

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  02/04/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all residents received care and treatment in accordance with professional standards of practice when facility nursing staff failed to provide appropriate neurological assessments (evaluation of the functioning of the nervous system, identifying any abnormalities or neurological deficits.) for three residents (Resident #1, Resident #2, and Resident #3) after each resident sustained a fall with potential for head injury. The facility census was 156. Review of the facility policy titled, Fall Management, dated 02/08/23, showed the following:-Prior to moving the resident, the charge nurse will evaluate for injury;-Complete neurological evaluation post-fall on resident with potential head injury or unwitnessed fall;-Provide emergency first aide treatment as applicable;-Notify physician, resident representative, supervisor, Director of Nursing (DON), and Administrator when appropriate;-Investigate the circumstances and surrounding where the fall occurred and implement intervention to reduce further occurrences;-Document in resident's medical record;-Implement post-fall evaluation/documentation, all shift evaluation/documentation for 72 hours. Review of the facility policy titled, Neurological Evaluation, dated 03/28/23, showed the following:-The licensed nurse may perform the neurological evaluation without a physician's order when there is a concern over change in mental status/functioning or a gradual/immediate change in motor/sensory status;-A change in level of consciousness constitutes the most significant or early signs of neurological deterioration. If there is a decline in the level of alertness/orientation: charge nurse will complete a neurological evaluation;-The licensed nurse shall perform a neurological evaluation as followed for a 72-hour timeframe, unless otherwise ordered by the physician. The results will be recorded on the Neurological Evaluation Form every 15 minutes for one hour, every 30 minutes for one hour, every hour for two hours, every two hours for eight hours, every four hours for 12 hours, and every shift for 48 hours. 1. Review of Resident # 1's face sheet showed the following:-admission date of 09/18/25;-Diagnoses included of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a stroke that resulted in paralysis on left side of the body), lack of coordination, abnormalities of gait and mobility, chronic obstructive pulmonary disease (COPD-inflammatory lung disease that causes obstructed airflow, making it difficult to breathe), and major depressive disorder. Review of the resident's comprehensive Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), modified 11/28/25, showed the following:-Cognitively intact;-Impaired on one side;-Resident ambulated independently in wheelchair;-Partial to moderate assistance with hygiene, dressing, and transfers;-No falls since admission. Review of the resident's care plan showed the following:-Activities of daily living self-care performance deficit due to stroke, impaired mobility, and balance;-Impaired cognitive function/dementia or impaired thought process due to stroke;-History of falls and a risk for falls. Review of the resident's progress note dated 01/28/26, at 4:18 P.M., showed nurse was called to nurses' station by staff. Staff said resident was outside at the assisted living entrance and came back in and slipped due</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 265188
		If continuation sheet Page 1 of 7

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>to melting snow around shoes. Resident hit back of head and his/her bottom on the ground when he/she fell. Neuro-checks (neurological assessments) initiated with vitals and range of motion within normal limits. Staff to continue fall monitoring and neuro checks. Review of the resident's Neurological Evaluation Log, dated 01/28/26, showed the following:-Neurological checks initiated on 01/28/26, at 3:30 P.M., and completed every fifteen minutes for one hour, 3:45 P.M, 4:00 P.M., and 4:15 P.M.;-Neurological checks completed every 30 minutes for one hour, 4:45 P.M, 5:15 P.M, and 5:45 P.M.;-Neurological checks completed every hour for two hours, at 7:45 P.M. and 8:45 P.M.,-No neurological checks documented every two hours for 8 hours;-Neurological checks completed every four hours for twelve hours completed on 01/29/26 at 12:00 A.M. and at 4:00 A.M. only;-No neurological checks documented on 01/29/26, at 8:00 A.M. and 12:00 P.M.;-No documentation of neurological checks every shift for 48 hours (a neurological check should have occurred at shift change on 01/29/26, at 6:30 P.M. and on 01/30/26, at 6:30 A.M.);-The resident incurred a new fall on 01/30/26, time unknown, and neurological checks were initiated at 3:00 P.M. During an interview on 02/03/26, at 12:00 P.M., Certified Medication Technician (CMT) B said nurses conducted neurological checks on the resident last week due to the resident hitting his/her head during a fall. During an interview on 02/03/26, at 12:10 P.M., Licensed Practical Nurse (LPN) C said the resident fell on Wednesday, 01/28/26. The resident denied hitting his/her head, but the nurse heard something hit and placed the resident on neurological checks. During shift change, LPN C advised the oncoming nurse of the neurological checks. During an interview on 02/03/26, at 12:30 P.M., LPN D said staff placed the resident on neurological checks last week because he/she fell and hit their head. LPN C believed the resident was toward the end of his/her neurological checks, as he/she only completed one set during his/her shift. During an interview on 02/03/26, at 12:51 P.M., CMT E said last week the resident fell and hit his/her head. CMT E believed neurological checks were initiated after the resident's fall. During an interview on 02/03/26, at 1:24 P.M., LPN F said the resident fell, but no injuries were noted. He/she did not believe neurological checks were initiated. During an interview on 02/03/26, at 1:35 P.M., LPN G said he/she started the resident's neurological checks but was unsure if they were complete. When he/she came back to work for his/her next shift, he/she believed the resident was still on neurological checks, but he/she could not find the sheet. He/she asked the other nurse on duty, and they said there were not aware the resident was on neurological checks. During an interview on 02/04/26, at 1:22 P.M., the Nurse Practitioner (NP) said the physician was notified of the resident's fall. The resident should have received neurological checks for 72 hours. During an interview on 02/04/26, at 2:10 P.M., the Assistant Director of Nursing (ADON) said he/she was unaware of the circumstances surrounding the resident's fall and was unsure if the resident was on neurological checks. During an interview on 02/04/26, at 3:20 P.M., the Administrator said the resident had a fall which required him/her to be placed on neurological checks. The Administrator believed staff missed a section on page two of the neurological evaluation form. 2. Review of Resident # 2's face sheet showed the following:-admission date of 08/09/24;-Diagnoses included of COPD, Type 2 diabetes (when the body cannot use insulin correctly and sugar builds up in the blood(, morbid obesity, unsteadiness on feet, and muscle weakness. Review of the resident's quarterly MDS, modified 01/26/26, showed the following:-Cognitively impaired;-Resident ambulates independently in wheelchair;-Substantial/maximal assistance with hygiene;-Supervision or touching assistance with transfers;-Two or more falls since prior assessment. Review of the resident's care plan showed the following:-Resident was at risk for falls as evidenced by deconditioning and gait/balance problems;-History of falls due to peripheral vascular disease (circulation disorder), venous wound (shallow, slow-healing open sores, usually on the lower leg or ankle, caused by chronic</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>contacted physician and gave update with new order received for right hip x-ray. Review of the resident's Neurological Evaluation Log, dated 01/26/26, showed the following:-Neurological checks initiated on 01/26/26, at 5:15 A.M., and completed every fifteen minutes for one hour, 5:30 A.M., 5:45 A.M., 6:00 A.M.;-Neurological checks completed every 30 minutes for one hour, 6:30 A.M. and 7:00 A.M.;-No neurological checks documented every hour for two hours;-No neurological checks completed every two hours for 8 hours;-Neurological check completed on 01/26/26, at 8:00 P.M.;-Neurological checks completed every four hours for 12 hours, checks completed on 01/27/26, at 12:00 A.M. and 4:00 A.M.;-No neurological check completed on 01/27/26, at 8:00 A.M.;-No neurological checks completed every shift for 48 hours. Review of resident's progress note dated 02/03/26, at 4:15 A.M., showed the resident requested for her as needed (PRN) pain medication due to left hip pain. The resident was sitting on the side of his/her bed when nurse entered the room. Resident wrote down in his/her notebook that he/she had fallen Sunday night, and she/he was given morphine and helped back into bed during that time. Review of the resident's progress notes show staff did not document a fall on 02/01/26 or 02/02/26. Review of the resident's Neurological Evaluation Log, dated 02/03/26, showed the following:-Neurological checks initiated on 02/03/26, at 5:00 A.M.;-No neurological checks documented every fifteen minutes for one hour, 5:15 A.M., 5:30 A.M., and 5:45 A.M.;-Neurological checks completed every 30 minutes for one hour, 6:20 A.M. and 6:50 A.M.;-Neurological checks completed every hour for two hours, 7:50 A.M., 8:50 A.M., and 9:50;-Neurological checks completed every two hours for 8 hours, 11:50 A.M.;-Neurological checks were still in progress while on site. During an interview on 02/03/26, at 11:49 A.M., Certified Nursing Assistant (CNA) A said he/she unaware of the resident currently being on neurological checks. During an interview on 02/03/26, at 12:00 P.M., CMT B said he/she believed the resident recently had a fall. During an interview on 02/03/26, at 12:10 P.M., LPN C said the resident fell on Sunday evening and was currently on neurological checks. During an interview on 02/03/26, at 12:30 P.M., LPN D said the resident was on neurological checks due to a fall. During an interview on 02/03/26, at 12:51 P.M., CMT E said he/she was unaware of the resident having any falls or being on neurological checks. During an interview on 02/04/26, at 12:15 A.M., the resident said he/she fell on Sunday night. During an interview on 02/04/26, at 12:50 P.M., the Unit Manager (UM) said the resident reported a fall and was currently on fall protocol, which included neurological checks. During an interview on 02/04/26, at 1:22 P.M., the NP said the resident has self-reported falls. The NP expected neurological checks to be complete on the resident for 72 hours as it was unwitnessed and unknown if he/she hit their head. During an interview on 02/04/26, at 2:24 P.M., the DON said the resident had self-reported falls. Staff should treat self-reported falls as unwitnessed falls, and neurological checks should be initiated. During an interview on 02/04/26, at 3:20 P.M., the Administrator said he/she was unaware of the resident having any falls. 4. During an interview on 02/03/26, at 11:49 A.M., CNA A said the following:-If a resident falls, staff notify the nurse, and the nurse will assess the resident prior to moving the resident;-Neurological checks were completed if the resident hit their head or if it was an unwitnessed fall;-Aides may complete neurological checks, which are complete every 15 minutes for an hour and then decrease in duration. There was a sheet that prompted staff on the time and duration the neurological checks that needed to be completed;-Staff notified the on-coming shift if a resident was receiving neurological checks;-Staff documented neurological checks on a sheet and give to the nurse when completed. During an interview on 02/03/26, at 12:00 P.M., CMT B said the following:-If a resident falls, staff obtain vitals and notify the nurse. The nurse will assess prior to moving the resident;-Neurological checks consist of checking vitals and eye movement, and are collected over a 24-hour period;-Staff notify the next shift, during report,</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>neurological checks for the full 72 hours. During an interview on 02/04/26, at 2:10 P.M., the ADON said the following:-If a resident fell, staff should ensure safety, obtain vitals, and a nurse should assess the resident;-If a resident hit their head, or the fall was unwitnessed, neurological checks were initiated;-Staff filled out the neurological check sheet, which was broken down into how frequent the checks needed to be complete, for approximately two to three days;-If was the expectation of management for neurological checks to be complete for the full required duration. During an interview on 02/04/26, at 2:24 P.M., the DON said the following: -If a resident fell, staff notified the nurse immediately, and the nurse would assess the resident;-If the resident hit their head, or the fall was unwitnessed, neurological checks were initiated;-CNAs may obtain vitals, but nurses completed the neurological assessment;-Staff fill out the neurological evaluation sheet at the nurses' station;-Staff completed neurological checks for three days;-Management expected staff to conduct neurological checks in full and there should not be any blanks on the sheet.-Staff documented residents receiving neurological checks in the report book, but also verbally notified on-coming staff. During an interview on 02/04/26, at 3:20 P.M., the Administrator said the following:-If a resident fell, a nurse would assess the resident;-Staff completed neurological checks if the resident hit their head or it was an unwitnessed fall for a duration of two days;-CNAs may obtain vitals, but the nurse validated and entered on the neurological evaluation sheet;-Staff reported to on-coming staff at shift change if a resident was receiving neurological checks. The neurological evaluation sheet should be at the nurses' station, and a progress note should be in the resident's chart indicating they are receiving neurological checks;-Staff should complete neurological checks as the sheet dictates and should be completed in full;-Staff turn in completed neurological evaluation check sheets to the ADON for review. Complaint #2731424</p>		