STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366116	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Masonic Community	3 Masonic Drive Springfield, OH 45501

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, interview with dishwasher technician, and review of facility policy, the facility filed to ensure dishwashers reached proper sanitation levels and ensure dietary staff were knowledgeable on checking dishwasher sanitation. This had the potential to affect all 74 residents who receive food from the kitchen. The census was 74.Findings include:Review of dishwasher logs form December 2025, January 2026, and February 2026 revealed wash and rinse temperatures were documented. Wash temperature varied form 140 F to 174 F. Rinse temperatures varied form 120 F to 185 F. Sanitizer levels were not documented on any of the logs.Observation of the dishwasher on 03/02/26 at 8:55 A.M. revealed the wash temperature reached 140 degrees Fahrenheit (F) and the rinse temperature reached 115 F. There was a bottle of sodium hypochlorite (bleach) sanitizer on top of the machine with tube running from it into the machine.Interview with Assistant Director of Dining Services (ADDS) #699 on 03/02/26 at 8:857 A.M. revealed the dishwasher was high temperature sanitizing and the bottle of bleach sanitizer was a back-up if the temperature did not go high enough.Observation of Director of Food Clinical Nutrition Services (DFCNS) #644 on 03/02/26 at 9:05 A.M. revealed she ran a sanitizer test strip through the entire wash and rinse cycle. The test strip when checked did not register a sanitizer level.Observation of DFCNS #644 on 03/02/26 at 9:10 A.M. revealed they were re-checking the dishwasher sanitation after reading directions posted on wall by dishwasher revealed sanitizer still remained less than required. The level of bleach sanitizer checked below 50 parts per million (PPM).Interview and observation on 03/02/26 at 3:05 A.M. with Dishwasher Repair Technician (DRT) #807 revealed he was repairing the dishwasher. DRT #807 confirmed the dishwasher used bleach sanitizer and was not using high temperatures to sanitize. The dishwasher had been using bleach sanitizer for several months.Interview with DFCNS #644 on 03/02/26 at 3:10 P.M. confirmed the dishwasher had not been serviced or changed from a high temperature to a sanitizing machine since she had worked for the facility. DFCNS #644 had worked a the facility approximately seven months. DFCNS #644 confirmed dietary staff were completing dishwasher check logs with water temperature readings that the dishwasher was not currently capable of reaching. DFCNS #644 confirmed dietary staff should have been checking and recording bleach sanitizer levels.During an interview on 03/05/26 at 8:15 A.M., the Director of Nursing (DON) stated all residents of the facility receive food from the kitchen.Review of the facility's policy titled Cleaning Dishes/Dish Machine dated reviewed January 2026 revealed prior to use, proper temperatures and/or chemical concentrations and machine function should be verified. Staff to confirm that soap and rinse dispensers are filled and have enough cleaning product for the shift. For a high temperature dish machine, wash temperatures should be from 150 F to 165 F. Final rinse temperatures should be 180 F. For a low temperature sanitizing dish machine, wash temperature should be 120 F and bleach sanitizer check be 50 PPM.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on staff interview and observation, the facility failed to ensure the carpet was in safe and comfortable conditions for the residents. This had the potential to affect the 29 residents who resided on the fourth floor of Rickly Commons. The facility census was 74. Findings include: Observation and interview on 03/03/26 between about 2:45 P.M. and 3:00 P.M. revealed the carpet on the fourth floor of Rickly Commons (RC) had multiple tears in carpet seams. The hallway between rooms RC428 to RC415 and the hallway between rooms RC410 to RC402 had multiple tears in carpet seams. Tears in hallway carpet seams were observed outside doorways to rooms RC402, RC404, RC405, RC408, RC407, RC410, RC420, RC422, RC423, and RC424. Torn carpet seams had bunching of carpet material beneath the handrail by electrical panel, outside room RC416 (biohazard storage room), and outside room RC413. Registered Nurse (RN) #773 confirmed tears in carpet seams were between rooms RC428 to RC415 and the hallway between rooms RC410 to RC402 and outside of rooms RC402, RC404, RC405, RC408, RC407, RC410, RC420, RC422, RC423, and RC424.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, review of medical records, and review of facility records, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) to a resident whose Medicare A benefits were ending. This affected one (Resident #24) of three residents reviewed for beneficiary notices. The facility census was 74.Findings include: Medical record review revealed Resident #24 was admitted [DATE]. Diagnoses included congestive heart failure. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact. Review of the Notice of Medicare Non-Coverage revealed Medicare Part A Services ended on 12/15/25 for Resident #24. The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted and Resident #24 remained in the facility. There was no documentation the facility provided the SNF ABN to Resident #24 and/or legal guardian. Interview with Social Services Director (SSD) #692 on 03/05/26 at 11:38 A.M. confirmed the facility did not provide the SNF ABN to Resident #24 and/or legal guardian when Medicare Part A Services ended on 12/15/25, did not exhaust benefit days, and remained in the facility.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records, observation, staff interview, laboratory services staff interview, and review of facility policy, the facility failed to residents were provided privacy during medical procedures. This affected #7 and #82 of residents observed dining in the memory care units. The facility census was 74.Findings include:1.Review of Resident #7's medical record revealed an admission date of 10/19/25. Diagnoses included Parkinson's disease, psychotic disturbance, bipolar disorder, and dementia.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had moderate cognitive impairment.Observation on 03/06/26 at 7:33 A.M. revealed Laboratory Technician (LT) #800 drawing blood from Resident #7's left arm while he was sitting at a table in the dining room. A female resident was sitting across the table from Resident #7. There were other residents sitting at a table behind Resident #7.Interview with LT #800 on 03/05/26 at 7:36 A.M. confirmed she had obtained a blood sample from Resident #7 was he was sitting at a table in the dining room. Interview with the Director of Nursing (DON) on 03/05/26 7:58 A.M. confirmed residents should not have blood samples drawn while in the dining room. The DON confirmed this violated their right to privacy.2. Review of Resident #82's medical record revealed an admission date of 01/29/24. Diagnoses included long term use of insulin, type two diabetes mellitus, cerebral infarction with residual effects, vascular dementia, and psychotic disturbances.Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #82 had severe cognitive impairment and received insulin injections.Observation on 03/05/26 at 7:41 A.M. revealed Resident #82 was given two insulin pen injections in the abdomen by Licensed Practical Nurse (LPN) #567 while she sitting at a dining room table. LPN #567 raised Resident #82's shirt and administered the insulin injections in the right lower abdomen. Other residents were sitting at the same dining room table and at various tables in the dining room.During and interview on 03/05/26 at 7:43 A.M., LPN #567 confirmed she had administered two insulin injections to Resident #82's right lower abdomen while she was sitting at the dining rooms table. LPN #567 confirmed insulin injections should not be given to residents while in the dining room.Interview with the Director of Nursing (DON) on 03/05/26 7:58 A.M. confirmed residents should not have insulin injections given while in the dining room. The DON confirmed this violated their right to privacy.Review of the facilities policy titled Injectable Medications dated 06/21/17 revealed staff will provide privacy to residents when administering injectable medications.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, facility failed to provide activities of interest and encourage participation to the residents. This affected three (#10, #34, and #78) of three residents reviewed for activities. The facility census was 74.Findings include1. Review of the medical record for Resident #78 revealed an admission date of 12/28/23. Diagnoses included Alzheimer's disease, epilepsy, diabetes, blindness in one eye, muscle weakness and cerebrovascular disease, vascular dementia, and history of traumatic brain injury. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had cognitive impairment and was dependent on staff for bed mobility and transfers.The undated care plan revealed Resident #78 was dependent on staff for meeting emotional, intellectual, physical and social needs with interventions to introduce the resident to other residents with similar backgrounds, invite residents to scheduled activities, and provide a program of activities that was of interest. The quarterly assessment dated [DATE] revealed Resident #78 liked visiting with staff about his time overseas, watching television in his room, pet visits and talking with other residents. The progress notes from 01/01/25 to 02/28/26 revealed on 01/07/26, activity staff went to the community center and got Resident #78 a cheeseburger and dessert. On 01/19/26, activity staff visited with the resident. Review of the activity participation documentation for January 2026 revealed Resident #78 was watching television in his room and on 12 occasions had staff room visits on 16 occasions. The activity participation documentation dated 02/2026 revealed Resident #78 was watching television in his room on 15 occasions and had staff room visits on 16 occasions. The participation documentation did not show where the resident was offered to talk with other residents and receive pet visits.Observations on 03/02/26 at 10:00 A.M., 11:27 A.M., 2:10 P.M., and 4:56 P.M. and on 03/03/26 at 8:25 A.M., 8:43 A.M., 12:40 P.M., and 3:40 P.M. revealed Resident #78 was sitting in his room. Resident was not observed to be out of his room at any time and no interactions with other residents was observed.Continuous observations on 03/04/26 from 8:35 A.M. to 10:10 A.M. revealed Resident #78 was sitting in his room with the television on. No staff entered his room to discuss mail, lunch choices, or the daily activities. Interview on 03/04/26 at 10:25 A.M. with Certified Nursing Aide (CNA) #710 revealed the residents did not participate in activities and acknowledged staff do not encourage residents to participate. The CNA acknowledged the facility should offer a variety of activities of interest and when asked about activities of interest, CNA declined to answer. The CNA confirmed most residents remain in their rooms all day. Interview on 03/04/26 at 10:40 A.M. with Activity Director (AD) #776 revealed activity staff provide one-on-one visits with every resident in the morning when they deliver mail and get food orders and they also inform every resident of the activities for each day. The AD was informed no activity staff was present in Resident #78's room to discuss any activities for the day. AD #776 verified Resident #78 should be provided activities of interest throughout the day. 2. Review of the medical record for Resident #10 revealed an admission date of 03/11/25. Diagnoses included respiratory failure with hypoxia, vascular dementia, muscle weakness dysphagia, psychotic disorder with delusions and epileptic disorder. Review of the care plan dated 08/27/25 revealed Resident #10 was dependent on staff for meeting emotional, intellectual, physical and social needs with interventions to introduce the resident to residents with similar backgrounds, invite residents to scheduled activities, music therapy to provide one session monthly, and provide a program of activities that was of interest. Review of the quarterly assessment dated [DATE] and 02/25/26 revealed Resident #10 enjoyed visits with staff and residents and was very social. He wound benefit from one to one visits as well as group activities and enjoyed the activity cart and enjoyed pet visits, watching television, happy hours on Fridays and other campus activities. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had impaired cognition and required partial/moderate assistance for activities of daily living.Review of the progress notes from 01/01/26 to 03/04/26 revealed on (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/21/26 and 03/02/26, staff delivered the menu and on 03/03/26, staff visited and chatted with resident.Review of the activity participation documentation dated 01/2026 revealed Resident #10 was watching television in his room on 15 occasions and had staff room visits on 17 occasions. The activity participation documentation dated 02/2026 revealed Resident #10 was watching television in his room on 12 occasions had staff room visits on 13 occasions. The activity participation documentation did not show where the resident was offered group activities, the activity cart, pet visits, happy hours and other campus activities.Observations on 03/02/26 at 10:00 A.M., 11:27 A.M., 2:10 P.M., and 4:56 P.M. and on 03/03/26 at 8:25 A.M., 8:43 A.M., 12:40 P.M., and 3:40 P.M. revealed Resident #10O was found sleeping in his room with no stimulation beside the television being on in the room. The resident was not observed to be out of his room at any time and no interactions with other residents was observed. Continuous observations on 03/04/26 from 8:35 A.M. to 10:10 A.M. revealed Resident #10 was sitting in his room with the television on. No staff entered his room to discuss mail, lunch choices, or the daily activities. No activity staff were observed encouraging the resident to participate in activities. The activity staff was observed getting a lunch meal order for only one resident on the unit (not Resident #10) and informing only one resident (not Resident #10) about a craft activity going on in the afternoon. Interview on 03/04/26 at 10:25 A.M. with Certified Nursing Aide (CNA) #710 revealed the residents did not participate in activities and acknowledged staff do not encourage residents to participate. The CNA acknowledged the facility should offer a variety of activities of interest and when asked about activities of interest, CNA declined to answer. The CNA confirmed most residents remain in their rooms all day.Interview on 03/04/26 at 10:40 A.M. with Activity Director (AD) #776 revealed the activity staff pass out mail and take resident orders for the luncheon which was on the activity calendar. She reported the luncheon was when staff get carryout food from either the commons or take residents to a restaurant for lunch. She reported residents were required to have a regular diet to be able to participate in this. She reported activity staff provide one-on-one visits with every resident in the morning when they deliver mail and get food orders and they also inform every resident of the activities for each day. AD #776 verified Resident #10 should be provided activities of interest throughout the day.Review of the diet list audit revealed Resident #10 had an order for a regular diet and regular texture.3. Review of the medical record for Resident #34 revealed an admission date of 05/29/23. Diagnoses included hemiplegia and hemiparesis, heart disease vascular dementia, dysphagia, and muscle weakness. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #34 had severe cognitive impairment and was dependent on staff for bed mobility and transfers.Review of the care plan dated 06/01/23 revealed Resident #34 was dependent on staff for meeting emotional, intellectual, physical and social needs with interventions including to introduce the resident to residents with similar backgrounds, invite residents to scheduled activities, and provide a program of activities that was of interest. Review of the quarterly assessments dated 11/19/25 and 02/18/26 revealed Resident #34 enjoyed visits from family and staff and enjoyed music, ice cream, going outside on sunny days and enjoyed reading about history. Facility to continue to offer and encourage activities. Review of the activity participation documentation dated 01/2026 revealed resident was watching television in his room on six occasions had staff room visits on 14 occasions. The activity participation documentation dated 02/2026 revealed resident was watching television in his room on two occasions had staff room visits on 14 occasions. The activity participation documentation did not show where the resident was offered music, ice cream and events related to history. Observations on 03/02/26 at 10:00 A.M., 11:27 A.M., 2:10 P.M., and 4:56 P.M. and on 03/03/26 at 8:25 A.M., 8:43 A.M., 12:40 P.M., and 3:40 P.M. revealed Resident #34 was sitting in his room with no television or music playing. The resident was not observed to be out of his room at any time and no interactions with other residents was observed. Continuous observations on 03/04/26 from 8:35 A.M. to 10:10 A.M. revealed Resident #34 was sitting in his room. No staff entered his room to discuss mail and an activity staff member informed Resident #34 of a craft activity. The activity staff member did not offer to turn on the television or music for (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident. Interview on 03/04/26 at 10:25 A.M. with Certified Nursing Aide (CNA) #710 revealed the residents did not participate in activities and acknowledged staff do not encourage residents to participate. The CNA acknowledged the facility should offer a variety of activities of interest and when asked about activities of interest, CNA declined to answer. The CNA confirmed most residents remain in their rooms all day.Interview on 03/04/26 at 10:40 A.M. with Activity Director (AD) #776 revealed the activity staff provide one-on-one visits with every resident in the morning when they deliver mail and they inform every resident of the activities for each day. AD #776 verified Resident #34 should be provided activities of interest throughout the day.Review of the facility policy titled Activities in Skilled Nursing dated 03/08/23 revealed facility shall provide an ongoing structured activity program designed to meet the individualized interest and support the well-being of each resident in accordance with regulations. The facility shall provide activities that were person-centered and to enhance the quality of life. Facility shall document activity participation including refusals and shall provide group social activities, cognitive stimulation, physical wellness activities, creative and expressive programs, spiritual programs, and community involvement opportunities, and one to one activities.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 interview, and policy review, the facility failed to accurately assess the resident's wound upon admission. This affected one (#100) out of three residents reviewed for pressure ulcers. The facility census was 74.Findings include:Review of the medical record for Resident #100 revealed an admission date of 02/20/26. Diagnoses included left hip fracture, diabetes mellitus, and Alzheimer's disease.Review of the hospital documentation dated 02/17/26 revealed Resident #100 had a unstageable pressure ulcer (slough and/or eschar, known but not stageable due to coverage of wound bed by slough and/or eschar) to coccyx which measured 1.5 centimeters (cm) in length, 2.0 cm in width, and 0.1 cm in depth and a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to right hip which measured 4.0 cm in length, 3.5 cm in width, and 0.1 cm in depth.Review of the admission assessment dated [DATE] revealed Resident #100 had severely impaired cognition and required staff assistance with activities of daily living. The Braden scale assessment dated [DATE] revealed Resident #100 was high risk for skin breakdown. Review of the skin observation evaluation dated 02/20/26 revealed the resident had several areas of skin breakdown and concerns. Resident #100 had a right hip pressure ulcer measuring 1.5 inches in length, 0.5 inches in width, and no depth; a surgical site to left hip; bruising to bilateral arms and legs; dry spots and scabbing to the right lower ankle on top; skin tear to left outer leg; and an area from moisture in the crack of the buttocks measuring 0.5 cm in length, 0.5 cm in width, and no depth. The evaluation did not contain documentation to support a description of the area to crack of the buttocks or if the area was pressure related injury. The physician orders dated 02/20/26 revealed an order to cleanse coccyx and right hip with normal saline and pat dry, apply collagen sheet to wound bed and cover with bordered foam dressing three times per week and as needed.The skin observation evaluation dated 02/25/26 stated Resident #100 had an unstageable pressure ulcer to the right hip measuring 2.5 cm in length, 2.0 cm in width, and 0.1 cm in depth and a Stage III pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed) to coccyx which measured 1.0 cm in length, 0.5 cm in width, and 0.1 cm in depth. The evaluation indicated Wound Nurse Practitioner to evaluate and orders in place. The evaluation stated the Stage III pressure ulcer to the coccyx was present upon admission. The Wound Nurse Practitioner note stated 02/25/26 revealed he initial evaluation and Resident #100 was being seen for wound to coccyx and right hip. The note indicated Resident #100 had an unstageable pressure ulcer to right hip which measured 2.5 cm in length, 2.5 cm in width, and 0.1 cm in depth and a Stage III pressure ulcer to coccyx which measured 1.0 cm in length, 0.5 cm in width, and 0.1 cm in depth. The wounds were noted to be present upon admission.Interview on 03/04/26 at 12:20 P.M. with Assistant Director of Nursing (ADON) #539 confirmed Resident #100's skin observation evaluation on 02/20/26 did not contain documentation to support Resident #100 had a pressure ulcer to coccyx upon admission. ADON #539 confirmed the skin evaluation did not have a description for the area to the crack of the buttocks to indicate whether the area was opened, skin was blanchable, or any drainage was noted. ADON #539 stated Resident #100's Stage III pressure ulcer to the coccyx is the same area that was documented as an area from moisture in the crack of the buttocks on the 02/20/26 skin observation. Review of the policy titled Skin Care Management revised 04/20/24revealed a resident who enters the facility without a pressure ulcer does not develop a pressure ulcer unless the individual's clinical condition demonstrates that the pressure ulcer was unavoidable and a resident having pressure ulcer receives necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing. The resident's skin evaluation and documentation included measurement and description of each chronic skin abnormality, current skin abnormality, and/or condition i.e. reddened areas, cuts, bruises, wounds, incisions, rashes, sutures, pressure ulcers, blisters, etc. The policy also stated if an ulcer has (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characteristics consistent with a pressure ulcer, but it is determined not to be one, document the clinical rationale which permits differentiating the ulcer type.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observations, staff interviews, and policy review, the facility failed to ensure insulin vials/pen-injectors were dated after opened. This affected two of three medication carts reviewed for medication storage and the facility identified there were six medication carts. This affected two residents (#59 and #105) reviewed for medication storage. The facility census was 74.Findings include:Observation and interview on 03/04/26 at 9:20 A.M. of medication cart two on the 400 Hall revealed Resident #59's Lantus pen-injector (insulin) was opened and did not have a date to indicate when it was opened. Interview with Registered Nurse (RN) #643 confirmed the insulin was in the medication cart, was opened, and did not have a date indicating when it was opened. Observation and interview on 03/04/26 at 9:55 A.M. of medication cart two on 300 hall revealed Resident #105's Toujeo pen-injector (insulin) was opened and did not have a date to indicate when it was opened. Interview with RN #557 confirmed Resident #105's Toujeo was in the medication cart, was opened, and did not have a date to indicate when it was opened. Review of the facility policy titled Medication Administration revealed the staff are to ensure that the opened date was documented on insulin vial or pen.

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	366116	A. Building B. Wing	03/05/2026

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and policy review, the facility failed to establish a communication system with hospice and ensure the hospice plan of care was readily available for staff to review. This affected one (Resident #78) of one resident reviewed for hospice services. The facility census was 74.Findings include:Review of the medical record for Resident #78 revealed an admission date of 12/28/23. Diagnoses included Alzheimer's disease, epilepsy, diabetes mellitus, cerebrovascular disease, and vascular dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 had cognitive impairment and was dependent on staff for bed mobility and transfers.Review of the physician order dated 02/11/26 revealed Resident #78 was admitted to hospice on 02/11/26 for a diagnosis of cerebrovascular disease. Review of hospice communication binder on 03/04/26 revealed it only included the provider names for the hospice medical director, nurse and aide and the off hours contact information and during business hours contact information. The binder included a sign in sheet that included only the hospice Certified Nursing Aide (CNA). The dates included 02/12/26, 02/16/26, 02/17/26, 02/18/26, 02/19/26, 02/20/26, 02/23/26, 02/24/26, 02/25/26, and 02/26/26 and had corresponding shower sheets on 02/12/26, 02/16/26, 02/19/26, 02/23/26, and 02/26/26. Observation, record review, and interview on 03/04/25 at 10:23 A.M. with Licensed Practical Nurse (LPN) #626 and Certified Nursing Aide (CNA) #710 revealed the hospice communication binder was found at the nursing station. Review of hospice communication binder on 03/04/26 revealed it only included the provider names for the hospice medical director, nurse and aide and the off hours contact information and during business hours contact information. The binder included a sign in sheet that included only the hospice CNA. The dates included 02/12/26, 02/16/26, 02/17/26, 02/18/26, 02/19/26, 02/20/26, 02/23/26, 02/24/26, 02/25/26, and 02/26/26 and had corresponding shower sheets on 02/12/26, 02/16/26, 02/19/26, 02/23/26, and 02/26/26. LPN #626 and CNA #710 confirmed not much information was in the binder and hospice staff should be signing in and putting in notes when they visit. They also acknowledged it should have other hospice documents such as the care plan and orders. Interview on 03/04/26 from 12:04 P.M. to 1:13 P.M. with the Director of Nursing confirmed the hospice binder had limited information and nothing from the past week. The DON acknowledged it should contain additional information such as visit notes and the hospice care plan. The DON stated Resident #79 was enrolled for hospice now for three weeks. Review of the facility policy titled Hospice Services in a Skilled Nursing Facility dated 02/04/24 revealed the facility shall support residents who elect hospice and collaborate with the hospice provider to ensure coordinated compassionate care. The hospice shall maintain the hospice care plan and the facility shall maintain its own comprehensive care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER: Springfield Masonic Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 3 Masonic Drive, Springfield, OH 45501	

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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. Based on medical record review, observation, staff interview, review of Centers for Disease Control and Prevention (CDC) guidance, and review of facility policy, the facility ailed to ensure therapy staff followed the physician orders for enhance barrier precautions (EBP) for residents who receive therapies while in the therapy room. This affected one resident (#45) and the facility identified eight residents who were on EBP and receiving therapy services. The facility census was 74. Findings include: Review of the medical record for Resident #45 revealed an admission date of 02/12/26. Diagnoses included sepsis, multiple myeloma, congestive heart failure, and other bacterial infections. The admission Minimum Data Set (MDS) assessment, dated 02/19/26, revealed Resident #45 was cognitively intact and required substantial/maximum staff assistance with transfers and bed mobility and was dependent upon staff for toilet hygiene and bathing. The physician order dated 02/23/26 revealed an order for EBP. Observation on 03/05/26 at 7:53 A.M. revealed Physical Therapy Assistant (PTA) #801 providing hands on assistance to Resident #45 with a transfer from his wheelchair to a set of steps in a common area on the unit. The observation revealed PTA #801 did not have on a gown or gloves. Interview on 03/05/26 at 7:55 A.M. with PTA #801 confirmed he provided Resident #45 with hands on assistance with transfer out of his wheelchair and continued to provide hands on assistance to Resident #45 for the steps. PTA #801 confirmed Resident #45 was on EBP because of a wound and he had not donned a gown or gloves when he provided hands on assistance with transfers. PTA #801 stated therapy staff do not wear gowns or gloves in the hallway or in the therapy room when they provided therapy services to residents under EBP. Interview on 03/05/26 at 7:58 A.M. with Occupational Therapy (OT) #802 stated therapy staff follow EBP when treating the residents in their rooms but stated EBP are not followed in the therapy gym when staff are providing hands on assistance. Interview on 03/05/26 at 8:01 A.M. with Director of Rehabilitation (DOR) #805 confirmed therapy staff do not follow EBP when providing treatment for residents with orders for EBP in the therapy gym. Review of the policy titled Enhanced Barrier Precautions revealed the facility is to implement EBP for the prevention of transmission of multi-drug resistant organisms (MRDOs). The policy stated EBP refers to an infection control intervention designed to reduce transmission of MRDOs that employs targeted gown and gloves use during high contact resident care activities. The policy stated EBP should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assistance with transfers and mobility. Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control (continued on next page)

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	366116	A. Building B. Wing	03/05/2026

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Springfield Masonic Community	3 Masonic Drive Springfield, OH 45501

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. This deficiency represents non-compliance investigated under Complaint Number 2748252.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, medical record review, observations, and policy review, the facility failed to ensure the the resident's call system was within the reach of the resident when lying in bed. The affected one (Resident #79) of 20 residents reviewed in the initial pool of the survey process. The facility had a census of 74 residents.Findings include: Review of the medical record for Resident #79 revealed an admission date of 10/03/24. Diagnoses included vascular dementia, metabolic encephalopathy, and cognitive communication deficit. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #79 had severe cognitive impairment. The care plan dated 01/12/26 revealed Resident #79 was dependent on staff for toileting and personal hygiene, and required substantial assistance from staff to reposition from lying to sitting on side of bed, reposition from sit to stand, and reposition from bed-to-chair transfer. Interventions included to ensure the resident's call light was within reach, encourage the resident to use it for assistance as needed, and the resident needs prompt response to all requests for assistance. Observation of Resident #79 on 03/02/26 at 11:03 A.M. revealed Resident #79 was lying in bed and was asking for ice cream. The call light was observed on the floor by the bed on the left hand side of where the resident was laying and was not within the resident's reach. Observation of Resident #79 on 03/02/26 at 11:53 A.M. revealed Resident #79 was lying in bed and a used lunch tray was sitting on an adjustable overbed table on the resident's right hand side. The call light was observed on the floor by the bed on the resident's left hand side. Observation of Resident #79 on 03/02/26 about 1:55 P.M. revealed Resident #79 was resting in bed and the call light was observed on the floor by the bed on the resident's left hand side. Observation and interview of Resident #79 on 03/02/26 about 3:09 P.M. revealed Resident #79 was awake lying in his bed and the call light was observed on the floor by the bed on the resident's left hand side. Registered Nurse (RN) #687 entered the room and asked the resident if they needed any care and services. RN #687 picked up the call light from the floor and placed it on the resident's bed with the resident's reach. RN #687 confirmed Resident #79's call light was on the floor by the bed and not within the reach of the resident. Review of the facility call light procedure dated 03/05/25 revealed call lights will be within reach of the resident when in resident room.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on resident interview and staff interview, the facility failed to ensure residents received delivered mail on Saturdays. The had the potential to affect all 74 residents residing in the facility. Findings include:Interview with Resident Council Members (#48, #59, #85, and #88) on 03/04/26 at 2:12 P.M. revealed they do not receive any mail on Saturdays. The residents stated the activity staff distribute mail at the facility.Interview with Director of Life Enrichment #776 one 03/04/26 2:28 P.M. revealed activity staff distribute mail at the facility. Mail received on the weekends gets distributed to residents on Monday.Interview with Business Office Manager #663 on 03/04/26 at 2:41 P.M. revealed mail was dropped off by post office staff in the mail room. Mail that is delivered on the weekends is distributed by activity staff on Monday. Resident do not receive any mail delivered on Saturday until the following Monday.