| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185336 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Springfield Nursing and Rehabilitation Center | 420 East Grundy Avenue<br>Springfield, KY 40069 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's documents and policy, the facility failed to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive for 12 of 14 sampled residents, Resident (R) 2, R7, R8, R9, R11, R12, R18, R20, R26, R42, R51, and R70.Review of those residents' admission packet document titled, Advance Directives Policy and Record, revealed the space indicating the resident had a Living Will, Declaration or Directive to Physicians was blank. Additionally, the facility could not provide documentation the residents or their representatives had been provided with written information on advance directives, how to formulate an advance directive, or had signed a declination to formulate an advance directive. The findings include:1. Review of R2's admission Face Sheet revealed the facility admitted R2 on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), cognitive communication deficit, and end stage renal disease.Review of R2's annual Minimum Data Assessment [MDS], with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 of 15, indicating no cognitive impairment.Review of R2's document Resident Rights, dated [DATE] and signed by R2, revealed R2 had the right to participate in establishing the expected goals and outcomes of her care, the type, amount, frequency, and duration of care and any other factors related to the effectiveness of her plan of care.Review of R2's document Advance Directives Policy and Record, unsigned by R2 and indicating R2 was her own representative, revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank.2. Review of R7's admission Face Sheet revealed the facility admitted R7 on [DATE] with diagnoses of left lower leg fracture, hypertension, and cerebral infarction.Review of R7's admission MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 15 of15, indicating no cognitive impairment.Review of R7's document Resident Rights, undated and signed by R7's spouse, revealed R7 had the right to participate in establishing the expected goals and outcomes of her care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of her plan of care.Review of R7's document Advance Directives Policy and Record, unsigned by R7 and indicating R7 was her own representative, revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank.3. Review of R8's admission Face Sheet revealed the facility admitted R8 on [DATE] with diagnoses of acute respiratory failure with hypoxia and peripheral vascular disease.Review of R8's quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 15 of 15, indicating no cognitive impairment.Review of R8's document Resident Rights, dated [DATE] and unsigned by R8, revealed R8 had the right to<br>(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 |
|---|---|---|

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | participate in establishing the expected goals and outcomes of his care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of his plan of care.Review of R8's document Advance Directives Policy and Record, unsigned by R8, revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank.During an interview with R8 on [DATE] at 2:51 PM, he stated, What is an advance directive? R8 further stated he had a Power of Attorney (POA). He stated he was not in good shape when he arrived at the facility, and he could not remember if anything like that was discussed with him. R8 stated his brother and sister handled his affairs.During a telephone interview on [DATE] at 6:40 PM with R8's sister, she stated she did not recall staff discussing or providing written information about advance directives at the time of admission. She also stated she and her brother were R8's POAs, but R8 currently made all of his own medical decisions. R8's sister stated she could not recall if a copy of his POA was provided to the facility or if staff asked them to provide a copy. 4. Review of R9's admission Face Sheet revealed the facility admitted R9 on [DATE] and readmitted him on [DATE] with diagnoses of chronic respiratory failure, quadriplegia, mild intellectual disabilities, and epilepsy. Further review of the document revealed R9 was under state guardianship.Review of R9's quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 99, indicating R9 was rarely/never understood.Review of R9's document Advance Directives Policy and Record, unsigned by R9 or his guardian, revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank.5. Review of R11's admission Face Sheet revealed the facility admitted R11 on [DATE] with diagnoses of COPD, diabetes, and congestive heart failure (CHF).Review of R'11s quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 15 of 15, indicating no cognitive impairment.During an interview on [DATE] at 1:29 PM with R11 and daughter, they both stated they remembered staff talking to them about a living will, advance directive, and power of attorney when R11 was admitted . However, they stated it was all verbal, and they received no paperwork explaining the differences.6. Review of R12's admission Face Sheet revealed the facility admitted R12 on [DATE] and readmitted her on [DATE] with diagnoses of COVID-19, traumatic below the knee amputation of right leg, and colostomy.Review of R12's quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS' score of 15 of 15, indicating no cognitive impairment.During an interview on [DATE] at 1:37 PM with R12, she stated her sister handled everything for her. She asked the State Survey Agency (SSA) Surveyor to call her sister because she did not know anything about her advance directives.During a telephone interview on [DATE] at 10:34 AM with R12's sister, she stated R12 took care of her own affairs, and the only thing she remembered the facility discussing with her was R12's code status. R12's sister further stated she herself had formulated an advance directive for herself with her own daughter, so she knew what it was but as far as she knew R12 did not have one. R12's sister stated she would like it to be discussed with R12 and for her to be notified and provided with a copy so she would also have the information.7. Review of R18's admission Face Sheet revealed the facility admitted R18 on [DATE] and was readmitted on [DATE] with diagnoses of cerebral infarction, COPD, and cognitive communication deficit.Review of R18's admission MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 15 of 15, indicating no cognitive impairment.Review of R18's document Resident Rights, dated [DATE] and signed by R18, revealed R18 had the right to participate in establishing the expected goals and outcomes of his care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of his plan of care.Review of R18's document Advance Directives Policy and Record, unsigned by R18, revealed R18 was his self-representative. Further review of the document revealed the Advance Directives<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank.During an interview on [DATE] at 1:00 PM with R18, he stated he did not remember any discussions with staff about code status, living will or power of attorney at the facility, and he did not know what they were. R18 stated his father made decisions for him, but he did not remember if his father signed any paperwork about it.During a telephone interview on [DATE] at 6:54 PM with R18's father and designated emergency contact, he stated the facility had discussed it with him and R18, but R18 was not able to understand any of it. R18's father further stated right now, R18 was still his own representative, and the family was discussing contacting a family friend who was a lawyer to begin the process for obtaining guardianship for R18. R18's father stated the facility did not provide him or R18 with any written information about formulating an advance directive, and he had not signed anything for R18 because R18 signed his own paperwork.8. Review of R20's admission Face Sheet revealed the facility admitted R20 on [DATE] and readmitted him on [DATE] with diagnoses of paraplegia, injury of the thoracic spinal cord, and hypertension.Review of R'20s admission MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 15 of 15, indicating no cognitive impairment.Review of R20's document Resident Rights, dated [DATE] and signed by R20, revealed he had the right to participate in establishing the expected goals and outcomes of his care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of his plan of care.Review of R20's document Advance Directives Policy and Record, unsigned, revealed R20 was his own representative. Further review of the document revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank. 9. Review of R26's admission Face Sheet revealed the facility admitted R26 on [DATE] and was readmitted on [DATE] with diagnoses of unspecified dementia, abnormal weight loss, and dizziness with collapse. Further review of the document revealed R26 had a legal guardian.Review of R'26s quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of three of 15, indicating severe cognitive impairment.Review of R26's document Advance Directives Policy and Record, unsigned, revealed R26 had a guardian. Further review of the document revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were blank. The sections designated no advance directives and discussed with resident/representative were blank.In review of a text message received on [DATE] at 10:55 AM from R26's Guardian, she texted the facility had not provided her with written advance directive information for R26, and she had not been asked about it. 10. Review of R42's admission Face Sheet revealed the facility admitted R42 on [DATE] and readmitted him on [DATE] with diagnoses of methicillin resistant staphylococcus aureus (MRSA) infection, hip fracture, and diabetes. Review of R'42s quarterly MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 14 of 15, indicating no cognitive impairment.During an interview on [DATE] at 1:29 PM with R42, he stated he had not received any information on advance directives, living will or power of attorney. He stated, as long as he could keep his own mind, he wanted to make his own decisions.11. Review of R51's admission Face Sheet revealed the facility admitted R51 on [DATE] with diagnoses of multiple sclerosis, cerebral infarction with flaccid hemiplegia of the left side, and cognitive communication deficit. Further review of the document revealed R51 had a designated POA.Review of R51's annual MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 12 of 15, indicating moderate cognitive impairment.Review of R51's document Resident Rights, dated [DATE] and unsigned, revealed R51 had the right to participate in establishing the expected goals and outcomes of her care, the type, amount, frequency and duration of care and any other factors related to the effectiveness of<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | her plan of care.Review of R51's document Advance Directives Policy and Record, unsigned, revealed R51's POA was her brother. Further review revealed the Advance Directives sections designating living will, declaration or directive to physicians, and durable power of attorney for healthcare/surrogate decision maker for healthcare were dated as not received on [DATE]. The sections designated no advance directives and discussed with resident/representative were blank.During an interview on [DATE] at 1:35 PM with R51, she stated her brother was her POA and took care of all her decision making. She stated she did not recall any discussions about advance directives, or it being reviewed with her at any time.During a telephone interview on [DATE] at 6:48 PM with R51's brother/POA, he stated a discussion was held on admission about R51's advance directives. He stated he was sure that he received written information about it, but he was not sure where it was now.12. Review of R70's admission Face Sheet revealed the facility admitted R70 on [DATE] with diagnoses of COPD, chronic kidney disease, and repeated falls and multiple fractures of ribs.R70's admission MDS had not been completed.During an interview on [DATE] at 1:25 PM with R70, he stated he did not remember any staff discussing POA, advance directives, or code status with him. R70 stated his brother made decisions for him.During a telephone interview on [DATE] at 7:02 PM with R70's brother, he stated the admission process was all new to him, and he was not sure what the papers he had were about. He then put his wife on the telephone, and she stated all the paperwork they had was from the hospital, and the facility had not discussed advance directives or given them copies of any paperwork when R70 was admitted .During an interview on [DATE] at 3:59 PM with the admission Coordinator (AC), she stated she had been doing admissions for 11 years at the facility. She stated the only information she had for residents about advance directives was what she had been provided by corporate, and it was in the admission agreement paperwork. The AC stated the document she was referring to was Advance Directive Policy and Record. The AC stated on admission, she reviewed cardiopulmonary resuscitation (CPR) choices and the state Do Not Resuscitate form with the resident or their representative. Additionally, she stated she knew their sister facilities had the same paperwork and offered the resident and/or resident representative the same information. The AC stated her regional contact was currently creating a document to address and indicate if the resident had an advance directive or had chosen to decline to formulate an advance directive so the facility would be sure to honor the resident's or the resident representative's wishes for care.During an interview on [DATE] at 4:05 PM with the Social Services Director (SSD), she stated on admission she addressed code status with the resident or their representative and made sure that was charted. The SSD further stated code status was addressed with each resident or resident representative at the resident care conference at least quarterly, but advance directives were not. The SSD stated, if a resident did not have a clear advance directive or declination of one on file, there could be confusion if that resident had an emergent decline in condition and family or next of kin could not be immediately reached, resulting in the resident's wishes not being honored.During an interview on [DATE] at 2:57 PM with the Director of Nursing (DON), she stated she had worked at the facility for two and a half years this time around but had left and returned several times. The DON stated a resident's code status was charted on the Medication Administration Record/Treatment Administration Record (MAR/TAR) indicating if the resident was a Do Not Resuscitate (DNR) or a Full Code. She further stated the information on advance directives was given to the resident or resident representative by the AC and/or SSD and was included in a packet which was in the resident's admission packet. The DON stated there was a document in the packet which had an area on it stating the resident and/or their representative had the option to formulate or decline to formulate an advance directive, and there was also a place on the document to indicate if they had an advance directive. The DON stated it was important to know the resident's wishes to provide nursing care for the resident, share that information with the hospital when needed, and to honor the resident's wishes. The DON stated the resident's code status (whether they were a full code or a DNR) was reviewed at every care plan meeting which was quarterly, but she was not sure when advance<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | directive choices were reviewed.During an interview on [DATE] at 3:14 PM with the Administrator, she stated she had worked at the facility for three weeks but had been an Administrator for 13 years. She stated the facility had adapted the admission packet to include the information about advance directives with a signature page for the resident or representative to sign. She stated she felt strongly the facility had provided education to the family and responsible party, and if they had not had it, the facility would have given them the information. The Administrator also stated it was important to honor the resident's and/or representative's wishes for resident care, and there was a difference between code status and advance directives. The Administrator stated resident code status was reviewed during care plan meetings, but the advance directives were not. She stated it was important to review advance directives with the resident's condition and cognition changes, so the resident's and their representative's care wishes were honored. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, review of an article from the Cleveland Clinic, and review of the facility's policy, the facility failed to ensure that all drugs and biologicals used in the facility were stored and labeled in accordance with professional standards, which affected 1 of 4 medication carts. The findings include:Review of the facility's policy titled, Label/Store Drugs & Biologicals Standard of Practice, most recently revised 4/2025, revealed drugs and biologicals must be labeled in accordance with currently accepted professional principles and include the expiration date when applicable. Further review revealed expired and/or discontinued medication shall be removed from the medication storage area. Continued review revealed if a multi-dose vial had been opened or accessed, then it should be dated and discarded within 28 days unless the manufacturer specified a different date. Review of the Cleveland Clinic article, Is it Okay to Take Expired Medicine? at https://health.clevelandclinic.org/can-you-take-expired-medicine, dated 02/22/2024, revealed the expiration date of medications reflected the end of the time the manufacturer guaranteed their safety and efficacy. Further review revealed the risks of expired medicines included becoming weaker, such that they could not treat the condition properly, and they could contain harmful germs because the preservatives in them had broken down.Observation of the East Unit Back Hall medication cart on 01/07/2026 at 2:30 PM revealed four insulin pens (lowered blood sugar) were not labeled with an opened date or use by date. Further observation revealed an opened vial of Humulin 70/30 insulin with no resident name label or open/use by date and an opened unit bottle of UTI Stat, a liquid supplement that promoted urinary health, with manufacturer's expiration date of 06/27/2025.During interview with Registered Nurse (RN) 2 on 01/07/2026 at 2:38 PM, he stated multi-dose insulin pens were kept in the refrigerator; and then, upon removal to a medication cart, labeled with the opened date. He further stated insulin vials retrieved from the Cubex, a medication storage device, should be labeled with the resident's name and the opened date. He stated the importance of adding the opened date to the label was so the medication would not be used after it had expired and might not be effective. He stated expired medications should be removed from the cart by the expiration date to ensure they were not given to residents.During interview with the Unit Manager on 01/08/2026 at 10:00 AM, she stated when the nurse obtained a new insulin pen, the nurse should put the date opened on the package before storing it in the medication cart. She stated the reason for this was so the staff knew when the insulin expired. She stated it was important not to give insulin after the expired date because it might not be effective.During interview with the Director of Nursing (DON) on 01/08/2026 at 1:54 PM, she stated insulin pens should be dated when opened, and a vial taken from the Cubex should be labeled and dated. She also stated expired medications or supplements should be removed from the cart by the expiration date. She stated that was important because staff did not want to give residents medicine that might not be effective.During interview with the Administrator on 01/08/2026 at 3:04 PM, she stated her expectation was that staff followed policies and procedures based on regulatory guidelines, which was once a multi-dose medication was opened, the medication must be dated with the opened date. She stated the regulation's point was staff did not use a medication that was expired, so the medication still would be effective. She stated her expectation was that supplements should be removed from the cart by the expiration date. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, record review, review of a Centers for Disease Control and Prevention (CDC) article, and review of the facility's policy, the facility failed to ensure staff complied with gowning while administering medications via gastrostomy tube, while the resident was under Enhanced Barrier Precautions (EBP) for 1 of 30 sampled residents, Resident (R) 60. The findings include: Review of the facility's policy titled, Infection Control, last revised 10/2018, revealed no specific guidance for Enhanced Barrier Precautions (EBP).Review of the CDC's article, Enhanced Barrier in Skilled Nursing Facilities, https://www.cdc.gov/infection-control/media/pdfs/Webinar-EBPinNH-Nov2022-Slides-508.pdf, dated 11/15/2022, revealed the use of gown and gloves was indicated for residents during high contact care activities when they were at high risk of colonization with Multi Drug Resistant Organisms (MDRO). Further review revealed high contact care activities included device care or use for indwelling catheters, tracheostomies, central lines, or feeding tubes,Review of the facility's EBP signage posted on R60's room door revealed staff must wear gloves and gown when caring for or using feeding tubes, central lines, urinary catheters, and tracheostomies.Review of R60's annual Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/04/2025, revealed the facility initially admitted R60 on 07/01/2012 with diagnoses including nontraumatic brain dysfunction, dementia, and Parkinson's disease. Further review revealed R60 took his nutrition from his g-tube.Observation of medication administration for R60 on 01/08/2026 at 8:59 AM revealed Registered Nurse (RN) 2 failed to don (put on) a protective gown prior to administering medication via gastrostomy tube (g-tube).During an interview with RN2 on 01/08/2026 at 9:12 AM, he stated it was expected to use a gown when giving medications via g-tube, but he just forgot. He further stated wearing a gown for medication administration was important to prevent cross-contamination.During an interview with the Assistant Director of Nursing (ADON) on 01/08/2026 at 1:21 PM, she stated the facility did not have a specific policy for administering medications via g-tube. She stated staff followed physician orders and standard of practice. She stated there was not a specific Enhanced Barrier Precautions policy, but they followed CDC guidelines. During additional interview with the ADON on 01/08/2026 at 2:44 PM, she stated having to gown to administer medications for residents who were under EBP and had a g-tube was controversial. She stated if the feeding tube had a stopcock, then the system stayed closed when switching from feeding to giving medications. However, she stated if the syringe was attached for medication administration and the stopcock was opened, then the system was open.During an interview with the Director of Nursing (DON) on 01/08/2026 at 2:52 PM, she stated the expectation was that staff would gown if caring for a g-tube, including giving medications.During an interview with the Administrator on 01/08/2026 at 3:04 PM, she stated her expectation was that all appropriate PPE was used when giving medications by g-tube. |