STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265188	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Health & Rehabilitation Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm 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 observation, interview, and record review, the facility failed to provide care per accepted standards of practice when staff failed to accurately document regarding administration, or lack of administration, of an ordered medication; failed to ensure the medication was available for administration; failed notify the physician of the missed doses in a timely fashion; and failed to care plan the use and/or refusals of the medication for one resident (Resident #1) out of a sample of four residents. The facility census was 156. Review of the facility's Medication Administration-General Guidelines Policy, revised October 2017, showed the following:-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so;-The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions;-The Medication Administration Record (MAR) is always employed during medication administration;-Residents may actively refuse medications;-Medication refusal must be reported to the prescriber based upon facility guidelines;-The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given;-If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a starter dose of an antibiotic needed), the space provided on the front of the MAR for that dosage administration is initialed and circled;-An explanatory note is entered on the reverse side of the record;-If a vital medication is withheld, refused, or not available the physician is notified;-Nursing documents the notification and physician response;-If an electronic MAR system is used, specific procedures required for resident identification, identifying medications due at specific times, and documentation of administration, refusal, holding of doses, and dosing parameters such as vital signs and lab values are described in the system's user manual. Review of the facility's Notification of a Change in Condition Policy, revised 02/06/25, showed the following:-The attending physician/physician extender (nurse practitioner, physician assistant, or clinical nurse specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State Regulations;-The guidelines for notification of physician/resident representative include, but is not limited to significant change in medical or cognitive baseline, accident/incident, abnormal laboratory results in conjunction with a change in condition, significant weight loss/gain as per Resident Assessment Instrument (RAI) guidelines or provider specific orders, refusal to take prescribed medications, and missing resident;-Document in the Interdisciplinary Team (IDT) notes the following: resident change in condition, physician/physician extender notification, and notification of resident representative. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #1's face sheet (basic information sheet) showed the following information:-admission date of 10/14/25;-Diagnoses included acute parametritis (the tissue between the uterus and pelvic wall) and pelvic cellulitis (an infection of the tissues surrounding the female reproductive organs, including the uterus, ovaries, and fallopian tubes), generalized muscle weakness, high blood pressure, lymphedema (tissue swelling caused by an accumulation of fluid usually drained by the body), not elsewhere classified, autoimmune hepatitis (a long-term liver disease where the body's immune system mistakenly attacks and damages healthy liver cells), menopausal and female climacteric states (a condition where a woman's reproductive function stops and causes hormonal changes), sepsis (a life-threatening condition that occurs when the body's immune system overreacts to a widespread inflammation and organ damage, unspecified organism, and obesity. Review of the resident's comprehensive Minimum Data Set (MDS – a federally mandated assessment completed by facility staff), dated 10/21/25, showed the following:-Cognitively intact;-Used wheelchair and required partial assistance from staff with personal hygiene and showers. Review of the resident's hospital Discharge summary, dated [DATE], showed an order for boric acid (help promote a balance of acid in the vagina) 600 milligram (mg) vaginal suppository. Insert one suppository vaginally daily for eight days. Review of the resident's October 2025 Physician Order Sheet (POS) showed an order, dated 10/14/25, for boric acid vaginal suppository 600 mg. Insert one suppository vaginally one time a day for antifungal for eight days Review of the resident's October 2025 Medication Administration Record (MAR) showed the following:-An order, dated 10/14/25, for boric acid vaginal suppository 600 mg. Insert one suppository vaginally one time a day for antifungal for eight days;-Staff documented administering the medication on 10/15/25 and 10/16/25. Review of the resident's progress note, dated 10/16/25, showed the facility Nurse Practitioner (NP) noted the resident has candida vulvovaginitis (an inflammation of the vulva and vagina caused by an overgrowth of Candida fungus) and was receiving boric acid vaginal suppository until 10/23/25. Review of the resident's October 2025 MAR showed the following:-Staff documented the boric acid was on hold on 10/17/25;-Staff documented the resident refused the boric acid on 10/18/25, 10/19/25, and 10/20/25;-Staff documented administering the boric acid on 10/21/25. Review of the resident' October 2025 Progress Notes showed staff did not document regarding holding or refusal of the boric acid and did not document physician notification of missed doses on 10/17/25, 10/18/25, 10/19/25, and 10/20/25. Review of a handwritten physician order sheet, dated 10/21/25, showed please provide boric acid vaginal suppository over the counter (OTC). Pharmacy will not provide. Review of the resident's October 2025 Physician Order Sheet (POS) showed the following: -The order, dated 10/14/25, for boric acid vaginal suppository 600 mg was place on hold and then discontinued on 10/21/25;-An order, dated 10/22/25, for boric acid vaginal suppository 600 mg. Insert one suppository vaginally one time a day for antifungal for eight days. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's October 2025 MAR showed the following:-An order, dated 10/22/25, for boric acid vaginal suppository 600 mg. Insert one suppository vaginally one time a day for antifungal for eight days;-Staff documented administering the boric acid on 10/22/25, 10/23/25, 10/24/25, 10/26/25, 10/27/25, and 10/28/25;-Staff documented the boric acid as not administered on 10/25/25;-Staff documented the resident out of the facility on 10/29/25. Review of the resident' October 2025 Progress Notes showed staff did not document regarding the missed dose or physician notification of the missed does on 10/25/25. Review of the resident's current care plan showed staff did not address the boric acid suppository on the care plan. During an interview on 10/31/25, at 3:23 P.M., Certified Medication Technician (CMT) F said the following:-He/she would notify the nurse if resident refused a medication;-He/she would notify the nurse and Director of Nursing (DON) if a resident refused a medication for a second time;-When staff enter a code for refusal of medication, a progress note automatically populates for documentation. During an interview on 11/03/25, at 1:30 P.M., Licensed Practical Nurse (LPN) D said the following:-He/She remembered the resident had an order for a boric acid vaginal suppository;-On 10/21/25, the resident self-administered the vaginal suppository after LPN D provided it to the resident. He/she was not in the room when it was self-administered. He/she only took it to the resident's room and provided the resident with privacy while the resident inserted the suppository; -The boric acid suppositories looked like a capsule rather than a suppository and he/she kept telling the central supply staff member that he/she ordered the wrong thing, but the central supply staff member said it was the correct medication;-He/She searched everywhere to find the boric acid suppository and it was in the med tech's cart when he/she found it on 10/21/25. It looked like an over-the-counter medication bottle;-He/she remembered the suppository was in a bottle with more than one dose;-He/she thought the suppository bottle may have had the resident's name on it, but he/she could not remember for sure;-The boric acid vaginal suppository got moved over to the med techs cart and a med tech figured out the resident had an unopened tampon applicator in the room that the resident could use to insert the suppository easier;-The resident may have had problems inserting the vaginal suppository far enough into the vagina without the use of the tampon applicator;-LPN D thinks he/she only provided the resident with one dose of the boric acid vaginal suppository.-The medication information comes up on the LPN/Registered Nurse (RN) MAR and that is how he/she knows when and what to give the resident;-If a medication is not on the med tech cart, he/she would go to the central supply staff member or to the unit nurse manager and let them know he/she could not find it;-If he/she was unable to administer a medication, he/she would document not administered (NA) on the MAR and let the unit nurse manager know and notify the physician;-He/She would also make a note in the resident's chart stating he/she was unable to administer the medication. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/25, at 3:20 P.M., LPN B said the following:-He/She remembered the resident, but he/she could not recall anything about a vaginal suppository, whether or not it was given, or whether or not there was an issue with the facility not having the suppository;-He/She does not recall the resident having a boric acid vaginal suppository order;-He/She does not recall documenting that resident refused the boric acid suppository on 10/18/25 and 10/19/25;-He/She administers medications off the electronic health record MAR and treatment administration record (TAR);-If a medication was not in the medication cart, he/she would see if it were in the long-term care pharmacy service;-If the medication was not available there, he/she would notify the physician and see if he/she can give something that is available;-If the medication that was unavailable was an over-the-counter medication, he/she would tell the central supply staff member and have him/her get it locally;-If he/she documented that a resident refused a medication he/she would notify the physician of the refusal;-He/She would not chart that a resident refused a medication for any other reason than a resident refusal;-If a resident refused a medication the expectation was for staff to mark refused on the MAR, notify the physician, and make a note in the electronic health record system explaining why the resident refused the medication;-He/She did not think there is a protocol to notify the Director of Nursing (DON) when a resident refused a medication. During an interview on 10/31/25, at 3:20 P.M., Registered Nurse (RN) A said the following:-He/She was not aware of the resident had been refusing the vaginal suppository;-There were a couple of days the RN could not find the vaginal suppository;-He/she documented on the MAR on 10/17/25 that the vaginal suppository was held and documented on 10/20/25 that the resident refused the vaginal suppository, even though the resident did not refuse the vaginal suppository. He/he did not make any additional notes regarding the reason the vaginal suppository was not administered those two days;-He/She should have documented the vaginal suppository was being held rather than refused due to the medication not being available for him/her to administer;-He/she recalled talking to the unit nurse manager and asking where the vaginal suppository was. The unit nurse manager's response was that he/she did not know where the missing medication was;-If a medication was not available and put on hold, he/she should make a progress note and notify the provider if not given for a period of time;-He/She did not investigate why he/she could not locate the vaginal suppository or how long it was not given;-He/She knew the physician should have been notified with each medication refusal;-If a medication was on hold because it cannot be located, he/she would notify the unit manager, which he/she did, but he/she did not document it in the resident's electronic record.-The facility expectation was for staff to administer all medications as ordered by the physician and document on the MAR;-If a nurse recognizes that a medication is not being administered by the CMT, the medication will be moved to the nurses' MAR for the nurse to administer;-If a resident refuses a medication for three consecutive days the physician should be notified;-If a resident refuses any medication, the staff have to contact the physician every time, not just when it is refused for three consecutive days;-Staff should document the refusal in a progress note next to the order in the MAR. The note should include information that the resident refused that medication and the provider was notified. There should also be a progress note made in the chart separate from the MAR.-Medication refusals should be passed on in report to other staff;-It should be care planned if a resident refused medications, but he/she was unsure who updates the care plans. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/25, at 3:45 P.M., LPN C/Unit Manager said the following:-He/She was not sure if the facility tried to obtain the resident's boric acid vaginal suppository from the pharmacy, but probably did;-Central supply was notified to order the vaginal suppository, and a second order was written to restart the medication;-He/She was not sure if his/her charted refusals for the resident's vaginal suppository were actual refusals or if the medication was not administered because it was not available;-He/She was not sure if the three doses of the suppositories were given as the MAR reflects. The entries could have been incorrect entries;-He/she could not remember if he/she gave the vaginal suppository or not or if the facility had any doses of the suppository in the facility when the first order was written;-The facility doctor honors discharge orders from the hospital;-The facility physician orders over-the-counter medications, and the facility obtains them from central supply;-Over-the-counter medications do not typically come from the pharmacy;-If central supply does not have a medication on hand, they order the medication online and will receive them pretty quick;-If a medication was refused by a resident, staff should enter a note showing the physician and family was notified of the refusal;-It was best to let the physician and family know about a medication refusal after each refusal, unless it was stated otherwise in the order;-The facility does not have a lot of residents that receive a vaginal suppository;-If the facility does not have an over-the-counter medication, the nursing staff would notify central supply and have more ordered. During an interview on 11/03/25, at 12:10 P.M., the Central Supply staff member said the following:-The facility did not have the boric acid vaginal suppository in their supply stock, so he/she ordered it from a mail order supplier at 4:00 P.M. on 10/21/25 and it arrived in the facility on 10/22/25;-The Administrator had the order form from when the vaginal suppository came into the facility;-Prior to him/her ordering the boric acid vaginal suppository for the resident, he/she had never heard of it;-The facility keeps over the counter medications in the facility and purchases them if they do not have something in stock that a resident needs;-If he/she cannot get the medication or supply through the supply company, he/she goes to a local retailer or orders it on-line. During an interview on 10/31/25, at 3:38 P.M., the Assistant Director of Nursing (ADON) said the following:-Residents who chronically refuse medication should have this information in the care plan;-The NP should be notified of any medication refusals and is updated daily on refusals;-CMT's should notify the nurse of any medication refusals;-Staff should make a corresponding progress note for resident refusals or any other reason medication is not administered;-OTC medications are available through the facility central supply, pharmacy, or local retail stores. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/25, at 4:31 P.M., the DON said the following:-He/She was not aware of a boric acid vaginal suppository order;-He/She did not know if the vaginal suppository was in supply at the facility when the resident was admitted ;-He/She was not sure if any other residents at the facility had an order for the boric acid vaginal suppository in the past;-If the vaginal suppository was not in stock at the facility it could be obtained quickly by letting the central supply staff member know;-For the resident, the physician did put the vaginal suppository on hold and said to stop the order until the facility received the medication;-The central supply staff ordered the boric acid suppository on 10/21/25 and the facility had the suppository in house on 10/22/25;-He/She did not know if the resident received any doses of the boric acid vaginal suppository prior to the arrival of the boric acid vaginal suppository to the facility on [DATE];-The unit nurse manager had the bottle of boric acid vaginal suppositories in his/her office and seven of the vaginal suppositories were administered out of the bottle;-If the facility received an order from the hospital for an over-the-counter medication, it would be a medication the facility would obtain from central supply;-The facility can buy over-the-counter medications in bulk online;-On the day of admission, the facility should know if they need a medication; however, it is typically the next day before some medications are available;-If central supply cannot get the medication, the facility will send someone to locally to purchase it;-Staff should let the physician know if they are not able to administer the medication;-Staff should be documenting medication administration accurately;-If a resident refuses a medication, staff should call the doctor and make a progress note in the resident's medical record showing the refusal;-Staff should not be documenting that a resident refused a medication if the medication is not available. During an interview on 11/03/25, at 5:13 P.M., the Administrator said the following:-The receipt provided to him/her from the central supply staff member shows the boric acid vaginal suppository was ordered on 10/21/25;-He/She was not sure if the facility had the vaginal suppository in the facility when the resident was admitted . He/she was not sure when the facility actually received it;-The pharmacy does not fill over the counter medications. The facility typically gets over the counter medications online or at a local retailer;-Staff have been educated on the process to document medication refusals by a resident as well as medications not administered due to the medication not being available or due to the resident being out of the facility;-The expectation is for staff to contact the primary care physician or physician on call and the family if a resident refuses a medication;-If staff report that they documented something wrong, that would be a clerical error, and they would need to complete a risk assessment to correct it. Complaint # 2650298

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents with tube feedings received sufficient nutrition when staff failed to understand how to document tube feeding intake, failed to document when tube feedings amounts varied from the ordered amount, and failed to document physician notification when tube feeding amounts varied from the ordered amount for one resident (Resident #2), who was at nutritional risk, out of a sample of four residents. The facility census was 156.Review of the facility's Notification of a Change in Condition Policy, revised 02/06/25, showed the following:-The attending physician/physician extender (nurse practitioner, physician assistant, or clinical nurse specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State Regulations;-The guidelines for notification of physician/resident representative include, but is not limited to significant change in medical or cognitive baseline, accident/incident, abnormal laboratory results in conjunction with a change in condition, significant weight loss/gain as per Resident Assessment Instrument (RAI) guidelines or provider specific orders, refusal to take prescribed medications, and missing resident;-Document in the Interdisciplinary Team (IDT) notes the following: Resident change in condition, physician/physician extender notification, and notification of resident representative. Review of the facility's Tube Feeding Policy, reviewed 07/31/25, showed nursing will receive tube feeding order written by physician. 1. Review of Resident #2's face sheet (basic information sheet) showed the following information:-admission date of 06/06/24;-readmission date of 09/04/24;-Diagnoses included nontraumatic intracerebral hemorrhage (a stroke that occurs when a blood vessel in the brain ruptures and bleeds into the surrounding brain tissue), unspecified. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by staff), dated 07/24/25, showed the following:-Cognitively intact;-Requires maximum assistance with toileting hygiene, dressing, transfers, and mobility;-Dependent on staff for eating and showering;-Resident had a feeding tube. Review of the resident's care plan, revised 07/28/25, showed the following:-Resident required alternative nutritional intake via tube feeding related to dysphagia (difficulty swallowing and inadequate intake history of stroke;-Malnutrition risk/history related to acute illness as evidenced by significant weight loss and inadequate oral intakes;-Need for night tube feeding to help ensure nutritional needs are met;-Resident will only eat food brought in by family;-Resident will maintain adequate nutritional and hydration status and weight stable with no signs or symptoms of malnutrition or dehydration through review date;-Resident will maintain/gain current weight of +/- 5 pounds through review date;-Resident wishes to gain weight. Weight prior to stroke was 160 pounds;-Assist with tube feeding and water flushes;-See physician orders for current feeding orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current Physician Orders (POS) showed the following:-An order, dated 11/07/24, to document tube feeding every night to document millimeters (ml/cc) given;-An order, dated 12/04/24, for tube feed of Jevity (therapeutic liquid food) 1.5 or comparable at 100 cubic centimeters (cc) per hour for 12 hours per day and a total volume to infuse of 1200 cc. Start at 6:00 P.M. and end at 6:00 A.M. to allow for stomach emptying/encourage hunger prior to breakfast with 100 ml water flushes four times a day for enteral feed one time a day for tube feeding related to unspecified protein-calorie malnutrition. Keep head of bed at 30 degrees while feeding is going on. May have 1200 cc to 1500 cc per resident request; Review of the resident's October 2025 Medication Administration Record (MAR) showed the following:-An order, dated 12/04/24, for tube feed Jevity 1.5 or comparable at 100 cc per hour for 12 hours per day and a total volume to infuse 1200 cc. Start at 6:00 P.M. and end at 6:00 A.M. to allow for stomach emptying/encourage hunger prior to breakfast with 100 ml water flushes four times a day for enteral feed one time a day for tube feeding related to unspecified protein-calorie malnutrition. Keep head of bed at 30 degrees while feeding is going on. May have 1200 to 1500 cc per resident request;-On 10/16/25, at 5:00 P.M. , staff documented 0 mls consumed;-On 10/17/25, 10/18/25, and 10/19/25, at 8:00 A.M. staff documented 1100 mls consumed; and at 5:00 P.M., staff documented 240 mls consumed;-On 10/25/25, at 8:00 A.M., staff documented 2505 mls consumed;-On 10/26/25, at 5:00 P.M., staff documented 2200 mls consumed;-On 10/30/25, at 5:00 P.M., staff documented 600 mls consumed. Review of the resident's progress notes showed staff did not document regarding the documented tube feeding amounts that varied from the ordered amount or physician notification of the variances. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/25, at 3:20 P.M., Registered Nurse (RN) A said the following:-The staff offer the resident the amount of feeding the physician ordered, but the resident will sometimes say he/she wants the tube feeding stopped before the ordered amount is completely administered;-The resident always gets 1200 mls put in the feeding bag and the feeding pump is already programmed for the resident to receive 1200 mls;-RN A clears the feeding tube volume infused from the feeding pump every morning when he/she is working;-He/She supposes that he/she should document the difference in intake and output measurements for the resident, but there are three different places for him/her to document output, oral intake, and tube feeding intake in the MAR for the resident, which is confusing;-The resident has an order for a minimum of 1200 mls of tube feeding formula and if only 1050 mls of the ordered feeding was infused, he/she does not see the need to enter a note into the resident's record explaining the difference of how much was received compared to how much was ordered;-If the resident only received 240 mls of his/her 1200 ml ordered tube feeding, then he/she would call the physician or send a quick text to the nurse practitioner (NP);-He/She was usually the nurse that started the resident's tube feeding at 5:00 P.M.;-The resident sometimes complained about his/her stomach hurting, so he/she refused to eat regular food, and to be hooked up to his/her tube feeding;-He/she was not sure that the resident's tube feedings were being documented correctly on the MAR;-He/she did not contact the physician or nurse practitioner on 10/11/25 after documenting not applicable, 10/16/25 after documenting zero, 10/17/25 after documenting 240 mls, 10/26/25 after documenting 2200 mls, or on 10/30/25 after documenting 600 mls instead of the 1200 to1500 mls physician ordered tube feeding. He/she monitored the resident's weight and oral intake, and he/she did not have any concern with either, so he/she did not see a need to report the differing amounts to the physician;-When he/she documented not applicable on the 10/11/25, at 5:00 P.M., in tube feeding area on the MAR, which showed no tube feeding was to be administered that day, that documentation was not correct;-The 10/16/25, tube feeding documentation at 5:00 P.M. for the amount to be administered was recorded correctly as zero being administered, but he/she failed to make a progress note explaining why the resident did not receive the ordered tube feeding. He/she remembered that the resident refused the tube feeding that day due to nausea and vomiting;-He/she thinks his/her documentation of 240 mls on the [DATE]/17/25 at 5:00 P.M. was not documented correctly. He/she believed the resident received 1200 mls of his/her feeding that day and that he/she may have mistakenly documented the resident's oral intake in the MAR instead of the feeding tube amount to be administered. He/she was confused on the documentation process in the MAR and could not verify that for sure;-He/she thought his/her 10/26/25 MAR documentation showing the resident was supposed to receive 2200 mls of the tube feeding at 5:00 P.M. was not accurate. He/she believed the amount of feeding that was supposed to be administered should have been documented as 1200 mls because the resident normally receives 1200 mls as ordered;-He/she documented on the MAR on 10/30/25 that the resident was going to receive 600 mls of his/her tube feeding at 5:00 P.M. that day, but he/she believed that was an error in his/her documentation and the resident was set up to receive1200 mls as ordered;-Last week, the resident reported that the med tech would not bring him/her Mylanta for nausea. During that instance, the resident vomited and requested to have the tube feeding disconnected. He/she could not remember if he/she documented that information in a progress note;-He/She thought the tube feeding should be included in the resident's care plan, but he/she does not enter information into the care plan or even look at the care plan due to a lack of time;-He/she believes the tube feeding should be entered on the resident's MDS and that the facility may have an MDS coordinator, but he/she is not sure;-Nursing judgment wise, if there is a ridiculous amount of difference in the amount of tube feeding formula that a resident receives than what is ordered, he/she should enter a note in the resident's record explaining the difference;-He/she does not have time to enter a note into a resident's record every time the feeding tube amount administered is different than the amount ordered;-It is the responsibility of the RN or unit nurse manager to notify the physician of any problems or concerns with a resident's tube feeding;-The unit nurse manager or the physician should be notified if a resident does not receive any of the tube feeding or not all his/her tube feeding as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265188	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Health & Rehabilitation Center	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/25, at 1:30 P.M., Licensed Practical Nurse (LPN) D said the following:-At 5:00 P.M., he/she documents on the resident's MAR the amount of tube feeding formula that he/she planned to administer through the feeding bag, not the amount of feeding that was administered to the resident. The amount of feeding that is administered is documented at 8:00 A.M., not at 5:00 P.M.;-If staff give more than 1200 mls of the tube feeding formula to the resident, they will have to add the additional amount of formula to the feeding bag at a later time because the feeding bag will only hold 1200 mls at a time;-Residents on a fluid restriction only receive 240 mls of fluid with each meal, so maybe staff mistakenly documented 240 mls of intake on the resident's MAR on 10/17/25, 10/18/25, and 10/19/25 as if he/she was on a fluid restriction; -The 600 mls documented on the resident's MAR at 5:00 P.M. on 10/30/25 would make sense if the resident only wanted half of the 1200 ml feeding, but he/she was not sure if the resident only wanted or received 600 mls of his/her feeding;-He/She thinks the 2504 mls documented on the MAR as the amount of tube feeding administered at 8:00 A.M. on 10/25/25 could be from staff adding 1200 mls of water administration along with 1200 mls of tube feeding formula, with the amount of water administered during bolus water flushes;-LPN D thought staff were documenting on the resident's MAR wrong;-If the resident refused the 1200 mls tube feeding amount ordered, LPN D would put a nurses' note in the MAR documenting the refusal and notify the nurse practitioner, physician, or unit nurse manager of the refusal;-LPN D did not know why the feeding tube administration documentation was scheduled on the resident's MAR for 8:00 A.M. when the tube feeding ends at 6:00 A.M. The 8:00 A.M. documentation area on the MAR should really be scheduled for 6:00 A.M. to be correct with the time the tube feeding administration should end;-If only 1100 mls of the resident's ordered 1200 ml tube feeding was administered LPN D would not notify the physician, unless the resident only received 1100 mls of the feeding several days in a row. In that instance, he/she would inform the unit nurse manager and the nurse practitioner, and make a note in the resident's record;-On 10/21/25, at 8:00 A. M., LPN D documented that 1100 mls of the resident's tube feeding was administered because that was the actual amount that was infused. When he/she went into the resident's room to administer his/her medications he/she noticed some of the feeding formula was still in the feeding bag, but the feeding was no longer running. LPN D offered to give the resident an additional 100 ml bolus feeding to complete the 1200 mls that was ordered, but the resident refused. LPN D did not make a note regarding this in the resident's record because the amount administered was only 100 mls less than what the physician ordered;-On 10/26/25, when the resident's MAR documentation shows more feeding formula was going to be administered than what was ordered, it could be because staff included the amount of water that would be administered through the feeding tube as well;-At first, he/she did not know how to document the intake and output in the MAR for the resident. For the first few days of working at the facility he/she just let the intake and output documentation section go red on the MAR and he/she did not document anything because he/she did not know what to document because it was so confusing to him/her;-RN A told him/her to just document times three in the output section for the resident, so that is what he/she started documenting, but he/she did not know what times three meant. He/she assumed that times three was a code that administration used for something specific and that the administrative staff that reviews the documentation would know what times three meant;-When he/she started working he/she was never trained on the med-bridge (500 and 600 halls), where the resident resides, before he/she was assigned to work the med-bridge halls;-Tube feedings are not started and stopped at the exact same time each day, so it would be unrealistic for staff to document that a resident received 1200 mls of their tube feeding if they are reading the amount administered off the residents feeding pump. LPN D looks at the resident's feeding bag to determine the amount of feeding administered and what to document on the MAR rather than reading the amount infused off the feeding pump. He/she has observed the resident's feeding pump set on 1100 mls rather than 1200mls as ordered;-The amount of tube feeding formula administered to a resident should match what is entered into the MAR as the amount given. (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/25, at 2:57 P.M., Licensed Practical Nurse (LPN) B said the following:-The intake amount for the resident is recorded everyday shift and every night shift;-For the resident, no staff has ever told him/her how much oral intake the resident took in, so he/she has not been documenting oral intake;-He/She just assumed the intake he/she was supposed to record on the MAR was the tube feeding and water that went into the resident's feeding tube;-He/She does not recall the physician's order stating the resident may receive1200 to1500 mls of formula per tube feeding;-If the resident said he/she was ill and he/she wanted the feeding pump turned off for half an hour then he/she would call the physician and let them know what happened;-He/She is not sure why the resident's tube feeding was scheduled on the MAR for 5:00 P.M. when the physician's order states it should be started at 6:00 P.M.;-He/She was confused by the 5:00 P.M. tube feeding documentation area on the MAR and he/she asked RN A why staff were supposed to document something before it was done;-Prior to discussing with RN A what should be documented at 5:00 P.M. on the resident's MAR, he/she guessed that the documentation at 5:00 P.M. was for flushing the feeding tube. It seemed to be an order that needed to be cleaned up and he/she does not know why it was on the MAR that way;-Most orders are put on the MAR for the time they are scheduled to be completed. He/she did not realize the resident had a 5:00 P.M. order where documentation needed to be completed on the MAR until he/she received a call this morning from the Assistant Director of Nursing (ADON);-He/She does not know who is entering the 5:00 P.M. MAR entry for the tube feeding amount that should be administered to the resident even though the MAR shows he/she made an entry on the resident's MAR at 5:00 P.M. on 10/18/25 and 10/19/25 showing that 240 mls of the 1200 mls ordered would be administered during the feeding both days. LPN B said he/she did not make those two MAR entries;-He/She does not recall documenting that the resident received only 1100 mls of his/her 1200 mls physician ordered tube feeding on 10/18/25 and 10/19/25. During an interview on 11/03/25, at 3:45 P.M., LPN C/Unit Manager said the following:-There was some confusion on the tube feeding order as written for the resident;-The start time for the tube feeding was ordered for 6:00 P.M. but the MAR shows a start time of 5:00 P.M.; -The end time for the tube feeding is scheduled for 6:00 A.M., but the documentation section for the tube feeding amount administered is on the MAR to be documented at 8:00 A.M.;-The 5:00 P.M. area on the resident's MAR is for staff to document the amount of tube feeding they are adding to the tube feeding bag and that they plan to administer;-The 8:00 A. M. area on the MAR is for staff to document the amount of tube feeding the resident actually received during the entire feeding;-It is very important for staff to pay attention to the resident's tube feeding order and to make sure the feeding pump is set to infuse 1200 mls;-Staff should notify the physician every time if the resident receives 1100 mls or less of his/her 1200 mls ordered tube feeding, whether it is because the resident refuses or for other reasons;-Typical intake and output orders include the same thing for all residents, but the resident's intake and output orders are vague;-The resident's intake is typically his/her tube feeding amount received;-Resident's output should be documented everyday shift at 6:30 A.M. and every night shift at 10:30 P.M.;-The resident's 10/11/25 intake amount of 1100 mls and 10/25/25 intake amount for 2504 mls should have had a progress note in the MAR showing the reason for the difference in what was administered and what was ordered. During an interview on 10/31/25, at 3:38 P.M., the ADON said the following:-Staff should administer tube feeding to a resident according to the physician orders;-Staff should document the reason why the ordered amount was not administered and should notify the provider;-The resident should receive between 1200 to 1500 mls of tube feeding and has a potential for weight loss if the ordered amount is not received (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/03/25, at 4:31 P.M., the Director of Nursing (DON) said the following:-There was some confusion on the tube feeding order as it was written for the resident;-The tube feeding was ordered to start at 6:00 P.M. but the MAR shows a 5:00 P.M. start time;-The tube feeding was ordered to end at 6:00 A.M., but the intake documentation was scheduled on the MAR for 8:00 A.M.;-Nurses have a one-hour grace period before or after the time ordered on the MAR to administer medications, but the residents feeding start time should be based on 6:00 P.M. as ordered;-The resident's tube feeding start time needed to be fixed on the MAR to match the order;-At 5:00 P.M., staff are expected to document the amount of tube feeding that is anticipated to be given to the resident, not the amount that was actually administered;-At 8:00 A.M., staff should document the amount of the resident's tube feeding that was delivered to the resident when the feeding ended at 6:00 A.M.;-If the order reads to administer 1200 to1500 mls and the resident only received 1100 mls, staff should not contact the physician unless the 1100 mls administered is an everyday occurrence. He/she would expect staff to notify the physician if a lesser amount is administered more than two times per week;-He/She does not think staff are accurately documenting all of the resident's intake because his/her family brings him/her food every day;-If a tube feeding is stopped before the ordered amount is administered, staff should document the reason such as refused or nauseated in a progress note and, in the MAR. The progress note should also say that staff called the physician;-Staff should use the tube feeding pump settings to document the amount of tube feeding administered;-Staff should document accurately in a resident's record. During an interview on 11/03/25, at 5:13 P.M., the Administrator said the following:-Some days the resident does not want the tube feeding, but staff need to document why the feeding was not given.-Staff should have entered a progress note on 10/11/25 when they documented the resident received 1100 mls of his/her ordered tube feeding amount and on 10/25/25 when they documented the resident received 2504 mls instead of 1200 mls as ordered;-The registered dietician for the facility reviews the tube feeding orders and he/she looks to see if there needs to be a change in a resident's tube feeding;-He/She is not sure what intake amounts staff should document;-If a tube feeding is not given for any reason, staff should put a note in the residents MAR showing why the resident did not receive it. Complaint # 2650298