STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365829	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Springfield Rehabilitation and Healthcare Ce	701 Villa Road Springfield, OH 45503

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interviews, and policy review, the facility failed to ensure medications were administered according to physician orders. This affected three (Resident #15, #9, #93) out of four residents reviewed for medication administration. Additionally, the facility failed to ensure medications prescribed were not borrowed and administered to other residents. This affected one (Resident #9) out of three residents reviewed for medication use. The facility census was 90.Findings Included:1. Medical record review for resident #15 revealed an admission date on 5/27/26. Diagnosis included fracture of Right humorous type two diabetes and hyperlipidemia.Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had intact cognition. Resident #15 required supervision to moderate assistance from staff members for eating, toileting, bed mobility and transfers. Review of the plan of care for Resident #15 dated 05/27/26 revealed the resident had an impaired musculoskeletal status related to a fracture of the right humorous. Interventions included administering pain medications as ordered, encouraging resident to ask for assistance and provide turning and repositioning as needed. Review of the active physician orders for Resident #15 revealed an order dated 5/27/26 for Lipitor (high cholesterol treatment) tablet 10 milligrams (mg) give one tablet by mouth at bedtime dated 05/28/26, and an order dated 05/30/26 for magnesium citrate oral solution give 148 milliliter (ml) by mouth one time only for constipation may repeat if no results. Review of the medication administration record for the month of May 2026 for Resident #15 revealed Lipitor 10 mg tablet was administered in the AM and the PM on 05/28/26 and magnesium citrate was not administered on 05/30/26 or 05/31/26. Review of the medication administration record for the month of June 2026 for Resident #15 revealed magnesium citrate 148 ml was administered on 06/02/26. Review of the progress notes dated 05/28/26 at 2:26 P.M. to 06/03/26 6:32 P.M. revealed the physician was not notified of the error or the delay in administration. Interview on 06/04/26 at 10:19 A.M., with the Director of Nursing (DON) verified the magnesium citrate was not administered as ordered on 05/30/26 and should have been and Lipitor 10 mg tablet was administered on two separate times on the same day in error after the order was altered to reflect a time change on 05/28/26. 2. Medical record review for Resident #93 revealed an admission date of 05/11/26. Diagnoses included hemiplegia, hemiparesis, stroke and type two diabetes. Review of the discharge MDS assessment dated [DATE] for Resident #93 revealed the brief interview for mental status was not completed. Resident #93 required staff assistance for eating and moderate assistance for bed mobility and transfers. Resident #93 was dependent on staff for toileting. Resident #93 was coded as receiving insulin during the assessment period. Review of the plan of care dated 05/12/26 for Resident #93 revealed resident had an impaired metabolic status related to diabetes mellitus. Interventions included administering medication and treatments as ordered, diet as ordered and monitor laboratory testing per physician orders.Review of the hospital discharge orders for Resident #93 dated 05/11/26 revealed an order to begin insulin glargine 100 unit/milliliter (u/ml) injection. Inject 10 units into the skin nightly and insulin lispro 100 unit/ml solution injection inject 0-10 units into the skin four times a day before meals and nightly. Review of (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician orders for Resident #93 revealed an order on 05/11/26 for insulin glargine 100 u/ml injection, inject 10 units into the skin nightly and an order dated 05/12/26 for Humalog injection solution 100 units/ml inject per sliding scale for a blood sugar of: 0-60 milligrams per deciliter (mg/dL) = 0 units and call medical doctor, 61-150 mg/dL = 0 units, 151-200 mg/dL = 2 units, 201-250 mg/dL = 4 units, 251-300 mg/dL = 6 units, 301-350 mg/dL = 8 units, 351-400 mg/dL = 10 units and 401-999 mg/dL call medical doctor, before meals and at bedtime. Review of the medication administration record (MAR) for Resident #93 revealed Humalog injection per sliding scale was not signed off as administered on 05/12/26 at 6:30 A.M. or 11:30 A.M. Resident #93 blood glucose level was charted at 4:30 P.M. at 500 milligrams per deciliter (mg/dL). The MAR for 05/12/26 was coded with a number nine and the nurses initials, with number 9 indicating a progress note was documented. Review of the progress note for Resident #93 dated 05/12/26 at 4:00 P.M. revealed resident's blood sugar was checked and reading was high. The nurse noted discharge summary from hospital mentions Humalog. The physician notified of need for specific orders for administration and glucose checks. New orders to administer Humalog and recheck at dinner time. New orders for sliding scale with Humalog and Lantus nightly dated 05/12/26. Interview on 06/04/26 at 10:30 A.M., the DON stated the order for the blood sugar check four times a day and the order for insulin lispro 100 unit/ml solution injection inject 0-10 units into the skin four times a day before meals and nightly was not transcribed on admission. The DON stated the error was noted when the second medication check was completed and the physician was notified. Additionally, the DON stated Resident #93 had multiple insulin changes during her hospital stay and her Glycosylated hemoglobin (A1C) was documented at 10.8 percent. The DON stated Resident #93 had not experienced any hospitalization related to the elevated blood levels. Resident #93 discharged against medical advice to return home with family members on 06/22/26.3. Medical record review for Resident #9 revealed an admission on [DATE]. Diagnoses included fusion of the cervical spine. Review of the comprehensive MDS assessment for Resident #9 dated 06/02/26 revealed an intact cognition. Resident #9 required set up assistance from staff for meals. Resident #9 was dependent on staff for toileting needs. Resident #9 required maximum assist for bed mobility and supervision for transfers. Resident #9 was coded as receiving opioids during the assessment period. Review of the plan of care for Resident #9 dated 05/27/26 revealed the resident had potential for pain related to recent surgery for cervical myelopathy. Interventions included monitoring pain levels, administration of pain medications and effectiveness. Review of the physician orders for Resident #9 revealed an order for Gabapentin oral capsule 300 mg, give one capsule by mouth every 8 hours for pain dated 05/27/26 and oxycodone tablet 10 mg give 0.5 tablet by mouth every 6 hours as needed for pain dated 05/26/26. Review of the MAR for Resident #9 for the month of May 2026 revealed oxycodone 10 mg 0.5 tab was administered on 05/27/26 at 9:13 A.M. and 05/29/26 at 9:37 A.M.Interview on 06/03/26 at 10:10 A.M. with Resident #9 stated the facility had not received his pain medication when he arrived at the facility and had to wait for it to arrive. Resident #9 stated they were able to get him something to help manage the pain until it arrived.Observation on 06/04/26 at 2:10 P.M. of the narcotic count sheet for Resident #9 revealed oxycodone 10 mg, 0.5 tablets were delivered to the facility on [DATE] by the pharmacy. Interview on 06/04/26 at 2:25 P.M., the DON verified the nurse did not pull the prescribed medication from the cube (onsite emergency medication supply storage) but borrowed it from another resident due to in house emergency supply not having the correct mg prescribed for Resident #9. The DON stated the medication would be replaced at the facility's expense. The DON verified that borrowing from another resident was not allowed. Review of the facility policy titled Administering Medication undated, revealed the facility did not follow the policy. The policy documented medication must be administered in accordance with the orders, including any time frame. This deficiency represents noncompliance investigated under Complaint Number 3017718.