| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366099 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Springfield Nursing & Independent Living | 404 E McCreight Ave<br>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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to provide a dignified dining experience for two (Residents #25 and #54) of 17 residents sampled. The facility census was 61 residents. Findings include: 1.Review of medical record for Resident #54 revealed an admission date of 08/23/13 with diagnoses including cerebrovascular disease, dementia, schizoaffective disorder, and major depressive disorder. Review of the Minimum Data Set (MDS) for Resident #54 dated 03/20/26 revealed the resident was severely cognitively impaired and required staff assistance with activities of daily living (ADLs.) Observation 06/01/26 at 9:47 A.M. revealed Resident #54 was sitting in the dining room wearing a hospital gown and an incontinence brief with the resident's back and incontinence brief exposed. Interview on 06/01/26 at 9:48 A.M. with Certified Nurse Aid (CNA) #305 confirmed Resident #54 was sitting in the dining room wearing only a hospital gown and a brief and the resident's back and the brief were exposed. Observation on 06/01/26 at 12:10 P.M. revealed Resident #54 was sitting in the dining room wearing a hospital gown and an incontinence brief with the resident's back and incontinence brief exposed. Interview on 06/01/26 at 12:10 P.M. with CNA #305 confirmed Resident #54 was still sitting in the dining room wearing a hospital gown and an incontinence brief with the resident's back and incontinence brief exposed. CNA #305 stated she should have placed a robe or a second hospital gown over the resident's back to provide privacy. Observation and interview on 06/01/26 at 12:50 P.M. with another CNA #333 who verified that Resident #54 was sitting in the dining room, with open hospital gown, incontinent brief exposed, and had strong urine odor. CNA #333 also verified that other residents were complaining about the urine odor while eating their meal. Interview on 06/01/26 at 12:58 P.M. with CNA #305 who verified that Resident #54 was still in the dining room from this morning and had never left the table. CNA #305 verified that she still had same gown on, and incontinent brief. CNA #305 verified there was a urine odor. Interview on 06/01/26 at 5:00 P.M. with CNA #305 stated she finally took Resident #54 back to her room to lay down. CNA #305 verified that she had not received activity of daily living today. 2. Observation on 06/01/26 at 12:06 P.M. revealed Residents #18, #25, and #34 were seated together in the dining room at lunch. CNA #305 delivered meals to Resident #18 and Resident #34 but did not deliver a meal tray to Resident #25. Observation on 06/01/26 at 12:26 P.M. revealed CNA #305 placed Resident #25's meal tray on the table in front of the resident and left. Interview on 06/01/26 at 12:26 P.M. with CNA #305 confirmed Residents #18 and #34 had been served lunch while Resident #25 sat at the table waiting for assistance with his meal. CNA #305 stated Resident #25 needed staff assistance with feeding and would need to wait for CNA #333 to finish some duties in the main dining room before coming back to feed Resident #25. Observation on 06/01/26 at 12:36 P.M. revealed CNA #333 was feeding Resident #25 lunch. Interview on 06/01/26 with CNA #305 verified Resident #25 had been sitting in the dining room since 12:06 P.M. and had watched Residents #18 and #34 consume their meals and had not been fed his lunch until 12:36 P.M. Review of the facility policy titled Resident Rights dated 06/01/24 revealed residents had the right to be treated with dignity and respect. This deficiency represents noncompliance investigated under Complaint Number 2711853 and Complaint Number 2671044 and Complaint Number 1382280. |

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 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed toconsider the views of residents in the decisions impacting the residents' home and lives, failed to discuss significant decisions impacting the residents with the residents, and failed to respond to the resident's concerns and grievances. This affected six (Residents #12, #20, #45, #47, #55, #59) of six residents reviewed for resident rights. The facility census was 61 residents. Findings include: Review of a memo posted on the door of the social services office dated 05/28/26 revealed as part of regional operational standards the facility had made the decision to have the two facility cats removed no later than 06/05/26. Review of a handwritten petition undated titled Save Our Cats revealed it had 35 signatures. Observation on 06/03/26 at 4:00 P.M. revealed Resident #55 expressed sadness and concern to the Administrator, over the plan to get rid of two facility cats. Resident #55 stated she enjoyed the cats and did not want them to be taken away. Interview on 06/03/26 at 12:15 P.M. with Resident #55 confirmed she was concerned because the facility was getting rid of the two nursing home cats on 06/05/26. Resident #55 stated the facility would not share where the cats were being taken. Resident #55 stated that for residents who were at the facility, the cats were great because they were therapy for the residents who were sick, on hospice, and were used for mental health. Resident #55 stated she will be very sad when the two brother cats are taken away. She reported last week management staff told the line staff and they told the residents. She stated some residents were crying. Resident #55 asked about contacting the Ombudsman and stated it was a violation of their rights. Interview on 06/04/26 at 1:03 P.M. with Resident #55 confirmed she started a petition to keep the facility cats because she and everyone else was upset about the facility administration's decision to get rid of the cats. Resident #55 stated she wanted the cats to stay in the facility because they kept the mouse population controlled, but mostly because they were therapeutic for her and many other residents. Resident #55 stated she gave the Administrator the petition to save the cats on 06/03/26 but when she talked with the Administrator on 06/04/26 the Administrator told her the cats had to go. Resident #55 stated the facility had not offered any type of grief counseling or alternatives to getting rid of the cats. The resident was observed with tears streaming down her cheeks during the interview and stated taking the cats away was a violation of the residents' rights. Observation on 06/04/26 at 12:45 P.M. revealed one of the facility cats was lying at the foot of Resident #59's bed. Interview on 06/04/26 at 12:45 P.M. with Resident #59 confirmed she concerned the facility cat to be her kitty and did not want the cats to be removed. Interview on 06/04/26 at 12:46 P.M. with Resident #45 confirmed she was very upset about the cats leaving and stated she had signed a petition for them to stay. Interview on 06/04/26 at 12:48 P.M. with Resident #20 confirmed he was very upset about the cats leaving the facility. He stated he used the cats for companionship and to help keep him calm and he would move out if the cats were gone. Interview on 06/04/26 at 12:56 P.M. with the Administrator confirmed she had seen the petition from the residents but stated the decision to remove the cats came from corporate and there was nothing she could do. She stated a memo had been distributed to the residents to notify them of the cats leaving. She reported any resident who was grieving could handle that through regular counseling means. Interview on 06/04/26 at 1:55 P.M. with the Social Services Designee (SSD #392) revealed notification about the cats leaving was discussed during activities. She stated she had not gone around to residents to notify them if they had not come to the group activity. Observation on 06/04/26 at 2:00 P.M. revealed the two facility cats were removed from the facility by outside parties while the residents watched. Interview on 06/04/26 at 2:00 P.M., the Administrator confirmed she received the petition on 06/03/26 and got rid of the cats the next day, which was a day earlier than stated on the memo provided to staff and residents. Interview on 06/04/26 at 2:27 P.M. with Resident #12 revealed he would will miss the cats and they should not have gotten rid of them as all the residents loved and enjoyed the cats. Interview on 06/04/26 at 2:30 P.M. revealed Resident #47 reported he wanted them<br>(continued on next page) |

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| Springfield Nursing & Independent Living | 404 E McCreight Ave<br>Springfield, OH 45503 |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | to keep the cats and he had a favorite one who laid at the end of the bed with him and made him happy. Review of the facility policy titled Safe and Homelike Environment dated 06/01/24 revealed in accordance with residents' rights, the facility would provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Review of the facility policy titled Resident Rights dated 06/01/24 revealed the residents had a right to make choices about their lives in the facility that were significant to them. Residents had a right to voice grievances and the facility must make prompt efforts to resolve any grievances the residents may have. This deficiency represents noncompliance investigated under Complaint Number 2711853. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, staff interview, and review of the facility policy, the facility failed to ensure the flooring in the common area was clean. This affected the 32 residents who reside on the secured unit. The facility census was 61 residents. Findings include: Observation on 06/01/26 at 11:00 A.M. of the west secured unit near the entrance and outside the dining room revealed the floor had loose dirt, scratch marks, and stains throughout on the entire floor. Interview on 06/01/26 at 11:55 A.M. with the Director of Nursing (DON) verified the floor outside the dining room at entrance to the west unit had dirt and spots on the entire floor. Observation on 06/01/26 at 12:00 P.M. of the west dining room prior to meal service revealed the floor was dirty and had food debris and spills of red liquid throughout the floor. Interview on 06/01/26 at 12:10 P.M. with Certified Nurse Aid (CNA) #305 confirmed the dining room floor to the west unit was dirty and the lunch meal had not been served yet. Review of the facility policy titled Safe and Homelike Environment dated 06/01/26 revealed the facility would provide residents with a safe, clean, comfortable and homelike environment. This deficiency represents noncompliance investigated under Complaint Number 2808183. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on medical record review, staff interview, review of facility Self-Reported Incidents (SRIs), and review of the facility policy, the facility to report allegations of misappropriation to the state agency. This affected one (Resident #33) of 17 sampled residents. The facility census was 61 residents. Findings include: Review of medical record for Resident #33 revealed an admission date of 02/04/16 with diagnoses including schizoaffective disorder, spinal stenosis, anxiety disorder, and major depressive disorder. Review of the Minimum Data Set (MDS) for Resident #33 dated 03/20/26 revealed the resident was cognitively intact. Review of the facility SRIs dated 02/01/26 through 06/01/26 revealed there were no SRIs filed for Resident #33. Interview on 06/01/26 at 11:00 A.M. with Resident #33 confirmed he had money in a lock box that was kept in the office of Former Administrator (FA) #500, but when FA #500 left the facility could not find the lock box of money. Interview on 06/04/26 at 8:16 A.M. with the Administrator confirmed in February 2026 Resident #33 stated he had been storing his money in a lock box kept in the office of FA #500, but the facility could not find the lock box of the resident's money. The Administer verified the facility had not reported Resident #33's allegation of the missing lock box of money to the state agency. Interview on 06/04/26 at 8:53 A.M. with Social Service Designee (SSD) #392 stated Resident #33 made an allegation in February 2026 that he a lock box containing $280 which had been stored in FA #500's office. SSD #392 called FA #500 who stated she knew about a lock box of money for Resident #33. SSD #392 stated Resident #33 agreed after this incident he would open a resident fund account. Review of the facility policy titled Abuse and Neglect dated 06/12/24 revealed should report allegations of misappropriation to the state agency. This deficiency represents noncompliance investigated under Complaint Number 2671044. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to provide proper incontinence care to dependent residents. This affected one (Resident #54) of 17 residents sampled. The facility census was 61 residents. Findings include:Review of medical record for Resident #54 revealed an admission date of 08/23/13 with diagnoses cerebrovascular disease, dementia, schizoaffective disorder, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) for Resident #54 dated 03/20/26 revealed the resident was severely cognitively impaired and required maximal assistance for toileting and personal hygiene. Review of the care plan for Resident #54 dated 03/23/26 revealed the resident was at risk for altered mood and behaviors related to having diagnoses of schizophrenia, had delusional thoughts, refused medication at times, and kicked and bit staff at times. Interventions included the following: always approach in calm manner, attempt to redirect when resistive to care, if unable to redirect ensure resident was safe and leave for short time and then reapproach to assist in to complete care, do not argue with resident, encourage the resident to comply with care daily. Review of the care plan for Resident #54 dated 03/23/26 revealed the resident had bladder and bowel incontinence. Interventions included staff should provide incontinence care using disposable briefs and staff should change the resident every two hours as needed. Observation 06/01/26 at 9:47 A.M. revealed Resident #54 was sitting in the dining room wearing a hospital gown and an incontinence brief. Interview on 06/01/26 at 9:48 A.M. with Certified Nursing Assistant (CNA) #305 confirmed Resident #54 was sitting in the dining room wearing a hospital gown and an incontinence brief. Observation on 06/01/26 at 12:10 P.M. revealed Resident #54 was sitting in the dining room wearing a hospital gown and an incontinence brief. Interview on 06/01/26 at 12:10 P.M. with CNA #305 confirmed Resident #54 was still sitting in the dining room wearing a hospital gown and an incontinence brief. Observation on 06/01/26 at 12:50 P.M. revealed Resident #54 was sitting in the dining room wearing a hospital gown and a disposable incontinence brief. There was a strong odor of urine in air near the resident. Interview on 06/01/26 at 12:50 P.M. with CNA #333 confirmed there was a strong urine odor emanating from Resident #54 and other residents in the dining room were complaining about the urine odor. Interview on 06/01/26 at 12:58 P.M. with CNA #305 confirmed Resident #54 was still in the dining room from the morning and had never left the table. CNA #305 verified Resident #54 was still wearing the same gown and incontinence brief from the morning. CNA #305 stated there was a urine odor emanating from Resident #54 and the aide verified Resident #54 had not received incontinence care. Observation on 06/01/26 at 5:00 P.M. of Resident #54 with CNA #305 revealed the resident was in bed lying on her side and was wearing a hospital gown and two incontinence briefs. Interview on 06/01/26 at 5:00 P.M. with CNA #305 confirmed at 3:30 P.M. she had taken Resident #54 back to her room and assisted her to bed. CNA #305 verified she had placed an extra brief on Resident #54 because she had refused to have her brief changed.Interview on 06/04/26 at 3:00 P.M. with Registered Nurse (RN) #334 confirmed staff should provide timely incontinence care and should never apply two briefs to a resident. RN #334 stated when Resident #54 refused care staff should reapproach the resident and should notify the nurse. Review of the facility policy titled Incontinence dated February 2023 revealed incontinent residents would receive appropriate treatment and services per the resident's care plan. Review of the facility policy titled Resident Rights dated 06/01/24 revealed residents had the right to be treated with dignity and respect and to receive timely care. The facility would ensure all direct care staff were educated on resident rights and how to properly care for residents. This deficiency represents noncompliance investigated under Complaint Number 3015945 and Complaint Number 2978326 and Complaint Number 2978226 and Complaint Number 2711853 and Complaint Number 1382280 and Complaint Number 1382279. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on medical record review, staff interview, physician interview, and review of the facility policy, the facility failed to ensure medications were administered per the physician's order. This affected one (Resident #53) of three residents reviewed for nutrition. The facility census was 61 residents. Findings include: Review of the medical record for Resident #53 revealed an admission date of 07/15/11 with diagnoses including schizoaffective disorder and moderate protein-calorie malnutrition. Review of the physician's orders for Resident #53 revealed an order dated 12/26/25 for Megace oral suspension five milliliters (ml) by mouth once daily to promote weight gain. Review of the Minimum Data Set (MDS) assessment for Resident #53 dated 05/15/26 revealed the resident had severely impaired cognition. Review of the Medication Administration Records (MARs) for Resident #53 dated December 2025, January 2026, February 2026, March 2026, April 2026, May 2026, and June 2026 revealed the medication was not administered because it was not available for administration. Interview on 06/01/26 at 1:01 P.M. with Registered Nurse (RN) #334 verified Resident #53 had a current order for Megace which had been in place since 12/26/25 but the medication had never been available for administration. RN #334 stated she thought it was because insurance would not cover the medication. RN #334 was unsure whether the physician had been notified the resident had not received the medication from December 2025 through June 2026. Interview on 06/04/26 at 2:50 P.M. with Physician #415 stated she did not recall being notified of the Megace not being available for Resident #3. Physician #415 stated her expectation was for staff to notify her if the medication was not available so she could determine the ongoing treatment plan. Review of the facility policy titled Medication Administration dated 06/02/26 revealed medications should be administered in accordance with physician orders. This deficiency represents noncompliance investigated under Complaint Number 2576619 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review of the facility policy, the facility failed to ensure medications were stored in a proper manner that prevented misidentification. This affected thirty residents with medications stored on the secured unit. The facility census was 61 residents. Findings include: Observation on [DATE] at 2:52 P.M. of the back medication cart in the behavior unit revealed there were 19 loose, unidentified pills lying on the bottom surface of the top drawer. Interview on [DATE] at 2:52 P.M. with Registered Nurse (RN) #338 confirmed the back medication cart contained 19 loose unidentified pills. Observation on [DATE] at 2:57 P.M. of the front medication cart in the behavior unit revealed there were 26 loose, unidentified pills lying on the bottom surface of the top drawer. The drawer also contained an opened bottle of glucose tablets with 10 tablets remaining with an expiration date of [DATE]. Interview on [DATE] at 2:57 P.M. with RN #338 confirmed front medication cart contained 26 loose unidentified pills and an expired bottle of glucose tablets. Review of facility policy titled Medication Storage dated [DATE] revealed all medication rooms should be routinely inspected by the consult pharmacist for discontinued or outdated medications.This deficiency represents noncompliance investigated under Complaint Number 3015945. |