STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366099	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Nursing & Independent Living	404 E McCreight Ave 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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to ensure a resident was provided written notification prior to a room change. This affected one (#10) out of three residents reviewed for room changes. The facility census was 63. Findings include: Review of the medical record for Resident #10 revealed an admission date of 03/22/22 with medical diagnoses of cerebral infarction with left hemiplegia, aphasia, ischemic cardiomyopathy, obesity, congestive heart failure, and chronic kidney disease stage III. Review of the medical record revealed Resident #10 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #10's quarterly MDS assessment, dated 05/02/25, indicated Resident #10 had severely impaired cognition, not able to make needs known, and was dependent upon staff for all ADL's including eating. The MDS indicated Resident #10 did not receive any by mouth (PO) intake and received 51%-100% nutrition via tube feeding. Review of the medical record for Resident #10 revealed under the Census Tab in the electronic medical record revealed the resident was moved in April 2025. Further review of Resident #10's medical record revealed there was no evidence the resident received written notification of the room change. Interview on 05/15/25 at 11:53 A.M. with Licensed Practical Nurse (LPN) #150 stated Resident #10 was moved from in April 2025 in order to consolidate beds. LPN #150 stated Resident #10 was not happy with the room change and stated Resident #10 enjoyed his prior room his bed was by the window and he could look outside and his bed in room [ROOM NUMBER] was by the door and he couldn't look out the window. Interview on 05/20/25 at 2:30 P.M. with admission #103 confirmed Resident #10 was moved rooms in April 2025. Admissions #103 stated Resident #10 was moved rooms to consolidate rooms due to the facility was running out of female beds. Admissions #103 stated she did not show Resident #10 or his representative of the room prior to the room change or provide written notice of the room change. admission #103 stated the facility never provided written notice of room changes. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Change of Room or Roommate, revised 03/01/25 stated the facility must inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change requiring notification. The policy stated circumstances which required notification included accidents, significant change in the resident's physician, mental, or psychosocial condition such as a deterioration in health, mental or psychosocial status. This deficiency was an incidental finding discovered during the course of the complaint investigation.

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	366099	A. Building B. Wing	05/22/2025

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of Self-Reported Incidents (SRI), staff interviews, and policy review, the facility failed to thoroughly and timely investigate allegations of abuse. This affected two (#10 and #46) out of the three reviewed for abuse investigations. The facility census was 63. Findings include: 1. Review of the medical record for Resident #10 revealed an admission date of 03/22/22 with medical diagnoses of cerebral infarction with left hemiplegia, aphasia, ischemic cardiomyopathy, obesity, congestive heart failure, and chronic kidney disease stage III. Review of the medical record revealed Resident #10 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #10 revealed a quarterly Minimum Data Set (MDS) assessment, dated 05/02/25, indicated Resident #10 had severely impaired cognition, not able to make needs known, and was dependent upon staff for all ADL's including eating. The MDS indicated Resident #10 did not receive any by mouth (PO) intake and received 51%-100% nutrition via tube feeding. Review of the medical record for Resident #10 revealed a nurses' note, dated 04/20/25 at 2:00 P.M., which stated Certified Nursing Assistant (CNA) #180 reported to the nurse Resident #10 was shaking during rounds. The note stated Resident #07 was known to do that when he was anxious or having a bowel movement. The note stated upon assessment, the resident seemed normal, responded in his normal manner, smiled, and vital signs within normal limits. Review of the nurse's note dated 04/20/25 at 5:45 P.M. stated Resident #07 was sent to the hospital for stroke symptoms. Further review of the nurses' note dated 05/20/25 at 5:56 P.M. stated nurse was called to Resident #07's room by CNA #112 at approximately 5:15 P. M. because Resident #07 was not acting right, vision was fixed to left, not responded per his usual, and he was pale and diaphoretic. The note stated upon further assessment Resident #07 was noted to have left facial drooping and he was sent to the emergency room. Review of the SRI, dated 04/30/25, indicated an investigation for allegation of neglect was conducted. The SRI stated on 04/20/25, CNA #180 reported Resident #07's change of condition which included right side body shaking, no eye contact, and Resident #07 could not speak. The SRI documentation noted Resident #07 was sent to the hospital around 5:15 P.M. on 04/20/25 for evaluation due to no response, head looking to the left, and sweating. The SRI stated the witnesses included Licensed Practical Nurse (LPN) #166 and CNA #180 and #112. The allegation was unsubstantiated by the facility due to lack of evidence. The SRI noted LPN #166 was terminated for failure to document a significant change in condition and required assessments in a timely manner per facility policy. Review of the SRI investigation revealed no documentation to support any staff, or resident interviews were completed related to concerns for neglect. Interview on 05/20/25 at 1:20 P.M. with CNA #112 stated she arrived to the facility around 1:00 P.M. on 04/20/25 and was assigned to Resident #07's unit. CNA #112 stated she conducted checks on Resident #07 several times from 1:00 P.M. to 5:00 P.M. on 04/20/25 and had not noticed any change in his condition until around 5:00 P.M. CNA #112 stated she notified LPN #166 of Resident #07's change in condition and he was sent to the emergency room. CNA #112 stated she was never asked to complete a witness statement or asked about the incident on 04/20/25. (continued on next page)

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	366099	A. Building B. Wing	05/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/22/25 at 9:34 A.M. with CNA #180 confirmed she worked on 04/20/25 and was assigned to Resident #07's unit. CNA #180 stated around 4:00 P.M. she reported to LPN #166 that Resident #07 was shaking, not making eye contact, and was not able to communicate. CNA #180 reported LPN #166 went to check on Resident #07 and stated the resident was fine. CNA #180 stated about one hour later Resident #07 was sent to the emergency room for a change of condition. CNA #180 stated she notified the Director of Nursing (DON) of concerns for possible neglect after Resident #07 was sent to the emergency room. CNA #180 stated she was never asked to provide a witness statement or asked about the incident on 04/20/25. 2. Review of the medical record for Resident #46 revealed an admission date of 04/22/24 with medical diagnoses of dementia, anxiety, chronic kidney disease stage III, and hypothyroidism. Review of the medical record for Resident #46 revealed an admission MDS assessment, dated 04/29/25, which indicated Resident #46 had severely impaired cognition and delusions. The MDS indicated Resident #46 required supervision with eating, toileting hygiene, bathing, and bed mobility. Review of the medical record for Resident #46 revealed a nurses' note dated 05/01/25 at 7:45 A.M. which stated Resident #46 reported to CNA that her groin hurt and stated, the man who is yelling in the hallway entered my room and raped me. CNA notified nurse and the nurse completed an assessment on resident. The note stated the DON was notified and when the DON interviewed Resident #46 the resident stated she didn't remember saying that and that she must have been dreaming. The note stated DON notified the police department (PD) and Resident #46 was sent to the hospital for an examination. Review of a nurses' note dated 05/01/24 at 11:00 A.M. stated Resident #46 returned from the hospital and the examination had negative results. Review of SRI, dated 05/01/25, for allegation of sexual abuse stated Resident #46 stated her groin hurt and reported a man raped her. The investigation indicated PD were notified and Resident #46 was sent to the hospital for examination with negative results. Review of the investigation revealed resident interviews were completed but did not contain documentation to support the facility conducted staff interviews or obtained witness statements. Interview on 05/22/25 at 7:39 A.M. with Registered Nurse (RN) #140 confirmed she was the nurse working the morning of 05/01/25 when Resident #46 stated she was raped. RN #140 stated she reported the allegation to DON and completed a skin assessment on Resident #46 and no concerns noted. RN #140 stated Resident #46 changed her story about what happened but Resident #46 was sent out to have rape kit completed. RN #140 stated DON did not interview her or any other staff on that shift regarding allegation. Interview on 05/22/24 at 12:15 P.M. with the Administrator confirmed there was no documentation to support staff, or resident interviews were conducted during the investigation for SRI involving Resident #10 and no staff interviews were conducted for the SRI involving Resident #46. Administrator confirmed SRI involving Resident #10 was not initiated until 04/30/25. Administrator stated the DON at the time of the allegation no longer worked for the facility and was the person who completed the SRI investigations. (continued on next page)

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	366099	A. Building B. Wing	05/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect, and Exploitation, revised 03/01/25 stated the facility was to provide protections for the health, welfare, and rights of each resident by developing and implementation written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. The policy stated that an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation or reports of abuse, neglect, or exploitation occur. The policy stated written procedures for investigation include: identify staff responsible for the investigation, exercise caution in handing evidence, investigating different types of alleged violations, identifying and interviewing all persons, including alleged victim, alleged perpetrator, witnesses, and other who might have knowledge of the allegations, focus the investigation on determining if abuse, neglect, exploitation, and/or misappropriation has occurred, and provide complete and thorough documentation of the investigation. This deficiency represents non-compliance investigated under Complaint Number OH00165446 and OH00165398.

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	366099	A. Building B. Wing	05/22/2025

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, review of the facility Minimum Data Set (MDS) policy, and review of the Long- Term Care Facility Resident Assessment Instrument 3.0 User (RAI) Manual, October 2024, the facility failed to complete significant change MDS as required. This affected one (#10) out of the three residents reviewed for change in condition. The facility census was 63. Findings include: Review of the medical record for Resident #10 revealed an admission date of 03/22/22 with medical diagnoses of cerebral infarction with left hemiplegia, aphasia, ischemic cardiomyopathy, obesity, congestive heart failure, and chronic kidney disease stage III. Review of the medical record revealed Resident #10 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #10 revealed an annual MDS, dated [DATE], which indicated Resident #10 was cognitively intact and required set-up assistance with eating. The MDS indicated Resident #10 was dependent upon staff for all Activities of Daily Living (ADL's). The MDS indicated Resident #10 received a by mouth intake and no documentation of tube feedings noted. Review of Resident #10's quarterly MDS assessment, dated 05/02/25, which indicated Resident #10 had severely impaired cognition, not able to make needs known, and was dependent upon staff for all ADL's including eating. The MDS indicated Resident #10 did not receive any by mouth (PO) intake and received 51%-100% nutrition via tube feeding. Review of the medical record for Resident #10 revealed a physician order dated 03/22/22 for regular diet, regular texture with thin liquids, an order dated 05/09/25 for tube feeding continuous, Jevity 1.5 at 75 milliliter (ml) per hour for 22 hours to allow for ADL care and an order to flush percutaneous endoscopic gastrostomy (peg) tube with 120 ml of free water before starting feeds and after stopping feeds. Interview on 05/15/25 at 11:53 A.M. with Licensed Practical Nurse (LPN) #150 stated after Resident #10's most recent stoke in April 2025, Resident #10 could no longer communicate with staff verbally, not able to make needs known, and received nutrition via tube feedings. Interview on 05/20/25 at 1:20 P.M. with Certified Nursing Assistant (CNA) #112 stated Resident #10 returned to the facility on [DATE] after a stroke. CNA #112 stated prior to the stoke, Resident #112 was able to scroll on his cell phone, communicate with staff, eat a regular diet by mouth and was cognitively intact. CNA #112 stated Resident #10 is no longer able to make his needs known, has severe cognitive impairment, and only received nutrition via a gastrostomy tube. Interview on 05/20/25 at 2:34 P.M. with MDS #109 stated she did not feel Resident #10 meet the requirements to complete a significant change in status MDS assessment after his return from the hospital on [DATE]. MDS #109 confirmed prior to Resident #10's stroke in April 2025, Resident #10 was cognitively intact, able to eat a regular diet after set-up assistance, and was able to communicate effectively with staff. MDS #109 stated after Resident #10's stroke he received all nutrition from tube feedings via gastrostomy tube, had severely impaired cognition, and was nonverbal and not able to make his needs known. (continued on next page)

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	366099	A. Building B. Wing	05/22/2025

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, MDS, revised 03/01/25, stated residents are assessed, using comprehensive assessment process, in order to identify care needs to develop an interdisciplinary care plan. The policy stated that a significant change in status assessment (SCSA) is a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements outlined in Chapter 2 of the RAI manual. Review of the Long-term Care Facility RAI 3.0 User Manual, October 2024 page 2-24 through 2-28, stated a SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either a major improvement or decline. The manual stated the significant change is a major decline or improvement on a resident's status: 1) that will not normally resolve itself without interventions by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting, 2) impacts more that one area of the resident's health status, 3) requires interdisciplinary review and/or revision of the care plan. The manual stated a SCSA was appropriate if there were either two or more areas of decline which included: resident's decision making ability had changed, any decline in an Activity of Daily Living (ADL) function where at least one ADL was newly coded as partial/moderate assistance, substantial/maximum assistance, or dependent, and an emergence of condition/disease in which a resident is judged to be unstable. This deficiency was an incidental finding discovered during the course of the complaint investigation.

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	366099	A. Building B. Wing	05/22/2025

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review and staff interview, the facility failed to ensure resident blood sugar levels were monitored as ordered. This affected one (#66) out of three residents reviewed for monitoring of blood sugar levels. The facility census was 63. Findings include: Review of the medical record for Resident #66 revealed an admission date of 04/09/25 with medical diagnoses of atrial fibrillation, hypertension, diabetes mellitus, and congestive heart failure. Review of the medical record revealed a discharge date of 04/23/25. Review of the medical record for Resident #66 revealed an admission Minimum Data Set (MDS) assessment, dated 04/15/25, which indicated Resident #66 was cognitively intact and required partial/moderate staff assistance with toilet hygiene, showers, supervision with transfers, and was independent with bed mobility. The MDS indicated Resident #66 received hypoglycemic medications. Review of the medical record for Resident #66 revealed a physician order dated 04/09/25 for Accu-Chek (fingerstick blood sugar monitoring) two times daily, if above 150 give morning dose of Jardiance, if below 150 hold morning dose of Jardiance. Review of the medical record for Resident #66 revealed documentation to support the facility completed Accu-Chek daily. The medical record did not have documentation to support the Accu-Chek's were completed two times per day as ordered. Interview on 05/22/25 at 11:00 A.M. with Director of Nursing confirmed Resident #66's order for Accu-Chek was to be monitored two times per day and the facility had only completed Accu-Chek daily. This deficiency represents non-compliance investigated under Complaint Number OH00164655.

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	366099	A. Building B. Wing	05/22/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, observation, and policy review, the facility failed to properly measure pressure ulcers and ensure treatments were timely initiated for a pressure ulcer. This affected one (#07) out of the three residents reviewed for pressure ulcers. The facility census was 63. Findings include: Review of the medical record for Resident #07 revealed an admission date of 07/20/24 with medical diagnoses of adult failure to thrive, dementia, right hemiplegia, and paranoid schizophrenia. Review of the medical record revealed Resident #07 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #07 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/28/25, which indicated Resident #07 was cognitively intact and required set-up assistance with eating and substantial/maximum staff assistance with toilet hygiene, showers, bed mobility, and transfers. The MDS did not have documentation to support Resident #07 had a pressure ulcer. Review of the medical record for Resident #07 revealed hospital documentation, dated 04/23/25, which indicated Resident #07 had a pressure ulcer to right buttock which measured 0.6 centimeters (cm) by 8 cm by 0.1 cm with treatment in place and a deep tissue injury (DTI) to coccyx which measured 4 cm by 2 cm by 0 cm. The DTI was noted to purple/maroon in color, non-blanchable, and a dressing was applied. Review of the medical record for Resident #07 revealed a nurses' note, dated 04/23/25 at 10:08 P.M., which stated Resident #07 returned from the hospital with right lower leg amputation, The nurse also stated Resident #07 was noted to have small area to right gluteal fold 0.1 cm by 1 cm and purplish bruised area to coccyx 8 cm by 4 cm. Review of the medical record for Resident #07 revealed a skin observation assessment, dated 04/23/25, which stated Resident #07 was observed to have DTI to coccyx which measured 8.5 cm by 4 cm by 0.1 cm, right gluteal fold noted with area which measured 1 cm by 1 cm by 0.1 cm, and surgical incision to right knee which measured 18 cm by 0.1 cm with 23 staples. Further review of the medical record revealed a weekly skin observation assessment, dated 05/06/25 which indicated right knee incision site, but no other skin issues were documented. A weekly wound evaluation, dated 05/13/25, indicated Resident #07 had an unstageable pressure ulcer to sacrum which measured 8.5 cm by 4.5 cm by 0.3 cm with serous drainage and was the first observation. Review of the weekly wound evaluation, dated 05/20/25, indicated an unstageable pressure ulcer to sacrum which measured 1.8 cm by 1.1 cm by 0.2 cm with serous drainage and surrounding redness had dissipated. Review of the medical record for Resident #07 revealed no documentation to support the facility had completed weekly wound evaluations for DTI to coccyx or area to right gluteal fold after 04/23/25 until 05/13/25. (continued on next page)

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	366099	A. Building B. Wing	05/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #07 revealed a physician order dated 04/24/25 for right stump to apply non adherent dressing, abdominal (ABD) pad, and wrap with kerlix daily. Review of the medical record revealed no documentation to support treatments were ordered for DTI to coccyx or open area to right gluteal fold. Review of the physician orders revealed an order dated 05/15/25 for sacrum wound to apply Santyl and foam dressing every other day. Review of the physician orders for Resident #07 revealed no order for Enhanced Barrier Precautions (EBP). Review of the medical record for Resident #07 revealed April 2025 Treatment Administration Record (TAR) revealed no documentation to support treatment was ordered for Resident #07's DTI to coccyx or open area to right gluteal fold. The review of the April TAR revealed treatment to surgical site to right knee was completed as ordered. Review of the May 2025 TAR revealed treatment for Resident #07's sacrum wound was initiated on 05/15/25 and completed as ordered. Interview on 05/21/25 at 3:33 P.M. with Director of Nursing (DON) confirmed the facility did not have documentation to support treatments were initiated on 04/23/25 when DTI to coccyx and open area to right gluteal fold were first observed and that the treatment to sacrum/coccyx area was not initiated until 05/13/25. DON also confirmed the facility had not completed weekly wound measurements. Observation on 05/22/25 at 1:43 P.M. of Licensed Practical Nurse (LPN) #134 complete wound care on Resident #07 revealed a wound to coccyx/sacrum area which appeared approximately 2 cm by 2 cm by 0.2 cm in size. The wound was observed to be circular in shape with purple tissue noted around the wound and white tissue in the wound bed. No drainage or odor was noted to wound. The observation revealed LPN #134 completed wound care as ordered. Review of the facility policy titled, Pressure Ulcer Injury Prevention and Management, revised 03/01/24 stated the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to health the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. The policy stated the facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as appropriate. The policy stated the Registered Nurse Unit manager or designee would review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly and documentation a summary of findings in the medical record. This deficiency represents non-compliance investigated under Complaint Number OH00165645.

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	366099	A. Building B. Wing	05/22/2025

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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 medical record review and staff interview, the facility failed to provide cares/services to restore eating skills. This affected one (#10) out of three residents reviewed for rehabilitation services. The facility census was 63. Findings include: Review of the medical record for Resident #10 revealed an admission date of 03/22/22 with medical diagnoses of cerebral infarction with left hemiplegia, aphasia, ischemic cardiomyopathy, obesity, congestive heart failure, and chronic kidney disease stage III. Review of the medical record revealed Resident #10 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #10 revealed an annual Minimum Data Set (MDS), dated [DATE], which indicated Resident #10 was cognitively intact and required set-up assistance with eating. The MDS indicated Resident #10 was dependent upon staff for all Activities of Daily Living (ADL's). The MDS indicated Resident #10 received a by mouth intake and no documentation of tube feedings noted. Review of Resident #10's quarterly MDS assessment, dated 05/02/25, which indicated Resident #10 had severely impaired cognition, not able to make needs known, and was dependent upon staff for all ADL's including eating. The MDS indicated Resident #10 did not receive any by mouth (PO) intake and received 51%-100% nutrition via tube feeding. Review of the medical record for Resident #10 revealed a physician order dated 05/09/25 for tube feeding continuous, Jevity 1.5 at 75 milliliter (ml) per hour for 22 hours to allow for ADL care and an order to flush percutaneous endoscopic gastrostomy (peg) tube with 120 ml of free water before starting feeds and after stopping feeds. Further review of the medical record for Resident #10 revealed an order dated 05/04/25 for occupational therapy one to three times per week for four weeks. Review of the medical record for Resident #10 revealed hospital Speech/Language Pathology (SLP) documentation, dated 04/28/25, which stated Resident #10 was seen for ongoing dysphagia evaluation, peg tube placed on 04/26/25, and tube feedings were initiated. The note stated Resident #10 did not follow any command upon presentation but opened his mouth to accept trials. The note indicated recommendations Resident #10 remain nothing by mouth (NPO) with continued long-term alternative nutrition as appropriate based on goals of care, to administer medications via alternate route, frequent oral care, and SLP to follow for ongoing evaluation. Further review of Resident #10's medical record revealed there was no further documentation regarding SLP ongoing evaluation or treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366099	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Nursing & Independent Living	404 E McCreight Ave Springfield, OH 45503

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/25 at 11:40 A.M. with Director of Rehab (DOR) #127 stated Resident #10 discharged to the hospital on [DATE] after a stroke. DOR #127 confirmed prior to stroke on 04/20/25, Resident #10 was eating a regular diet with set-up assistance, was able to make his needs known, and was cognitively intact. DOR #127 confirmed Resident #10 readmitted to the facility on [DATE] with orders for NPO and tube feedings continuously due to dysphagia. DOR #127 confirmed Resident #10 received SLP services while hospitalized and did not readmit to the facility with SLP orders. DOR #127 stated when Resident #10 first returned from the hospital he was not cognitively able to participate with SLP services but after the first week Resident #10's cognition improved, and he would benefit from SLP services. DOR #127 stated the facility did not offer SLP services due the facility has not had a Speech Therapist since October 2024. DOR #127 stated if there were swallowing concerns for a resident, she would get an order for modified barium swallowing evaluation and then follow the recommendations for diet form the study. This deficiency represents non-compliance investigated under Complaint Number OH00164655.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and staff interviews, the facility failed to ensure daily nursing staffing information was posted as required. This had the potential to affect all 63 residents residing in the facility. The facility census was 63. Findings include: Observation on 05/14/25 at 12:45 P.M. revealed the daily nursing staffing posted at the front receptionist desk was dated 05/12/25. Observation on 05/15/25 at 8:10 A.M. revealed the daily nursing staffing posted at the front receptionist desk was dated 05/12/25. Interview on 05/15/25 at 8:14 A.M. with Receptionist #120 confirmed the daily nursing staffing posted on the receptionist desk was dated 05/12/25. Observation on 05/20/25 at 7:58 A.M. revealed the daily nursing staffing posted at the front receptionist desk was dated 05/12/25. Interview on 05/20/25 at 8:00 A.M. with Director of Nursing confirmed the daily nursing staffing posted was dated 05/12/25. This deficiency was an incidental finding discovered during the course of the complaint investigation.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interview and policy review, the facility failed to administer medications as ordered resulting in two medication errors out of 27 medication opportunities or a 7.4 percent (%) medication error rate. The affected two (#42 and #53) out of three residents observed for medication administration. The facility census was 63. Findings included: Review of Resident #53's medical record revealed an admission date of 03/13/16. Diagnoses included hypertension, and transient cerebral ischemic attack. Review of Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #53 was alert and oriented. Review of plan of care dated 03/17/25 revealed that Resident #53 had diuretic therapy related to having hypertension. Intervention was to administer medication as ordered. Review of physician order dated 12/26/24 revealed that Resident #53 had an order for Verapamil HCL Extended Release 240 milligrams (mg). Review of Resident #42's medical record revealed admission date 05/12/25. Diagnoses included type two diabetes, and hypertension. Review of Entry MDS dated [DATE] revealed that Resident #42 MDS was in progress. Review of plan of care dated 05/13/25 revealed that Resident #42 was at risk for receiving medications. Review of physician order dated 05/12/25 revealed that Resident #42 had an order for Metformin HCL 1,000 mg one tablet twice a day. Observations of medication pass on 05/20/25 8:20 A.M. with Registered Nurse (RN) #138 revealed the nurse administered Resident #53's medications which included Verapamil HCL 120 mg two tablets. Further observations at 8:35 A.M. with RN #138 revealed the nurse administered Resident #42's medications which included Metformin HCL 500 mg one tablet. Interview on 05/20/25 at 10:45 A.M. with RN #138 verified she only gave Resident #42 one Metformin 500 mg. RN #138 also verified that she gave Resident #53 Verapamil HCL 120 mg two tablets in medication pass. RN #138 stated here was the new medication Verapamil 240 mg extended release (ER) in bottom of medication cart for Resident #53. RN #138 verified she was unaware he should have given the Verapamil 240 mg ER. Review of the facility document titled Medication Administration dated 03/01/25 revealed that medication is administered by licensed nurses, or other staff who are legally authorized to do so. Facility was to ensure that all rights: right resident, right drug, right dosage, right route, right time, and right documentation were followed. Administer medication as ordered in accordance with manufacturer specifications. This deficiency represents non-compliance investigated under Complaint Number OH00165649, OH00165508, OH00165525, OH00165398, OH00163547.

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	366099	A. Building B. Wing	05/22/2025

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, the facility failed to offer or provide Speech/Language Pathology (SLP) services. This affected one (#10) out of the three residents reviewed for rehabilitation services. The facility census was 63. Findings include: Review of the medical record for Resident #10 revealed an admission date of 03/22/22 with medical diagnoses of cerebral infarction with left hemiplegia, aphasia, ischemic cardiomyopathy, obesity, congestive heart failure, and chronic kidney disease stage III. Review of the medical record revealed Resident #10 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #10 revealed an annual Minimum Data Set (MDS), dated [DATE], which indicated Resident #10 was cognitively intact and required set-up assistance with eating. The MDS indicated Resident #10 was dependent upon staff for all Activities of Daily Living (ADL's). The MDS indicated Resident #10 received a by mouth intake and no documentation of tube feedings noted. Review of Resident #10's quarterly MDS assessment, dated 05/02/25, which indicated Resident #10 had severely impaired cognition, not able to make needs known, and was dependent upon staff for all ADL's including eating. The MDS indicated Resident #10 did not receive any by mouth (PO) intake and received 51%-100% nutrition via tube feeding. Review of the medical record for Resident #10 revealed a physician order dated 05/09/25 for tube feeding continuous, Jevity 1.5 at 75 milliliter (ml) per hour for 22 hours to allow for ADL care and an order to flush percutaneous endoscopic gastrostomy (peg) tube with 120 ml of free water before starting feeds and after stopping feeds. Further review of the medical record for Resident #10 revealed an order dated 05/04/25 for occupational therapy one to three times per week for four weeks. Review of the medical record for Resident #10 revealed hospital Speech/Language Pathology (SLP) documentation, dated 04/28/25, which stated Resident #10 was seen for ongoing dysphagia evaluation, peg tube placed on 04/26/25, and tube feedings were initiated. The note stated Resident #10 did not follow any command upon presentation but opened his mouth to accept trials. The note indicated recommendations Resident #10 remain nothing by mouth (NPO) with continued long-term alternative nutrition as appropriate based on goals of care, to administer medications via alternate route, frequent oral care, and SLP to follow for ongoing evaluation. Further review of Resident #10's medical record revealed there was no further documentation regarding SLP ongoing evaluation or treatment. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/25 at 11:40 A.M. with Director of Rehab (DOR) #127 stated Resident #10 discharged to the hospital on [DATE] after a stroke. DOR #127 confirmed prior to stroke on 04/20/25, Resident #10 was eating a regular diet with set-up assistance, was able to make his needs known, and was cognitively intact. DOR #127 confirmed Resident #10 readmitted to the facility on [DATE] with orders for NPO and tube feedings continuously due to dysphagia. DOR #127 confirmed Resident #10 received SLP services while hospitalized and did not readmit to the facility with SLP orders. DOR #127 stated when Resident #10 first returned from the hospital he was not cognitively able to participate with SLP services but after the first week Resident #10's cognition improved, and he would benefit from SLP services. DOR #127 stated the facility did not offer SLP services due the facility has not had a Speech Therapist since October 2024. DOR #127 stated if there were swallowing concerns for a resident, she would get an order for modified barium swallowing evaluation and then follow the recommendations for diet from the study. This deficiency represents non-compliance investigated under Complaint Number OH00164655.

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	366099	A. Building B. Wing	05/22/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, staff interviews, observations, and policy review, the facility failed to follow infection control procedures during wound care and failed to ensure a resident was in Enhanced Barrier Precautions (EBP) as required. This affected one (#07) out of three residents reviewed for infection control procedures. The facility census was 63. Findings include: Review of the medical record for Resident #07 revealed an admission date of 07/20/24 with medical diagnoses of adult failure to thrive, dementia, right hemiplegia, and paranoid schizophrenia. Review of the medical record revealed Resident #07 was discharged to the hospital on [DATE] and readmitted to the facility on [DATE]. Review of the medical record for Resident #07 revealed a quarterly Minimum Data Set (MDS) assessment, dated 02/28/25, which indicated Resident #07 was cognitively intact and required set-up assistance with eating and substantial/maximum staff assistance with toilet hygiene, showers, bed mobility, and transfers. The MDS did not have documentation to support Resident #07 had a pressure ulcer. Review of the medical record for Resident #07 revealed a weekly wound evaluation, dated 05/13/25, indicated Resident #07 had an unstageable pressure ulcer to sacrum which measured 8.5 cm by 4.5 cm by 0. 3 cm with serous drainage and was the first observation. Review of the weekly wound evaluation, dated 05/20/25, indicated an unstageable pressure ulcer to sacrum which measured 1.8 cm by 1.1 cm by 0.2 cm with serous drainage and surrounding redness had dissipated. Review of the medical record for Resident #07 revealed a physician order dated 05/22/25 to apply mesalt external to buttock topically in the afternoon for wound care and an order for foam dressing to be applied to buttocks in the afternoon for wound care. Review of the physician orders revealed no documentation to support an order for Enhanced Barrier Precaution (EBP). Observation on 05/22/25 at 1:43 P.M. of Licensed Practical Nurse (LPN) #134 prepare Resident #07 for wound care. LPN #134 explained the procedure to Resident #07 then washed hands and applied gloves. LPN #134 was observed to remove old dressing to sacral wound, then removed gloves, applied new gloves, and completed dressing change as ordered. The observation revealed LPN #134 had not washed hands between glove change and LPN #134 had not donned a gown when performing wound care. The observation revealed Resident #07 did not have an EBP sign posted in room or on her door. The observation revealed an isolation cart was outside of the room next to Resident #07. Interview on 05/22/25 at 1:50 P.M. with LPN #134 confirmed Resident #07 should have been under EBP and that she had not donned a gown when she performed wound care. LPN #134 also confirmed she had not washed her hands between glove changes. (continued on next page)

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	366099	A. Building B. Wing	05/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Enhanced Barrier Precautions, revised 03/01/25 stated the facility was to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDRO). The policy stated EBP referred to an infection control intervention designed to reduce transmission of MDRO that employs targeted gown and gloves use during high contact resident care activities. The policy stated high contact activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care and wound care. This deficiency represents non-compliance investigated under Complaint Number OH00165645.

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	366099	A. Building B. Wing	05/22/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, the facility failed to ensure a safe, clean, and homelike environment. This had the potential to affect all 63 residents residing in the facility. The facility census was 63. Findings include: Observation on 05/20/25 at 10:45 A.M. of the [NAME] Hall shower room revealed the flooring was peeled up along the walls and a hole in the drywall near the baseboard of the wall near the shower. The observation revealed the drywall was protruding from the wall and some drywall chunks were laying on the floor near the shower entrance. The observation also revealed two ceiling tiles with large circular brownish colored marks. Interview on 05/20/25 at 10:50 A.M. with Registered Nurse (RN) #138 confirmed the shower room on the [NAME] Hall had a hole in the drywall near the shower with drywall protruding from the wall, drywall chunks on the floor, and stained ceiling tiles in the shower. RN #138 stated the shower room has had the issues with drywall broken, a hole in the wall, and stained ceiling tiles for several months. RN #138 stated all the residents on the [NAME] Hall utilize the shower room. Interview on 05/21/25 at 4:20 P.M. with Maintenance #147 confirmed the [NAME] Hall shower room has had a hole in the drywall and stained ceiling tiles for over one year. Maintenance #147 stated the facility had a company provide the facility for an estimate for repairs but have not received the quote yet. Observation with interview on 05/21/25 at 4:45 P.M. with Maintenance #147 revealed the employee entrance door to the facility, located in the basement, did not fit the doorframe and would not close. The observation revealed the employee entrance door was open at all times and staff were not able to securely close the door. Interview with Maintenance #147 confirmed the employee entrance door did not close because the door did not fit the doorframe and had been that way for quite some time. Maintenance #147 stated residents can come down to the basement via the elevator and he had seen residents from the nursing home in the basement. Maintenance #147 stated he was not aware of any residents leaving the facility through the employee entrance door. Maintenance #147 confirmed a person from the community could enter the employee entrance door and enter the facility at any time. This deficiency represents non-compliance investigated under Complaint Numbers OH00165645, OH00165398, OH00164655, and OH00163547.