

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Springfield Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 420 East Grundy Avenue Springfield, KY 40069	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, review of the Lippincott Manual of Nursing Practice Ninth Edition, 2010, and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases. The facility failed to implement the appropriate infection prevention and control practices during wound care. The facility failed to identify and correct problems relating to infection prevention practices affecting 2 of 4 sampled residents reviewed for infection control, Resident (R) 1 and R3. The findings include: Review of the facility's policy titled, Infection Control, revised 10/2018, revealed staff was to prevent infections and maintain a safe, sanitary, and comfortable environment. According to the policy, all employees were expected to follow infection control procedures, use appropriate personal protective equipment (PPE), and support a clean, safe, and sanitary environment to reduce the risk of disease transmission. Review of the facility's policy titled, Hand Hygiene, no date, revealed proper hand hygiene was a fundamental infection prevention measure in resident care. According to the policy, healthcare workers were required to perform hand hygiene before and after resident contact, before and after glove use, before and after aseptic procedures, and after contact with contaminated wound dressings. Furthermore, the policy stated adherence to proper hand hygiene practices minimized the risk of cross-contamination, prevented the transmission of microorganisms, and promoted resident safety. Review of the facility's nursing standards of practice Lippincott Manual of Nursing Practice Ninth Edition, 2010, revealed nurses should follow aseptic (clean) technique during dressing changes to minimize contamination and reduce the risk of healthcare-associated infections. The procedure included preparing the resident and supplies, performing hand hygiene, using appropriate PPE, carefully removing the old dressing, and applying a new dressing. Additionally, after removing the contaminated dressing, soiled gloves should be removed and hand hygiene performed following the principles of moving from dirty to clean. Throughout the procedure, the nurse should maintain aseptic technique and prevent infection to support optimal wound healing. Review of R1's admission Record, found in the resident's electronic medical record (EMR) under the Profile tab, revealed the facility admitted the resident on 07/24/2024 with diagnoses to include cellulitis of left lower limb, peripheral vascular disease, and atherosclerotic heart disease. Review of R1's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/13/2026, found in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 99, indicating R1 was unable to complete the interview. Review of R1's Order Report, dated 07/2026, found in the resident's EMR under the Orders tab, revealed a pressure wound treatment order included Dakin's External Solution 0.125% to cleanse wound to the left heel, pack with moistened rolled gauze, apply padding and an Ace (elastic) wrap, twice daily. Review of R3's admission Record, found in the resident's EMR under the Profile tab, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185336	If continuation sheet Page 1 of 3

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed the facility admitted the resident on 09/05/2023 with diagnoses to include abnormal weight loss, cerebral infarction, and multiple pressure ulcers. Review of R3's admission MDS, with an ARD of 06/16/2026, found in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a BIMS score of seven out of 15, indicating R3 had severe cognitive impairment. Review of R3's Order Report, dated 07/2026, found in the resident's EMR under the Orders tab, revealed a pressure wound treatment order included cleanse wound with Dakin's External Solution 0.125%, apply Santyl (topical enzymatic) ointment, cover with border gauze, and change daily and as needed. 1. Observation of Registered Nurse (RN) 1 performing R1's wound dressing on 07/21/2026 at 2:00 PM revealed RN1 gathered supplies from the treatment cart. The supplies included Dakin's solution, sterile gauze, rolled gauze, a calcium alginate dressing, and scissors. RN1 opened the sterile gauze package, poured Dakin's solution over the gauze to moisten it inside of its wrapper, and placed it on top of the treatment cart without a protective barrier. Scissors were obtained from the treatment cart drawer and used to cut the calcium alginate dressing. Before proceeding into the resident's room, RN1 returned the used scissors and opened calcium alginate dressing to the top drawer of the treatment cart. RN1 then put the supplies in the room on top of a bare, uncleaned bedside table. RN1 did not perform hand hygiene before she donned (put on) a gown and gloves. Further observation of RN1 performing R1's wound dressing on 07/21/2026 at 2:00 PM revealed RN1 removed an elastic wrap, gauze bandage, and a 4 x 4 inch gauze pad and placed the soiled dressings on the bed. The elastic wrap contained an approximately 1 inch blood tinged dried stain. She did not obtain a clean elastic wrap. The dressing over the heel was tinged with an approximately 3 inch round area of what appeared to be serosanguineous drainage. RN1 placed the soiled dressing directly on the bed linen. She did not change gloves or perform hand hygiene after removing the soiled dressings and before applying the clean dressing. RN1 applied the dampened sterile gauze to the wound, followed by rolled gauze, and reapplied the stained elastic wrap. Furthermore, while wearing the same contaminated gloves, RN1 touched the bed controls, bed linens, and R1. RN1 then removed the soiled dressings from the bed, discarded them, and doffed (removed) personal protective equipment. During an immediate interview on 07/21/2026 at 2:00 PM, RN1 stated the procedure was not a sterile procedure but infection control should be adhered to. She stated the resident was in enhanced barrier precautions (EBP), which required a gown and gloves during direct care. She stated she received infection control training and did nursing check offs upon hire and received ongoing infection control education. She stated following infection control protocols was important for resident safety and to prevent the spread of infection. 2. Observation on 07/22/2026 at 10:50 AM revealed the Staff Development Coordinator (SDC), also a registered nurse, performed wound care for R3. The SDC changed her gloves several times throughout the dressing change procedure when she transitioned from the dirty field to the clean field. However, although she changed her gloves appropriately, she performed hand hygiene only once after removing the old dressing and before donning a new pair of gloves. No additional hand hygiene was observed between the three glove changes while handling the soiled dressing. During an interview with the SDC on 07/22/2026 at 2:25 PM, she stated she knew there was concern that she failed to perform hand hygiene between some glove changes during observation of R3's wound care. However, the SDC did not mention the cause of her breach of the infection control practice of proper hand hygiene. The SDC stated nursing staff was educated and checkoffs were performed regarding infection control practices, including proper hand hygiene, glove changes, equipment storage, and cleaning and disinfecting reusable instruments, such as scissors, between residents and uses. During the continued interview with the SDC on 07/22/2026 at 2:25 PM, she stated staff was expected to maintain a clean environment, use (continued on next page)		

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