

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 11/16/2015
--	---	--	---

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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 9, 10, 12, 13, and 16, 2015</p> <p>Facility Number: 012188 Provider Number: 155776 AIM Number: 200958030</p> <p>Census bed type: SNF: 16 SNF/NF: 70 Total: 86</p> <p>Census payor type: Medicare: 24 Medicaid: 49 Other: 13 Total: 86</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed November 18, 2015 by 29479.</p>	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review on or after 11-30-2015.	
F 0315	483.25(d)			

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 11/16/2015	
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			
SS=D Bldg. 00	<p>NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to maintain urinary drainage tubing in a sanitary manner to prevent infections for 2 of 2 residents who met the criteria for urinary catheters. (Resident #169 and #146)</p> <p>Findings include:</p> <p>1. On 11/12/15 10:15 a.m., Resident #169 was observed propelling self in a wheelchair in the hallway. A urinary drainage collection bag was hung under the seat of the chair and the drainage tubing was in contact with the floor.</p> <p>Resident #169's clinical record was reviewed on 11/12/15 at 11:00 a.m. The resident's Minimum Data Set (MDS) admission assessment, dated 10/7/15, indicated the resident required extensive assistance of two for bed mobility and</p>	F 0315	<p>F315 No Catheter, Prevention UTI, Restore Bladder</p> <p>It is the policy of this provider to maintain urinary drainage tubing in a sanitary manner to prevent infections.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents # 169 and # 146's catheter tubing was anchored in a way so as not touch the floor.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents that reside at the facility with a catheter may be affected by alleged deficient practice.</p> <p>Staff members have been re-educated</p>	11/30/2015			

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 11/16/2015
--	---	--	---

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>transfers. The resident was non ambulatory and utilized a urinary indwelling catheter.</p> <p>A plan of care, dated 10/1/15, included but was not limited to, "The resident required an indwelling catheter due to urinary retention and was at risk for infection. An approach was noted of "Do not allow tubing or any part of the drainage system to touch the floor."</p> <p>A urinalysis report, dated 11/2/15, indicated the resident's urine was positive for an infection of the organism Klebsiella Pneumoniae Enterococcus. A physician's order, dated 11/8/15, indicated an intravenous antibiotic to treat the urinary tract.</p> <p>2. On 11/9/15 at 11:45 a.m., staff were observed transferring Resident #146 in a wheelchair down the hallway to the Moving Forward Dining Room and positioned at a dining table. The resident had a urinary drainage bag hung under the seat of the wheelchair and the catheter tubing was in contact with the floor.</p> <p>Resident #146's clinical record was reviewed on 11/16/15 at 10:00 a.m. An admission MDS, dated 9/1/15, indicated the resident required extensive assistance of one for transfers, and was totally</p>		<p>on cathetertubing and infection prevention on 11-24-2015 by the DNS.</p> <p>The DNS or designee will make rounds on every shiftto ensure compliance.</p> <p>What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur?</p> <p>Education oncatheter tubing and infection prevention will be given to all nursing personnelupon hire, quarterly and as needed.</p> <p>The DNS/Designee will make rounds daily to encompass every shift to ensure compliance.</p> <p>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?</p> <p>CQI tool Infection Control will be completed by DNS/Designee for a time period of weeklytimes 4 weeks, bi-monthly times 2 months, monthly times 6 months and thenquarterly to encompass all shifts until continued compliance is maintained for2 consecutive quarters.</p> <p>DNS/Designee will monitor for compliance and report the Quality Assurance Committee times 2quarters. If 100% threshold is notachieved an action plan will be</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 11/16/2015
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	
F 0371 SS=E Bldg. 00	<p>dependent for locomotion around the facility. The resident's diagnoses included, but was not limited to, history of bladder cancer and urostomy. A physician's order was noted dated 11/13/15, for an antibiotic to treat a urinary tract infection.</p> <p>On 11/16/15 at 1:32 p.m., the Administrator and Director of Nursing were interviewed. The staff indicated the drainage tubing should have been kept off of the floor, the same as with an indwelling Foley catheter.</p> <p>A facility policy titled "Indwelling Urinary Catheter care, emptying Drainage Bag & Catheter Removal," with the last review date of 12/2012, and identified as current by the Administrator and Director of Nursing, on 11/16/15 at 1:32 p.m., did not address the positioning of the drainage tubing.</p> <p>3.1-41(a)(2)</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</p>		developed. The 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 <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/16/2015
--	---	---	---

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>local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review the facility failed to ensure sanitary food handling for 2 of 2 dining observations and a kitchen environment free of potential contamination with staff beverage for 1 of 2 kitchen observations. This deficient practice affected 5 of 31 residents assisted in the main dining room and had the potential to affect 83 of 86 residents receiving food prepared and served from the kitchen (Residents #173, #11, #61, #150, and #59).</p> <p>1. On 11/9/15 during the noon meal service in the main dining room the following was observed:</p> <p>a). At 12:06 p.m., CNA # 1 touched Resident # 173's sandwich bun with her bare hands as she placed tarter sauce on his sandwich.</p> <p>b). At 12:11 p.m., CNA # 1 touched Resident # 11's sandwich bun with her bare fingers while she cut the sandwich in half for the resident.</p> <p>c). At 12:12 p.m., CNA # 1 touched Resident # 61's sandwich bun with her bare hands as she placed tarter sauce on the resident's sandwich.</p>	F 0371	<p>F371 Food Procure,Store/Prepare/Serve-Sanitary It is the policy of this facility to ensure sanitary foodhandling, and a kitchen environment free of potential contamination. What corrective action(s) will be accomplished for those residents found to have been affected by thedeficient practice? Residents# 173, #11, #61, #150, #59 were assessed by a licensed nurse and no signs or symptoms of food borne illness noted to present. How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken? Residents that reside in the facility have the potential to be affected by the alleged deficient practice. C.N.A #1 received immediate corrective action and re-education regarding proper food handling. Cook # 3 received immediate corrective action and re-education regarding personal drinks in the kitchen. All Dietary Employees were re-educated on 11/25/2015 by the Registered Dietitian regarding the policy on personal drinks in the kitchen. All personnel who assist in passing trays in the dining room have been re-educated on proper food handling on 11/25/2015 by the DNS. What measures will be</p>	11/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155776	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/16/2015
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>d). At 12:14 p.m., CNA # 1 touched Resident # 150's sandwich bun with her bare hands as she placed tarter sauce on the resident's sandwich.</p> <p>2. On 11/13/15 during the noon meal service in the main dining room the following was observed:</p> <p>a). At 12:16 p.m., CNA # 1 touched Resident # 59's sandwich bun with her bare hands while she cut the sandwich in half for the resident.</p> <p>b). At 12:20 p.m., CNA # 1 touched Resident # 150's sandwich bun with her bare hands while she cut the sandwich in half for the resident.</p> <p>During an interview on 11/12/15 at 11:02 a.m., Dietary Manager indicated staff should not be touching food items with their bare hands.</p> <p>During an interview on 11/16/15 at 10:28 a.m., CNA # 4 indicated staff should never touch the resident's food with their bare hands. She further indicated if a resident needs help placing condiments on their sandwich a fork should be used to pick up the bun and not bare hands.</p> <p>A policy, dated 07/15, identified as</p>		<p>put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The dining room manager will monitor how food is being handled during the meal services to encompass all three meals. All staff that assists in serving meals in the dining room received a demonstration on proper food handling to avoid contamination by the Registered Dietitian on 11/25/2015. All staff will be educated upon hire, quarterly and as needed on proper food handling. All Dietary staff will be educated upon hire, quarterly and as needed on the policy regarding no personal drinks in the kitchen. 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. CQI tool Infection Control will be completed by DNS/Designee for a time period of daily, five days per week times 4 weeks to encompass all three meals, bi-monthly times 2 months to encompass all three meals, monthly times 6 months to encompass all three meals, and then quarterly to encompass all three meals until continued compliance is maintained for 2 consecutive quarters. DNS/Designee will monitor for compliance and report the Quality Assurance Committee times 2</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 11/16/2015
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>current, titled, "General Food Preparation and Handling", provided by the (Director of Nursing) DON on 11/16/15 at 12:30 p.m., included but was not limited to, "...4. Bare hands should never touch raw or ready to eat food directly...."</p> <p>3. During a kitchen observation on 11/12/15 at 11:12 a.m., a 24 ounce cold beverage cup was on a shelf that contained spices in the food prep area. The cup was 3/4 full of a cold drink.</p> <p>During an interview on 11/12/15 at 11:06 a.m., the Dietary Manager indicated staff should not have any personal drinks in the kitchen.</p> <p>During an interview on 11/12/15 at 11:07 a.m., Cook # 3 indicated the personal drink belonged to her and she had forgotten she had left the drink on the shelf.</p> <p>A policy, dated 07/15, identified as current, titled, "Infection Control", provided by the Administrator on 11/16/15 at 1:00 p.m., included but not limited to, "...g. Personal items should not be stored on food preparation equipment or in food storage areas...."</p> <p>3.1-21(i)(2)</p>		quarters. If 100% threshold is not achieved an action plan will be developed. The 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 11/16/2015
--	---	--	---

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
F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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</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 11/16/2015
--	---	--	---

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>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and record review, the facility failed to ensure adequate hand sanitation for 1 of 1 observation of infection control practices during medication administration via a gastrostomy (surgical opening through the abdomen) tube (Resident #148).</p> <p>Finding includes:</p> <p>On 11/13/2015 from 8:50 a.m. until 9:15 a.m., LPN #6 wore gloves during administration of medication to Resident #148 through a gastrostomy tube (g-tube). The LPN did not change gloves after dispensing the crushed medication through the tube, "milking" the tubing to clear an occlusion, and before reconnecting the tubing to the feeding pump.</p> <p>Resident #148's clinical record was reviewed on 11/16/15 at 2:05 p.m. A physician's order, dated 4/15/15 was noted of "May crush appropriate medications and administer per G-tube."</p> <p>The facility's policy titled "Hand Hygiene", with most recent review date of 03/2012, indicated, "Note: 5 Moment of required hand hygiene:</p>	F 0441	<p>F441 Infection Control, Prevent Spread, Linens. It is the policy of this provider to ensure adequate hand sanitation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident# 148 was assessed for signs and symptoms of infection. The Resident had no negative outcome. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents that reside in the facility have the potential to be affected by the alleged deficient practice. LPN# 6 received immediate corrective action, and re-education. LPN # 6 completed demonstration and return demonstration for proper gloving and hand washing during a G-tube medication administration with the Clinical Education Coordinator on 11/17/2015. All Licensed Nurses were re-educated on proper gloving and hand washing during a G-tube medication administration on 11/24/2015. What measures will be put into place or what systemic changes you will make to ensure that the</p>	11/30/2015

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 11/16/2015
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	
F 0465	Before patient, Before an aseptic task, After body fluid exposure risk, After patient contact, After contact with patient surroundings." 3.1-18(l) 483.70(h)		deficientpractice does not recur. AllLicensed Nurses will be educated upon hire and quarterly on the proper procedure forgloving and hand washing during a G-tube medication administration. AllLicensed Nurses have completed a skills validation demonstration and returndemonstration with the Clinical Education Coordinator for G-tube medicationrelated to infection control on 11/25/2015 DNS/Designee will make rounds to encompass every shift to ensure compliance. 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. CQltool Infection Control will be completed by the DNS/Designee for a time period of daily, five days per week times 4 weeks to encompass all shifts, bi-monthly times 2 months to encompass all shifts, monthly times 6 months to encompass all shifts and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. DNS/Designee will monitor for compliance and report to the Quality Assurance Committee times 2 quarters. If 100% threshold is notachieved an action plan will be developed. The Executive Director will monitor forcompliance.		

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 11/16/2015	
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			
SS=A Bldg. 00	<p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on interview and observation, the facility failed to ensure an over the bed light was maintained in working order for 1 of 35 residents' rooms (Resident #50).</p> <p>Finding includes:</p> <p>During an observation on 11/10/15 at 10:14 a.m., Resident #50's over the bed light switch was broken.</p> <p>During an environmental tour with the Maintenance Supervisor on 11/16/15 at 11:09 a.m., Resident #50's over the bed light was not operational. The Maintenance Supervisor indicated the switch for the light fixture was broken. The Maintenance Supervisor indicated he had not received a maintenance request form for the light fixture.</p> <p>The Administrator (ADM), on 11/16/15 at 11:20 a.m., indicated staff should have completed a maintenance request form for repairing the broken light.</p> <p>On 11/16/15 at 2:00 p.m., the ADM indicated there was not a facility policy concerning light fixtures working properly.</p>	F 0465	<p>SpringhillVillage is requesting a paper IDR review. We respectfully request additional evidentiary information be considered to reduce F465 in scope and severity on the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.</p> <p>F465 Safe/Functional/Sanitary/Comfortable Environment It is the policy of this provider to ensure all over bed lights are maintained in working order. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The broken pull string for the over bed reading light was immediately replaced. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents that reside at the facility may be affected by alleged deficient practice. All staff has been educated on</p>	11/30/2015			

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 11/16/2015
--	---	--	---

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
	3.1-19(f)		<p>completing maintenance work requisitions for needed repairs on 11/24/2015 by the DNS. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff received education on 11/24/2015 by the DNS on completing maintenance requisition forms for needed repairs. All staff will be educated upon hire, quarterly and as needed on the procedure for filling out maintenance requisitions. Customer Care Representatives will check their rooms daily to ensure both light cords are present and functioning. 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? CQI tool Environment 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 100% threshold is not achieved an action plan will be developed. The Executive Director will monitor for compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155776	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 11/16/2015
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	