STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155776	A. BUILDING 00 B. WING	11/17/2023

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

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F 0000 Bldg. 00		F 0000		

This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00421212, IN00421213, and IN00421314.

Complaint IN00421212 - No deficiencies related to the allegations are cited.

Complaint IN00421213 - No deficiencies related to the allegations are cited.

Complaint IN00421314 - No deficiencies related to the allegations are cited.

Survey dates: November, 13, 14, 15, 16, and 17, 2023

Facility number: 012188
Provider number: 155776
AIM number: 200958030

Census Bed Type:
SNF/NF: 63
SNF: 18
Total: 81

Census Payor Type:
Medicare: 10
Medicaid: 33
Other: 38
Total: 81

These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on November 28, 2023.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacey Hubbell	Executive Director	12/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the accuracy of a Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), for 1 of 19 resident MDS assessments reviewed (Resident 63). Finding includes: Resident 63's record was reviewed on 11/15/23 at 9:21 a.m. The profile indicated the resident had been admitted to hospice (end of life) services on 9/19/23, for the diagnoses which included, but were not limited to chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems). A physician's order, dated 9/19/23, indicated hospice services to evaluate and treat. A care plan, dated 9/21/23, indicated the resident required hospice services for diagnosis of COPD. A significant change MDS, dated 9/27/23, lacked documentation of the resident having a prognosis (the act or art of foretelling the course of a disease) of a life expectancy of 6 months or less, if the disease process runs its normal course. During an interview, on 11/15/23 at 11:49 a.m., the MDS Coordinator indicated a different MDS staff person had completed the resident's significant change assessment. The prognosis section had	F 0641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 63 Hospice status on the MDS did not also include <6 months to live. A modification was completed that day to include this statement.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. All facility residents on Hospice have been audited to ensure both sections are identified. No other residents were found missing either section. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. MDS staff were re-educated to ensure both statements are identified when filling out MDS sections for Hospice residents. **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?**1.QAPI audit tool,	12/15/2023

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	been coded incorrectly. It should have indicated the resident had a prognosis of life expectancy of 6 months or less. On 11/15/23 at 11:51 a.m., the MDS Coordinator referred to Section J of the "Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2019, and indicated it was the manual currently used by the facility. The manual indicated, "...J1400: Prognosis...Residents with conditions or diseases that may result in a life expectancy of less than 6 months have special needs that may benefit from palliative or hospice services...Steps for Assessment: 1. Review the medical record for documentation by the physician that the resident's condition...may result in a life expectancy or less than six months or that they have a terminal illness...Coding instructions...Code 1, yes: if the medical record includes physician documentation...2) the resident is receiving hospice services...." 3.1-31(c)(1)		Hospice, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to			

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	attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure that a care plan was implemented for 1 of 2 residents reviewed for activities (Resident 14).	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 14 1:1	12/15/2023

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	Finding includes: During an interview on 11/13/23 at 11:14 a.m., Resident 14 indicated he did not come out of his room for group activities and the facility has an activity person come into his room once a week for one of one (1:1) activities. Resident 14's record was reviewed on 11/15/23 at 10:30 a.m. The profile indicated the resident's diagnoses included, but were not limited to, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), contracture of left knee (causes the envelope of the knee to stiffen and become rigid so the knee can no longer move the way it used to), and contracture of left hip (develops when the normally elastic connective tissues in the hip are replaced by inelastic fiber like tissue). A quarterly Minimum Data Set (MDS) assessment, dated 10/3/23, indicated the resident was cognitively intact and required 2 persons assist for transfers, bed mobility, and toilet use. A Care plan, dated 9/13/22, indicated the resident enjoys the following types of activities: watching television and movies, playing games, listening to music, etc. The resident will be receiving 1:1 engagement due to not being able to participate in group activities. Interventions included but were not limited to, resident would be seen 3 times per week for 1:1 activities. During an interview, on 11/16/23 at 2:30 p.m., the Director of Nursing Services (DNS) indicated she was unable to provide documentation of 1:1		activity Care Plan reviewed and staff will schedule visits and documentation to verify visits and 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?**1. All facility residents could be impacted.2. An audit of all 1:1 resident activities was completed then reviewed with Activity staff to ensure they are aware of the Care Plan and required documentation for each person identified.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Re-education of Activity staff was completed to ensure they were aware of the Care Plan details and the times indicated for visits. Also, reviewed the required documentation to verify visits and outcome. **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?**1.QAPI audit tool, 1:1 tool, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will	

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	activities were provided to resident 14 as care planned for three times a week. During an interview, on 11/17/23 at 8:30 a.m., the Administrator indicated the facility was unable to provide documentation of 1:1 activities being completed for Resident 14 as care planned. On 11/17/23 at 10:54 a.m., the Administrator provided a document, dated 1/2006, titled, "Activities," and indicated it was the policy currently being used by the facility. The policy indicated, " ...It is the policy of this facility to provide an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident in accordance with the comprehensive assessment ...." 3.1-35(a)		be developed. Executive Director to monitor for compliance.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;			

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	(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident's indwelling urinary catheter (a semi-flexible plastic tube with one end inserted into the bladder) attached to a urinary drainage bag (a bag that collects urine) did not touch the floor for 1 of 1 resident reviewed for catheter care (Resident 75). Findings include: On 11/13/23 at 9:33 a.m., Resident 75 was observed lying in bed with a foley catheter drainage bag attached under the wheelchair next to the bed. The drainage bag was uncovered and was touching the floor. On 11/15/23 at 9:56 a.m., Resident 75 was observed sitting in wheelchair asleep. The foley catheter bag was in a dignity bag (a urinary drainage bag holder which restores the dignity of catheterized patients by concealing urinary	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 75 will be offered a leg bag when up, to prevent tubing from touching the floor and to help minimize urethral trauma. If he chooses not to use, frequent checks will be done to see if resident needs to lie down so staff can assist with moving the bag to the bed with the dignity bag. Draping of the tubing along the bed will be done as needed to prevent tubing from coming in contact with floor.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents	12/15/2023

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	drainage bags from public view) which was attached to the underside of the wheelchair. The bag and catheter tubing were touching the floor. On 11/15/23 at 10:00 a.m., Licensed Practical Nurse (LPN) 5 indicated the foley drainage bag and tubing should not be touching the floor. On 11/15/23 at 12:36 p.m., Resident 75 was observed sitting in a wheelchair while being transported toward the dining area. The foley drainage bag was inside of a dignity bag attached to the underside of the wheelchair. The bag and tubing were dragging on the floor while the resident was being transported. On 1/15/23 at 12:17 p.m., LPN 8 indicated the catheter bag should not be attached to the wheelchair while the resident was in bed. The LPN indicated the resident transfers himself to bed at times. The LPN acknowledged the resident should have a leg bag to prevent trauma, and the drainage bag which was attached to the wheelchair should be placed into a dignity bag and it should not be touching the floor. On 11/15/23 at 11:16 a.m., clinical record review of Resident 75. Diagnoses include, but are not limited to paroxysmal atrial fibrillation (an irregular heart rhythm that begins in the upper atria of your heart), urinary tract infection (includes cystitis, infection of the bladder/lower urinary tract), ischemic cardiomyopathy (refers to heart weakening caused by reduced blood flow to your heart), ventricular fibrillation (a type of arrhythmia, or irregular heartbeat, that affects your heart's ventricles), hypotension (low blood pressure), muscle weakness (generalized) and difficulty in walking.		could be impacted.2. All facility residents with a catheter have been reviewed and staff that care for these residents have been inserviced on the requirements of their device in regards to infection control and dignity.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** 1. Nursing staff re-educated on catheter tubing. oxygen tubing and such equipment touching the floor. 2. Nursing will now sign off in medication record the verification of catheter bag being changed to a leg bag daily if up out of bed.**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?**1.QAPI audit tool, Catheter, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance.	

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	Physicians Orders included but are not limited to, up as needed in wheelchair with assistance, change foley catheter, and urinary drainage bag as needed for dislodgement, leakage, or occlusion. Foley catheter care, catheter securement device in place (a device to secure the catheter to the leg, preventing displacement of the tube), nurse to record output every shift, foley catheter size 16 French (Fr) with 10 milliliter (ml) bulb. A significant change, Minimum Data Set (MDS) a standardized assessment tool that measures health status in nursing home residents), dated 11/6/23, indicated the resident had an indwelling foley catheter during the assessment period. A care plan, dated 10/10/23, indicated the resident required an indwelling urinary catheter related to urinary retention (a condition in which you are unable to empty all the urine from your bladder). The goal was the resident will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma. A nursing intervention, dated 10/10/2023, indicated do not allow tubing or any part of the drainage system to touch the floor. On 11/16/23 at 3:45 p.m., the Director of Nursing Services (DNS) provided a document, titled, "Nursing" dated 02/2012, 06/2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...COMPONENTS/GUIDELINES ...2. RESIDENT CARE EQUIPMENT ...b. Urinary catheters should have a catheter bag cover over them or a wash basin underneath them as a barrier to prevent catheter bag or tubing from touching the ground ...." 3.1-41(a)(1)			

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure proper storage of respiratory equipment for 2 of 4 residents reviewed for respiratory care (Residents 45 and 63). Findings include: 1. On 11/13/23 at 11:12 a.m., Resident 45's unbagged nebulizer mouthpiece and tubing were observed on the resident's nightstand table next to the nebulizer machine along with an unbagged CPAP (continuous positive airway pressure) mask and it was on lying top of the CPAP machine. On 11/14/23 at 11:47 a.m., Resident 45 was observed sitting up in his wheelchair in his room. An unbagged nebulizer mouthpiece, tubing, and CPAP mask were observed on his nightstand table. The nebulizer mouthpiece was sitting next to the nebulizer machine and the CPAP mask was on top of the CPAP machine. On 11/15/23 at 9:45 a.m., Resident 45 was sitting up in his wheelchair asleep in his room. An unbagged nebulizer mouthpiece, tubing, and CPAP mask were observed on his nightstand	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 45 and 63 had their respiratory equipment placed in bags as per policy when not in use.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents using respiratory equipment could be impacted.2. All residents with respiratory equipment were audited and they did have their equipment in bags.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Nursing staff will be inserviced on respiratory equipment policy on bagging following use. 2. Nursing will now sign off in medication record the	12/15/2023

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	table. The nebulizer mouthpiece was sitting next to the nebulizer machine and the CPAP mask was next to the CPAP machine. On 11/17/23 at 8:48 a.m., Resident 45 was sitting up in his wheelchair eating breakfast in his room. An unbagged nebulizer mouthpiece, tubing, and CPAP mask were observed on his nightstand table. The nebulizer mouthpiece was sitting next to the nebulizer machine and the CPAP mask was next to the CPAP machine. Resident 45's record was reviewed on 11/14/23 at 2:07 p.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing-related problems) and acute and chronic respiratory failure with hypoxia (acute or chronic impairment of gas exchange between the lungs and the blood causing hypoxia [inadequate supply of oxygen] with or without hypercapnia [too much carbon dioxide in your blood]). A significant change Minimum Data Set (MDS) assessment, dated 10/30/23, indicated the resident was cognitively intact and received oxygen therapy. A care plan, dated 7/19/23, indicated resident has potential for impaired gas exchange related to shortness of breath while lying flat secondary to COPD, chronic diastolic congestive heart failure (a condition in which your heart's main pumping chamber becomes stiff and unable to fill properly), and OSA (obstructive sleep apnea). Interventions included but were not limited to CPAP as ordered, administer oxygen as ordered, and administer meds as ordered.		verification of equipment being bagged following use. **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?**1.QAPI audit tool, Respiratory Equipment bagged, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance.	

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	A physician order, dated 10/25/23, indicated ipratropium-albuterol solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier) 0.5 milligrams (mg) - 3mg/3 milliliters (ml) 1 ampule via inhalation twice daily. A physician order, dated 10/27/23, indicated CPAP to be set a 20 twice daily. On at bedtime and off upon waking. During an interview, on 11/16/23 at 9:55 a.m., Registered Nurse (RN) 4 indicated nebulizer mouthpiece and tubing should be placed in a bag when not in use. During an interview, on 11/17/23 at 9:31 a.m., Infection Preventionist Nurse indicated the CPAP masks should be bagged when not in use. 2. During the initial pool observation, on 11/13/23 at 10:39 a.m. Resident 63's nebulizer (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece) was observed sitting on top of the resident's bed side table and was un-bagged. During a random observation, on 11/13/23 at 2:15 p.m., Resident 63's nebulizer was observed sitting on top of the resident's bed side table and was un-bagged. Resident 63's record was reviewed on 11/15/23 at 9:21 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems). A significant change Minimum Data Set (MDS)			

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	155776	A. BUILDING 00 B. WING	11/17/2023

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	assessment indicated the resident had a diagnosis of COPD and was short of breath (SOB) when lying flat. A care plan, dated 9/21/23, indicated the resident required hospice (end of life) services related to the diagnosis of COPD. A physician's order, dated 11/7/23 and discontinued (DC'd) on 11/14/23, indicated ipratropium-albuterol solution (a class of medication called bronchodilators-relaxes the muscles in the lungs and widening the airways [bronchi]) for nebulization; 0.5 (milligrams) mg-3 mg (2.5 mg base)/3 (milliliters) mL inhalation, three times daily. A physician's order, dated 11/7/23 and DC 'd on 11/15/23, indicated ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL inhalation, as needed. A physician's order, dated 11/15/23, indicated ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg (2.5 mg base)/3 mL inhalation, every 4 hours as needed. During an interview, on 11/17/23 at 9:33 a.m., Infection Preventionist (IP) 7 indicated nebulizer masks should be stored in a bag when not being used. On 11/15/23 at 11:57 a.m., the Director of Nursing Services (DNS) provided an undated document titled, "Aerosolized Medication Therapy," and indicated it was the policy currently used by the facility. The policy indicated, "...Procedure: ...16) When finished, place the nebulizer in a labeled bag with patient name and date. 17) Change the nebulizer equipment weekly or according to your			

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	company's policy...." On 11/17/23 at 10:10 a.m., the IP provided an undated document titled, "Cleaning Nebulizer," and indicated it was the policy currently being used by the facility. The policy indicated, "...5. Shake off excess water and lay on clean paper towel or towel dry. 6. Once dry reassemble and place in clear labeled bag." 3.1-47(a)(6)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure proper handling of oral medications during the medication administration pass and failed to ensure expired insulin medication was not administered to a resident resulting in a medication error rate of greater than 5 percent (Residents 46, 38, and 35). Findings include: 1a. During a medication administration observation, on 11/16/23 at 9:20 a.m., Registered Nurse (RN) 4 was preparing oral medications for Resident 46. The nurse dropped a Sertraline (anti-depressant medication) pill onto the top of the medication cart from the pill pack, she picked up the pill with her bare hand and placed it into the medication cup to be administered. RN 4 administered the Sertraline pill along with other medications to the resident. Resident 46's record was reviewed on 11/16/23 at	F 0760	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Upon notification of error the staff were re-educated on proper medication administration to prevent further episodes of improper handling. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. All nurses and QMA's that have contact with medication will be required to complete inservice training and check-off's. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not**	12/15/2023

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	2:00 p.m. The profile indicated the resident's diagnosis included, but were not limited to, major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest in activities that once brought joy). A physician order, dated 6/8/23, indicated Sertraline 50 milligram (mg) give one tablet orally once a day. 1b. During a medication administration observation, on 11/16/23 at 9:40 a.m., RN 4 was preparing oral medications for Resident 38. The nurse dropped a Tradjenta (anti-diabetic medication) pill onto the top of the medication cart from the pill pack, she picked up the pill with her bare hand and placed it into the medication cup to be administered. RN 4 administered the Tradjenta pill along with other medications to the resident. Resident 38's record was reviewed on 11/16/23 at 2:15 p.m. The profile indicated the resident diagnosis included, but were not limited to, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 8/23/23, indicated Tradjenta 5mg, give one tablet orally once a day. 1c. During a medication administration observation, on 11/16/23 at 11:10 a.m., RN 4 was preparing oral medications for Resident 35. The nurse placed a Midodrine (medication used to treat low blood pressure) tablet into her bare hand from the pill pack and placed it into the medication cup. The nurse placed a Linzess (a medication used to treat irritable bowel syndrome with constipation) pill into her bare hand from the pill pack and placed it into the medication cup. The		**recur?**1. Audits/check-offs will continue to be done for safe handling and verification of expiration dates to ensure this deficient practice does not recur. These will follow the QAPI protocol for compliance. Weekly for one month and monthly for four months, results reviewed in QAPI to determine need for continuance. 2. Newly hired nurses will be checked off on medication administration prior to being alone on a cart. **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?**1.QAPI audit tool, Medication Administration, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance.	

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	nurse dropped a Protonix (relieves symptoms such as heartburn, difficulty swallowing, and cough) pill onto the top of the medication cart from the pill pack, she picked up the pill with her bare hand and placed it into the medication cup. The nurse placed a Norco (pain medication) pill into her bare hand from the pill pack and placed it into the medication cup. RN 4 administered all the above medications to the resident along with other medication in the med cup. Resident 35's record was reviewed on 11/16/23 at 2:30 p.m. The profile indicated the resident diagnoses included, but were not limited to, Gastro esophageal reflux disease (GERD) (a digestive disease in which stomach acid and or bile irritates the food pipe lining), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and Type 2 diabetes mellitus. A physician order, dated 6/21/23, indicated Midodrine 5mg give one tablet three times a day. A physician order, dated 5/22/23, indicated Linzess 145 micrograms (mcg) give one capsule once a day. A physician order, dated 6/28/23, indicated Protonix 40mg give one tablet once a day. A physician order, dated 5/22/23, indicated Norco 5mg-325mg give one tablet three times a day. 2. During a medication administration observation, on 11/16/23 at 9:40 a.m., RN 4 was preparing insulin medication to administer to Resident 38. The lispro (anti-diabetic medication) insulin vial was dated 10/14/23. The nurse administered the insulin to the resident.			

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	A physician order, dated 6/29/23, insulin lispro (insulin medication) 100 unit/ml (milliliter), by subcutaneous (under the skin) injection. Inject 30 units three times a day. During an interview, on 11/16/23 at 11:37 a.m., the Director of Nursing Services (DNS) indicated nursing staff should not touch oral medications with their bare hands. The DNS indicated if a pill was dropped onto the medication cart, then the nurse should destroy the medication and should not be given to the resident. She further indicated nursing staff should not administer expired insulin medication. On 11/16/23 at 2:05 p.m., the DNS provided a document with a revised date of 1/1/22, titled, "General Dose Preparation and Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...3.4 Facility staff should not touch medication when opening a bottle or unit dose package. 3.5 If a mediation which is not in a protective container is dropped, facility staff should discard it according to facility policy ...4.1.3 check the expiration date on the medication ...." On 11/16/23 at 2:05 p.m., the DNS provided an undated document and identified it as the currently facility policy, titled, "Insulin Vials and Pens." The policy indicated, " ...discard after 28 days ...." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of for 1 of 2 medication carts reviewed (Resident 38 & 35). Finding includes: 1a. On 11/16/23 at 9:57 a.m., the 100-hall medication cart contained an insulin (medication used to lower blood sugar) vial that had an open date of 10/14/23. The vial contained a label that indicated it was for Resident 38. During an interview, on 11/16/23 at 9:57 a.m.,	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 35 and 38 had their expired medications disposed. An audit of their other medications did not reveal any other medications beyond the acceptable date.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	12/15/2023

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	Registered Nurse (RN) 4 indicated insulin was good for 30 days once opened. She further indicated Resident 38's insulin vial should have been discarded. Resident 38's record was reviewed on 11/16/23 at 11:45 a.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A physician order, dated 6/29/23, insulin lispro (insulin medication) 100 unit/ml (milliliter), by subcutaneous (under the skin) injection. Inject 30 units three times a day. 1b. On 11/16/23 at 9:57 a.m., the 100-hall medication cart contained a NovoLog (insulin medication) pen with an open date of 9/22/23. The insulin pen contained a label that indicated it was for Resident 35. During an interview, on 11/16/23 at 9:57 a.m., RN 5 indicated the insulin pen for Resident 35 was expired and should have been discarded. Resident 35's record was reviewed on 11/16/23 at 12:00 p.m. The profile indicated the resident's diagnosis included, but were not limited to, Type 2 diabetes mellitus with ketoacidosis without coma (a condition develops when the body can't produce enough insulin). A physician order, dated 5/25/23, with a discontinue date of 10/31/23, Novolog pen 100 unit/ml, by subcutaneous inject. Inject 35 units at bedtime. During an interview, on 11/16/23 at 10:12 a.m., Licensed Practical Nurse (LPN) 5 indicated insulin		**taken?**1. All facility residents could be impacted.2. All facility medication carts were audited and will continue to be following the QAPI protocol, weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Nursing Medication Administration training will be required for all handling medications including handling and verification of expiration dates. 2. On-going audits will be completed by nursing to ensure on-going compliance. **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?**1.QAPI audit tool, Medication Administration, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance.	

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	was good for 30 days once it had been opened. On 11/16/23 at 2:05 p.m., the Director of Nursing Services (DNS) provided and identified a document as a current facility policy, titled, "Storage and Expiration Dating of Medications, Biologicals," with a revised date of 7/21/22. The policy indicated, " ...5.3 If a multi dose vial of an injectable medication has been opened or accessed, the vial should be dated and discarded within 28 days ...." On 11/16/23 at 2:05 p.m., the DNS provided an undated document and identified it as the currently facility policy titled, "Insulin Vials and Pens." The policy indicated, " ...discard after 28 days ...." 3.1-25(j)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable			

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	diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP			

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	and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure proper handling of the glucometer (small portable machine that's used to measure how much glucose [type of sugar] is in the blood) meter during medication administration pass for 2 of 4 residents reviewed during medication administration (Residents 38 and 35). Findings include: 1. During a medication administration observation, on 11/16/23 at 11:06 a.m., RN 4 had a glucometer meter on top of the medication cart, no barrier was placed under the machine. The nurse entered Resident 38's room and placed the glucometer onto her side table, no barrier was placed under the meter. The nurse did not clean the side table prior to placing the glucometer on it. RN 4 cleaned off the glucometer with a disinfectant wipe and placed the wipe on a paper towel. The nurse obtained the resident's blood sugar and exited the room. The nurse wiped the glucometer with the same wipe that she had used in the resident's room, once she wiped the meter down, she placed it on top of the medication cart with no barrier underneath the meter.	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Upon notification of error the staff were re-educated on proper glucometer use to prevent further episodes of improper handling.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. All nurses and QMA's that utilize a glucometer will be required to complete inservice training and check-off's. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Audits/check-offs will continue to be done for safe handling of medication and nursing equipment. These will follow the QAPI protocol for compliance.	12/15/2023

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	Resident 38's record was reviewed on 11/16/23 at 2:15 p.m. The profile indicated the resident diagnosis included, but were not limited to, Type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). 2. During a medication administration observation, on 11/16/23 at 11:09 a.m., RN 4 entered Resident 35's room with a glucometer meter, this was the same meter as used in the above encounter. The nurse placed the glucometer on the resident's bedside table with no barrier underneath the meter. The nurse did not clean the side table prior to placing the glucometer on it. RN 4 obtained the resident's blood sugar and exited the room with the meter, she placed the glucometer on the medication cart, no barrier was placed underneath the meter. Resident 35's record was reviewed on 11/16/23 at 2:30 p.m. The profile indicated the resident diagnosis included, but were not limited to, Type 2 diabetes mellitus. A physician order, dated 5/26/23 indicated obtain an Accu check (quantitatively measures glucose in whole blood) four times a day at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8:00 p.m. During an interview, on 11/16/23 at 11:37 a.m., the Director of Nursing Services (DNS) indicated nursing staff should place a barrier down underneath the glucometer machine when placing it on a surface. The machine should be cleaned in between residents, and they should allow 3 minutes to dry after a disinfectant wipe is used on the glucometer. On 11/16/23 at 2:05 p.m., the DNS provided a document dated 7/2011, titled, "Blood Glucose		Weekly for one month and monthly for four months, results reviewed in QAPI to determine need for continuance. **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?**1.QAPI audit tool, Medication Administration, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance.	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Meter Cleaning/Disinfecting and Testing," and indicated it was the policy currently being used by the facility. The policy indicated, " ...6. Wipe extern surface of the blood glucose meter with wipe and allow the surface of the meter to remain wet for 3 minutes ...7. Place cleaned meter on paper towel, in plastic cup, or on clean barrier. 8. Allow meter to completely dry ...1. Perform hand hygiene ...16. Place glucometer on paper towel, plastic cup, or other barrier that was left on the mediation cart ...." 3.1-18(b)(1)			