

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Springfield Nursing & Independent Living		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review and policy review, the facility failed to ensure temperatures were maintained in a safe and comfortable range. This had the potential to affect all 58 residents residing in the facility. The facility census was 58. Findings include: Observation on 01/27/26 from 11:20 A.M. through 11:55 A.M. revealed residents in the East Hall were observed lying in bed with multiple (two or more) blankets on. Staff in the East Hall Nurses Station were observed wearing jackets and hats. Residents in the East TV Room were observed sitting in their wheelchairs and wearing coats. Residents in the [NAME] Hall were observed lying in bed also with multiple blankets. The air temperature felt warmer in the [NAME] Hall than in the East Hall. The dining room was observed with multiple residents eating, wearing sweatpants and hooded sweatshirts. Two random residents were observed wearing coats and hats. Staff were also observed wearing hooded sweatshirts. No observation of space heating units was noted anywhere in the facility. Interview on 01/27/26 at 11:23 A.M. with Resident #10 revealed she acknowledged the facility was cold and added this is the worst it has ever been. Resident #10 shared she had on two layers of pants, shirts and socks on and it should not be necessary to do just to stay warm. Interview on 01/27/26 at 11:33 A.M. with Licensed Practical Nurse (LPN) #100 revealed measures to fix the heating unit started on 01/23/26 when the cold temperatures were noticed. LPN #100 stated resident room doors were kept closed in an attempt to keep residents warm. Interview on 01/27/26 at 11:36 A.M. with Certified Nursing Assistant (CNA) #101 revealed the cooler temperatures in the facility were noted after a recent cold snap and acknowledged the facility remained cold. Observation with Maintenance Technician (MT) #104 on 01/27/26 between 1:26 P.M. and 2:00 P.M. of facility revealed the [NAME] Hall temperatures were between 53.1 degrees Fahrenheit (F) and 55.4 degrees F, the nurse station was 55.6 degrees F, the dining room was 63.9 degrees F and the common area was 69.6 degrees F. Resident room temperatures were as follows: Resident #16 room was 53.8 degrees F; Residents #17 and #18 room was 56.8 degrees F; Resident #18 room was 56.8 degrees F; Resident #10 room was 56.8 degrees F; Residents #34 and #35 room was 55.4 degrees F; and Residents #19 and #20 room was 58.8 degrees F. The East Hall nurses station was 61.2 degrees F, the East Hall temperatures were between 57.6 degrees F and 61 degrees F. Room temperatures were as follows: Resident #13 room was 59.4 degrees F; Residents #36 and #37 was 58.6 degrees F; Resident #18 room was 63.0 degrees F; Resident #17 room was 63.3 degrees F; Resident #16 room was 62.6 degrees F; and Resident #38 room was 70.5 degrees F. Interview on 01/27/26 at 1:37 P.M. with MT #104 while obtaining facility temperatures revealed the facility had recently installed a new heat system. The heat system began blowing cold air over the last week and the department notified the Gas Company, mechanical company and the installer to assess the issue. At the time of the interview, the source of the heating issue had not been discovered. Interview on 01/27/26 at 3:00 P.M. with the Administrator revealed there was no plan of action for the low temperatures at the facility and added, I do not know what they want me to do. The Administrator stated she would contact Corporate to see what she should do. A second interview on 01/28/26 at 3:44 P.M. with the Administrator revealed (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	contact had been made with the Regional Director of Operations (RDO) #105 and delivery of four portable heaters had been placed. Delivery time had yet to be verified, but the Administrator added it should be delivered that day. Observation on 01/27/26 from 3:20 P.M. to 3:29 P.M. revealed there were five random residents in the [NAME] Hall common area wearing jackets and or multiple layers of clothing. There was a notable decrease in temperature when entering the East side of the facility. There were four random residents in the common area wearing coats, two staff members were observed at the nurse's station wearing coats and hats and one resident was walking in the hall wearing a coat. Interview on 01/28/26 at 8:19 A.M. with Maintenance Director (MD) #103 revealed he was not at the facility on 01/27/28 and was not aware prior to his arrival that morning of the need for portable heaters. MD #103 explained he was on his way to get the heaters. Observation on 01/28/26 at 9:22 A.M. revealed no portable space heaters were observed in the facility. Observation with MT #104 on 01/28/26 at 9:39 A.M. of facility revealed [NAME] Hall temperatures were between 66.0 degrees F and 72.3 degrees F. Room temperatures were as follows: Residents #26 and #27 room was 67.8 degrees F; and Residents #25 room was 50.4 degrees F. The East Hall nurses station was 58.6 degrees F, the East Hall temperatures were between 58.3 degrees F and 60.1 degrees F. Room temperatures were as follows: Residents #34 and #35 room was 59.5 degrees F; Residents #10 room was 60.4 degrees F; Resident #58 room was 58.8 degrees F; Residents #17 and #18 room was 61.3 degrees F; and Resident #16 room was 61.2 degrees F. Interview and record review with the Administrator on 01/28/26 at 10:05 A.M. of the Performance Improvement Action Plan (PIAP) revealed the air temperature issue was noted on 01/23/26. The action/intervention was for residents to be provided with extra blankets and clothing. MD #103 was responsible for twice daily temperature checks in areas identified as having temperature concerns until the temperatures were between 71.0 degrees F and 81.0 degrees F. The Administrator verified MD #103 was aware of the twice daily temperature log requirement. Interview on 01/28/26 at 12:30 P.M. with CNA's #109 and CNA #110 revealed the facility had been cold in the past, but it had been really bad since Friday, 01/23/26. CAN #109 and CAN #110 acknowledged residents had complained about the cold temperature. Each stated they offered extra blankets, warm beverages and encouraged the residents to stay in bed where it was warm. Interview on 01/28/26 at 2:30 P.M. with RDO #105 revealed MD #103 had gone to the store to purchase four space heaters. RDO #105 explained and offered documentation he had ordered seven space heaters online to be delivered to the facility on [DATE], but the store cancelled the order. The four larger portable units were scheduled to arrive by 5:00 P.M. on 01/28/26. Observation on 01/28/26 from 2:35 P.M. to 2:43 P.M. revealed there were two room sized space heaters on the [NAME] Hall. Four residents were in the [NAME] Hall common area. Three random residents were observed wearing sweatshirts and one wore a coat. There was a notable decrease in temperature upon entering the East side of the facility. There were two room sized space heaters on the East Hall. Five random residents were observed in the common area, three were wearing coats. Three staff members were at the nurse's station all were wearing coats, two had on hats. Interview on 01/28/26 at 3:16 P.M. with LPN #106 revealed residents had been complaining about the cold temperatures in the facility and management was aware. During an interview on 01/28/26 at 3:19 P.M. Resident #13 was observed in bed under three blankets. Resident #13 acknowledged her room was cold and she needed the extra blankets to stay warm. Resident #13 added the staff offered her hot chocolate throughout the day. During an interview on 01/28/26 at 3:30 P.M. Resident #11 had voiced frustration to CNA #107 because she was unable to go outside to smoke. CNA #107 explained management informed staff the residents could not go outside to smoke due to the cold temperatures outside. Resident #11 replied it was cold inside the facility, feel my hands. CNA #107 did not respond to Resident #11 and left the room. Resident #11 acknowledged it was cold in her room and the staff had supplied extra blankets and had offered her hot chocolate. Interview on 01/28/26 at 4:02 P.M. with RDO #105 revealed if the portable heaters did not arrive by 5:00 P.M. as scheduled, he would have MD #103 go uptown to purchase more portable space heaters. Discussion was had regarding the results (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the morning temperatures, and a request was made for the second set of temperatures as the PIAP plan required. RDO #105 explained he would contact MD #103 to provide them. Interview on 01/28/26 at 5:00 P.M. with MD #103 revealed he had not taken temperatures since the morning walk through. MD #103 voiced frustration at taking a second set of temperatures. The PIAP document was shown to MD #103 and he denied knowledge of the document, or of receiving instruction to take temperatures twice daily. Observation on 01/29/26 at 8:12 A.M. of the facility temperatures with MT #104 revealed [NAME] Hall temperatures were between 67.3 degrees F and 69.4 degrees F. Approximately seven feet from one hall space heater the temperature was 64.9 degrees F. MT #104 acknowledged the space heaters were meant to be used in rooms and not the square footage of the unit. Resident rooms were as follows: Resident #38 room was 67.6 degrees F; Resident #39 and #40 room was 66.6 degrees F; Resident #41 and #43 room was 67.3 degrees F; and Resident #25 room was 46.4 degrees F. The East Hall nurse station was 61.2 degrees F, the hall temperatures were between 57.6 degrees F and 61.0 degrees F. The Resident rooms were as follows: Resident #13 room was 59.4 degrees F; Residents #36 and #37 room was 58.6 degrees F; Resident #18 room was 63.0 degrees F; Resident #17 room was 63.3 degrees F; Resident #16 room was 62. 6 degrees F; and Resident #38 room was 70.5 degrees F. Interview on 01/29/26 at 8:50 A.M. with MD #103 revealed he had not been made aware until 7:43 A.M. the portable heaters had not arrived at the facility. MD #103 stated he had left the facility around 5:30 P.M. to 5:45 P.M. on 01/28/26. MD #103 verified the portable heater had not been delivered and he had not purchased more portable space heaters. MD #103 then explained after he arrived at the facility he had been notified by a staff member one large portable heater had arrived at some point last night and he requested to end the interview to locate it. Interview on 01/29/26 at 9:17 A.M. with RDO #105 revealed one portable heater was delivered at some point last night, but it was not set up because there was no maintenance staff present to set it up. RDO #105 stated he did not have maintenance purchase additional space heaters on 01/28/26 because the portable heaters were scheduled to arrive. RDO #105 acknowledged he left the facility on [DATE] prior to the arrival of an additional heat source. During an interview on 01/29/26 at 11:00 A.M. Resident # 14 was observed in the East Hall in front of the nurse's station, in a wheelchair wearing a thick flannel shacket. Resident #14 stated even with the heaters on, the facility was still cold. An interview and observation on 01/29/26 at 11:30 A.M. with MD #103 revealed there were two residents with air-conditioning units in their windows. MD #103 stated he was not aware there were two resident rooms who had air-conditioning units in the windows. MD #103 acknowledged the units should be removed with the current heat issue at the facility. Interview on 01/29/26 at 12:13 P.M. with Resident #12 revealed the facility had been extremely cold for some time. Resident #12 added the temperature had gotten better but it was still cold. An interview with RDO #105 was completed on 01/29/26 at 2:18 P.M. which revealed RDO #105 reached out to his procurement team on 01/26/26 for the rental of four portable heaters. RDO #105 verified the order was not placed until 01/27/26 with an anticipated delivery date of 01/28/26 by 5:00 P.M. Additional space heaters were purchased online for an additional heat source. RDO #105 stated the provider cancelled the order, and on 01/28/26 MD #103 was sent uptown to purchase space heaters for the facility. RDO #105 acknowledged when he left the facility on [DATE] no additional space heaters or portable heaters had been provided as an additional heat source. Review of the facility policy titled Temporary Heat Policy dated 10/01/25 documented the facility would maintain safe indoor temperatures and implement temporary heat measures when the primary heat system was not functioning or the temperatures fell below acceptable temperature. The facility would make every reasonable effort to maintain a temperature of at least 71 degrees F in resident care areas. When temperatures fall below acceptable levels, temporary heating interventions would be initiated immediately. Resident support measures included providing additional blankets and layered bedding, encouraging layered clothing, monitoring residents for signs of cold stress and increased monitoring and rounding as needed. This deficiency represents non-compliance investigated under Complaint Number 2727504.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, staff interviews and policy review, the facility failed to implement an effective pest control program for the eradication of pests and rodents. This had the potential to affect all 58 residents residing in the facility. The facility census was 58. Findings include: Observation on 01/28/26 at 8:19 A.M. revealed the facility cat was observed in the facility on the west side of the front desk. The cat was playing with a mouse, swiping at it. Maintenance Technician (MT) #103 and Maintenance Director (MD) #104 were also observed walking down the same hall when they stopped beside the cat and mouse. The mouse was lying still with the cat right beside it. MT #103 bent down and grabbed the mouse and walked off to dispose of it. MD #104 verified the mouse had been in the facility. Observation on 01/29/26 at 9:20 A.M. revealed a random resident was overheard to say, the cat got another one. The same cat was observed to the east of the front lobby hunched over in a corner and eating a mouse. This was verified with Housekeeping Supervisor #111, who stated she would mop and disinfect the area after the cat ran off. Review of the facility policy, Pest Control Program revised 2025 documented the facility would maintain an effective pest control program which eradicated common household pests and rodents. This deficiency is based on incidental findings discovered during the course of this complaint investigation.		