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	05/15/2026

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. Based on interview and record review, the facility failed to provide care per standards of practice and care plan when staff failed to document full follow-up assessments, including neurological checks, for 72-hours post fall, failed to provide all assessed information to the physician when reporting a change of condition post fall, and failed to transcribe physician orders post fall for one resident (Resident #1) who had multiple falls. The facility census was 157.Review of the facility policy titled Fall Management, dated 02/28/23, showed the following information:-Prior to moving the resident, the charge nurse will evaluate for injury;-Complete neurological evaluation as applicable;-If an injury is suspected, provide emergency first aid;-Notify the physician, resident representative, supervisor, and Director of Nursing (DON);-Document in the resident's medical record, complete an incident report, implement post-fall evaluations, and documentation for 72 hours. Review of the facility policy titled Physician Orders, dated 09/28/22, showed the following information:-Orders must be documented clearly in the medical record;-Physician order sheet (POS) will be maintained with current physician orders as new orders are received. 1. Review of Resident #1's face sheet (brief look at resident information) showed the following information:-admission date of 04/15/24;-Diagnoses included dementia, unsteadiness on feet, repeated falls, and high blood pressure. Review of the resident's care plan, dated 04/25/26, showed the following information:-Anticipate and meet needs;-Ensure the call light is within reach and encourage the resident to use it for assistance;-Requires prompt assistance to all requests for assistance;-Ensure the resident is wearing appropriate footwear when ambulating or mobilizing in the wheelchair;-Follow facility fall protocol. Review of the resident's late entry progress note dated 05/01/26, at 8:23 A.M., showed the following information:-Follow-up to the resident falling. Nurse and certified nursing assistant (CNA) thoroughly assessed the resident, including passive range of motion (PROM) of the residents upper and lower extremities;-The resident was confused but said he/she had pain in his/her left knee. The resident frequently complained of pain in this area;-Resident had a slight protrusion on forehead;-The nurse notified the physician and administered as needed (PRN) pain medication.(Staff did not document initiation of neurological checks.) Review of the resident's Fall Incident Audit Report, dated 05/01/26, showed the following:-At 6:15 P.M., the resident fell;-At 8:58 P.M., staff found the resident on the floor just outside of the bathroom, sitting on the floor with legs forward with knees slightly bent. The resident propped his/her chest up with arms. Staff gave tresident a quilt and pillow to prop him/herself up with so he/she could rest his/her arms. Staff completed a quick neurological and eye assessment (PERRLA) with resident at baseline. Resident was able to follow commands and alert and oriented x 1 (only knows own identity). Staff noted no bruising or contusions. Sensation intact all extremities. Right and left hand grasp were good. Good strength in BUE (both arms and hands). Resident complained of pain. Staff had already administered Tylenol. Staff notified the Nurse Practitioner (NP) and a new order for tramadol (opioid used for the management of moderate to moderately severe pain) was received. Vital Signs within normal levels. Staff assisted resident to bed;-At 9:04 P.M., staff notified the NP and family;-At 9:05 P.M., staff notified the Assistant Director of Nursing (ADON) and (DON);-At 9:34 P.M., when standing, the resident's shoulders were humped over. He/she was unable to walk two feet, gait unsteady, and drags left foot;-At 9:55, the care plan was reviewed.(Staff did not (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document regarding continued monitoring after the fall, including neurochecks.) Review of the resident's late entry progress note dated 05/01/26, at 6:56 P.M., showed the following information:-The resident complained of his/her hip hurting;-The resident had a history of osteoporosis (disease characterized by weak, porous bones that break easily);-Staff notified the NP and requested more pain medication.(Staff did not document regarding continued monitoring after the fall, including neurochecks.) Review of the resident's progress note dated 05/01/26, at 7:18 P.M., showed staff notified the resident's family member of the fall. Review of the resident's Fall Incident Audit Report showed the following:-On 05/01/26, at 9:40 P.M., the resident fell;-On 05/02/26, at 08:11 A.M., the resident was found on the floor in her bathroom. The resident was on his/her right side with his/her head laying on his/her arms. He/She had a small protrusion on his/her left forehead. Staff noted no abrasions, lacerations, or wounds. Resident had no bleeding or bumps on his/her head. Staff assisted resident back to bed. Staff will continue with neurological checks and vital signs. Injury on top of scalp. Resident was very confused. He/She was not able to acknowledge his/her fall or where he/she was at. Resident was ambulatory with assistance;-On 05/02/26, at 8:19 P.M., staff notified the physician;-On 05/02/26, at 8:23 P.M., staff notified the ADON and DON;-On 05/02/26, at 8:24 P.M., staff notified the family.(Staff did not document regarding continued monitoring after the fall, including neurochecks.) Review of the resident's late entry progress note dated 05/01/26, at 9:52 P.M., showed the following information:-At 9:15 P.M., the resident had an unwitnessed fall, landing on the floor, with his/her head touching the door frame;-The resident's blood pressure was elevated;-The resident had a small bump on the left side of his/her forehead and was unable to bear weight on the left leg. The resident was moaning;-The nurse notified the NP. Review of the resident's medical record showed staff did not document neurological checks initiated, assessment of range of motion, or any deformity present. Staff did not document regarding ongoing monitoring post-fall. Review of the resident's SBAR Communication Form (communication form used to report concerns to the physician) dated 05/01/26 at 10:18 P.M., showed the following:-The resident fell and was experiencing pain with no changes observed with resident's mental status;-The resident was declining and argued regarding medication administrations;-The physician responded and ordered blood tests, an x-ray, and medication changes.(Staff did not document related to fall evaluation, neurological checks, or inability of resident to bear weight.) Review of the resident's Physician Order Sheet (POS), dated 05/01/26, showed staff did not transcribe the physician's order for x-ray and blood test. Review of resident's progress notes dated 05/01/26, at 11:29 P.M., showed the following:-Resident had fallen twice during shift;-Staff were conducting neurological and vital checks;-Staff notified the physician, DON, and family;-The physician gave new orders. Review of the resident's SBAR communication form dated 05/01/26, at 11:34 P.M., showed the following information:-Concerns of falls, functional decline (worsening function and/or mobility), pain (uncontrolled), tired, weak, confused, or drowsy;-The resident experienced a fall and had increased confusion, physical and verbal aggression, and pain;-The resident was more confused and attempted to get up by his/herself and falls. He/she fell in the bathroom and by his/her bed;-Staff notified physician who adjusted medication.(Staff did not document related to fall evaluation, neurological checks, or inability of resident to bear weight.) Review of the resident's progress note dated 05/02/26, at 3:49 P.M., showed the following information:-The resident's family requested the resident be sent to the hospital;-Orders for stat (immediate) x-ray were given, but the family declined and wanted the resident to go to the hospital due to the resident's further decline;-The resident was lethargic and was having difficulties following simple commands. Staff put medication in the resident's mouth and had to repeat numerous times before resident would swallow. This was not baseline for the resident;-Staff notified the NP, ADON, and DON. Review of the resident's POS, dated 05/02/26, showed staff did not transcribe an order for an x-ray. Review of the resident's electronic medical record showed staff did not document continued neurological checks after the residents' falls. During an interview on 05/14/26, at 12:51 P.M., Registered Nurse (RN) A said the following:-If a resident falls, it is the expectation of staff to ensure (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident is safe, assess the resident's neurological status, obtain vital signs, and notify the resident's physician, family, and administration;-Fall follow-up documentation is expected to be completed for 72 hours and documented in the progress notes;-If a resident with confusion falls and has elevated vital signs, or guards a body part and/or grimaces with pain, he/she would notify the physician, administer PRN pain medication, and order an x-ray;-He/she was the nurse on duty when the resident fell twice;-He/she assessed the resident after the fall, including a pain assessment, but did not complete any range of motion (ROM) assessment;-He/she did not notice any shortening or rotation of the legs and/or any grimacing with pain;-The resident seemed worse after the second fall and was unable to walk;-He/she contacted the physician due to concerns with pain control; however an x-ray was not ordered after either fall;-It can be difficult to assess a dementia resident as they can be consistently dramatic;-The resident's family requested the resident be sent to the hospital the next day. He/she informed the family that he/she would obtain an x-ray order, but they wanted the resident to be assessed at the hospital. During an interview on 05/14/26, at 2:06 P.M., Certified Nursing Assistant (CNA) B said the following information:-He/she was on shift at the time of the resident's falls;-The resident appeared to be fine after the first fall. After the second fall, the resident experienced a lot of pain and had a change in mobility;-RN A completed the assessments after each fall;-If a resident falls, the CNA notifies the nurse and the nurse completes an assessment, notifies the family and physician, and documents accordingly. During an interview on 05/14/26, at 2:28 P.M., the ADON said the following:-Staff were to report falls to the nurse. The nurse should assess the resident to ensure safety and obtain vital signs;-Neurological checks should be initiated on unwitnessed falls;-After a resident falls, staff should conduct monitoring for 72 hours. The monitoring is documented in the progress notes and a change of condition (SBAR) form should be completed;-The physician, and family should be notified;-If a resident falls and shows signs of pain and decreased mobility, staff should notify the physician for an x-ray order and document the conversation in the progress notes. The x-ray order should be added to the POS;-If a resident had a change of condition, staff should intervene in a timely manner, which could include obtaining an order for an x-ray or other interventions;-The ADON was on shift during the first fall, and did not observe any changes;-If a resident experienced rotation and shortening of a leg, staff should assess and recognize the issue;-The day after the resident fell twice, his/her demeanor was different. The ADON told the nurse to contact the physician, however family arrived and wanted the resident sent to the hospital. During an interview on 05/14/26, at 3:21 P.M., the MDS Coordinator said the following:-If a resident falls, staff were instructed to not move the resident until the nurse completed their assessment and obtained the resident's vital signs;-If a resident had elevated vital signs, increased pain, and a change in mobility, she would call the doctor and have the resident sent to the hospital for evaluation;-After a fall, staff should assess for rotation and shortening as it is a sign of a fracture. During an interview on 05/14/26, at 3:21 P.M., the Director of Nursing (DON) said the following:-Staff were expected to notify a nurse if a resident falls;-The nurse should complete an assessment, obtain the resident's vital signs, assess the resident's neurological status, ensure the resident's safety, and notify the physician, family, and administration;-After a resident falls, staff should conduct monitoring for 72 hours and document in the progress notes;-If the resident experienced pain, medication should be administered as ordered;-The physician should be notified of resident pain, to determine if x-rays or a different pain medication needed to be ordered;-Staff should recognize signs of fractures such as rotation or shortening of the limb;-The DON received notification of the residents' falls on the night of 05/01/26. The ADON asked if an x-ray should be obtained. The resident slept through the night after medication was administered, therefore an x-ray was not warranted;-On 05/02/26, the resident's family requested the resident be sent to the hospital. During an interview on 05/14/26, at 4:00 P.M., the Administrator said the following:-If a resident falls, she expected staff to assess the resident, notify the physician, family, and administration;-If there is a concern after the fall, staff should notify the physician and follow their instructions. Staff should document any concerns and/or notifications (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the progress notes;-Staff are expected to assess for signs of fractures and follow the facility's policy on fall protocol. Complaints #2993154, #2980667, #3001655, #3001683, and #3001699

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed implement a complete and effective infection control program when staff failed to properly discard a blood contaminated glucose (sugar) test strip and sharps (any device with points or edges that can puncture or cut skin) in the designated sharps container for one resident (Resident #2). The facility census was 157.Review of the facility policy titled Standard Precautions, dated 10/25/22, showed the following information:-Place sharps in a puncture resistant container;-Follow procedures for disposal of regulated/infectious waste when items are saturated with blood and meet the definition of regulated infectious waste. Review of the SafeNeedleDisposal.org's What To Do with Used Sharps in Missouri, dated 10/23/25, showed the following: -Put sharps in a strong, plastic container;-Sharps should never be thrown loosely into the trash or toilet;-Sharps that retract after use, or are very small, should be disposed of like all other sharps. Review of the Centers for Disease Control and Prevention page Regulated Medical Waste, dated 01/08/24, showed the following: -Medical waste requires careful disposal and containment before collection and consolidation for treatment;-Puncture-resistant containers located at the point of use (e.g., sharps containers) are used as containment for discarded slides or tubes with small amounts of blood, scalpel blades, needles and syringes, and unused sterile sharps. 1. Review of the Resident's #2 face sheet (brief look at resident information) showed the following information:-admission date of 09/05/23;-Diagnoses include dementia, diabetes, and high blood pressure. Review of the resident's care plan, dated 09/19/23, showed administer diabetic medications as ordered. Review of the resident's most recent Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff) resident received injections seven times a week. Observation on 05/14/26, at 12:07 P.M., showed the following: -Licensed Practical Nurse (LPN) C obtained a blood glucose level on the resident;-After obtaining the level, LPN C placed the used alcohol swab, cotton swab, blood contaminated glucose strip, and contaminated lancet (a medical instrument/needle used for blood sampling) into a plastic cup, within a tray he/she was carrying around;-LPN C then entered the open-door nurses' station, placed the tray on top of the medication cart, took off his/her gloves and placed them into the plastic cup;-LPN C obtained the plastic cup full of contaminated supplies and threw it into the trash bin located on the side of the medication cart. During an interview on 05/14/26, at 12:15 P.M., LPN C said the following:-He/she discarded the blood contaminated test strip, lancet, alcohol swab, cotton swab, and gloves into the trash bin, on the side of the medication cart;-He/she usually discards blood contaminated test strips and lancets in regular trash bins. During an interview on 05/14/26, at 12:51 P.M., Registered Nurse (RN) A said the following:-Glucose test strips and lancets should be discarded in the sharps container;-Blood contaminated items and/or lancets should not be placed in the regular trash bins. During an interview on 05/14/26, at 2:06 P.M., Certified Nursing Assistant (CNA) B said the following:-Blood contaminated items, and/or lancets should be placed in a sharps container;-Sharps containers are located throughout the building, but specifically in the nurse's station on the unit and the shower room. During an interview on 05/15/26, at 9:30 A.M., the Infection Preventionist said the following:-Staff were to dispose of sharps in the sharps containers. The containers are located within all the medication carts;-Staff should discard any blood contaminated products in the sharps containers and/or a biohazard trash bag;-It is unacceptable to place lancets and/or blood contaminated products in the regular trash bins. During an interview on 05/14/26, at 2:28 P.M., the Assistant Director of Nursing (ADON) said the following:-Glucose test strips and lancets should be discarded in the sharps container;-It was unacceptable to place blood contaminated items and/or lancets in the regular trash bins. During an interview on 05/14/26, at 3:00 P.M., the Director of Nursing (DON) said the following information:-Glucose test strips and lancets should be discarded in the sharps container;-Blood contaminated items and/or lancets should not be placed in the regular trash bins. During an interview on 05/14/26, at 4:00 P.M., the Administrator said the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:-Glucose test strips and lancets should be discarded in the sharps container;-It is unacceptable to place blood contaminated items and/or lancets in the regular trash bins. Complaints #2993154, #3001683, and #3001699