

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 12/03/2025
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to properly store medication and label insulin vials for 4 of 6 residents in a sample of 37 residents residing in the facility. Findings include: On 9/29/2025 at 1:07 PM the facility's F Hall medication cart was inspected. The cart contained the following: 1. 2 of R21's open and partially used multi dose Lantus Subcutaneous Solution 100 UNIT/ML vials. The vials documented no open or expiration date. 2. An open and partially used Humulin R vial. The vial documented no name, and no open or expiration date. 3. R7's open and partially used multi dose Tresiba FlexTouch Subcutaneous Solution Pen-injector 200 UNIT/ML. The pen documented no open or expiration date. On 9/29/2025 at 1:09 PM V8, Licensed Practical Nurse (LPN) stated that the R21's Lantus vials were open and in use. V8 stated that the Humulin R vial was open and in use. V8 stated that the vials are to be labeled with an open date when open. V8 stated that the Humulin R multidose vial is a stock medication that anyone can use if they have an order and no allergy. On 9/29/2025 at 1:20 PM the facility's C Hall medication cart was inspected. The cart contained the following: 4. R88's open and partially used multi dose Insulin Lispro Injection Solution 100 UNIT/ML vial. The vial documented no open or expiration date. 5. R100's open and partially used multi dose Insulin Lispro Injection Solution 100 UNIT/ML vial. The vial documented no open or expiration date. The Long-Term Care Facility Application for Medicare and Medicaid (CMS 671), dated 9/29/2025, documents 63 total residents in facility. The facility's Storage, Labeling of OTC Medication, Destruction & Disposal of Medication, dated 9/2021, documents Purpose: To ensure that medications and biological are stored in a safe, secure storage and safe handling. Procedure 3. No discontinued, outdated or deteriorated medications should be available for use in the facility. Stock Medications & Labeling 3. OTC medications must be dated upon opening the container.		

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews the facility failed to complete hand hygiene prior to conducting resident care, prior to and after donning gloves, and failed to apply a gown for enhanced barrier precautions for 5 of 8 residents (R14, R60, R57, R44 and R67); reviewed for infection control in a sample of 37. Findings include: 1. R14's Facesheet documented he was admitted to the facility on [DATE] with diagnosis of spinal stenosis, acute pancreatitis, and peripheral vascular disease. 2. R60's Facesheet documented she was admitted to the facility on [DATE] with diagnosis of senile degeneration of brain, nausea, and palliative care. 3. R57's Facesheet documented she was admitted to the facility on [DATE] with diagnosis of spinal stenosis, generalized osteoarthritis, and vitamin deficiency. 4. R44's Facesheet documented she was admitted to the facility on [DATE] with diagnosis of senile degeneration of brain, palliative care, and chronic pain. On 9/29/25 at 12:20 PM, V5 Certified Nursing Assistant (CNA), V6 (CNA) and V7 (CNA) came out with the meal cart, all wearing gloves already. V5, V6 and V7 all served food without completing hand hygiene or glove changes in between each resident for R14, R60, R57 and R44. V7 cut up R14's food without hand hygiene or glove change. V5 removed gloves and did not complete hand hygiene prior to assisting R60 with tucking a towel into the collar of her shirt. V5 then sat down next to R57 and applied new gloves without completing hand hygiene to feed her. On 9/29/25 at 12:39 PM, V5 (CNA) sat down again next to R57, removed her old gloves and applied new ones without completing hand hygiene to feed R57 dessert. On 12/2/25 at 1:37 PM V23 (CNA) stated hand hygiene is supposed to be conducted before assisting residents with feeding, serving their trays, applying gloves and after, and before and after resident care. On 12/2/25 at 1:40 PM, V22 (CNA) stated hand hygiene is supposed to be completed before and after glove use, before serving food trays and before and after resident care. On 12/2/25 at 1:58 PM, V2 Director of Nursing (DON) stated she expects staff to be performing hand hygiene at a minimum between each resident. V2 stated for hand hygiene to also be completed before and after resident care, before and after glove use and before and after serving meal trays. 5. On 09/30/2025 at 9:00 AM, V11, RN, entered R67 room, donned gloves without benefit of hand hygiene and did not don an isolation gown prior to administering medication via R67's enteral feeding tube. R67's door to her room had a sign on it that read Enhance Barrier Precautions. R67's Face sheet, dated 12/2/2025, documented diagnoses of Cerebral Infarction, Dysphagia and Dysphagia following Cerebral Infarction. R67's MDS, dated [DATE], documented that her cognition was not intact. R67's Physicians order sheet, dated 9/5/25 documented, Infection precautions - enhanced barrier (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff wear gown/ gloves when in direct patient contact R67's Care Plan, dated 10/1/2025, documented, Enhanced barrier in place for high contact care activity per facility policy. On 12/02/2025 at 1:09 PM, V11, RN stated that she would wash her hands before putting gloves on and wear an isolation gown when giving medication through an enteral feeding tube. On 12/02/2025 at 1:21 PM, V13, RN stated that she would wash her hands before putting gloves on and wear an isolation gown when giving medication through an enteral feeding tube. On 12/02/2025 at 1:25 PM, V9, LPN, stated that she would wash her hands before putting gloves on and wear an isolation gown when giving medication through an enteral feeding tube. The facility's policy, Enhanced Barrier Precautions, dated 10/28/2025, documented, High-contact resident care activities include but are not limited to: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care, any skin opening requiring a dressing. It continues, PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. It continues, Staff will wear a clean, non-sterile gown to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood or body fluids, secretions, or excretions and during specific high-contact resident care activities. The facility's policy, Hand Hygiene, dated 4/24/2024, documented, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, resident, and visitors. This applies to all staff working in all locations within the facility.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to check residual, for 1 of 1 (R67) resident, reviewed for enteral gastrostomy tube maintenance, in a sample of 37. Findings include: On 09/30/2025 at 9:00 AM, V11, Registered Nurse (RN), prepared medications for R67, she then entered R67's room donned a pair of gloves, and administered Modafinil 100 milligrams (mg), Norco 7.5 mg/325 milliliters (ml), Vitamin B-1 100 mg and an 81 mg chewable aspirin through R67's enteral feeding tube without out checking for residual or placement. R67's Face sheet, dated 12/2/2025, documented diagnoses of Cerebral Infarction, Dysphagia and Dysphagia following Cerebral Infarction. R67's MDS, dated [DATE], documented that her cognition was not intact. R67's Physicians order sheet, dated 9/5/25 documented Specify: Flush with 50 ML's water before and after admin of tube feed. Flush with 30 ML's water before and after each med administration, It continues, Infection precautions - enhanced barrier Staff wear gown/ gloves when in direct patient contact R67's Care Plan, dated 10/1/2025, documented, Enhanced barrier in place for high contact care activity per facility policy. It continues, Check for tube placement and gastric contents/residual volume per facility protocol and record. On 12/02/2025 at 1:09 PM, V11, RN stated that she would check residual prior to administrating medication via an enteral feeding tube. On 12/02/2025 at 1:21 PM, V13, RN stated that she checks residual before giving medications to a resident through an enteral feeding tube. On 12/02/2025 at 1:25 PM, V9, Licensed Practical Nurse (LPN0, stated she would check residual of a residents enteral feeding tube before administering medication through it. The facility's policy, Tube Care, dated 11/28/2025, documented, Medication Administration. It continues, 10. Verify ube placement check for residual gastric contents by aspirating the syringe. 11. Return gastric contents removed during residual check back into stomach.		