

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802
--------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: November 17, 18, 19, 20, 21, and 24, 2014</p> <p>Facility number: 012188 Provider number: 155776 AIM number: 200958030</p> <p>Survey Team: Mary Weyls RN TC Laura Brashear RN Vickie Nearhoof RN Geoff Harris RN 11/24/2014</p> <p>Census bed type: SNF: 18 SNF/NF: 78 Total: 96</p> <p>Census by payor source: Medicare: 36 Medicaid: 45 Other: 15 Total: 96</p> <p>These deficiencies also reflects State Findings in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed 12/3/14 by</p>	F000000	<p>SpringhillVillage is requesting paper IDR for F371 as facility disagrees with scope andseverity. The creation and submission of this Plan of Correctiondoes not constitute an admission by this provider of any conclusion set forthin the statement of deficiencies, or of any violation of regulation. Thisprovider respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credible Allegation and requests a <b>Post Survey Desk Review on or after 12-12-2014.</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802
--------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F000241 SS=D	<p>Brenda Marshall, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity was afforded for 2 of 3 residents reviewed who met the criteria for dignity. (Residents #100, #16 )</p> <p>Findings include:</p> <p>1. Resident #100 was observed seated in a wheelchair in her room, facing the wall eating breakfast on 11/19/14 at 10:19 a.m. The serving tray was positioned vertically on half of the over bed table personal items were on the other half of the table. The privacy curtain was pulled and did not allow any natural light to the resident's side of the room. The resident was interviewed at the same time and indicated she did not feel she was treated with respect and dignity as she was served breakfast in her room and indicated she told staff she preferred to eat at a dining table.</p> <p>The resident's clinical record was reviewed on 11/19/14 at 11:00 a.m. The</p>	F000241	<p><b>F241 Dignity and Respect of Individuality</b></p> <p>It is the policy of this provider to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b> Resident # 100 will be asked upon serving her breakfast if she would prefer it in her room or in a different dining location and Resident request will be accommodated at that time. Resident #16's bed was returned to the location she prefers. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> Residents that reside at the facility may be affected by</p>	12/10/2014
-----------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Minimum Data Set assessment, dated 7/3/14, coded the resident with no cognitive impairment.</p> <p>On 11/24/14 at 9:50 a.m., the resident was observed in her room, in a wheelchair, facing the wall, eating breakfast. The privacy curtain was closed and did not allow any natural light to the resident's side of the room.</p> <p>On 11/24/14 at 9:55 a.m., CNA #6 was interviewed. The CNA indicated the resident was served breakfast in her room and she was not aware the resident did not want to eat in her room. The CNA indicated the resident ate lunch and supper in the Main Dining Room, and there were other areas of the facility that could have been used for the resident to be seated at a dining table for breakfast after the main serving times</p> <p>The undated facility policy, titled "Resident Rights," indicated, "...Quality of Life...(a) Dignity A facility must care for its residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."</p> <p>2. During interview of Resident #16 on 11/9/14 at 1:10 p.m., the resident indicated she did not feel she had been treated with dignity. The resident</p>		<p>alleged deficient practice. Staff members have been educated on dignity on 12-9-2014 by the DNS. Staff members were educated on reporting changes in Resident preferences to the DNS so updates can be made to the Resident care plan/ profile information. All Residents were interviewed by their Customer Care Representative using the QIS dignity questions. All issues were addressed. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Dignity in service education will be given upon hire and quarterly to staff members. Any change in Resident preferences will be reported to the DNS so that changes can promptly be made. All Residents will be asked the QIS dignity questions monthly. All issues will be addressed. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> CQI tool Dignity and Privacy will be completed by DNS/Designee for a time period of weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. DNS/Designee will monitor for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014	
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated her bed had been moved to a different area in her room and she wanted the bed put back to the original position. The resident indicated she told staff she wanted her bed placed back in the original position, and was informed it was easier to change her incontinent brief with the bed in the current position.</p> <p>During interview of Housekeeper #3 on 11/21/14 9:30 a.m., the housekeeper indicated Resident #16's bed was moved last week from against the wall to the current location. The housekeeper stated "She keeps asking me to move the bed back but I tell her I can't without ok from nursing. I don't know why they moved her bed."</p> <p>During interview of CNA's #1 and #2 on 11/21/14 at 9:55 a.m., both CNAs indicated they provided care for Resident #16 and didn't know why the bed was moved. CNA #1 stated "sometimes nights do things".</p> <p>During interview on 11/21/14 at 3 p.m., the Unit Director indicated she was unaware of the resident's bed being moved.</p> <p>An undated facility policy titled "Resident Rights" was received from the Administrator on 11/24/14 at 10:40 a.m.</p>		<p>compliance and report the Quality Assurance Committee times 2 quarters. If 95% threshold is not achieved an action plan will be developed. The Executive Director will monitor for compliance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014	
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000242 SS=D	<p>The policy indicated, "...(f) Grievances A resident has the right to...(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents...."</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents' choices in regard to frequency of showers for 2 of 4 residents reviewed for choices. (Resident #'s 45, and 187).</p> <p>Findings include:</p> <p>1. During interview of Resident #45 on 11/18/14 at 11:31 a.m., the resident stated, concerning frequency of showers, "They gave me an assignment. I've gotten used to it now. I did take a shower every day at home. I would like to have a shower every day, it would be nice. When they questioned me, I've told them</p>	F000242	<p><b>F242 Self-Determination-Right to make choices</b> It is the policy of this facility that that each Resident has the right to choose activities, schedules and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside of the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> Resident # 45 will be offered a shower daily, until her preferences change Resident</p>	12/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>I would like a shower every day but the schedule hasn't changed."</p> <p>During review of Resident #45's clinical record on 11/21/14 at 12:22 p.m., the most recent annual assessment was dated, 11/21/14. The assessment indicated the resident as cognitively intact.</p> <p>During review of a form titled, "Shower's 200 Hall," received from the DON (Director of Nursing) on 11/24/14 at 10 a.m., the form indicated Resident #45 received a shower on Tuesdays and Fridays. Documentation on the bottom of the form indicated, "Do not change shower days!"</p> <p>During review of a form titled "Preferences for Daily Customary Routines", received on 11/21/14 at 11:42 a.m. from the DON, the form indicated the resident was interviewed on 10/30/14, and documentation indicated the resident preferred showers every morning.</p> <p>2. Resident #187 was interviewed on 11/21/14 at 12:04 p.m. The resident indicated he had not had his preference for showers honored since admission. The resident indicated the previous night he was asked if he wanted a shower at 8:45 p.m. and he indicated that it was too late.</p>		<p># 187 no longer resides in the facility.</p> <p>Activity Director will continue to review preferences upon admission, quarterly and annually. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> Residents that reside in the facility have the potential to be affected by the alleged deficient practice. Staff members were educated on 12-9-2014 regarding the facility policy on Resident preferences. Staff members were educated on reporting changes in Resident preferences to the DNS so updates can be made to the Resident profile information and Resident preferences can be accommodated. All Residents have been questioned regarding bathing preferences by their Customer Care Representative; all preferences will be documented on the Resident care plan and profile. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Resident preference sheets will be completed upon admission, quarterly, annually and with any change in preferences. DNS/Designee will conduct rounds daily to ensure that Residents are receiving their shower per preference and plan</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802
--------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A nursing note, dated 11/13/14 at 7:48 p.m., was noted of: "At the beginning of evening shift CNA went to resident to ask him if he wanted his shower before or after dinner, resident stated he wanted to take shower after dinner. After dinner CNA went to resident to ask him if he was ready to take shower. Resident stated he didn't want to take a shower tonight he wants to take it tomorrow. CNA told resident she couldn't guarantee he could get a shower tomorrow. Resident stated he will take his chances on getting a shower tomorrow. Nurse explained to resident that today is his assigned shower day if he doesn't take it today there is no guarantee staff will have time to fit him in tomorrow since other residents have their showers to take as well. Resident asked when he could be guarantee [sic] (11/17/14) to get his next shower, nurse told him his next shower day is Monday. Resident stated that he understood, he didn't want to take a shower tonight and that he would take his chances."</p> <p>A form titled "Preferences for Daily Customary Routines," completed on 9/30/14, provided by the Director of Nursing (DON) on 11/21/14 at 11:42 a.m., indicated the resident did not want to get up before 7:30 a.m. and wanted a bath or shower in the evenings 1-2 times</p>		<p>of care. Staff members were re-educated on 12-9-2014 by the DNS regarding facility policy and reporting changes in preferences to the DNS. All Residents will be asked monthly by their customer care representative about their bathing preferences. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</b> CQI tool Accommodation of Needs will be completed by DNS/Designee for a time period of weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. DNS/Designee will monitor for compliance and report the Quality Assurance Committee times 2 quarters. If 95% threshold is not achieved an action plan will be developed. The Executive Director will monitor for compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014	
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000371 SS=D	<p>weekly. The form indicated it was "very important" to the resident to choose between tub, shower, or bed bath.</p> <p>The resident's Shower Reports sheets, provided by the DON on 11/24/14 at 11:30 a.m., identified as a tool utilized to track showers given, had documentation on many days that the resident refused a shower. It did not address the time the shower was offered or reason for the refusal.</p> <p>The undated facility policy, titled "Resident Rights," indicated, "...Quality of Life...(b) Self-determination and participation...(1) Choose activities, schedules, and health care consistent with his or her interests, assessments, plans of care; ...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...."</p> <p>3.1-3(u)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and</p>	F000371	Springhill Village is requesting a paper IDR for tag F371 as facility	12/10/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>record review, the facility failed to ensure failed to ensure adequate hand washing. This had the potential to affect 94 of 96 residents who received food that was prepared in kitchen.</p> <p>Findings include:</p> <p>On 11/21/14 at 11:40 a.m., Dietary Aide #8 (DA#8) was observed washing his hands at the kitchen hand washing sink. After DA#8 had washed his hands, he was observed to turn off the faucet with his bare hand, and then proceeded to dry his hands with a paper towel.</p> <p>On 11/21/14 at 11:45 a.m., DA#8 began setting up residents' trays for the noon meal. At 11:48 a.m., DA#8 was observed to pull up his pants with his right hand, then continued to set up residents' trays without sanitizing his hands.</p> <p>On 11/24/14 at 9:00 a.m., the Dietary Manager (DM) indicated the staff were instructed to wash hands and to turn off the faucet after handwashing with a paper towel. She indicated staff were to perform hand hygiene before they start work and after completion of a task before moving to a clean area. The DM</p>		<p>disagrees with the scope and severity. <b>F371 Food Procure, Store/Prepare/Serve-Sanitary</b> It is the policy of this provider to ensure to (1) procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store,prepare, distribute and serve food under sanitary conditions. <b>What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?</b> Dietary Aide #8 was educated with a demonstration and return demonstration on hand washing on 12/5/2014 by the Clinical Education Coordinator. Dietary Aide #8 received education on proper procedure for cleansing hands and the procedure for sanitizing hands following touching clothing or apron prior to moving to a clean area on 12/5/2014 by the Registered Dietitian. <b>How will you identify other residents having the potential to be affected by the same deficient practiceand what corrective action will be taken?</b> Residents that reside in the facility have the potential to be affected by the alleged deficient practice. Dietary staff members have been re-educated on 12-9-2014 by the Registered Dietitian regarding proper hand washing procedures and the appropriate times to sanitize hands when moving from a "dirty"</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802
--------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated DA#8 had been reminded several times not to touch his clothing nor his body while performing the kitchen duties.</p> <p>On 11/24/14 at 9:00 a.m., the DM provided a current policy and procedure, titled "AMERICAN SENIOR COMMUNITIES Dietary Personal Hygiene," dated 02/07, for hand washing. The document indicated, "...Proper handwashing is the most critical aspect of personal hygiene. Dietary employees must wash their hands before they start work and after: ...c. Touching the hair, face, or body...j. Touching clothing or aprons...."</p> <p>On 11/24/14 at 9:30 a.m., the Administrator (ADM) provided a current policy and procedure, dated 3/12, titled "HAND HYGIENE," indicated "...Procedure Steps: ...Turn off faucet with clean paper towel and discard towel immediately...."</p> <p>3.1-21(i)(3)</p>		<p>to "clean" area. Registered Dietitian/Designee will observe meal service weekly to ensure proper and timely hand washing.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Dietary Staff members completed a demonstration and return demonstration of correct hand washing techniques on 12-10-2014, by the Clinical Education Coordinator. Dietary Staff members were re-educated on 12-10-2014 by the Registered Dietitian and were able to correctly identify the appropriate times to sanitize hands. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>CQI tool Kitchen Sanitation/Environmental review will be completed by the Registered Dietitian/ Designee for a time period of weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 months and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. Registered Dietitian/Designee will monitor for compliance and report to the Quality Assurance Committee times 2 quarters. If 95% threshold is not achieved an action plan will be developed. The</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread</p>		Executive Director will monitor for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/24/2014
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802
--------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of infection.</p> <p>Based on observation, interview and record review the facility failed to ensure hand hygiene was maintained for 1 of 1 residents observed receiving a medication injection.</p> <p>Findings include:</p> <p>On 11/24/14 at 10:18 a.m., LPN #9 administered an IM (intra-muscular) medication injection to Resident #51. LPN #9 did not wash her hands prior to the injection and did not wear gloves. She wiped blood from the injection site with an alcohol swab using her bare hands.</p> <p>On 11/24/14 at 10:25 a.m., LPN #9 stated, "I messed up!" She indicated she should have washed her hands and worn gloves.</p> <p>On 11/24/14 at 10:50 a.m., the DON (Director of Nursing) indicated all staff should wash their hands and put on gloves prior to administering a medication injection to a resident.</p> <p>A facility policy titled "INJECTION INTRA-MUSCULAR PROCEDURE," dated 9/2012, was provided by the DON on 11/24/14 at 11:20 a.m., indicated, "...Procedure Steps: ...2. Perform hand</p>	F000441	<p><b>F441 Infection Control</b></p> <p>It is the policy of this provider to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</b></p> <p>LPN #9 received immediate corrective action on 11/24/2014. A demonstration and return demonstration of proper infection control procedures when administering an intramuscular injection was completed on 11/24/2014 and again on 12/2/2014.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>Residents that reside at the facility may be affected by alleged deficient practice.</p> <p>Licensed Nurses have been educated on infection control on 12-9-2014 by the DNS as it relates to providing intramuscular injections. Licensed Nurses completed a skills</p>	12/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	hygiene...5. Put on gloves...."  3.1-18(a)		validation forIntramuscular injections. Skills validations will be completed for all nursesupon hire, annually and as needed.  <b>What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur</b> Licensed Nurses completed a skills validation forIntramuscular injections on 12-9-2014 by the Clinical Education Coordinator. Skills validations will be completed for all nursesupon hire, annually and as needed. DNS/Designee will conduct rounds every shift toensure proper hand washing and infection control techniques during anIntramuscular injection.  <b>How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place</b>  CQI tool Infection Control will be completed by DNS/Designee for a time period of weekly times 4 weeks, bi-monthly times 2 months,monthly times 6 months and then quarterly to encompass all shifts untilcontinued compliance is maintained for 2 consecutive quarters. Registered Dietitian/Designee will monitorfor compliance and report the Quality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/24/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGHILL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E SPRINGHILL DR TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			Assurance Committee times 2quarters. If 95% threshold is notachieved an action plan will be developed. The Executive Director will monitor for compliance.		