse did not have concerns about the resident's vital signs;-He/she thought the nurse would go assess the resident, but he/she did not. LPN I told him/her to go ahead and take the resident to his/her dialysis appointment and dialysis would take care of him/her if it was really that bad. LPN I did not go talk to the resident;-He/she would have considered what was going on with her has really bad;-He/she did what the nurse told (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	him/her to do and transported the resident to dialysis;-He/she let the receptionist at dialysis know that the resident was not him/herself;-A staff member immediately came out and assessed the resident;-The resident's speech was now slurred and the staff from dialysis immediately sent him/her to the hospital;-He/she called the Administrator and told him/her that the resident was being sent to the hospital and about the change in condition and mumbling speech;-The Administrator asked if he/she had told the nurse. He/she told the Administrator that he/she had and he/she said okay and the conversation ended. The Administrator did not ask if the nurse had assessed the resident;-Generally, if there is a change in condition or anything seems off with a resident the CNA's are supposed to let the nurse know so they can assess them. The CNA's can take vital signs to help with the assessment. During an interview on 10/29/25, at 11:30 A.M., CNA I said the following:-The resident seemed out of it on the morning of 10/27/25. The resident had a normal baseline of being oriented and coherent. He/she could generally brush his/her teeth with set up from staff. He/she did not generally mumble or slur his/her words;-The resident was mumbling on 10/27/25 and just acting off and really tired;-He/she was not sure if anything serious was going on and felt it should be reported to the nurse;-He/she thought he/she told LPN I around 10:45 A.M. that the resident was not acting like him/herself;-He/she expected that LPN I would assess the resident before leaving for his/her dialysis appointment. The resident generally leaves around 11:00 A.M. because his/her appointment is at 11:30 A.M.,-He/she remembered LPN I saying he/she thought the resident would be admitted to the hospital from dialysis due to him/her acting weird;-The resident got admitted to the hospital from dialysis;-CNA's are supposed to report any changes in condition to the nurse. He/she felt this was a change in condition and that was why she reported it to LPN I. During an interview on 10/29/25, at 11:12 A.M., Certified Medication Tech (CMT) K said the following:-He/she was to report any resident changes in condition to the nurse;-On 10/27/25, at around 9:45 A.M. to 10:00 A.M., he/she went to give the resident medications. The resident was leaning far over to the left side and when he/she asked the resident why he/she was leaning he/she said there was a man pushing her and he/she had told him to stop but there was nobody else in the room;-He/she felt this was a change in condition because the resident does not usually hallucinate, and he/she was not acting like her/himself;-He/she repositioned the resident;-He/she then let the nurse know that the resident thought there was a man in her room and he/she was not acting like herself. He/she thought it was LPN I that he/she spoke to;-He/she then continued on passing medications and did not see LPN I assess the resident, but he/she assumed that he/she would. During an interview on 10/30/25, at 8:31 A.M., LPN I said the following:-The resident went to dialysis three times a week;-On the morning of 10/27/25, at around 10:30 A.M., he/she was told by two staff , CNA J and CNA K, that the resident was not acting like him/herself;-The resident was talking to him/herself and acting different from his/her normal;-The CMT said that the resident was talking to someone that was not there;-He/she had a CNA get vital signs and they were okay for the resident;-He/she did not go and assess the resident;-The resident has had hallucinations in the past, but it is when the resident has metabolic encephalopathy or a urinary tract infection and she goes to the hospital;-He/she did tell the CNA to go ahead and take him/her to dialysis and he/she would assess him/her when she returned;-If the resident was not going to dialysis, he/she would have assessed him/her. Due to the resident going to dialysis, he/she did not think he/she needed to. Normally, he/she would assess for change in condition and contact the physician;-He/she forgot to put in a nurses note regarding the change in condition. He/she would generally put in a note;-The resident was sent to the hospital from dialysis. During an interview on 10/30/25, at 12:05 P.M., the resident's Physician said the following:-The resident's health waxes and wanes, but he/she was able to converse and hold a (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	toothbrush;-He/she would expect the nurse to complete and face to face assessment if the resident was acting out of the normal;-He/she could understand why the nurse would want the resident to go ahead to the dialysis appointment, but he/she would have liked an assessment first;-He/she felt it was important for the resident to get to his/her dialysis appointment due to it possibly helping the resident's change in condition;-Any changes in the resident's condition should be documented. During an interview on 10/31/25, at 8:01 A.M., the resident's Nurse Practitioner (NP) said the following:-On 10/27/25, he/she did not get to assess the resident because he/she had just left for dialysis when he/she was arriving to the building;-He/she was informed by LPN I that the resident was not acting right more confused and talking out of her head ;-He/she ordered labs for the resident, but the resident did not return from dialysis;-The resident tends to get very sick quickly due to all his/her conditions;-The resident can sometimes have some confusion but had not heard of her having hallucinations or dropping her toothbrush multiple times at her normal baseline;-The resident missed dialysis on 10/24/25;-He/she assumed that LPN I had assessed the resident, and he/she would have expected for the nurse to assess the resident;-If a resident had a change in condition, they should be assessed with a head-to-toe assessment and check vital signs;-He/she had heard from the hospital that the resident was diagnosed with metabolic encephalopathy and his/her blood sugars were very low. During an interview on 11/06/25, at 12:59 P.M., LPN F said the following:-If a resident was acting out of their normal baseline then the nurse should assess them;-A resident that is normally oriented that is acting more confused and hallucinating would indicate to him/her a change condition that would require an assessment;-Then he/she would document in the chart the resident's status and steps taken to address the change in condition. During an interview on 11/06/25, at 2:28 P.M., the Assistant Director of Nursing (ADON) said the following:-The majority of the time the resident is oriented, and he/she was not aware of the resident having any hallucinations and would consider that a change condition;-He/she was not aware of the resident having a change in condition, but would expect the nurse to assess a resident if they have a change in condition;-He/she took care of the resident the night before on 10/26/25 and he/she was not acting confused, but he/she did refuse to eat. During an interview on 11/06/25, at 3:05 P.M., at the DON said the following:-He/she initially thought that the resident's NP had assessed the resident due to there being lab orders;-He/she would expect a nurse to check on and assess any resident that is acting off or with a change in condition;-A change in condition should be reported to the DON and documented in the resident's progress notes;-He/she would expect a CNA to get the ADON or the DON if they report a change in condition and the nurse does not assess the resident. During an interview on 11/06/25, at 3:39 P.M., the Administrator said the following:-He/she was not aware of the resident having hallucinations;-He/she would have expected the nurse to assess the resident. A nurse should assess resident's if they have a change in condition;-He/she would expect there to be a note in the resident's chart regarding the resident's change in condition. 2653479

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to ensure an environment as free from accident hazards as possible when staff failed to identify, assess, investigate, and document bruising of an unknown source for one resident (Resident #1). The census was 123. Based on observations, interview, and record review the facility failed to ensure an environment as free from accident hazards as possible when staff failed to identify, assess, investigate, and document bruising of an unknown source for one resident (Resident #1). The census was 123. Review of the facility's policy named, Event Investigation, undated, showed the following:-Purpose to investigate the cause of all marks, discolorations, skin breaks and injuries which have not been witnessed and to identify any injuries after a resident sustains an event;-Handle resident gently, examine the entire skin surface, interview the resident to determine cause of any conditions identified, interview any witnesses to determine cause of any conditions identified, measure vital signs, assess pain, identify all skin discolorations, redness, swelling, edema (swelling), tenderness, breaks, or changes in temperature, measure the size, depth, color and location of any skin conditions identified, palpate peripheral pulses, gently perform passive and active range of motion of all joints, assess any change in mental and cognitive status through observation and interview of the resident, observe and assess all neurological signs, notify the resident's attending physician of a change of condition or any concerns that have been identified,notify the resident's representative of a change of condition or any concerns that have been identified, attempt to determine the cause of any conditions identified, implement preventive measures as appropriate, if resident abuse is suspected, proceed with abuse investigation;-Complete a Report of Event Form as soon as possible whenever there is an unusual, unexpected and/or unintended event that is not consistent with the routine operation of the facility, the routine care of the resident and/or adversely effects or has the potential to adversely affect a resident or visitor;-Examples of when a form should be completed include allegation or known abuse of a resident by a staff member, visitor or resident, fracture/dislocation of unknown origin, bruise/skin tear of unknown origin, elopement from the facility, equipment malfunction, fall or person found on the floor, burn/scald from hot beverage or hot water temperature, occurrence involving medication, self-inflicted injury, suicide or attempted suicide, and damaged or lost personal property;-Any staff member who discovers, witnesses or is involved in an event should immediately report the event to the nurse in charge. The charge nurse is responsible for completion of the Report of Event form and forwarding to the Director of Nursing (DON) as soon as possible. Events resulting in injury, life-threatening nature and/or allegation of or known abuse/neglect, the charge nurse will notify the DON and Administrator immediately. Upon notification of an event resulting in hospitalization or need to notify outside agency, the Administrator will notify the Quality Assurance Nurse Consultant and Director of Operations immediately;-The following should be completed on the form facility name; who the event involved; person's by name; date and time of the event; description of the event; witness names and contact information; primary diagnoses; cognitive status; exact location of event; equipment involved; type of event; observations; exact location of the injury and measurement ; vital signs; mental/neuro status - after the event; range of motion; complaint of pain; first aid given; what was done immediately to prevent event from happening again; nurse completing report and date with nurse signature with date;-Follow up section to be - These questions are to be completed by the DON to ensure an entry was made in the nurses' notes regarding the event, the event was logged for tracking/trending purposes, the facility's investigation was completed to determine causal factors of the event and to (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine changes in resident plan of care or facility practice to reduce the likelihood of recurrence, the plan of care was revised, 72 hour monitoring initiated in nurses' notes and any further comments. If any of the questions are answered no there must be further explanation of why;-Administrative action taken, to be completed by the Administrator after review of the event report and investigation findings. Provide information regarding any further administrative action including but not limited to personnel action or policy revision. 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 10/23/25;-Diagnoses included cerebral infarction (the death of brain tissue due to a lack of blood flow, typically caused by a blood clot), hemiplegia and hemiparesis (a complete paralysis on one side of the body, while hemiparesis is weakness on one side), muscle weakness, cognitive communication deficit, dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), anxiety disorder, and aphasia (impaired speech) following cerebral infarction. Review of the resident's admission clinical assessment dated [DATE], at 7:26 P.M., showed staff noted no skin issues. Review of the resident's skin monitoring shower sheet, dated 10/27/25, showed staff noted no new skin conditions. Review of the resident's weekly skin assessment, dated 10/27/25, showed the resident had scattered bruising especially right arm prior to admission.Review of the resident's care plan, dated 10/27/25, showed staff did not care plan regarding any bruising.Observations of the resident on 10/29/25, at 9:38 A.M., showed the following:-The resident had bruising on the right side of his/her forehead about the size of a golf ball that was dark purple in color;-The resident had dark purple bruising to the left ring finger.During an interview on 10/29/25, at 9:38 A.M., the resident's family said the following:-The resident did not have the bruising on his/her forehead or finger prior to her coming to the facility or as of 10/26/25;-They reported to the staff that the resident had new bruising. They did not think the nurse had assessed the resident;-The resident was not able to tell them what caused the bruising;-The facility did not report any incidents that may have caused the bruising. During an interview on 10/29/25, at 10:42 A.M., Licensed Practical Nurse (LPN) A said the following:-He/she was not aware of any bruising on the resident's forehead of finger when he/she worked on 11/26/25;-He/she noticed bruising to the resident's left finger about an hour ago and planned to assess it;-He/she was not aware of any bruising on the resident's forehead;-He/she planned to talk to the certified nurse aides (CNA) regarding the bruising to figure out the possible cause;-He/she would also notify the Director of Nursing (DON) and Assistant Director of Nrusing (ADON) of the bruising;-Any new bruising on the resident should be documented;-There was nothing documented or told to him/her in report that would have caused the bruising overnight;-The resident does lower him/herself to the floor, but he/she does not fall or go down unsafely.Review of the resident's progress note, late entry on 10/29/25 at 1:06 P.M., showed LPN A said the resident's family noti?ed him/her of bruising to left third ?nger. It was purple in color. The resident reported no pain and was unable to recall any incident related to the area of concern due to advanced state of disease process. ADON and DON aware of bruising. Family aware at time of discovery by this nurse. (The resident's progress notes did not show any documentation regarding a bruise on the resident's forehead.) During an interview on 10/29/25, at 12:52 P.M., CNA B said the following:-He/she gave the resident a shower on 10/24/25. He/she remembered there being bruising on the right shoulder/arm from admission, but that was it. He/she saw bruising on the resident's finger earlier this morning around 8:30 A.M. It appeared to be blackish/ purple in color and swollen;-There was also a purple circular bruise on the resident's forehead. He/She did not tell the nurse because the morning was hectic;-He/she did not know how he/she got the bruising, but the resident does put (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him/herself down on the floor and will crawl around at times. During an interview on 10/29/25, at 3:13 P.M., CNA G said the following:-Today around 7:00 A.M., he/she saw bruising on the resident's left hand/finger. It was reddish purple and swollen. He/she did not tell the nurse;-He/she worked on 11/26/25 and he/she did not have the bruise then. He/she assumed the bruise happened in the two days that he/she had off;-If there is new bruising he/she was supposed to report to nurse;-He/she was not aware of the bruise on his/her forehead, but he/she had bangs so she maybe would not see it. During an interview on 10/30/25, at 7:48 A.M., LPN C said the following:-He/she worked on the nights of 10/27/25 and 10/28/25;-He/she was not aware of any new bruising on the resident;-The CNA's generally report any new bruising to him/her and he/she would assess the resident;-If a resident had new bruising it should be documented so it can be monitored. During an interview on 10/30/25 at 8:04 A.M., CNA D said the following:-He/she saw bruising on the resident's left ring finger on 10/27/25, in the evening. It was dark purple. He/she did not report the bruising because he/she thought maybe he/she had come from the hospital with it;-He/she thought it could have been from a ring;-The resident was unable to say where the bruise came from;-If a resident had bruising and the staff member was not sure the nurse is aware of it they should report it;-He/she also brushed the resident's hair that night and did not notice any bruising on his/her head. During an interview on 10/31/2,5 at 5:02 A.M., CNA E said if a resident had any new bruises the CNA's are supposed to report it to the nurse so they can assess it. During an interview on 10/31/25, at 8:59 A.M., the Social Services Designee he/she spoke with the resident the morning of 10/29/25 and noticed a bruises on the resident's left finger and on forehead. They were both purple in color. He/she did not report the bruises to the nurse because he/she believed he/she was aware of it. During an interview on 11/06/25, at 12:59 P.M., LPN F said the following:-He/she saw bruising on the resident's left finger, but he/she did not feel it was significant. It was purple in color. He/she did not assess it. He/she did not document anything about it. He/she was not sure what day he/she saw it;-He/she did not see bruising on the resident's forehead but if he/she had, he/she would have assessed it and most likely started neuro checks. He/she would have made a nurses note, and an event made. They generally investigate the bruise to find the cause if possible;-The resident had been witnessed getting down on the floor on purpose and then refusing to let staff help her up. During an interview on 11/06/25, at 2:18 P.M., CNA H said he/she remembered the resident having a bruise on his/her forehead. He/she believed it was on the left side. He/she believed he/she notified LPN F. During interviews on 10/29/25, at 2:35 P.M., and on 11/06/25, at 2:28 P.M., the ADON said the following:-He/she saw bruising on the resident's finger this morning. He/she did not remember seeing it the morning of 10/29/25. He/she did not see bruising on the resident's head;-The CNA should report any new bruising to the nurse. If it is of unknown origin the nurse should contact on call person;-The nurse should assess the resident and notify the on-call person. He/She would expect the nurse to document information regarding the bruise such as location, description and how the resident got the bruise and out in an event. During interviews on 10/29/25, at 2:09 P.M., and on 11/06/25\, at 3:05 P.M., at the DON said the following:-The resident's family reported bruising on her finger and her forehead. He/she was not sure where it came from;-The CNA's should always report new bruising to the nurse. They should check with the nurse if they are not sure if it is new;-The nurse should assess the resident and then document what they observed in a note and an event;-A bruise on a resident's head should he assessed timely;-All events should be reported to the DON. During an interview on 11/06/25, at 3:39 P.M., the Administrator said the following:-If a CNA sees bruising on a resident, they should report it to the nurse so they can assess it. There should be documentation regarding the bruise and the assessment in a progress note;-All bruising should be (continued on next page)

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	265814	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Villa	1100 East Montclair Springfield, MO 65807

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to the nurse within the same shift. 26534798

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, the facility staff failed to post nursing staff information in a prominent readily accessible area and failed to show the total number of hours worked for nursing staff directly responsible for nursing care. The census was 116. Review of the facility records did not show a policy regarding posted nurse staffing. Review of the facility's daily staffing roster, dated 01/31/26, 02/01/26, and 02/02/26 showed the following: -Staff names and what schedule they worked;-The staff names did not all have designations to differentiate registered nurses from licensed practical nurses or certified nurses aides from nurse aides;-The roster did not provide a total number of actual hours worked for the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Observations at the facility on 02/02/26 at 1:06 P.M., showed there was no posted nurse staffing by the Assistant Director of Nursing's (ADON) door. Observations at the facility on 02/02/26 at 1:08 P.M., showed a nursing roster taped to the top of the counter on 100 hall. During an interview on 02/02/26 at 1:20 P.M., certified nurse aide(CNA) J said the following: -He/she was not sure where the nursing staff posting was. During an interview on 02/02/26 at 2:04 P.M., licensed practical nurse (LPN) I said the following: -The nursing staff roster is generally up at the front of the facility near the ADON's door;-They post the roster daily but recently he/she was told to tape it to the top of the counter;-The resident's that use wheelchairs would most likely not be able to look at it without help. During an interview on 02/02/26 3:54 P.M., the ADON said the following:-The nursing roster is generally posted on the wall outside his/her office;-He/she was not sure when it fell off the wall but it was maybe a few weeks ago;-He/she has not been told that he/she needed to make sure it was hung up outside his/her door;-He/she was not sure of all the requirements for the nurse posting. During an interview on 02/02/26 at 1:20 P.M., the Director of Nursing said the following: -The nurse posting was generally hung outside the ADON's office, bedside the door, and updated daily;-The plastic holder fell of the wall a little while ago and had not been fixed yet. He/she was not sure how long it had been broken;-The staff roster was now placed on top of the counter on 100 hall;-The residents in wheelchairs could be assisted by the nurses if they wanted to see it;-He/she thought the nursing roster/schedule on the counter was adequate to meet the requirement of the nurse posting. During an interview on 02/02/26 at 3:35 P.M., the Administrator said the following: -He/she was not aware the nurse roster was not hanging up;-Generally, they hang the staff roster that has the nursing staff names and their schedule.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to provide medications as ordered for one resident (Resident #1). The facility census was 116.Review of the facility's 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 the care, signs, symptoms, etc., as well as the resident's progress, guidance to the physician in prescribing appropriate medications and treatments, nursing services personnel with a record of the physical and mental status of each resident, assistance in the development of a plan of care for each resident, The elements of quality medical nursing care, a legal record that protects the resident, physician, nurse, and facility;-Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations;-Be concise, accurate, and complete and use objective terms. Avoid incomplete, monotonous, and meaningless entries;-Document only the facts. Use only approved abbreviations and symbols.-Chart as often as necessary and as the need arises;-Medication Administration should include, date and time medication was administered, name and strength of medication and how administered, frequency of administration, reason for as needed administration and its effects on the resident, pulse and blood pressure if appropriate;-Document on the Medication Administration Record (MAR) as the medications are administered. Review of the facility's policy, titled, Medication Administration, undated, showed the following:-Medications are to be given to benefit the resident's health as ordered by the physician. 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 01/23/26 at 5:45 P.M.;-Diagnosis included, Unspecified dementia, moderate without behavioral disturbance (a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Type 1 diabetes, muscle wasting and atrophy (involves the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging (sarcopenia), or diseases affecting nerves or muscles), muscle weakness, cognitive communication deficit (an impairment in communication due to underlying issues with cognitive processes like memory, attention, and executive function, rather than a primary language disorder), abnormalities of gait, hypertension (high blood pressure), and polyneuropathy (a condition characterized by damage to multiple peripheral nerves, usually causing symmetrical numbness, tingling, pain, and weakness, often starting in the feet and hands);-Discharge to the hospital on [DATE] at 2:05 P.M. Review of the resident's physician order sheet, dated January 2026, showed the following:-An order for Atorvastin (used to lower cholesterol) 80 milligrams (mg) tablet once at bedtime, dated 01/23/26;-An order for Donepezil(used to improve cognitive function), one 10mg tablet at bedtime, dated 01/23/26;-An order for Quetiapine (an antipsychotic medication) 25 mg tablet once at bedtime, dated 01/23/26. Review of the resident's MAR, dated January 2026, showed the following:-An order for Atorvastin 80 mg tablet once at bedtime, dated 01/23/26, was not administered 01/24/26 and 01/25/26 due to drug unavailable;-An order for Donepezil, one 10mg tablet at bedtime, dated 01/23/26, was not administered, 01/24/26 and 01/25/26 due to drug unavailable;-An order for Quetiapine 25 mg tablet once at bedtime, dated 01/23/26, was not administered 01/24/26 and 01/25/26 due to drug unavailable. Review of the resident's progress notes, showed the following:-On 01/24/26 at 9:56 A.M., Licensed Practical Nurse (LPN) B said there was a new order for Zofran (used for nausea) 4 mg as needed every six hours;-The nurses notes did not mention contacting the physician or pharmacy regarding medications. During an interview on 01/29/26 at 1:32 P.M., LPN D said the following:-The Director of Nursing (DON) put in all the orders, including those for medications;-He/she was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not aware the resident was not getting medications as ordered;-The nurse should contact the pharmacy if they do not have medications for the resident. During an interview on 01/29/26 at 2:32 P.M., Certified Medication Tech (CMT) G said the following:-He/she noticed the resident did not have most of his/her medications on Saturday 01/24/26 that were ordered and let LPN E know. He/she is not sure what LPN E did with that information, but the resident still did not have medication on 01/25/26;-He/she checked and the medications were not available in the facility's emergency supply of medication;-Medications should be administered per the physician's order. During an interview on 01/29/26 at 2:47 P.M., LPN E said the following:-He/she was not aware Resident #1 did not have any medications from the pharmacy and did know medications were not administered due to not being available. Staff should check the emergency supply of medications and call the pharmacy;-He/she does not recall any CMTs reporting issues regarding Resident #1's medication. During an interview on 01/29/26 at 3:03 P.M., LPN A said the following:-He/she was aware of any medications not being administered that were ordered for Resident #1;-If medications are not delivered from the pharmacy the nurse should call the pharmacy. During an interview on 01/29/26 at 3:22 P.M., LPN B said the following:-He/she was not aware Resident #1 did not receive medications as ordered or that they were not delivered from the pharmacy;-He/she would have expected the nurse to get it from the emergency medication supply and call the pharmacy. During an interview on 01/30/26 at 2:40 P.M., the Assistant Director of Nursing (ADON) said the following:-Medication should be administered per order;-If medication is not available, then they should call and get it from the pharmacy. During an interview on 01/29/26 at 4:22 P.M., the DON said the following:-He/she entered the medication orders for the resident upon his/her admission;-He/she was not aware Resident #1 was not getting his/her medication while at the facility. He/she was not aware the medication had not been delivered by the pharmacy while the resident was at the facility;-Residents should get medication as ordered and if it is unavailable the staff can look in the emergency medication kit. Staff should contact pharmacy for any medication not received. The medication should have been received the next morning since the resident was admitted after 5:00 P.M During an interview on 01/29/26 at 4:45 P.M., the Administrator said the following:-If the medications do not arrive from the pharmacy the staff should follow up with the pharmacy and should let the physician know if they are having difficulty getting medications;-Medications should be administered as ordered. During an interview on 01/30/26 at 10:39 A.M., the resident's physician said residents should receive medication as ordered and if there is an issue they should let him/her know. MO2728765MO2727145

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on interview and record review, the facility failed to have hospital transfer agreements in place. The census was 116. Review showed the facility did not have a transfer agreement policy. Review of the records showed no transfer agreements. During an interview on 02/02/26 at 3:35 P.M., the Administrator said the following: - He/she was not aware the facility needed to have transfer agreements with the hospital. He/she has never had any issues with transferring residents to the hospital;- He/she has not been the administrator at the facility very long, but he/she would attempt to find transfer agreements; - He/she was unable to locate any transfer agreements. He/she has contacted the local hospitals and is working on getting them.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility staff failed to employ a social services designee (SSD) that met the minimal qualifications for a social worker at the facility with more than 120 beds. The facility had a capacity of 146 and the census was 116 at the time of the survey. Review of the facility's policy, titled, Job Description, Social Worker, dated 05/06, showed the following: -The minimum qualifications require a graduation from an accredited four-year college or university with a degree in social work, sociology, or closely related degree.-Two years of experience in long term care. During an interview on 02/02/26 at 1:59 P.M., the SSD said the following:-He/she is in charge of the social services department at the facility;-He/she does not have a bachelors degree;-He/she is currently working on his/her bachelors degree in psychology and has about a year left;-He/she thinks he/she has the required qualifications to be the social worker in the facility due to taking a continuing education course to be the SSD in long term facilities offered by the state. During an interview on 02/02/26 at 1:59 P.M., the SSD assistant said he/she does not have a bachelors degree and has not started a degree program yet. During an interview on 02/02/26 at 3:44 P.M., the Director of Nursing (DON) said the following:-The SSD is in charge of the social services department;-He/she was not aware the SSD did not have a bachelors. He/she is not sure what all of the qualifications are, but thought that he/she was qualified. During an interview on 02/02/26 at 3:35 P.M., the Administrator said the following: -He/she was not aware the SSD did not have a bachelors degree and did not meet the requirement;-He/she was the SSD prior to him/her becoming the administrator.