

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Springfield Suites Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3089 Old Jacksonville Road Springfield, IL 62704	

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 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on interview and record review, the Facility failed to ensure residents are treated with dignity and respect by providing timely care which promotes quality of life for 2 of 24 residents (R117, R11) reviewed for dignity, in the sample of 44. This failure resulted in R117 experiencing prolonged pain and feeling undignified, and R11 feeling embarrassed.</p> <p>Findings include:</p> <p>1. On 11/18/2024 at 9:53 AM, R117 stated he turned on his call light the night prior, to request pain medication. R117 states he has a lot of pain due to a broken left hip as well as chronic pain in both legs. R117 stated it was approximately two hours before he received his pain medication, which did provide some relief after he received it. R117 stated the nurse chewed him out about using my call light too much and that once is enough. R117 stated he had to use it more than once to get help. R117 stated he did not tell anyone about it because he did not feel like it was abusive, but it did make him feel like I don't matter much.</p> <p>On 11/19/2024 at approximately 12:10 PM, R117 stated he wrote the times down when he first pressed his call light and when he received his pain medication. R117 stated he activated his call light at 7:45 PM and received his pain medication at 9:15 PM.</p> <p>R117's Minimum Data Set (MDS) dated [DATE] documents R117 is cognitively intact.</p> <p>R117's Medication Administration Record (MAR) documents on Sunday 11/17/2024 R117 received his Oxycodone 15 milligrams (mg) at 1:07 PM and again at 9:07 PM.</p> <p>2. R11's Facesheet, undated, documents R11 was admitted to the facility on [DATE] with diagnosis of Internal right knee prosthesis, Sepsis, Encephalopathy, Type 2 Diabetes Mellitus (DM), Parkinson's disease, Depression, and Benign prostatic hyperplasia (BPH), Overactive bladder, and Dementia.</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
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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R11's Care Plan, dated 11/11/24, documents At risk for falls related to weakness, impaired mobility, balance, age. R11 is alert and oriented with confusion at times related to dementia. R11 has had falls in the past 6 months/year, but number is unknown. Interventions: Toilet after meals, educate wife to notify staff when leaving, bed and chair alarm, fall risk assessment on admit and per protocol, keep personal items and frequently used items within reach, encourage to call for assistance as needed, assist to toilet upon request, fall risk. It continues R11 has an Activities of Daily Living (ADL) deficit. Interventions: R11 requires assist of two with transfers and 1-2 with ADL's. R11 has a bed/chair alarm, and the bed is in low position. There are no other interventions for fall precautions seen in R11's room.</p> <p>R11's Minimum Data Set (MDS), dated [DATE], documents R11 has a moderate cognitive impairment and requires partial/moderate assistance from staff for ADLs. R11 is occasionally of both bowel and bladder.</p> <p>On 11/20/24 at 10:00 AM, R11 sitting in recliner with Intravenous (IV) antibiotic running into left upper arm Peripheral Inserted Central Catheter (PICC) line. R11 had t-shirt on and no pants, only an incontinence brief which appeared to be saturated. R11 has his wife V4, and visitors in the room with him. R11 was seen with a folded bath blanket across his lap and kept pulling it up to cover himself with it. V4 was visibly upset and in tears. V4 stated she arrived to the facility around 9:00 AM this morning and found R11 like this. V4 stated that R11 wanted to use the restroom and she put the call light on, and a Certified Nursing Assistant (CNA) came in and stated she couldn't get R11 up until the nurse disconnects his IV and that the CNA let the nurses know. V4 stated R11's IV pump had been going off for at least 30 minutes and they still have not gotten anyone in the room to assist R11. V9, Licensed Practical Nurse (LPN), was notified and stated she was not able to disconnect R11's IV due to the PICC line and that it had to be a Registered Nurse (RN). V13, RN, entered to disconnect R11's IV. V14, CNA, entered to assist R11 to restroom. V14 applied gait belt around R11 and put walker in front of him. V14 stood and walked to restroom to use toilet. Upon R11 standing, his incontinence brief dropped to the floor due to being so heavy and saturated with urine, and his chair alarm did not go off. V14 held brief up while R11 walked to restroom and was assisted to the toilet.</p> <p>On 11/20/24 at 10:20 AM, V13, RN, stated that she was the one who got R11 out of bed and to his chair this morning to start his IV antibiotic. V13 stated she did not perform incontinent care at that time.</p> <p>On 11/20/24 at 10:25 AM, V7, CNA, stated that she normally gets R11 out of bed and to the shower early morning and she cleans him up at that time. V7 stated when she walked in, the nurse had already gotten R11 up to a chair and she could not get him up with the IV infusing. V7 stated she did not do incontinent care on R11 this morning.</p> <p>On 11/20/24 at 10:57 AM, when asked if sitting in his chair with a wet brief on while he had visitors was embarrassing to him, R11 stated Well two weeks ago I would have been embarrassed, but since I've been here, it seems like everyone wants to see my butt.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility's Resident Rights Policy, dated 11/14/16, documents Residents have basic rights guaranteed by Federal and State laws. Residents will receive equal access to care regardless of diagnosis, severity of condition, or payment source. Residents are entitled to exercise their rights and privileges to the fullest extent possible without interference, coercion, discrimination or reprisal from the facility and will be supported in the exercise of their rights. Each resident will be treated with dignity and respect and receive care that promotes, maintains, or enhances quality of life, recognizing each resident's individuality.</p> <p>The Facility's Call Lights policy documents, Purpose: To meet the guest's requests and needs within an appropriate time period. It continues, All staff is responsible for answering call lights for all guests. A call light should be answered as soon as possible. It further documents. Respond to the guests call light asking, 'What can I do for you today?' If you are unable to assist the guest, find a staff member who can.</p> <p>40701</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for 3 of 15 residents (R14, R18, R35) reviewed for care plans in a sample of 44.</p> <p>Findings include:</p> <p>1.) R14's face sheet, undated, documented R14 has diagnoses including major depressive disorder and anxiety disorder.</p> <p>R14's physician orders document orders for buspirone 15 mg 1 tab bid (two times per day) for anxiety disorder with a start date of 6/4/24 and an order for citalopram 10 mg daily for depression with a start date of 6/4/24.</p> <p>R14's care plan, dated 11/17/24, does not address R14's diagnoses of major depressive disorder and anxiety disorder. The facility also failed to address R14's need and orders for the prescribed psychotropic medication nor does R14's care plan document any care approaches/interventions for R14's diagnoses of depression and anxiety.</p> <p>2.) R18's face sheet, undated, documented R18 has diagnoses including vascular dementia and altered mental status.</p> <p>R18's physician progress note, dated 10/25/24, documented vascular dementia, mild, with mood disturbance. This physician progress note documented HPI (History of Present Illness) [AGE] year-old female being seen today for nursing home follow-up. She has had 1 hospitalization this year which was to local hospital at the beginning of April for altered mental status. At this time, it was ultimately felt to be likely due to her untreated sleep apnea. Patient continues to be noncompliant with her CPAP and diet restrictions for weight loss. It continues, nursing staff report that in the evenings the patient becomes very agitated, verbally fights with staff, and refuses care. SLUMS (mental exam) done on 10/13/24 was a 12/30 indicating dementia.</p> <p>R18's care plan, dated 11/18/24, does not address R18's diagnoses of dementia nor does it document any care approaches for R18's dementia diagnosis.</p> <p>3.) R35's face sheet, undated, documented R35 has diagnoses including traumatic subdural hemorrhage, anemia, anxiety, and atherosclerotic heart disease.</p> <p>R35's progress note, dated 10/15/24 at 7:15 AM documented writer placed call to local hospital ER (emergency room), RN (Registered Nurse) currently overseeing R35 stated that resident is currently seeing plastics for hematoma on left forearm and will call facility if resident will be discharged or admitted .</p> <p>R35's fall/event investigation, dated 10/14/24, documented investigation of R35's arm injury concluded R35 bumped her left forearm while propelling self in wheelchair causing the arm injury.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R35's weekly skin progress note dated 10/29/24 at 2:16 PM documented writer saw resident today for weekly skin check and obtained the following information. Large wound to LFA (left forearm) measuring 8.3 cm x 5.2 cm x 0.5 cm. Wound bed is red. Packed with NS (normal saline), dry dressing, and kerlix. Ace wrap from fingers to above elbow. Guest is getting skin graft done on 10/31/24.</p> <p>R35's local hospital patient discharge plan, dated 10/31/24, documented R35 had a split thickness skin graft surgical procedure to left forearm secondary to a hematoma.</p> <p>R35's care plan, dated 10/20/24, documented Problem: Potential for skin impairment related to impaired mobility. Guest admits with scattered bruising to BUE (bilateral upper extremities) in various stages of healing and scar to abdomen. 9/26/23 S/T (skin tear) lower left arm. 11/13/23 S/T to lower left arm. 11/13/23 S/T healed. 10/16/23 S/T left lateral elbow. 10/23/23 S/T healed.</p> <p>R35's care plan does not document anything regarding R35's arm injury that occurred on 10/14/24 nor does it address any skin care approaches/post-surgical care for R35's left arm skin graft.</p> <p>The facility also failed to care plan the root cause of R35's arm injury that occurred on 10/14/24 nor did the care plan document any new interventions to prevent R35 from developing any new skin impairments.</p> <p>The facility's Care Plan policy, dated 11/14/16, documented Policy: An individualized person centered care plan, consistent with resident rights that includes measurable objective and time tables to assist the resident to attain or maintain the resident's highest practicable physical mental and psychosocial needs, is to be developed by the interdisciplinary team for each resident within 7 days after completion of the comprehensive assessment. It continues, the person centered care plan identifies the services that are to be furnished to attain or maintain the resident practicable physical, mental and psychosocial well-being, as well as services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment. The care plan is designed to: incorporate identified problem areas, incorporate identified problem areas, incorporate risk factors associated with identified problems; build on resident strengths/needs; reflect resident goals for admission, care and treatment; reflect treatment goal time tables and objectives; outcomes; identify professional services that are responsible for each element of care aide in prevention or reduction of decline in resident functional status.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on Interview, Observation, and Record Review, the facility failed to provide and implement safety measures to prevent a resident from falling, failed to complete a Fall Risk Assessment after a fall for 1 of 8 residents (R11) reviewed for falls in the sample of 44.</p> <p>Findings include:</p> <p>R11's Facesheet, undated, documents R11 was admitted to the facility on [DATE] with diagnosis of Internal right knee prosthesis, Sepsis, Encephalopathy, Type 2 Diabetes Mellitus (DM), Parkinson's disease, Depression, and Benign prostatic hyperplasia (BPH), Overactive bladder, and Dementia.</p> <p>R11's Care Plan, dated 11/11/24, documents At risk for falls related to weakness, impaired mobility, balance, age. R11 is alert and oriented with confusion at times related to dementia. R11 has had falls in the past 6 months/year, but number is unknown. Interventions: Toilet after meals, educate wife to notify staff when leaving, bed and chair alarm, fall risk assessment on admit and per protocol, keep personal items and frequently used items within reach, encourage to call for assistance as needed, assist to toilet upon request, R11 is a fall risk. It continues R11 has an Activities of Daily Living (ADL) deficit. Interventions: R11 requires assist of two with transfers and 1-2 with ADL's. R11 has a bed/chair alarm, and the bed is in low position. There are no other interventions for fall precautions seen in R11's room.</p> <p>R11's Minimum Data Set (MDS), dated [DATE], documents R11 has a moderate cognitive impairment and requires partial/moderate assistance from staff for ADLs. R11 is occasionally of both bowel and bladder.</p> <p>The Facility's Fall Log, dated 5/19/24 through 11/19/24, documents R11 had a fall on 11/3/24 at 12:15 PM. Description: Was on the floor in his room.</p> <p>R11's Nursing Note, dated 11/3/24 at 12:21 PM, documents Guest was in his room sitting in bedside chair his wife left the room and closed the door when she returned the guest was on the floor and the alarm was sounding the bedside table was pushed out of the way and the w/c (wheelchair) was pushed towards the door and guest was on his bottom and legs out in front of him, guest is able to move all extremities without any discomforted, guest voiced that he needed to go to the bathroom, staff helped him up and placed in the w/c and was taken to the bathroom to get cleaned up after he was inc. (incontinent) of BM (bowel movement), writer took off the old dressing and checked his knee, all staples intact no open area to incision large amount of drainage noted on old dressing, area cleaned and new dressing applied, Dr. call a nurse was called and fall was reported, the wife here and is aware and looked at the knee manager on call aware.</p> <p>On 11/18/24 at 10:25 AM, V4, R11's Wife, stated (R11) has fallen once getting out of bed himself, and he had bleeding to his leg from the fall. (R11) has a bed/chair alarm that is about the only thing I am aware of for fall precautions. I was told that if I leave (R11's) room, I have to leave the door open so they know he is by himself.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R11's Admission Fall Assessment, dated 10/29/24, documents R11 is a fall risk.</p> <p>There is no other fall assessment completed in R11's medical record, even after his fall on 11/3/24.</p> <p>R11's Fall Investigation, dated 11/3/24, documents Root Cause: Wife had been visiting and left without notifying staff and had closed door. Guest attempted to self transfer. staff did not hear alarm with door closed. Guest had been incontinent as well. Intervention(s): Educate wife to notify staff when leaving, toilet after meals - offer.</p> <p>On 11/20/24 at 10:00 AM, R11 sitting in recliner with Intravenous (IV) antibiotic running into left upper arm Peripherally Inserted Central Catheter (PICC) line. V14, CNA, assisted R11 to stand and walk to the restroom to use toilet. Upon R11 standing, his chair alarm did not go off and was not visible in his chair. R11's alarm pad was seen lying on his bed.</p> <p>On 11/20/24 at 10:55 AM, V4, R11's wife, stated (R11's) alarm is still on his bed and is not in his chair with (R11). V4 demonstrated this by sitting on R11's bed and getting up and the alarm went off. V4 stated They are supposed to put the alarm in his chair when they get him up.</p> <p>On 11/20/24 at 12:25 PM, V14, CNA, stated It makes sense to me, if a resident has a bed alarm and gets up to a chair, that alarm should be placed in his chair as well.</p> <p>On 11/25/24 at 10:40 AM, V2, Director of Nursing (DON), stated I would expect the staff to transfer the bed alarm to the chair when getting a resident up to a chair when that resident requires an alarm for fall precautions. A Fall Risk Assessment should be completed after every fall.</p> <p>The Facility's Falls Policy, undated, documents Purpose: To identify interventions related to the guest's specific risks and causes to try to prevent the guest from falling and to try to minimize complications from falling. Procedure: 4. The licensed nurse is responsible for completing a Fall Risk Assessment following a fall as well as identifying and implementing relevant intervention(s) to try to minimize serious consequences of falling.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on Interview, Observation, and Record Review, the facility failed to provide complete and timely incontinent care for 4 of 5 residents (R11, R48, R176, R27) reviewed for incontinent care in the sample of 44.</p> <p>The findings include:</p> <p>1. R11's Facesheet, undated, documents R11 was admitted to the facility on [DATE] with diagnosis of Internal right knee prosthesis, Sepsis, Encephalopathy, Type 2 Diabetes Mellitus (DM), Parkinson's disease, Depression, and Benign prostatic hyperplasia (BPH), Overactive bladder, and Dementia.</p> <p>R11's Care Plan, dated 11/11/24, documents At risk for falls related to weakness, impaired mobility, balance, age. R11 is alert and oriented with confusion at times related to dementia. R11 has had falls in the past 6 months/year, but number is unknown. Interventions: Toilet after meals, educate wife to notify staff when leaving, bed and chair alarm, fall risk assessment on admit and per protocol, keep personal items and frequently used items within reach, encourage to call for assistance as needed, assist to toilet upon request, fall risk. It continues R11 has an Activities of Daily Living (ADL) deficit. Interventions: R11 requires assist of two with transfers and 1-2 with ADL's. R11 has a bed/chair alarm, and the bed is in low position. There are no other interventions for fall precautions seen in R11's room.</p> <p>R11's Minimum Data Set (MDS), dated [DATE], documents R11 has a moderate cognitive impairment and requires partial/moderate assistance from staff for ADLs. R11 is occasionally of both bowel and bladder.</p> <p>On 11/20/24 at 10:00 AM, R11 sitting in recliner with Intravenous (IV) antibiotic running into left upper arm Peripheral Inserted Central Catheter (PICC) line. R11 had t-shirt on and no pants, only an incontinence brief which appeared to be saturated. R11 has his wife V4, and visitors in the room with him. R11 was seen with a folded bath blanket across his lap and kept pulling it up to cover himself with it. V4 was visibly upset and in tears. V4 stated she arrived to the facility around 9:00 AM this morning and found R11 like this. V4 stated that R11 wanted to use the restroom and she put the call light on, and a Certified Nursing Assistant (CNA) came in and stated she couldn't get R11 up until the nurse disconnects his IV and that the CNA let the nurses know. V4 stated R11's IV pump had been going off for at least 30 minutes and they still have not gotten anyone in the room to assist R11. V9, Licensed Practical Nurse (LPN), was notified and stated she was not able to disconnect R11's IV due to the PICC line and that it had to be a Registered Nurse (RN). V13, RN, entered to disconnect R11's IV. V14, CNA, entered to assist R11 to restroom. V14 stood and walked to restroom to use toilet and upon standing, R11's incontinence brief dropped to the floor due to being so heavy and saturated with urine, and R11's chair alarm did not go off. V14 held R11's brief up while R11 walked to the restroom and was assisted to the toilet. R11 stated he thought he was going to try and have a bowel movement.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/20/24 at 10:13 AM, after R11 used the toilet, V7, CNA, and V14, CNA, assisted R11 from the toilet to the shower to get cleaned. No checking or wiping of R11 buttocks/anal area was seen done after R11 stood from toilet and assisted to the shower. A slight amount of feces noted on some toilet paper in the toilet from R11 attempting to wipe himself prior to getting up.</p> <p>On 11/20/24 at 10:20 AM, V13, RN, stated that she was the one who got R11 out of bed and to his chair this morning to start his IV antibiotic. V13 stated she did not perform incontinent care at that time.</p> <p>On 11/20/24 at 10:25 AM, V7, CNA, stated that she normally gets R11 out of bed and to the shower early morning and she cleans him up at that time. V7 stated when she walked in, the nurse had already gotten R11 up to a chair and she could not get him up or to the toilet with the IV infusing. V7 stated she did not do incontinent care on R11 this morning.</p> <p>On 11/21/24 at 9:20 AM, V14, CNA, stated I round on my residents every two hours and provide peri-care at that time if needed. I change my gloves when they are visible soiled and when going from dirty to clean areas.</p> <p>On 11/21/24 at 10:45 AM, V2, Director of Nurses (DON), stated I would expect the staff to provide timely and complete incontinent care, including proper cleaning of the peri-area by retracting foreskin in an uncircumcised male. I would expect the staff to change their gloves when soiled and when going from dirty to clean areas, and to do hand hygiene before, in between glove changes, and after care provided.</p> <p>2. R48's Facesheet, undated, documents R48 was admitted to the facility on [DATE] with diagnosis of Rhabdomyolysis, Neuropathy, Constipation, Depression, Hypertension, and Falls.</p> <p>R48's Care Plan, dated 11/12/24, documents R48 has an ADL deficit. Interventions: Assist to bedpan/toilet upon request and per mobility kardex instruction. It continues R48 has potential for skin impairment.</p> <p>R48's MDS, dated [DATE], documents R48 is cognitively intact and is dependent on staff for toileting. R48 is occasionally incontinent of urine and always continent of bowel.</p> <p>On 11/20/24 at 12:58 PM, V6, CNA, and V14, CNA, provided incontinent care to R48. A basin of soapy water with a few washcloths, a package of wipes, and linen were on the bedside table. R48's incontinent brief was unfastened and tucked between R48's legs. V14 used a disposable wipe to wipe R48's left groin, R48 was rolled to his right side showing a large bowel movement (BM). V14 used a wet washcloth to wipe R48's anal area and using the same soiled gloves, obtained another wet washcloth from the basin of water, contaminating the clean water with feces soiled gloves. V14 used the bath blanket under R48 to wipe more feces off his buttocks, then tucked it under him. V14 continues to grab wet wipes from the package and wet washcloths from the basin of water with soiled gloves on. R48 was rolled to his back and cream applied to his groins and testicles. There was no cleaning of R48's penis, including retracting the foreskin, at any time. V14 applied a clean incontinence brief to R48.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Springfield Suites Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3089 Old Jacksonville Road Springfield, IL 62704	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. R176's Facesheet, undated, documents R176 was admitted to the facility on [DATE] with diagnosis of Atherosclerotic Heart Disease (ASHD), Non-ST Elevation MI (NSTEMI), Abdominal Aortic Aneurysm, Congestive Heart Failure (CHF), Atrial Fibrillation, Cerebral Infarction, Major Depressive Disorder, Anxiety Disorder, and Emphysema.</p> <p>R176's Care Plan, dated 10/11/24, documents R176 has an ADL deficit. Interventions: Assist to bedpan/toilet upon request and per mobility kardex instructions.</p> <p>R176's MDS, dated [DATE], documents R176 is cognitively intact and is dependent on staff for toileting.</p> <p>On 11/19/24 at 1:30 PM, V6, Certified Nursing Assistant (CNA), and V8, CNA, performed incontinent care on R176. Only supplies brought in was a pack of wipes, a clean incontinence pad, and a new incontinence brief. V6 held R176 while V8 performed incontinent care. Soiled brief unfastened and tucked between R176's legs. V8 got a wipe from the package and wiped R176's right groin, left groin, then down middle of her vagina. V6 then rolled R176 over to her right side, V8 used the same soiled gloves and obtained more wipes from the package, wiping R176's anal area with feces. V8 grabbed more wipes out of the package several times using the same soiled gloves to clean R176's anal area, and then buttocks. V8 then doffed her gloves, washed her hands, and donned new gloves, then put a clean incontinence pad on bed, wiped A&D ointment on R176's buttocks/anal area, then put new brief on R176. R176's buttocks and anal area appeared reddened with V8 stating that R176 had a yeast infection all over and was using Nystatin cream and it is getting better now. There was no drying of R176 during peri-care or before applying a clean incontinent brief.</p> <p>49494</p> <p>#4) R27's face sheet, undated, documented R27 has diagnoses of dementia, hemiplegia and hemiparesis secondary to a cerebrovascular accident, atherosclerotic heart disease, anxiety, and neuromuscular dysfunction of bladder.</p> <p>R27's MDS dated [DATE], documented R27 is severely cognitively impaired.</p> <p>R27's MDS, dated [DATE], documented R27 is incontinent of bowel and bladder and requires extensive assistance with ADLS.</p> <p>On 11/19/24 at 1:19 PM V15 CNA was observed as she entered R27's room with a sit to stand lift. V15 did not perform hand hygiene upon entering R27's room. V15 then placed the lift sling under R27. V15 then exited the room without performing hand hygiene. V15 then returned to R27's room along with V16 CNA. V15 nor V16 performed hand hygiene prior to transferring R27 from wheelchair to bed with the sit to stand lift. V15 and V16 then washed their hands and donned gloves. V15 then removed R27's pants and urine saturated disposable brief. V15 then cleansed R27's inner thighs and then cleansed R27's penis without cleansing the urethra region nor scrotum. V15 nor V16 dried R27's frontal region. V15 and V16 then rolled R27 onto his right side. V15 cleansed R27's buttocks and then placed a new adult brief on R27. V15 did not dry R27's buttock. V15 stated that she forgot to bring any towels into the room. R27's buttock appeared reddened. V15 nor V16 applied barrier cream on R27's buttock. V15 then covered R27 up while wearing the same disposable gloves that was used during incontinent care. V15 and V16 then removed their gloves and exited R27's room without performing hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Incontinent/Perineal Care policy, undated, documented Purpose: It is the policy of the facility to provide incontinent/perineal care for the guests as indicated by the guest's condition and ability to provide self-care. Perineal care will cleanse the perineum and prevent infections and odors. Incontinent care will include all skin surfaces exposed to urine and/or feces. Procedure: Use the following procedure when providing perineal care to a guest while in bed. Explain the procedure to the guest. Assemble any necessary equipment to the bedside. (No rinse cleanser, washcloths and towels. Provide privacy to the guest. Wash your hands and put on gloves. Expose the perineal area and drape the guest to avoid any unnecessary exposure. Moisten the washcloth with warm water and no rinse cleaner. Cleanse the area, wiping from front to back to avoid the spread of germs. Cleanse al skin areas that have been exposed to urine and/or feces. Repeat cleansing, if necessary, using each cloth only once. Pat dry. Apply protective barrier cream or ointment if the guest is incontinent and/or susceptible to moisture. If the guest has a catheter, cleanse the catheter from the meatus down the catheter about 4 inches. Separate the labia for females. If uncircumcised male, retract the foreskin gently. Remember to pull foreskin back after the procedure. Remove and discard soiled gloves after completing perineal care and prior touching anything clean (sheets, blankets, etc.). Wash your hands. Position and cover the guest for comfort. Ensure the call light is within reach of the guest. Remove any dirty linen or trash.</p> <p>The Facility's Hand Hygiene Policy, undated, documents Purpose: The facility considers hand hygiene the primary means to prevent the spread of infection. Procedure: 2. All employees shall follow the hand hygiene procedures to help prevent the spread of infection to other employees, guests and visitors. 5. Employees must wash their hands for at least fifteen seconds using soap and water under the following conditions: when hands are visibly soiled (soap and water), before and after direct guest contact for which hand hygiene is indicated by acceptable professional practice, before and after assisting guests with meals, before and after assisting a guest with personal care, before and after assisting a guest with toileting.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>40701</p> <p>Based on observation, interview and record review, the Facility failed to follow their Facility Policy regarding tube feeding administration for 1 of 2 residents (R31) reviewed for enteral tube feeding, in the sample of 44.</p> <p>Findings include:</p> <p>On 11/18/2024 at 12:08 PM, there was a bottle of enteral tube feeding, with 200 milliliters remaining and a bag of water with 100 ml remaining, hanging without a date or time of when the feeding was opened.</p> <p>On 11/29/2024, at 9:32 AM, there was a bottle and water that had been spiked and was undated and no time to indicate when it was opened.</p> <p>R31's Physician Order Report dated 11/6/2024 documents, Monitor TF (Tube Feeding) through night to ensure it is still running. Replace bottle as needed and restart feeding.</p> <p>On 11/21/2024 at 8:32 AM, V2 Director of Nursing (DON) stated there should be a date and time to indicate when the tube feeding was opened.</p> <p>The Facility's Tube Feeding Management Protocol undated, documents, Purpose: to outline the nursing management of guests receiving continuous or intermittent enteral tube feedings via gastrostomy, duodenostomy, or jejunostomy tubes. Tube feeding are utilized to meet the nutritional needs when normal oral intake is altered or contraindicated. It further documents, Replace container/tubing/syringe every 24 hours. Discard unused or open container of feeding formula.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>The facility failed to provide Oxygen (O2) to a resident requiring O2 to maintain an O2 Saturation above 92%, to administer the correct O2 dose per physician order, and to change and date the humidified water bottle for 2 of 3 residents (R170, R175), reviewed for respiratory care in the sample of 44.</p> <p>The findings include:</p> <p>1. R170's Facesheet, undated, documents R170 was admitted to the facility on [DATE] with diagnosis of Congestive Heart Failure (CHF), Neoplasm of esophagus, Malnutrition, Hypertension, Atherosclerotic Heart Disease, and Atrial Fibrillation.</p> <p>R170's Care Plan, dated 11/15/24, documents R170 requires hospice related to gastroesophageal cancer with (local hospice). Interventions: Notify Hospice when there is any change in condition, administer drugs as needed for palliation. R170's Care Plan does not mention R170 on oxygen (O2) or requiring oxygen.</p> <p>R170's Minimum Data Set (MDS), dated [DATE], documents R170 has a moderate cognitive impairment and is dependent on staff for all ADLs.</p> <p>On 11/18/24 at 10:00 AM, R170 was seen lying in bed on O2 at 2 Liters (L)/Nasal Cannula (NC) with humidity bottle attached, half full, and not dated. There is no sign posted (No Smoking/Oxygen in Use) indicating that R170 is on oxygen.</p> <p>On 11/19/24 at 9:12 AM, R170 asleep in bed, O2 on at 1.5 L/NC with the long NC tubing lying on the floor and appears coiled up in a pile, and was not on R170. The humidified bottle of water was just short of half full and was not dated.</p> <p>R170's Electronic Medical Record, under Vitals, dated 11/19/24 at 9:42 AM, documents O2 Saturation 90%. Oxygen Use: No. Respirations: 20 per minute.</p> <p>On 11/19/24 at 12:00 PM, R170 still asleep in bed with his O2 NC lying on the floor with O2 on at 1.5 Liters per minute (LPM).</p> <p>On 11/20/24 at 9:55 AM, R170 lying in bed with O2 at 1.5L/NC and appears to be same bottle of water which is now quarter full, and not dated.</p> <p>On 11/21/24 at 9:10 AM, R170 lying in bed with O2 on at 1.5 L/NC, the water humidifier bottle remains less than quarter full of water and not dated, appears to be the same bottle he has had since beginning of survey observation.</p> <p>R170's Physician Order (PO), dated 11/14/24, documents Oxygen at 1-5 LPM (liter per minute) PRN (as needed) via nasal cannula to maintain oxygen saturations above 92%. May increase liter flow an additional 2 liters as needed. If saturation level is not maintained, call physician.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R170's PO, dated 11/14/24, documents Change oxygen tubing and humidifier bottle weekly. Once A Day on Wed.</p> <p>2. R175's Facesheet, undated, documents R175 was admitted to the facility on [DATE] with diagnosis of Pneumonia, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and Obstructive Sleep Apnea (OSA).</p> <p>R175's Care Plan, dated 11/13/24, documents R175 has potential for acute signs/symptoms (s/s) of respiratory distress related to lung disease: COPD, OSA. Wears Bipap Hours Sleep (HS). O2/2L NC. Interventions: Change O2 tubing and humidifier as ordered/needed, Respiratory medications as ordered. Monitor for side effects.</p> <p>R175's MDS, dated [DATE], documents R175 is cognitively intact and requires partial/moderate assistance from staff for bathing, and dressing, needs supervision for transfers.</p> <p>On 11/19/24 at 9:23 AM, R175 sitting in wheelchair with 4 liters of Oxygen (O2) per NC on, R175 stated he is only supposed to be on 2 L/NC and not 4. There is no sign posted (No Smoking/Oxygen in Use) indicating that R175 is on oxygen.</p> <p>On 11/19/24 at 11:55 AM, R175's still has his O2 on at 4 L/NC.</p> <p>R175's PO, dated 10/24/24, documents Oxygen at 2 LPM continuously via nasal cannula to maintain oxygen saturations above 92%. May increase liter flow an additional 2 liters as needed. If saturation level is not maintained, call physician.</p> <p>R175's PO, dated 10/24/24, documents Change oxygen tubing and humidifier bottle weekly. Once a day on Wed.</p> <p>R175's Electronic Medical Record, under Vital Signs, dated 11/19/24 at 9:56 AM, documents O2 Saturation: 92%. Oxygen Use: No. Respirations: 22 per minute.</p> <p>R175's Electronic Medical Record, under Vital Signs, dated 11/18/24 at 19:04 PM, documents O2 Saturation 99%. Oxygen Use: Yes - Liter flow - 2. Respirations: 17 per minute.</p> <p>On 11/21/24 at 10:47 AM, V2, Director of Nursing (DON), stated The nurses are responsible for changing the humidified bottles for oxygen use weekly and they should be dating them when a new bottle is started. If a resident has a physician order to maintain an O2 sat above a certain number, then I would expect the staff to make sure the resident has his oxygen on and to adjust the oxygen as needed and per physician order.</p> <p>On 11/21/24 at 10:55 AM, V17, LPN, stated If a resident is on oxygen, I know the water bottle is supposed to be hooked up. I am not sure when to change the water bottle or the tubing. I would ask my DON and she would let me know.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility's Oxygen Administration Policy, undated, documents The purpose of this procedure is to provide guidelines for oxygen administration. The following equipment and supplies will be necessary when performing the administration of oxygen: 1. Portable oxygen cylinder. 2. Nasal Cannula or mask, as ordered by the physician. 3. Humidifier bottle if utilizing an oxygen concentrator. 4. No Smoking/Oxygen in Use sign. Procedure: 6. Place the Oxygen in Use sign on the outside of the room entrance door. Close to the door. 9. Place appropriate oxygen device on the guest (mask or nasal cannula). 10. Adjust the delivery device so that it is comfortable to the guest and the proper flow of oxygen is being administered.</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701</p> <p>Based on interview and record review, the Facility failed to ensure residents pain was addressed, assessed and medication provided in a timely fashion for 1 of 24 residents (R117) reviewed for pain management, in the sample of 44. This failure resulted in R117 experiencing prolonged, unrelieved pain.</p> <p>Findings include:</p> <p>R117's Face Sheet, undated, documents R117 was admitted to the facility on [DATE] with diagnoses including left femur fracture and chronic pain syndrome.</p> <p>On 11/18/2024 at 9:53 AM, R117 stated he turned on his call light the night prior, to request pain medication. R117 states he has a lot of pain due to a broken left hip as well as chronic pain in both legs. R117 stated it was approximately two hours before he received his pain medication, which did provide some relief after he received it.</p> <p>On 11/19/2024 at 1:56 PM, V20, Minimum Data Set (MDS) and Care Plan Coordinator, stated R117 was on scheduled Oxycodone for pain, but it was changed to a PRN (as needed) order on 11/13/2024. V20 stated R117 was on Oxycodone prior to experiencing his fracture due to chronic pain and cancer.</p> <p>On 11/19/2024 at 2:24 PM, R117 stated he wrote the times down when he first pressed his call light to request his pain medication and when he received his pain medication. R117 stated he activated his call light at 7:45 PM and received his pain medication at 9:15 PM.</p> <p>On 11/21/2024 at 9:25 AM, R117 stated occasionally the nurses ask him to rate his pain, but not usually. R117 stated the night of 11/17/2024, when he requested his pain medication, his pain was at a 7 on a 1-10 pain scale. R117 stated his pain level went up to a 9 by the time he received his pain medication.</p> <p>R117's Medication Administration Record (MAR) documents on Sunday 11/17/2024 R117 received his Oxycodone 15 milligrams (mg) at 1:07 PM and again at 9:07 PM.</p> <p>On 11/21/2024 at 8:34 AM, V2, Director of Nursing (DON) stated she would expect for the nurse to have address resident pain in a more timely fashion.</p> <p>The Facility's Pain Management Policy, undated, documents, Purpose: Guests will receive the best level of pain control that can safely be provided in order to prevent unrelieved pain. Policy: To provide guidelines to caregivers in how to assess, treat, and assist in managing a guest's pain. Pain is whenever the experiencing person says it is, existing whenever he/she says it does. Self-report is the preferred indicator of pain. Pain relief is the alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the guest and is demonstrated by a decrease in the guest's pain scale rating.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>49494</p> <p>Based on observation, interview and record review, the facility failed to post the daily nursing staff hours daily. This failure has the potential to affect all 58 residents residing in the facility.</p> <p>Findings include:</p> <p>On 11/19/24 at 11:30 AM, the survey team observed the posted daily nursing staffing hours by the front entrance to the facility. This document was dated 11/14/24.</p> <p>On 11/20/24 at 1:43 PM, V1, Administrator stated that the nursing department hours are supposed to be posted every day and she does not know why it had not been posted since 11/14/24 when the nursing department staffing post was observed by the survey team on 11/19/24. V1 stated V21 is responsible for posting the daily nursing department staffing hours.</p> <p>On 11/21/24 at 10:08 AM, V21, Scheduler stated that she is the one responsible for posting the daily nursing department hours. V21 stated that she does not know who is responsible for posting the nursing department hours on the weekends. V21 stated that her shift does not start until 10 AM and she does not know why the last daily nursing staff hours posted was dated 11/14/24 when observed by the survey team on 11/19/24.</p> <p>On 11/25/24 at 11:15 AM, V1, and V2, Director of Nursing (DON), both stated the facility does not have a policy for posting their staffing available for everyone to see.</p> <p>The CMS 671 Form dated 11/18/2024 documents there are 58 residents residing at the Facility.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>40701</p> <p>Based on interview and record review, the Facility failed to re-evaluate the need for psychotropic medications for 2 or 6 residents (R19 and R6) reviewed for unnecessary medications, in the sample of 44.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. R19's Physician Order Report dated 10/21/2024-11/21/2024 documents R19 was prescribed alprazolam 0.5 milligrams (mg) BID (twice a day) as needed on 10/18/2024 and does not have an end date. 2. R6's Care Plan dated 3/14/2024 documents R6 requires hospice care related to senile degeneration of brain. (Hospice) to coordinate care. <p>R6's Physician Order Report documents R6 was prescribed lorazepam 0.5 mg every four hours as needed on 3/21/2024 and does not have an end date.</p> <p>On 11/21/2024 at 8:34 AM, V2, Director of Nursing (DON) stated she is aware orders for psychotropic medications should be re-evaluated and the orders be re-written every 14 days. V2 stated she was not aware the same rules apply for hospice residents.</p> <p>As of 11/25/2024 at 10:40 AM, the Facility still had not provided a policy that addresses unnecessary/psychotropic medications.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49494</p> <p>Based on observation, interview, and record review, the facility failed to safely prepare medication, properly store medication, and to date medication bottles when opened, the Tuberculin (TB) vial was opened and undated and is used for all staff and residents. This has the potential to affect all residents living at the facility.</p> <p>Findings include:</p> <p>On 11/19/24 at 8:55 AM, V5, LPN (Licensed Practical Nurse) was observed with 5 unlabeled medication cups containing multiple pills that were placed on top of the F hall medication cart. Surveyor asked V5 how she safely administers the medications to the residents when the cups are unlabeled and already pre-poured into the individual unlabeled medication cups. V5 stated I just go in order by room number, so I don't label the cups. V5 then proceeded down the F hall with the 5 medication cups in her hands and passed the medications to R64, R47, R44, R27, and R17. V5 did not perform hand hygiene at any time during administration of the medications. V5 assisted with repositioning R47 during this observation and at no time did V5 perform hand hygiene before nor after caring for R47. V5 then proceeded to administer medications without the benefit of hand hygiene. V5 did not document the medication administration immediately after administering the medication to each of the 6 residents who received the pills from the unlabeled medication cups.</p> <p>On 11/20/24 at 1:10 PM, V11, LPN stated that she does not pre-pour resident medications and that she administers medications to the residents one at a time so she can check the medications against the MAR (Medication Administration Record). V11 stated it is not the facility procedure to pre-pop medications for the residents. V11 stated that she performs hand hygiene before and after each resident during medication administration.</p> <p>On 11/20/24 at 1:43 PM, V1, Administrator stated that the facility nurses are not supposed to pre-pour medications and that the nurses should be performing hand hygiene before and after each resident.</p> <p>44967</p> <p>On 11/19/24 at 9:32 AM, V9, LPN, was seen passing meds to R8 while eating breakfast, there was no hand hygiene seen done before or after meds given.</p> <p>On 11/19/24 at 11:25 AM, V9 was seen passing meds to R48, with no hand hygiene done prior to or after meds given.</p> <p>On 11/19/24 at 11:33 AM, V9 was seen transferring a resident to the dining room, then went back to give meds to R171 with no hand hygiene prior to giving R171 meds. V9 gave R171 Gabapentin 100 MG X 2 (200 MG).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 11/20/24 at 12:45 PM, C-Hall medication cart was inspected with V9. Upon opening the cart, a unlabeled medicine cup with three miscellaneous pills was seen sitting in the top drawer. V9 stated I know exactly whose those are, they are for (R168) I popped them out and put them in the cup and took them to her, and she did not want to take all of her morning meds, so I have been holding them for her. She just told me she wants them now. I did document that they were already given this morning. Also in the med cart was an Basaglar Insulin pen with no name or date on it. There were miscellaneous pills in sections of the top drawer: Amoxicillin 250 MG X 2, Zofran 4 MG X 4, Zofran 8 MG X 1, Cefdinir 300 MG X 1, Glipizide 5 MG X 1, and Doxycycline 100 MG X 1. A Tuberculin (TB) Vial 5 ML was in the top drawer open with no open date and box indicated to be stored in the refrigerator. V9 stated Yes, that TB is supposed to be in the fridge and dated when opened. It is used for all residents and staff.</p> <p>On 11/20/24 at 1:45 PM, V9 stated I did just give (R168) her medications and I amended the Medication Administration Record (MAR) to reflect this.</p> <p>On 11/21/24 at 10:55 AM, V17, LPN, stated I usually put the med cart in the middle of the hallway and will prepare each resident's meds one by one. I will then walk the cup of meds to the resident and watch them take them. I never prepare multiple residents at the same time. If a resident refuses or only wants to take part of the meds, I would let the DON know and then waste those meds not taken. I never leave the cup of meds at the bedside for the resident to take on their own.</p> <p>The facility's Storage of Medications policy, undated, documented Purpose: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Procedure: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. 2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 5. Hazardous drugs are clearly marked and stored separately from other medications. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. 7. Mediations requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. 8. Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications. a. Controlled medications that are part of a single unit dose distribution system may be stored with non-controlled medications when the supply is minimal, and shortages are readily detectable.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's Medication Administration policy, undated, documented Orders: 1. Do not give any medication without a physician's order. 2. Before a medication is crushed, make sure the rug is allowed to be crushed. 3. Six Rights of Medication Administration a. Right Drug b. Right Guest c. Right Time d. Right Dose e. Right Form f. Right Route. Preparation: 1. Medication Administration Record (MAR) must always be used when giving any medication. 2. Timing must be appropriate. This includes one hour before and after scheduled times: at least 30 minutes prior to meals if medication is ordered or scheduled before meals; one hour after meals if medication is scheduled after meals; with the meal if ordered this way by the physician. 3. Read the label and compare to the MAR. It continues Administration of Oral Medications: 1. Identify the guest by either looking at their photo or asking them to verify their identity. 2. Take blood pressure or pulses before administration of medications, as order by the physician. 3. Answer any questions that the guest may have regarding their medications. 4. Administer the medications with at least 4 oz of water. 5. Observe the guest swallow the medication. 8. document the medication immediately after giving the medication. Best Practices: Be aware of your time window for passing medications. Ensure hand hygiene between guests. Observe the guest take their medications unless they self-administer. Do not administer medications from unlabeled container or if label is not legible.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50840</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored in a manner that prevents potential contamination and failed to ensure required kitchen staff wear beard coverings. This has the potential to affect all 58 residents living in the facility.</p> <p>Findings include:</p> <p>On 11/19/24 at 9:26 AM, an initial tour was conducted of the kitchen and the following was noted:</p> <p>On 11/19/24 at 09:26 AM V10, Food and Beverage Manager, had a facial beard and was not wearing beard guard or cover.</p> <p>On 11/19/2024 at 9:40 AM, in the dry storage area, three bags of spaghetti noodles were open, unsealed, and not dated or labeled. A bag of dry corn cereal, dry multi-colored cereal, and dry frosted cereal were found to be open, unsealed, and not dated or labeled. A bag of all-purpose flour was open, unsealed, and not dated or labeled.</p> <p>On 11/19/2024 at 9:43 AM, in the walk-in refrigerator, a bag of shredded white cheese and a bag of shredded orange cheese were rolled up, unsealed and not dated or labeled. Two containers of barbecue sauce were open and undated. Two containers of chicken base paste were open and undated.</p> <p>On 11/19/2024 at 9:47 AM, in the walk-in freezer there were bags of French fries, garden vegetables, and egg omelets that were opened, but were not dated upon opening. All three bags had been opened and not resealed, leaving the content open to air. Solid ice noted to floor in the freezer.</p> <p>On 11/19/24 at 11:40 AM, V10 was not wearing a beard cover and had a beard.</p> <p>On 11/19/24 at 11:50 PM, V10 was preparing resident's food trays with no beard covering.</p> <p>On 11/19/2024 at 12:50 PM, there was condensation dripping from light fixture in walk in freezer. There was liquid dripping onto a large box containing seventy-five 4-ounce cartons of chocolate shakes. The pipes extending from the freezer condenser were covered with a solid ice build-up. There was a box of chocolate shakes under the condenser covered with a solid chunk of ice. Condensation was dripping from two conductor fans and piping underneath fan system onto another box of chocolate shakes. There was ice buildup on the floor of freezer, and on bottom of the freezer door.</p> <p>On 11/19/2024 at 2:14 PM, V10 was not wearing covering to beard.</p> <p>On 11/20/2024 at 12:54 PM, three bags of spaghetti pasta noodles that was previously observed opened are still not sealed or dated. A box containing graham cracker crumbs found open to air. Four bags containing dry cereal continues to be rolled up, not secure, or dated.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 11/20/2024 at 12:56 PM, a line of ice noted to the floor in front of the freezer door. Freezer's light fixture is covered with icicles. There continues to be a box of chocolate shakes covered in a thick layer of ice from drippings of condenser fan. The pipes under the condenser fan are covered in ice. There were boxes of hushpuppies, egg omelets, fried eggs, and chicken tenders that had been opened and the plastic inside was not resealed, leaving the contents open to air. The boxes were not dated upon opening.</p> <p>On 11/21/2024 at 2:20 PM, a line of frozen ice still on floor and in front of door in the walk-in freezer. Light fixture still covered with icicles. There continues to be a box of chocolate drinks covered in a thick layer of ice. The pipes under the condenser fan continue to be covered in ice.</p> <p>On 11/21/2024, at 2:20 PM, V10 denied any current issues with the freezer and stated the freezer is serviced monthly. V10 stated the ice formations in the freezer are likely due to the staff coming in and out of the freezer frequently and for long periods of time. V10 stated every now and then the freezer will have some condensation and it will drip, however there is not a current system issue with the freezer. V10 stated he expects the kitchen staff to wrap, seal, label, and date all products once they are opened. V10 stated he is currently conducting in house training on the topic on food storage. V10 stated all kitchen staff is expected to wear a hair covering. V10 stated staff who have beards that are crazy are expected to wear a beard covering especially if they are a cook or aide. V10 still currently not wearing a beard covering. When asked about beard covering V10 stated it is no shave November and he usually does not have a beard.</p> <p>The facility's Hair Restraint/Jewelry/Nail Polish undated policy documents, Food and nutrition service employees shall wear hair restraints and beard guards. Hairnet will be worn at all times in the kitchen. [NAME] guards or masks will be worn as indicated.</p> <p>The facility's Food Storage (Dry, Refrigerated and Frozen) policy reviewed 08/12/2023 documents food storage areas will be clean. Dry, and maintained at temperatures as required to ensure food safety. Food shall not be stored in any of the following areas: under leaking water lines, sprinkler head or condensers. All open products (as able) will be sealed (rolled, closed, wrapped closed, with lid closed, etc.) to ensure quality and prevent contamination against pests or rodents. Goods that have been opened with no date, left on the floor, or not properly sealed will be discarded. Dry foods: all open products are sealed, labeled, and dated. Refrigerated foods: open products are sealed, labeled, and dated.</p> <p>The Facility's Long-Term Care Facility Application For Medicare And Medicaid dated 11/18/24 documents there are 58 residents living in the Facility.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>13986</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive policy and procedure for Quality Assurance Improvement Plan and failed to ensure corrective actions/performance improvement is sustained. This has the potential to affect all 58 residents living in the facility.</p> <p>Finding include:</p> <p>1. On 11/18/24, the facility provided Quality Assessment and Assurance Policy, effective date of 11/28/16. This was a one-page document. The policy documents The committee will: Meet at least quarterly, and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality improvement projects required under the QAPI program, are necessary; AND Develop and implement appropriate plans of actions to correct identify quality deficiencies; AND Regularly review and analyze data, including data collected under the QAPI Program and data resulting from drug regimen review, and act on available data to make improvements. This policy did not address procedures regarding how the facility will obtain feedback from residents and staff, how data will be collected and monitored, and how the facility will identify, report, track and monitor concerns.</p> <p>On 11/21/24, at 9:51 AM, V1, Administrator, confirmed that the policy given was the only policy for QAPI. V1 stated that there was no policy or documentation regarding the process and explanation of the process. V1 stated she could update the policy.</p> <p>2. The last annual survey, dated 12/14/23, the facility was cited pharmacy services related to label/store drugs and biologicals.</p> <p>On 11/19/24, at 8:47 AM, V5, Licensed Practical Nurse, LPN, was passing medication. V5 had multiple cups of medications prepared with no labels indicating residents' names. At 8:55 AM, V5 stated, I just go in order, room number so I don't label the cups.</p> <p>During the medication storage labeling review, on 11/20/24 at 12:45 PM, there was a medicine cup with three pills in the top drawer of the medication cart on C-hall. V9, LPN, noted that she had prepared medications for R168 in the morning but R168 did not want the medications, so she was holding the medication. The cup was not labeled as to the contents or the resident's name. In this medication cart was an Insulin pen with no name or date on it. There was a vial of Tuberculin with no opened date and the box noted it should be stored in the refrigerator. There were miscellaneous pills stored in the section of the top drawer and no labeling as to who these pills belong to.</p> <p>On 11/21/24, at 9:51 AM, V1 stated that the Pharmacy Service deficiency cited last year, the facility did in servicing, daily rounds for 3 months and then backed off because they were in compliance. V1 stated that the nurse manager will do daily audits, check rooms for pre-poured medications, and CNAs will report if they see any medications left in the room. She was unaware of the issue regarding labeling and storing of medications.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 11/21/24, at 10:59 AM, V2, Director of Nursing (DON), stated she was not aware of the pre-pouring of medications and labeling issues noted during the current survey. V2 stated after the facility was cited for Pharmacy Services the last previous survey, they provided education, did audits, came in on all shifts and weekends, and would randomly audit the medications carts.</p> <p>The facility's Long-Term Care Application for Medicare and Medicaid, dated 11/18/24, documents the facility has 58 residents.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>13986</p> <p>Based on observation, interview, and record review, failed to provide ongoing tracking and trending of residents' and employees' infections, failed to update infection control policies, failed to implement infection control precautions, and failed to provide hand-hygiene during medication administration and resident care to prevent the spread of infections. This has the potential to affect all 58 residents in the facility.</p> <p>Findings include:</p> <p>1. On 11/18/24, the facility provided the infection control log. There was no infection control log for November 2024.</p> <p>On 11/19/24, at 2:54 PM, V2, Director of Nursing (DON), stated the infection control log was a work in progress.</p> <p>On 11/21/24 at 11:11AM V2, Director of Nursing stated she pulls the antibiotic list from the facility's system. She stated she attempts to pull the antibiotic list weekly and then transfers the information to the log. She said that she has not completed November. She said that she does review the cultures. She said that if a resident is admitted from the hospital with an antibiotic, and they do not receive a laboratory result as to why they are on the antibiotic, she will sometimes she call the hospital but most of the time she doesn't. She noted that she tracks and trends the infections by using the log which is listed by halls. She said it list the infection type and the resident's name. She said that is where she trends the infections also. When questioned regarding tracking employee illness, she said she does not but will start.</p> <p>2. The facility's Infection Control policy, undated, documents Purpose: To ensure that nosocomial infections are prevented, if possible, and monitored. The policy documents 3. The facility has an established infection control program which has been designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection. 4. The Infection Control program investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation, should be applied to a particular guest; and maintains a record of correction actions related to infection control necessary.</p> <p>On 11/21/24, at 2:25 PM, V1, Administrator, was asked to clarify why there were no dates on the infection control policies. V1 confirmed there were no dates on the policies and stated the policies were old and they would update if issues came up. She stated the some of the policies used are from (Company that provides healthcare facilities policies and procedures) which were encouraged when the facility was attempting to get accredited by Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation.</p> <p>On 11/21/24, the facility provided a grouping of infection control policies covering different areas. The (Company that provides healthcare facilities policies and procedures) were dated 2001 with revision dates of 2009, 2011 and 2012. The policies that were provided from the facility, undated were titled Isolation Initiating Transmission-Based Precautions, Isolating Discontinuing Transmission-Based Precautions, and Clostridium Difficile.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. On 11/18 through 11/21/24, R31 resided on B-hall.</p> <p>On 11/18/24 at 12:08 PM, R31 had bottle of tube feeding hanging on a tube feeding poll.</p> <p>On 11/21/24 at 1:20 PM, there was no signage R31's door regarding Enhanced Barrier Precautions.</p> <p>4. On 11/18 through 11/21/24, R119 resided on B-Hall</p> <p>On 11/20/24, R119 stated he had issues with urinary leakage about 3 years ago and had a suprapubic catheter placed.</p> <p>R119's Physician's Order (PO), dated 11/5/24, documented Suprapubic cath site: Cleanse with NS (normal saline) or wound wash BID (twice daily).</p> <p>On 11/21/24, there was no signage on R119's door regarding Enhanced Barrier Precautions.</p> <p>R119's Resident Progress Note, dated 11/17/24, documents Suprapubic catheter in place with clear amber urine.</p> <p>R119's Progress Notes from day of admission on 11/5/24 through 11/17/24, had no documentation that R119 was on Enhanced Barrier Precaution.</p> <p>On 11/21/24, V17, Licensed Practical Nurse, who was the nurse on the B-hall, stated that there was no one on Enhanced Barrier Precautions on B-hall.</p> <p>On 11/21/24, at 11:43 AM, V2 stated that the facility does not use Enhanced Barrier Precautions. She stated that they should, but they just talked about this in the last few weeks. When asked if anyone would be a candidate for Enhanced Barrier Precautions, she stated she did not know and would have to check.</p> <p>V2 provided Infection Control Policies on 11/21/2024. The policies included Isolation Initiating Transmission-Based Precautions, Isolation Transmission-Based Precautions, and Isolation which were undated. This policies did not address Enhanced Barrier Precautions.</p> <p>The Centers for Disease Control and Prevention (CDC), website, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), April 2, 2024, documents Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. The website documented Because enhanced Barrier precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of indwelling medical device that placed them at higher risk.</p> <p>The Facility's Long-Term Care Application for Medicare and Medicaid, CMS 671, dated 11/18/24, documents there are 58 residents living in the facility.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13986</p> <p>[NAME]</p> <p>Based on interview and record review, the facility failed to ensure that residents do not receive antibiotics without indication for use for three of three residents (R119, R6, R318) reviewed for antibiotic stewardship in the sample of 44.</p> <p>Findings include:</p> <p>1. On 11/19/2024 at approximately 1 PM, the infection control log was requested and at this time, V2, Director of Nursing (DON) stated, It's a work in progress.</p> <p>On 11/20/2024 the Infection Control Log was received and reviewed. There was no documentation for the month of November 2024.</p> <p>R6's Progress Notes dated 11/9/2024 at 9:25 AM documents hospice saw R6 and ordered Cipro 500 Milligrams (mg) twice a day for 7 days for UTI (Urinary Tract Infection).</p> <p>On 11/19/2024 at 12:43 PM, V2, Director of Nursing (DON) stated if a resident is on hospice, the hospice company sometimes just goes ahead and treat with Macrobid (Broad Spectrum Antibiotic).</p> <p>On 11/19/2024 at 12:47 PM, R6's urine culture was requested.</p> <p>On 11/19/2024 at 12:52 PM, V2 stated she could not provide R6's urine culture because a urine (urinalysis) was not completed.</p> <p>On 11/21/2024 at 12:54 PM, V18, Certified Nursing Assistant (CNA) stated she has not recognized or heard R6 complain of signs or symptoms of a Urinary Tract Infection (UTI).</p> <p>2. R119's Progress Notes dated 11/12/2024 documents, Received call from (Attending Physician's office staff)- d/c (discontinue) Keflex, start Macrobid 100 mg BID x's 7 days (stop prophylactic tx (treatment) while on the 7 day course.</p> <p>R119's Physician Order Report documents, 11-5-2024-11/12/2024 Macrobid 100 mg once an evening. Dx (diagnosis) personal of Urinary Tract Infections (UTI). Special instructions: no stop date-prophylactic treatment. It further documents, 11/11/2024-11/12/2024-Cephalexin 500 mg twice a day. Dx UTI. It continues, 11/12/2024-11/13/2024 Macrobid 100 mg twice a day. It further documents, 11/13/2024-11/20/2024 Cefdinir 300 mg twice a day Dx UTI.</p> <p>On 11/21/2024 at 1:24 PM, V2 stated, (R119) went to the hospital. Usually when they go to the hospital I don't get that culture (urine). I just finished the course (Infection Preventionist) so it's a work in progress. It someone is here long term; I would contact their primary doctor to see if they wanted them on prophylactic treatment.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Springfield Suites Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3089 Old Jacksonville Road Springfield, IL 62704	
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/2024, the Facility provided a fax of R119's urine culture that was collected on 11/11/2024, but did not include a culture.</p> <p>As of 11/25/2024 at 12:12 PM, The Facility still had not provided a policy regarding Antibiotic Stewardship.</p> <p>[NAME]</p> <p>3. R318's Face Sheet, undated, documents R318 was admitted to the facility on [DATE] with diagnoses of sepsis unspecified organism-Citrobacter in urine, urinary tract infection (UTI) not specified.</p> <p>R318's Progress Note, dated 10/17/2024, documented Guest 78, female, Full code; admitted fr (from) (local hospital) s/p (status post) sepsis for UTI.</p> <p>R318's Physician's Order Report dated 10/17/2024, documented R318 received ciprofloxacin hcl (an antibiotic), 500 milligrams (mg), 1 tablet daily, for UTI. End date for this this medication was 10/20/2024.</p> <p>The hospital records document there were urinalysis done one 10/11/24, with abnormal levels of protein, blood, leukocytes, and bacteria present. No Culture and Sensitivity was found in the hospital records maintained by the facility.</p> <p>The facility's October 2024 Infection Control Log documented that R318 was admitted to the facility on [DATE] with a UTI. The Log did not indicate the causative organism for the UTI or if antibiotic use criteria was met.</p> <p>The facility's Infection Control and Surveillance Policy Cultures, MED-PASS revised April 2012, documents 8. The Infection Preventionist and the Infection Control committee (or QA Committee) shall review statistics and other information related to infection control, including culture reports.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>13986</p> <p>Based on interview and record review, the facility must have an Infection Preventionist (IP) who has completed professional training before becoming the IP in the facility and implements infection control procedures which is applicable with standards of practice. This has the potential to affect all 58 residents living in the facility.</p> <p>Findings include:</p> <p>1. On 11/21/24 at 11:11 AM V2, Director of Nursing (DON)/Infection Preventionist (IP) stated she been at the facility for the last 2 years and has been doing the infection control for about 1 year. She stated she just recently got her certification. V2 stated that currently she does not track or trend employee illness as part of the infection control program.</p> <p>V2's Center's for Disease Control and Prevention (CDC) certificate for Completion for Nursing home Infection Preventionist Training Course was dated 10/29/24.</p> <p>On 11/21/24, at 1:19PM, V1, Administrator stated I do have my certification but (V2) is in charge of infection control. I actually did infection control during COVID, but she does it now.</p> <p>2. On 11/18/24, the facility provided the infection control log. There was no infection control log for November 2024.</p> <p>On 11/19/24, at 2:54 PM, V2 stated the infection control log was a work in progress.</p> <p>On 11/21/24, at 11:11 AM, V2 stated that she did not have the November 2024 infection control log done. She stated that her procedure was to pull the antibiotic list from the facility's system and then transfer that information on the log.</p> <p>3. During the survey from 11/18 through 11/21/24, R6 and R119 were receiving antibiotics for Urinary Tract Infections.</p> <p>R6's Physician's Order, dated 11/9/24, documented she received ciprofloxacin hcl (antibiotic) for urinary tract infection (UTI).</p> <p>There was no urinalysis or culture and sensitivity in R6's medical record.</p> <p>R119's Physician's Order, dated 11/20/24, documented he was to receive Macrobid (antibiotic) daily and no stop date-prophylactic tx (treatment).</p> <p>There was no urinalysis or culture and sensitivity in R119's record or medical justification for the use of the prophylactic antibiotic.</p> <p>(continued on next page)</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 11/21/24, at 11:11 AM, V2 stated that she does not always ask for or follow-up with the hospital to obtain culture and sensitivity if the resident is admitted with from the hospital on an antibiotic for UTI. She also stated that if a resident is on an antibiotic they will ask the physician why.</p> <p>4. During the survey from 11/18 through 11/21/24, the R119 had a suprapubic catheter, R41 and R118 had indwelling catheters, and R31 had a gastrostomy tube. None of these residents were on Enhanced Barrier Precautions.</p> <p>On 11/21/24 at 11:43 PM, the infection control binder provided by V2 contained signage for contact, and droplet transmission precaution. There was none for enhanced barrier precautions. V2 stated the facility does not use Enhanced Barrier Precautions. V2 stated she was aware that the facility should implemented EBP, but they just started to talk about this in the last few weeks. I know we should. She was unable to identify any resident in the facility who may require EBP.</p> <p>The Centers for Disease Control and Prevention (CDC), website, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), April 2, 2024, documents Because enhanced Barrier precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of indwelling medical device that placed them at higher risk.</p> <p>On 11/25/24 at 11:55 AM, V2 stated We don't have a policy on Infection Preventionist or the job description for the IP position, that is something that we have to work on yet.</p> <p>The facility's Long-Term Care Application for Medicare and Medicaid, CMS 671, dated 11/18/24, documents the facility has 58 residents.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>40701</p> <p>Based on interview and record review, the Facility failed to follow their influenza/pneumococcal vaccines policy for for 2 of 5 residents (R6, R31) reviewed for influenza/pneumococcal vaccines per their Facility Policy, in the sample of 44.</p> <p>Findings include:</p> <p>1. R6's Physician Order Report dated 10/21/2024-11/21/2024 documents, 1/11/2024- May administer influenza vaccine annually, if not contraindicated.</p> <p>On 11/21/24 1:18 PM, V1 Administrator (ADM) stated vaccinations are offered to everyone who is admitted . V1 stated At that time, the risks and benefits are explained and they sign if they want it or decline it. It looks like (R6) didn't receive it (Influenza Vaccine). My guess on her is that she is hospice and they opted not to do it.</p> <p>On 11/21/24 at 1:31 PM, V1 stated, (R6) did not get her influenza vaccine and we have no proof of declination.</p> <p>R6's Face Sheet dated 11/21/2024 documents, Rec'd (Received) flu vac (vaccine) this facility? Not UTD 11/30/2022.</p> <p>2. R31's Progress Note dated 10/25/2024 documents, Guest received FLuzone High Dose IM and Pevnar 20 IM (Intramuscularly) today in left deltoid.</p> <p>The Facility's Influenza/Pneumococcal Vaccine Policy dated 11/27/2016 documents, Policy- The Facility will provide influenza and or pneumococcal vaccine to residents upon request. It further documents, The resident's clinical record will reflect that the resident or the resident's representative was provided with education regarding the benefits and potential side effects of the influenza or pneumococcal immunization and whether or no the resident received the vaccine was not administered due to medical contraindication or refusal. It further documents, The pneumococcal and influenza vaccines may be administered at the same time, as long as the injections are given in opposite limbs.</p>		