STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265871	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunterra Springs Springfield	4935 S National Ave Springfield, MO 65810

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure pain services provided per standards of practice when staff failed to document providing appropriate pain medication to address pain in a timely manner for one resident (Resident #93) admitted from the hospital after knee replacement surgery. The facility census was 37. Review of the facility policy admission Orders. revised 04/2025, showed the following: -A physician must personally approve, in writing, a recommendation that an individual be admitted to a facility. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide written and/or verbal orders for the resident's immediate care and needs; -The written and/or verbal orders should include at a minimum dietary, medication orders if indicated, and routine care orders; -The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission; -The orders should provide information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. Review of the facility's policy Pain Management, revised 04/2025, showed the following: -Acute pain refers to pain that is usually sudden in onset and time-limited with a duration of less than one month and often is caused by injury, trauma, or medical treatments such as surgery; -Chronic pain refers to pain that typically lasts greater than three months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause; -Subacute pain refers to pain that has been present for one to three months; -Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated; -Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265871	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2025
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences; -Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to change in gait (e.g. limping), skin color, vital signs (increased heart rate, respirations, and/or blood pressure), perspiration; loss of function or inability to perform activities of daily living (ADLs); fidgeting, increased or recurring restlessness; facial expressions (grimacing, frowning, fright, or clenching of the jaw); behaviors such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities; difficulty eating or loss of appetite; weight loss; difficulty sleeping (insomnia); negative vocalizations (groaning, crying, whimpering, or screaming); decline in activity level; and skin conditions; -Facility staff will be aware of verbal descriptor a resident may use to report or describe their pain. Descriptors include but are not limited to heaviness or pressure, stabbing, throbbing, hurting or aching, gnawing, cramping, burning, numbness, tingling, shooting or radiating, spasms, soreness, tenderness, discomfort, pins and needles, feeling rough, tearing, or ripping; -The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain; -Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team may necessitate gathering the following information as applicable to the resident such as history of pain and its treatment; asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual de scriptor that is appropriate and preferred by the resident; reviewing the resident's current medical conditions (pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, post CVA (stroke), venous and arterial ulcers, and multiple sclerosis); identifying key characteristics of the pain: duration of pain, frequency, location, timing, pattern (constant or intermittent), radiation of pain; -Obtaining descriptors of the pain (stabbing, aching, pressure, spasms); identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain; impact of pain on quality of life (sleeping, functioning, appetite, and mood); current prescribed pain medications, dosage and frequency; and the resident's goals for pain management and his/her satisfaction with the current level of pain control; -Based upon the evaluation, the facility in collaboration with the attending physician, other health care professionals, and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission; -Factors influencing the choice of treatments include cause, location and severity of resident's pain, current medical condition, current medications, resident's desired level of relief and tolerance for adverse consequences (partial pain relief for fewer significant adverse consequences), potential benefits, risks and adverse consequences of medications; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Non-pharmacological interventions will include, but are not limited to environmental comfort measures(adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning), loosening any constrictive bandage, clothing or device, applying splinting (pillow or folded blanket), physical modalities (cold compress, warm shower/bath, massage, turning and repositioning), cognitive/behavioral interventions (music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain); -Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain. The following general principles the facility will utilize for prescribing analgesics: -Evaluate the resident's medical condition, current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic therapy for pain; -Consider administering medication around the clock instead of PRN (on demand) or combining longer acting medications with PRN medications for breakthrough pain; -Use lower doses of medication initially and titrate slowly upward until comfort is achieved; -Reassess and adjust the medication dose to optimize the resident's pain relief while monitoring the effectiveness of the medication and work to minimize or manage side effects; -Opioid treatment for acute pain, subacute pain, and chronic pain will be prescribed and dosed in accordance with current professional standards of practice and manufacturers' guidelines to optimize their effectiveness and minimize their adverse consequences; -Opioid treatment should be individualized for each resident with consideration by the prescriber of utilizing immediate-release opioids instead of extended-release and long-acting forms of opioids; -Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen. 1. Review of Resident #93's face sheet (admission information at a glance) showed the following: -admission date of 05/25/25; -Diagnoses included aftercare following joint replacement surgery, osteoarthritis (degeneration of joint cartilage and underlying bone which causes pain and stiffness, especially in hip, knees, and thumb joints), anxiety disorder, fibromyalgia (widespread body pain and tiredness), and neuropathy (a nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body). Review of the resident's care plan, initiated 05/25/25, showed the following: -At risk for acute pain related to right total knee replacement; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Goal to have no unaddressed pain with current pain interventions; -Interventions included monitor pain as prescribed, offer non-pharmacological approaches to pain management (massage, ice, reposition), monitor for side effects of pharmacological pain interventions, and notify physician with positive signs or symptoms of side effects; -Administer medications as prescribed. Review of the resident's Physician's Orders (POS), dated 05/25/25, showed the following: -Complete and document pain assessment using numeric/facial/[NAME] pain scale every shift; -Non-pharmacological interventions for pain include 1=repositioning, 2=cool pack, 3=warm pack, 4=dim light/quiet environment, 5=relaxation, 6=distraction, 7=music, and 8=massage every shift; -Acetaminophen (for mild pain) oral tablet 500 milligrams (mg) two tablets by mouth every eight hours as needed for mild pain; -Hydromorphone HCL (opioid narcotic to treat moderate to severe pain) tablet, 2 mg tablet, give one tablet by mouth every four hours as needed for pain (maximum daily amount 12 mg); -Tramadol HCL (narcotic medication for moderate to severe pain) 50 mg tablet give one tablet by mouth every six hours as needed for moderate and severe pain. Review of the resident's progress note dated 05/25/25, at 1:11 P.M., showed Registered Nurse (RN) C did a pain assessment that showed the resident had frequent moderate pain making it hard to sleep at night, limited participation in rehabilitation therapy sessions, limited day-to-day activities, pain intensity of five with worst pain moderate, and resident vocalized complaints of pain. Location was the right knee with aching, spasm, stiffness, cramping, nonradiating, and multiple times a day. Cool compresses applied. Non-medication interventions provided relief. PRN medication provided. Review of the resident's pain level summary sheet dated 05/25/25, at 1:12 P.M., showed a pain level of 5 (moderate pain). Review of the resident's Medication Administration Record (MAR), dated 05/25/25, showed an order for acetaminophen oral tablet 500 mg, give two tablets every eight hours as needed for mild pain. Staff did not documentation administration of the resident's acetaminophen on 05/25/25. Review of the resident's pain level summary sheet dated 05/26/25, at 1: 08 A.M., showed a pain level of moderate pain. Review of the resident's progress notes dated 05/26/25, at 9:07 A.M., showed Registered Nurse (RN) F documented the resident was very upset this morning about not having any pain medications. RN F called the pharmacy and the pharmacy said they would STAT (immediately send) them to the facility. Review of the resident's pain level summary sheet dated 05/26/25, at 2:26 P.M., showed Certified Medication Tech (CMT) A documented pain level 5 (moderate pain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical records showed staff did not document administration of pain medication to address the resident's pain. Review of the resident's pain level summary sheet dated 05/26/25, at 8:40 P.M., showed Licensed Practical Nurse(LPN) N documented resident's pain level was 6 (moderate pain). Review of the resident's MAR, dated 5/26/25, showed at 8:40 P.M., LPN N administered hydromorphone 2 mg and documented the medication was effective for treatment of the resident's pain. Review of the resident's pain level summary sheet dated 05/26/25, at 9:51 P.M., showed LPN N documented pain level of 4 (less pain but moderate level). Review of the resident's MAR, dated 5/27/25, showed the following: -At 12:40 A.M. and 12:51 A.M., (2 1/2 hours after hydromorphone administered), LPN N administered another hydromorphone 2 mg tablet and the pain level was 5 (moderate). The LPN document the medication was effective in treating the resident's pain; -At 5:41 A.M., the resident's pain level was 6 (moderate pain) and LPN administered hydromorphone 2 mg; -At 7:10 A.M., the resident's pain level was 5 (moderate pain); -At 12:11 P.M., the resident's pain level was 7 (moderate to severe pain) and staff administered hydromorphone 2 mg tablet. Review of the resident's medical record showed staff did not notify the physician of the increased pain level. During an interview on 05/30/25, at 9:25 A.M., RN C said the following: -He/she worked days from 6:30 A.M. to 7:00 P.M. usually. Last weekend, 05/24/25 and 05/25/25, there were lots of new admissions. He/she will go over paperwork, do a head-to-toe assessment, make progress note when a new admission arrived at the facility, how they arrived, put on a regular diet, if they were on O2 (oxygen), chart vital signs, do their 1st step tuberculin tine (tuberculosis) test, go over their paper work with the resident and/or family, and get something for them to drink. -The residents are upset when they get there. They expect all their medications to be there and their pharmacy is in Lenexa, Kansas which takes 3 to 4 hours to deliver medications. If they have a common medication, they may have the medication there in the facility. Monday to Friday, the pharmacy made a 5:00 P.M. delivery. On weekends, they deliver later; -f a resident requested pain medication, they can give Tylenol (for mild pain); -If they don't have a physician's prescription, they won't get the narcotic medications; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Narcotic medications were the biggest things. It has been taking too long for the physician to sign the hard (written) prescription and the staff were unable to get an electronic code to pull the narcotics. -They do try to get them Tylenol (a medication for mild pain); -The hospitals were to send the prescription with the resident or send an electronic prescription directly to the pharmacy; -RN C admitted the resident in the afternoon. The resident's family brought him/her there. The resident had a recent knee replacement surgery. They assisted the resident in a wheelchair to a room. The resident didn't want to sign any paperwork, but the family member signed it. RN C got ice water for the resident who wanted to lie down in bed. -They did not have signed physician's orders for pain medicines for the resident yet and he/she had not asked for any pain medications. The resident came from the hospital and had an order for Valium (for anxiety). RN C thought the resident was angry and not necessarily in pain. The resident was frustrated. The hospital staff was supposed to administer pain medication before the resident discharged such as a narcotic pain medication like hydromorphone or Dilaudid (for moderate to severe pain). They would have needed the hard prescription order or an electronic prescription there at the facility to give pain medications to the resident. They did have Tylenol they could administer every 8 hours; -On admission, he/she did a pain assessment and he/she put a 5 for a little bit of pain from the ride over from the hospital. This was what the resident said. The resident did not ask for any pain medication. During an interview on 05/30/25, at 12:13 P.M., Certified Nurse Aide (CNA) K said the resident's family came in with the resident. RN C helped toilet the resident and he/she helped transfer the resident to bed and put an ice bag on the resident's right knee. Later, the resident mentioned having pain to him/her after the Assistant Director of Nursing (ADON) had been in the resident's room. When he/she helped toilet the resident later, the resident said his/her leg was hurting. They had to wait for the pharmacy medications to come in. The ADON did bring pain medicine to the resident after 5:00 P.M. During an interview on 05/30/25, at 8:22 A.M., CMT B said she/he worked last Saturday (05/24/25) and Sunday (05/25/25) on the day shift. They had several new admissions which was normal at this facility. They usually did not get the new resident's medications orders until the second day for the medication cart. They usually have to pull medications for the resident the first day. A majority of new admissions come in the afternoon and early evening. As soon as they get a signed physician's order, such as a hard copy from the physician, they will pull medications such as blood pressure, diabetic and pain medications from the emergency kit. Sometimes there was a delay getting a signed order from the physician. The nurses talk to the physician. He/she did not remember administering any medications or any pain medication to the resident that first day the resident was admitted on [DATE]. During interview on 06/02/25, at 2:15 P.M., Licensed Practical Nurse (LPN) M said the following: (continued on next page)

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-He/she worked as charge nurse on the 200 hall on Sunday night (05/25/25). He/she began work around 5:30 P.M. since this was the first time to work at this facility. He/she remembered the resident because the resident turned his/her call light on frequently all night. The resident complained of not getting his/her medication and had not received them for the second day. LPN M said the resident had admitted to the facility that day and felt the resident was confused.

-The resident did not complain of pain and was in bed and covered up. The main thing the resident asked was to get a hold of his/her family member;

-LPN M did not remember giving any medications to the resident including any pain medications. He/she did assess for pain and the resident said he/she had no pain. The resident didn't show any signs of severe pain. He/she said Tramadol was delivered for the resident early and he/she put the medication in the narcotic drawer on the shared narcotic cart;

-He/she did not administer Tramadol or any pain medication to the resident.

During an interview on 06/02/25, at 8:40 A.M., LPN L said the following:

-If they have an admission early, like mid-day or in the week, and know the resident is coming, the physician signs the orders. The delay can be on the weekend or at night. They do have an on-call pharmacy for urgent meds;

-If a resident needed pain med, they can get it out of the emergency kit. They can give a code and make sure the doctor signed the order.

-If a resident had a knee replacement, he/she would expect a lot pain and hope the pain is more manageable by the time they come to the facility;

-Tylenol would not be a drug of choice for moderate and severe pain, but for mild pain;

-He/she would assess pain and pain was subjective. If he/she saw grimacing, withdrawing, not getting up to transfer to toilet, or verbalized pain, it could be a higher level of pain;

-Nonverbal pain can be with assessed with facial expressions;

-He/she would be looking at higher doses of medication if pain was at a severe level.

During an interview on 05/29/25, at 3:30 P.M., LPN G (unit manager) said the following:

-Usually they knew beforehand of a new admission. admission information was faxed, emailed, or scanned from the hospital beforehand;

-There was a 5:00 P.M. cut off time for the pharmacy. If a resident admitted to the facility before noon, they would receive their medications before 5:00 P.M. If they were admitted in the afternoon, they received their medications at night;

-Physician's orders were only activated when resident was in the building. There was an emergency supply kit. The kit contained vital medications for blood pressure and pain;

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