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	01/13/2025

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	This visit was for a Recertification and State Licensure Survey. Survey dates: January 7, 8, 9, 10, and 13, 2025 Facility number: 012188 Provider number: 155776 AIM number: 200958030 Census Bed Type: SNF/NF: 64 SNF: 12 Total: 76 Census Payor Type: Medicare: 5 Medicaid: 37 Other: 34 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 23, 2025.	F 0000	Please consider this plan of correction as our credible allegation of compliance to the compliant survey conducted January 7th-13th 2025. We respectfully request paper compliance.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 4 of 24 residents reviewed for care plan meetings (Residents 24, 28, and 37), and the facility failed to ensure the resident and or the resident representative was present for an initial care plan meeting for 1 of 24 residents reviewed. (Resident 64).	F 0657	Residents 24, 28, 37 will have care plans meetings established, in accordance with policy, family, representatives and residents will be invited. These care plans will be implemented with the IDT team. Resident 64 no longer resides at Springhill Village.	02/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emma Abbott	Executive Director	02/04/2025

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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	Findings include: 1. During an interview, on 1/8/25 at 10:12 a.m., Resident 24 indicated he did not remember being invited to or attending a care plan meeting recently. He thought maybe the last one was 6 months ago. Resident 24's record was reviewed on 1/9/25 at 10:42 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/12/24, indicated the resident had no cognitive impairment. Census information indicated the resident was admitted to the facility on 6/6/23. A care plan summary note, dated 6/26/24 indicated a care plan meeting was conducted on this day for Resident 24. A care plan summary note, dated 10/30/24, indicated a care plan meeting was conducted on this day for Resident 24. Resident 24's record lacked documentation of quarterly care plan meetings being conducted for the last year, January 2024 to January 2025. 2. During an interview, on 1/7/24 at 11:46 a.m., Resident 28 indicated she did not remember being invited to or attending a care plan meeting. She could not recall when the last one was. Resident 28's record was reviewed on 1/9/25 at 11:42 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident had no cognitive impairment. Census information indicated that the resident was admitted to the facility on 5/6/24.		All residents have the potential to be affected by the alleged deficient practice. Social Service Director (SSD)/Designee reviewed the last 3-months care plan meetings to ensure all residents have had care plan meeting. If care plans were missed, care plan meeting will be immediately established. SSD/IDT team to be educated on Care Plan Review Policy and Procedure by whom regional RAI specialist by 2/11/25. The ED/Designee will be responsible for ensuring proper care plan documentation occur for prior day in morning meeting. If concerns noted, ED/designee will immediately correct and a new care plan may be established. SSD/SSA will be responsible for monitoring/auditing the POC QAPI tool Weekly times 4 weeks, monthly times 5, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed.	

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	A care plan summary note, dated 6/4/24, indicated a care plan meeting was conducted on this day for Resident 28 . Resident 28's record lacked documentation of quarterly care plan meeting being conducted from June 2024 to January 2025. 2. On 1/07/25 at 12:07 p.m., during an interview, Resident 37 indicated she had not attended a care plan meeting. On 1/9/25 at 11:23 p.m., the medical record for resident 37 was reviewed. Diagnosis included but were not limited to nontraumatic intracerebral hemorrhage (bleeding in the brain that occurs without trauma or other known causes), dated 11/29/2023. Parkinsons disease (a brain disorder that causes movement problems, including tremors, stiffness, and difficulty with balance), dated 1/02/2025. A quarterly Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident was cognitively intact. The medical record documentation indicated a care plan summaries, dated 5/8/24 and 10/30/24, were completed. The meeting notes indicated the resident attended. The record lacked documentation of any disciplines attending. The record lacked evidence of additional care plan meetings before 5/8/24 or after 10/30/24. 3. Resident 64's record was reviewed on 1/8/25 at 3:01 p.m. The profile indicated the resident had been admitted to the facility on 12/13/24. The resident's diagnoses included, but were not limited to, type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and adult failure to thrive (a state of			

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	decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments). An admission Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the resident had severe cognitive deficit. A Road to Recovery meeting document (a document that summarizes a person's health conditions, care needs, and treatments), dated 12/16/24, lacked documentation that the resident and/or her representative were present and participated in the meeting or a reason why they had not attended. The document indicated Social Services were the only persons in attendance. A Social Services progress note, dated 1/2/25 at 2:04 p.m., indicated a meeting had taken place to discuss the resident's clinical information, goals, and discharge plan. The document indicated members of the Interdisciplinary Team (IDT-a group of health care professionals with various areas of expertise who work together toward the goals of their residents) and Social Services had attended the meeting. The note lacked documentation that the resident and/or her representative had attended or participated in the meeting or a reason why they had not attended. On 1/9/25 at 9:46 a.m., the Social Services Director (SSD) provided a document, with a postmark date of 12/16/24, and indicated it was a letter that had been sent to the resident's representative. The letter requested that her representative call to schedule a meeting to discuss her plan of care. The resident's record lacked documentation of any return contact from her representative about scheduling a meeting. The record lacked			

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	documentation of any follow-up attempt by the facility, to contact the resident's representative regarding the letter. During an interview, on 1/9/25 at 11:55 a.m., the Social Service Director (SSD) indicated he was hired in March 2024 to fill a vacant SSD position and completed his training in May 2024. He indicated the facility did not have a good system in place to keep track of the quarterly care plan meetings and he was now working on that and they had an action plan in place. He was unable to provide documentation that the care plan meetings were conducted quarterly for the above residents. The SSD indicated that a post card was mailed out or handed to the residents and/or resident representatives to remind them to call the facility to schedule a care plan meeting, but he had noticed that they were not calling the facility to schedule the care plan meetings, and they were getting missed. On 1/9/25 at 12:51 p.m., the Executive Director (ED) provided a document, with a revision dated of 8/2023, titled, "IDT Comprehensive Care Plan Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: Care plan review will be interdisciplinary and should include, to the extent possible, nursing, social services, activities, dietary, therapy, pharmacy, physician, direct care staff, and hospice (if indicated). Resident, resident representative, or others as designated by the resident will be invited to the care plan review. The care plan review will be conducted face-to-face, via phone conference, video conference, or through written communication per resident and/or representative preference. Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team			

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	periodically and following completion of each MDS assessment...." 3.1-35(a)(2)(C) 3.1-35(e)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on interview and record review, the facility failed to ensure residents who were dependent on staff for shaving facial hair, received the service for 1 of 24 residents reviewed for Activities of Daily Living (ADL) assistance (activities related to personal care). (Resident 65) Findings include: On 1/07/25 at 11:54 a.m., during an observation, Resident 65 was observed in his room with extensive beard growth. The resident indicated he wanted to be shaved. He indicated the staff had shaved him before and needed to do it again. He did not like to have facial hair. On 1/8/25 at 10:45 a.m., observed Resident 65 in his room with facial hair. He indicated the staff had not offered to shave him. On 1/9/24 at 10:30 a.m., observed Resident 65 in the hall with extensive facial hair. On 1/9/25 at 11:35 a.m., during an interview, Certified Nurse Aide (CNA) (15) indicated she shaved residents on their designated shower day. On 1/9/24 at 11:38 a.m., during an interview CNA (13) indicated residents were to be shaved on shower days.	F 0677	Resident 65 received shaving per his preference. All residents have the potential to be affected by the alleged deficient practice. Personal hygiene including shaving was provided by appropriate staff to all resident per their preference. All nursing staff will be educated by SDC/Designee on ADL care, including shaving, and ensuring residents are offered shaving during bed baths and showers. An in-service will be completed on or before by 2/11/2025 by SDC/designee regarding ADL care, including shaving, and ensuring residents are offered shaving during bed baths and showers. A daily rounding tool including resident hygiene to be utilized by Care Companions/Department managers to ensure good grooming and personal hygiene. To ensure compliance the DNS/Designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse	02/11/2025

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	On 1/9/24 at 2:30 p.m., during an interview the Director of Nursing Services (DNS) indicated Resident 65 often refused showers and those were the days he would have been shaved. The DON provided shower records indicated the resident had refused showers and records indicated the resident had been shaved on other days. On 1/9/24 at 2:45 p.m., the medical record of Resident 65 was reviewed. The resident was admitted to the facility with diagnoses including but not limited to, Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems) and need for assistance with personal care, dated 10/23/24. An admission Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident was cognitively intact and required assistance from the staff for activities of daily living (ADL) care. A care plan, dated 10/24/24, indicated the resident required assistance and monitoring for a.m. and p.m., care. Interventions included but were not limited to, a.m. and p.m. care tasks included bathing, dressing, hair combing, and oral care. On 1/9/2025 at 12:51 p.m., the DNS provided a document, titled, "AM Care," dated, and indicated it was the policy currently being used by the facility. The policy indicated, "...8. Shave resident, if needed or requested ...."		manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.	

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F 0689 SS=D Bldg. 00	3.1-38(a)(3) 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure that 1of 1 residents observed for transfers and reviewed for accidents had adequate assistance devices and interventions in place to prevent potential for accidents (Resident 8). Findings include: On 1/7/25 at 1:00 p.m., observed Certified Nurse Aide (CNA) 16 transfer Resident (8) from bed to chair. CNA failed to apply a gait belt, nor shoes or non-skid socks prior to assisting to transfer from the bed to a chair next to the resident's bed. The CNA assisted the resident by lifting under the resident's left arm, stood and transferred the resident to the chair. The resident required extensive assistance to transfer and was unsteady when standing. On 1/7/25 at 1:07 p.m., during an interview, CNA 16 indicated the resident refused to wear shoes or socks and indicated sometimes she used a gait belt to transfer a resident. On 1/7/25 at 1:10 p.m., during an interview, Resident 8 indicated the staff always made her wear her shoes when transferring her. She could not recall if the CNA had offered to apply shoes or non-skid socks. On 1/9/24 at 11:40 a.m., during an interview, CNA 14 indicated she placed shoes and or non-skid socks on residents before assisting to transfer.	F 0689	Shoes or nonskid socks for resident 8 were initiated. Staff were also instructed to use a gait belt when transferring resident 8. All residents in need of assistance while transferring have the potential to be affected by the alleged deficient practice. DNS/Designee will complete a facility-wide audit to ensure all fall interventions are in place per order and resident profile. Corrective Action will be taken as needed. All nursing staff will be in-service by SDC/Designee on Gait Belt use and validating fall interventions on or before 2/11/25. All Nursing staff will be in-serviced by SDC/Designee on Gait Belt use and validating fall interventions by 02/11/2025 Care companions/Designee will round to ensure fall interventions are in place. Any concerns noted may be addressed during morning meeting. DNS/Designee will round randomly and random shifts and days to ensure gait belt utilization. POC/QAPI Tool will be utilized weekly x 4 weeks, then monthly x 5 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement	02/11/2025

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	On 1/9/25 at 1:00 p.m., the medical record of Resident 8 was reviewed. The resident was admitted with diagnoses including but not limited to vascular dementia, unspecified severity, (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), chronic congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and hypertension (high blood pressure). The record indicated the resident had multiple falls since admission and was identified as high fall risk. An annual Minimum Data Set (MDS) assessment, dated 11/5/24, indicated the resident was cognitively intact and required staff assistance with transfers. A care plan, dated 1/30/24, indicated Resident was a high fall risk for falls per a Johns Hopkins score of 25 points due to: age, one or more falls in the last 6 months, incontinence, on 2 or more high fall risk drugs, unsteady gait, impulsive, lack of understanding of one's physical and cognitive limitations, and requires assist/supervision with mobility/transfers or ambulation. Interventions included but were not limited to, shoes to be placed next to bed and non-skid footwear, dated 12/16/2024. On 1/9/2025 at 12:51 p.m., the Director of Nursing Services (DNS) provided a document, titled, "Transfer to Wheelchair," dated 9/2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...9. put non-skid footwear on resident and securely fasten		committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	...11. Place gait belt around resident's waist. 12. Grab belt securely on both sides. 13. With legs on the outside of the resident's legs, brace resident's lower legs to prevent slipping. 14. Instruct resident on count of three to slowly rise and stand ...." 3.1-45(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 1 of 3 residents (Resident 172) observed during the medication pass when 2 medication errors were observed during 29 opportunities for error in medication administration resulting in a medication error rate of 6.9%. Findings include: On 1/10/25 at 8:51 a.m., during an observation of the medication pass, Licensed Practical Nurse (LPN) 17 was observed to prepare medications for Resident 172. The LPN was observed administering Timolol 5% eye drops (a medication used to treat the pressure within the eye caused by glaucoma) one drop into each eye of Resident 172. At 8:52 a.m., the LPN administered Dorzolamide HCL 2% (a medication used to treat the pressure within the eye caused by glaucoma) one drop into each eye. The LPN failed to wait a specific time period between administering the eye drops.	F 0759	Resident 172 had no negative outcome from this alleged deficient practice Resident 172 no longer resides at Springhill Village All residents have the potential to be affected by the alleged deficient practice. 100% Licensed nursing staff will be re-educated by DNS/designee related to eye drop medication administration policy on or before 2/11/25. 100% Licensed nursing staff will be re-educated by DNS/designee related to eye drop medication administration policy on or before 2/11/25. DNS/Designee will do random audits on varying med times to include eye drop administration ensuring compliance to policy. To ensure compliance the DNS/Designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse	02/11/2025

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	On 1/10/25 at 8:55 a.m., during interview LPN 17 indicated she would normally wait five minutes between eye drops but the physician order did not indicate to wait between drops. On 1/10/25 at 9:05 a.m., the medical record of Resident 172 was reviewed. The resident was admitted with diagnosis of Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve.) Physician orders included but not limited to, Timolol 5% eye drops administer one drop into each eye two times daily for diagnosis of glaucoma. Dorzolamide HCL 2% administer one drop into each eye two times daily for diagnosis of glaucoma. On 1/10/2025 at 10:41 a.m., the Director of Nursing (DNS) provided a document, titled, "Medication Administration (Medication Pass Procedure)," dated 07/2023, and indicated it was the policy currently being used by the facility. The policy indicated, "...15. Eye drops separated 3 minutes, when using multiple medications to allow proper absorption ...." 3.1-48(c)(1)		manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure the scoop used to place ice into residents drink glasses was maintained in a safe and sanitary fashion, and to ensure proper hand hygiene was used when	F 0812	No residents were effected by the alleged deficient practice Staff educated regarding safe handling of food/ice and handwashing on or before 2/11/25	02/11/2025

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	assisting residents in eating their meals for 2 of 2 dining observations. Findings include: 1. During an observation in the main dining room, on 1/7/25 at 11:59 a.m., the Activity Director was preparing a drink for a resident. She scooped ice into the glass and returned the scoop into the ice bucket. The Activity Director served the juice to a male resident. The ice scoop remained in the ice bucket until 12:12 p.m., the Marketing and Admission Director walked over to the drinks and prepared a lemonade for a resident. She scooped the ice into a glass and returned the scoop into the ice bucket. She then served the lemonade to a female resident. The ice scoop remained in the ice bucket until 12:20 p.m. During an interview, om 1/13/25 at 8:30 a.m., Registered Nurse (RN) 19 indicated staff were not to leave the ice scoop in the ice bucket. They were to return it to the empty container by the ice bucket. On 1/13/25 at 8:43 a.m., the Executive Director (ED) provided a document, dated 02/10, titled, "Passing Fresh Ice Water," and indicated it was the policy currently being used by the facility. The policy indicated, " ... 4. Replace ice scoop in proper covered container or cover it with a clean towel or plastic bag to prevent contamination ...." 2. During the initial dining observation in the west unit dining room, on 1/7/25 at 12:00 p.m., the following was observed: a. On 1/7/25 at 12:26 p.m., Qualified Medication Aide (QMA) 10 was observed assisting Resident 47 and Resident 27 with their lunch meals. The QMA failed to perform hand hygiene		by SDC/designee. All residents have the potential to be affected by this alleged deficient practice. All staff educated on safe handling ice scoop and handwashing by 2/11/25 by DNS/Designee. Meal managers will also check during their dining room duty rotations to ensure compliance with hand washing as well as ensuring ice scoop holder is utilized appropriately. Any concerns noted will be immediately corrected. To ensure compliance the DNS/Designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved an action plan will be developed	

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	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	between residents while assisting them. b. On 1/7/25 at 12:27 p.m., Certified Nursing Assistant (CNA) 11 was observed assisting Resident 221, Resident 40, and Resident 63 with their lunch meals. The CNA failed to perform hand hygiene between residents while assisting them. 3. During a follow-up dining observation, on 1/10/25 at 12:15 p.m., Certified Nursing Assistant (CNA) 12 was observed assisting Resident 27 and Resident 221 with their lunch meals. The CNA was observed touching the residents to help them with their positioning while assisting the residents to eat their meal. She was moving back-and-forth between the residents while assisting them. The CNA failed to perform hand hygiene while assisting the residents with their meals. During an interview, on 1/10/25 at 1:45 p.m., the Director of Nursing (DON) indicated the staff should always perform hand hygiene when assisting residents with their meals. If they were assisting more than one resident, hand hygiene should be done between residents. On 1/10/25 at 3:24 p.m., the DON provided a document, with a revised date of 9/2023, titled, "Nursing Skills Competency...Feeding a Resident," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure Steps: ...17. Perform hand hygiene...." 3.1-21(i)(3)			