

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Spring Valley Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2915 South Fremont Ave Springfield, MO 65804	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interview and record review, the facility failed to ensure all allegations of possible abuse were reported immediately to management and within two hours to the state licensing agency (Department of Health and Senior Services - DHSS) when staff failed to report an allegation of physical abuse by one resident (Resident #1) to management and DHSS in a timely fashion. The facility census was 159.</p> <p>Review of the facility's policy titled, Abuse Prevention, revised October 2022, showed the following:</p> <ul style="list-style-type: none"> -The facility is committed to protecting the residents from abuse by anyone including, but not limited to: facility staff; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish or emotional distress; -Abuse is an employee purposefully beating, striking, wounding, or injuring any consumer; -Abuse is an employee mistreating or mistreating a consumer in a brutal or inhumane manner; -Abuse is an employee handling a consumer with any more force than is reasonable for a consumer's proper control; -The Administrator and Director of Nursing (DON) must be promptly notified of suspected abuse or incidents of abuse; -Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than two hours after the allegation is made. <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; <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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included malignant neoplasm of larynx (cancer of the voice box), spinal stenosis (narrowing of the spinal column that puts pressure on the spinal cord and nerves), muscle weakness, cognitive communication disorder (difficult to speak due to brain injury), and paraplegia (inability to voluntarily move the lower parts of the body).</p> <p>Review of the resident's care plan, initiated on 12/20/24, showed the following:</p> <ul style="list-style-type: none"> -Resident had inability to manage, respond to, or make decisions surrounding a stressful situation, or everyday tasks; -Resident required assistance for meeting emotional, intellectual, physical and social needs; -Assist with activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) as required during the activity. <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/20/24, showed the following:</p> <ul style="list-style-type: none"> -Memory okay, independent on decision making, and no behaviors; -Dependent upon staff for eating, toileting hygiene, showers, upper and lower body dressing, personal hygiene, sit to lying, lying to sitting, chair to bed transfer and toilet transfer; -Substantial assistance required with rolling from left to right. <p>During an interview on 01/23/25, at 1:35 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <ul style="list-style-type: none"> -On 01/17/25, around 1:00 P.M. or 2:00 P.M., Certified Nurse Aide (CNA) C came to him/her and said the resident was going to tell him/her that CNA C was rough with him/her, when CNA C and CNA D, put the resident to bed; -LPN asked CNA C, if he/she was rough and CNA C said no; -LPN went into the resident's room and the resident said CNA C jerked his/her leg and the resident was mad; -Resident also said CNA C broke his/her leg, but the resident didn't complain of pain; -LPN A completed an assessment on the resident's leg; -The resident's family came in and the resident complained of the aides to the family; -LPN A told LPN B, the resident said CNA A broke his/her leg, He/she didn't know if anyone else knew, but there were several staff in and out of the resident's room; -He/she didn't feel like it was an allegation of abuse. LPN A thought the resident was only mad at CNA C; <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she questioned CNA C and CNA D, on whether anything happened during the transfer and they both said nothing out of the ordinary happened;</p> <p>-He/she felt like CNA C should not do cares for the resident any longer, and that would take care of the situation;</p> <p>-He/she reports abuse to the Administrator.</p> <p>Review of DHSS records showed the facility did not self-report the allegation of staff to resident abuse.</p> <p>During an interview on 01/23/25, at 2:00 P.M., CNA C said the following:</p> <p>-On 01/17/25, he/she assisted CNA D with transferring the resident;</p> <p>-The resident had a normal transfer and did not complain of pain during the transfer;</p> <p>-The resident put on his/her call light later, and said he/she was having pain;</p> <p>-If a resident said a staff jerked or broke his/her leg, he/she would report that to the nurse and the Administrator as it would be abuse;</p> <p>-The facility reports abuse to the state within two hours.</p> <p>During an interview on 01/23/25, at 2:00 P.M., CNA D said the following:</p> <p>-On 01/17/25, he/she assisted CNA C with transferring the resident from the wheelchair to the bed;</p> <p>-There were no issues during the transfer, and the resident did not complain of pain during the transfer, it was after he/she was in bed;</p> <p>-Once the resident was in bed he/she yelled out my leg, you broke my leg;</p> <p>-He/she didn't see anything out of the ordinary on the resident's leg;</p> <p>-He/she didn't know why the resident would think someone broke his/her leg;</p> <p>-If staff jerked or broke a resident's leg, it would be abuse;</p> <p>-If he/she saw abuse, he/she would report it to the Administrator, Director of Nursing (DON) and charge nurse;</p> <p>-He/she didn't know if the facility was supposed to report allegations of abuse to the state.</p> <p>During an interview on 01/23/25, at 3:00 P.M., CNA E said the following:</p> <p>-If a resident said staff jerked, or broke their leg, it would be considered abuse;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she would inform the charge nurse and the state was to be called in two hours.</p> <p>During an interview on 01/23/25, at 3:15 P.M., CNA H said the following:</p> <p>-He/she would consider jerking a resident's leg, or breaking it to be abuse;</p> <p>-He/she would tell human resources.</p> <p>During an interview on 01/23/25, at 3:05 P.M., Certified Medication Technician (CMT) F said the following:</p> <p>-If a resident accused staff of being rough, or breaking his/her leg, he/she would assess the resident to ensure the resident was stable and report to the charge nurse;</p> <p>-The facility reports any allegations of abuse to the state immediately, but no later than two hours.</p> <p>During an interview on 01/23/25, at 3:10 P.M., LPN G, said the following:</p> <p>-If a resident reported their leg being jerked and/or broke by staff, he/she would report it to administration immediately;</p> <p>-Jerking on a resident to intentionally cause pain, or breaking a bone would be considered abuse;</p> <p>-The state is to be called immediately or within two hours.</p> <p>During an interview on 01/23/25, at 3:27 P.M., the Social Service Director (SSD) said the following:</p> <p>-If a resident says staff jerked and/or broke their leg, he/she would tell the Administrator;</p> <p>-Facility is to report all allegations of abuse within two hours;</p> <p>-He/she was not aware of the resident saying staff jerked or broke his/her leg. That should be reported to the state.</p> <p>During an interview on 01/23/25, at 2:28 P.M., the DON said the following:</p> <p>-On 01/17/25, he/she was told the resident thought his/her knee popped when he/she was transferred;</p> <p>-When he/she arrived to the resident's room, the resident's knee was upright and LPN A was doing an assessment;</p> <p>-There was no redness or bruising, but the resident said his/her knee ached;</p> <p>-He/she got an order for an x-ray of the knee;</p> <p>-The resident never made the accusation an aide jerked or broke the resident's leg;</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she wasn't told by any staff the resident said an aide jerked, or broke his/her leg;</p> <p>-Accusations of abuse are reported to the Administrator and the state is notified within two hours.</p> <p>During an interview on 01/23/25, at 3:47 P.M., the Administrator said the following:</p> <p>-On 01/17/25, the resident had been out for treatment and upon return he/she was transferred to bed using a Hoyer lift (mechanical lift);</p> <p>-To the best of his/her knowledge, the resident did not complain of knee pain during the Hoyer transfer. It was after the transfer;</p> <p>-He/she was not told the resident made an accusation that staff jerked or broke his/her leg;</p> <p>-If residents make accusations of abuse, staff should check out the body part and follow the facility policy;</p> <p>-Staff should be notifying the DON and the Administrator;</p> <p>-He/she would send in a report to the state within two hours.</p> <p>MO00248329</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on interview and record review, the facility staff failed to immediately begin an investigation and take steps to protect all residents after all allegations of possible abuse when staff failed to follow their abuse policy by not completing an abuse investigation and taking steps to protect all residents immediately after one resident's (Resident #1) allegation of possible abuse by staff. The facility census was 159.</p> <p>Review of the facility's policy titled, Abuse Prevention, revised October 2022, showed the following:</p> <ul style="list-style-type: none"> -The facility is committed to protecting the residents from abuse by anyone including, but not limited to: facility staff; -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish or emotional distress; -Abuse is an employee purposefully beating, striking, wounding, or injuring any consumer; -Abuse is an employee mistreating or maltreating a consumer in a brutal or inhumane manner; -Abuse is an employee handling a consumer with any more force than is reasonable for a consumer's proper control; -The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included malignant neoplasm of larynx (cancer of the voice box), spinal stenosis (narrowing of the spinal column that puts pressure on the spinal cord and nerves), muscle weakness, cognitive communication disorder (difficult to speak due to brain injury), and paraplegia (inability to voluntarily move the lower parts of the body). <p>Review of the resident's care plan, initiated on 12/20/24, showed the following:</p> <ul style="list-style-type: none"> -Resident had inability to manage, respond to, or make decisions surrounding a stressful situation, or everyday tasks; -Resident required assistance for meeting emotional, intellectual, physical and social needs; -Assist with activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) as required during the activity. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/20/24, showed the following:</p> <ul style="list-style-type: none"> -Memory okay, independent on decision making, and no behaviors; -Dependent upon staff for eating, toileting hygiene, showers, upper and lower body dressing, personal hygiene, sit to lying, lying to sitting, chair to bed transfer and toilet transfer; -Substantial assistance required with rolling from left to right. <p>During an interview on 01/23/25, at 1:35 P.M., Licensed Practical Nurse (LPN) A said the following:</p> <ul style="list-style-type: none"> -On 01/17/25, around 1:00 P.M. or 2:00 P.M., Certified Nurse Aide (CNA) C came to him/her and said the resident is going to tell you he/she was rough with him/her, when CNA C and CNA D, put the resident to bed; -LPN asked CNA C, if he/she was rough and CNA C said no; -LPN went into the resident's room, and the resident said CNA C jerked his/her leg and the resident was mad; -The resident also said CNA C broke his/her leg, but the resident didn't complain of pain; -LPN A completed an assessment on the resident's leg; -The resident's family came in and the resident complained of the aides to the family; -LPN A told LPN B, the resident said CNA C broke his/her leg. He/she didn't know if anyone else knew, but there were several staff in and out of the resident's room; -He/she didn't feel like it was abuse. He/she thought the resident was only mad at CNA C; -He/she questioned CNA C and CNA D, on whether anything happened during the transfer and they both said nothing out of the ordinary happened; -He/she felt like CNA C should not do cares for the resident any longer and that would take care of the situation; -CNA C did continue to work the remainder of his/her shift, he/she just didn't work with the resident; -He/she reports abuse to the Administrator and he/she does an investigation; -The accused staff is suspended. <p>Review of facility records showed the facility did not provide a written investigation of the allegation of possible abuse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Department of Health and Senior Services records showed the facility did not provide a written investigation of the allegation of abuse.</p> <p>During an interview on 01/23/25, at 2:00 P.M., CNA C said the following:</p> <ul style="list-style-type: none"> -On 01/17/25, he/she assisted CNA D with transferring the resident; -The resident had a normal transfer and did not complain of pain during the transfer; -The resident put on his/her call light later, and said he/she was having pain; -He/she did not provide any more cares for the resident after the transfer; -He/she did work the floor the remainder of his/her shift, that ended at 6:30 P.M.; -If a resident said a staff jerked or broke his/her leg, he/she would report that to the nurse and the Administrator as it would be abuse; -The facility investigates the allegations; -The accused would be sent home. <p>During an interview on 01/23/25, at 2:00 P.M., CNA D said the following:</p> <ul style="list-style-type: none"> -On 01/17/25, he/she assisted CNA C with transferring the resident from the wheelchair to the bed; -There were no issues during the transfer and the resident did not complain of pain during the transfer, it was after he/she was in bed; -Once the Resident was in bed, he/she yelled out my leg, you broke my leg; -He/she didn't see anything out of the ordinary on the resident's leg; -He/she doesn't know why the resident would think someone broke his/her leg; -He/she didn't feel like it was abuse; -CNA C worked the rest of his/her shift, but not with the resident; -If staff jerked or broke a resident's leg, it would be abuse; -The facility probably investigates allegations of abuse. <p>During an interview on 01/23/25, at 3:00 P.M., CNA E said the following:</p> <ul style="list-style-type: none"> -If a resident says staff jerked, or broke their leg, it would be considered abuse; <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she would inform the charge nurse and he/she believes the facility suspends the accused staff, and the facility investigates the allegations.</p> <p>During an interview on 01/23/25, at 3:15 P.M., CNA H said the following:</p> <p>-He/she would consider jerking a resident's leg, or breaking it to be abuse;</p> <p>-He/she believed the facility would talk to other residents, but he/she wasn't sure of the process;</p> <p>-He/she wasn't sure if the staff accused of breaking the resident's leg would be sent home, but if it's abuse they would probably be suspended.</p> <p>During an interview on 01/23/25, at 3:05 P.M., Certified Medication Technician (CMT) F said the following:</p> <p>-If a resident accused staff of being rough, or breaking his/her leg, he/she would assess the resident to ensure the resident is stable and report to the charge nurse;</p> <p>-The staff accused of causing the resident pain, would be sent home;</p> <p>-The facility does an investigation.</p> <p>During an interview on 01/23/25, at 3:10 P.M., LPN G said the following:</p> <p>-If a resident reported their leg being jerked and/or broke by staff, he/she would report it to administration immediately;</p> <p>-He/she was not sure if the accused staff would be sent home, but they probably would be sent home;</p> <p>-Jerking on a resident to intentionally cause pain, or breaking a bone would be considered abuse;</p> <p>-The facility would investigate the allegations.</p> <p>During an interview on 01/23/25, at 3:27 P.M., the Social Service Director (SSD) said the following:</p> <p>-If a resident says staff jerked and/or broke their leg, he/she would tell the Administrator;</p> <p>-The staff being accused of breaking the resident's leg would be suspended, pending an investigation;</p> <p>-The facility does an investigation which includes speaking to residents and appropriate staff;</p> <p>-He/she was not aware of the resident saying staff jerked or broke his/her leg. That should be investigated.</p> <p>During an interview on 01/23/25, at 2:28 P.M., DON said the following:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 01/17/25, he/she was told the resident thought his/her knee popped when he/she was transferred;</p> <p>-When he/she arrived to the resident's room, the resident's knee was upright and LPN A was doing an assessment;</p> <p>-There was no redness, bruising, but the resident said his/her knee ached;</p> <p>-The resident never made the accusation an aide jerked or broke the resident's leg;</p> <p>-He/she wasn't told by any staff the resident said an aide jerked, or broke his/her leg;</p> <p>-He/she did not do an investigation of the resident saying an aide jerked or broke his/her leg;</p> <p>-If he/she would've been made aware of the accusation, he/she would've done an investigation, and CNA C would've been sent home;</p> <p>-The Administrator does an investigation.</p> <p>During an interview on 01/23/25, at 3:47 P.M., the Administrator said the following:</p> <p>-On 01/17/25, the resident had been out for treatment and upon return he was transferred to bed using a Hoyer lift (mechanical lift);</p> <p>-To the best of his/her knowledge, the resident did not complain of knee pain during the Hoyer transfer;</p> <p>-The resident did complain of knee pain when he got back from the chemo treatment;</p> <p>-He/she was not told the resident made an accusation that staff jerked or broke his/her leg;</p> <p>-If residents make accusations of abuse, staff should check out the body part and follow the facility policy;</p> <p>-The accused staff would be removed and he/she would interview the staff;</p> <p>-He/she would complete an investigation, including interviewing residents and other staff;</p> <p>-He/she would ensure the resident was protected.</p> <p>MO00248329</p>		