AND PLAN (		X1) PROVIDER/SUPPLIER/CLIA	(12) 101	L TIPLE CO	ONSTRUCTION	(13) DAT	E SURVEY
ANDILAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COME	PLETED
		155767	B. WIN	G		02/2	7/2023
	ROVIDER OR SUPPLIE	P	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
					MERIDIAN RD		
SPRING	HURST HEALTH C	CAMPUS		GREE	NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	Ī	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
= 0000							
Bldg. 00							
J			F 000	00	Preparation or execution of	his	
	This visit was for a	a Recertification and State	1 000		plan of correction does not		
	Licensure Survey.	This visit included a State			constitute admission or agre	ement	
	Residential Licens				of provider of the truth of the		
					alleged or conclusions set for	orth on	
	Survey dates: Feb	ruary 20, 21, 22, 23, 24, and 27,			the Statement of Deficiencie	s. The	
	2023				Plan of Correction is prepare		
					executed solely because it is		
	Facility number: (				required by the position of F	ederal	
	Provider number:				and State Law. The Plan of		
	AIM number: 201	068810			Correction is submitted to re to the allegation of noncomp	-	
	Census Bed Type:				cited during the Annual Surv		
	SNF/NF: 26				conducted February 20 – 27	-	
	SNF: 26				2023.	,	
	Residential: 51				Please accept this Plan of		
	Total: 103				Correction as the provider's		
					credible allegation of compli	ance	
	Census Payor Type	e:			as of April 1, 2023. The prov	rider	
	Medicare: 19				respectfully requests desk re		
	Medicaid: 18				with paper compliance to be		
	Other: 15				considered in establishing th	at the	
	Total: 52				provider is in substantial		
	These deficiencies	raflect State Findings sited in			compliance.		
	accordance with 4	reflect State Findings cited in					
	accordance with 4.	10 11 10 10.2-3.1.					
	Quality review cor	npleted on February 28, 2023					
- 0582	483.10(g)(17)(18	)(i)_(y)					
SS=D		re Coverage/Liability Notice					
Bldg. 00	§483.10(g)(17) T						
		edicaid-eligible resident, in					
		e of admission to the					
	-	nd when the resident					
	becomes eligible						
	(A) The items and	d services that are included					

# LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Marshall Hopkins Executive Director 03/17/2023

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. PRINTED:

05/08/2023

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/27/2023	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP CO MERIDIAN RD	D	
SPRING	HURST HEALTH (	CAMPUS		NFIELD, IN 46140		
(X4) ID PREFIX	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	plan and for which charged; (B) Those other if facility offers and be charged, and those services; a (ii) Inform each M when changes a services specifie (B) of this section §483.10(g)(18) T resident before, of and periodically of services availabl charges for those charges for servit Medicare/ Medic diem rate. (i) Where change items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (ii) Where change other items and service and/or by the Met must provide not change as soon (iii) If a resident of the facility must n resident represent applicable, any of paid, less the facility applicable, any of paid, less the facility applicable above	Medicaid-eligible resident re made to the items and d in §483.10(g)(17)(i)(A) and h. The facility must inform each for at the time of admission, during the resident's stay, of e in the facility and of e services, including any ces not covered under aid or by the facility's per es in coverage are made to es covered by Medicare edicaid State plan, the facility ice to residents of the as is reasonably possible. es are made to charges for services that the facility r must inform the resident in D days prior to				

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767		VILDING	onstruction <u>00</u>	(X3) DATE COMPL <b>02/27</b> /	ETED
	PROVIDER OR SUPPLIE HURST HEALTH C			628 N	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	resident represent due the resident v resident's date of (v) The terms of a on behalf of an in to the facility mus	ust refund to the resident or tative any and all refunds within 30 days from the discharge from the facility. an admission contract by or dividual seeking admission t not conflict with the					
	requirements of the	nese regulations.	F 05	00	F582 – Medicaid/Medicare		04/01/2023
	failed to provide Rd of Medicare Non-C calendar days prior Part A services for reviewed. Findings include: The clinical record on 2/23/2023 at 1:1 Medicare Part A se last covered day of A NOMNC with a	and record review, the facility esident 207 with a Notification Coverage (NOMNC) at least two to discharge from Medicare 1 of 3 beneficiary notices for Resident 207 was reviewed 5 p.m. Resident 207 started revices on 11/29/2022 and the Part A services was 1/3/2023. last covered day of Medicare s dated for 1/3/2023 and was 207 on 1/3/2023.		.02	Coverage/Liability Notice "Facility failed to provide Resi 207 with a Notification of Med Non-Coverage (NOMNC) at le two calendar days prior to discharge from Medicare Part services for 1 of 3 beneficiary notices reviewed." 1: What corrective action(s) be accomplished for those residents found to have affected by the deficient practice? - Residents 207 was affected by the alleged deficient practice with no adverse effect noted. - Residents was given	licare east A will	
	2/24/2023 at 3:57 p unable to provide a aware of Medicare discontinued prior unable to explain w the NOMNC soone	the Executive Director on o.m., indicated the facility was a notice that Resident 207 was Part A services to be to the NOMNC and he was why Resident 207 was not given er. NOMNC Completion SOP			<ul> <li>2: How other residents havi the potential to be affected by the same deficient practice w be identified and what corrective action will be take - All Medicaid/Medicare covered residents have the</li> </ul>	y will	
	[Standard Operatin by the Clinical Sup The policy indicate	g Procedure]", was provided port on 2/24/2023 at 11:05 a.m. ed, "For residents being nuation of their Medicare			<ul> <li>potential to be affected by the alleged deficient practice.</li> <li>Social Services was educated on presenting the</li> </ul>		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QYO711 Facility ID: 005954

If continuation sheet Page 3 of 56

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVI	FV
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	51
AND FLAN	OF CORRECTION	155767	B. WING	00	02/27/2023	
		100101			02/21/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
SPRING	HURST HEALTH (	JAMPUS	GREEN	NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	1PLET
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	coverage, the NO	ANC is requested to be issues 2		NOMNC to appropriate reside	ents	
	calendar days prio	r to the actual discharge from		at least 2 calendar days befor	e	
	Medicare"			coverage termination.		
				- All inhouse residents		
	3.1-12(a)(15)			currently receiving		
				Medicare/Medicaid coverage	were	
				audited on 3.10.2023 by the		
				Social Services/designee for		
				NOMNC timeliness. No resid	ents	
				qualified for documentation		
				change.		
				Education provided:		
				o Form Instructions for the		
				Notice of Medicare Non-Cove	rade	
				(NOMNC) CMS-10123	lage	
				3: What measures will be pu	+	
				into place or what systemic		
				changes will be made to		
				ensure that the deficient		
				practice does not recur?		
				- Social Services/design	ee	
				will ensure weekly accuracy		
				review of all residents NOMN	c I	
				through the program monitori		
				tool to ensure that any reside	-	
				appropriate for NOMNC issua		
				does so at least 2 days prior t		
				services ending and for prope		
				monitoring weekly for 4 weeks		
				biweekly for 8 weeks, and	5,	
				monitored monthly in QAPI fo	r 6	
				months.		
				4: How the corrective action		
				will be monitored to ensure		
				deficient practice will not re-	cur	
				i.e., what quality assurance		
				program will be put into place		
				- DHS/Social Services v	vill	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction 00	COMI	E SURVEY PLETED
		155767	B. WING		- 02/2	7/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	DD	
SPRING	HURST HEALTH C	CAMPUS		MERIDIAN RD NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	FROFRIATE	DATE
- 0625 SS=D Bidg. 00	483.15(d)(1)(2) Notice of Bed Ho §483.15(d) Notice return- §483.15(d) Notice return- §483.15(d)(1) No nursing facility tra hospital or the re- leave, the nursing information to the representative that (i) The duration of any, during which return and resum facility; (ii) The reserve b state plan, under any; (iii) The nursing fa bed-hold periods with paragraph (e permitting a reside	Id Policy Before/Upon Trnsfr e of bed-hold policy and tice before transfer. Before a ansfers a resident to a sident goes on therapeutic g facility must provide written e resident or resident at specifies- f the state bed-hold policy, if n the resident is permitted to e residence in the nursing ed payment policy in the § 447.40 of this chapter, if acility's policies regarding , which must be consistent e)(1) of this section, lent to return; and on specified in paragraph (e)		be responsible for the N issuance program, mon compliance of the week procedure for 6 months results of these audits w reviewed by the QA con overseen by the Execut Director. If a threshold of not achieved, an action be developed. The fac the QAPI program, will u update, and make chan POC as needed for sus substantial compliance than 6 months.	itoring ly . The vill be nmittee ive of 100% is plan will ility through review, ges to the taining	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767		VILDING	ONSTRUCTION 00	(X3) DATE COMPI <b>02/27</b>	LETED
	PROVIDER OR SUPPLIE			628 N	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	At the time of trar hospitalization or facility must provi resident represen specifies the dura described in para Based on record re failed to provide w of 2 residents revie (Resident 15) Findings include: Resident 15's recon 1:23 p.m. The reconding diagnoses that incl liver disease, type infection, heart fail depression. A Quarterly Minin assessment, dated was cognitively int Progress notes, dat indicated Resident hospital. Census documenta sent to the hospital 12/30/22. There was no docut that indicated a beat the resident or fam hospital.	d-hold notice upon transfer. Insfer of a resident for therapeutic leave, a nursing ide to the resident and the native written notice which ation of the bed-hold policy lograph (d)(1) of this section. Inview and interview, the facility written bed hold information for 1 ewed for hospitalization. The weak for hospitalization. The weak reviewed on 2/22/23 at ord indicated Resident 15 had uded, but were not limited to, 2 diabetes mellitus, urinary tract lure, heart disease, anxiety and num Data Set (MDS) 1/4/2023, indicated Resident 15 fact. The detailed the resident was 15 was transported to a local tion indicated the resident was 10 n12/26/22 and returned on mentation in the clinical record d hold notice was provided to ily upon discharge to the w, on 2/24/23 at 2:45 p.m., the	FO	525	<ul> <li>F625 – Notice of Bed Hold Policy Before/Upon Trnsfr "The facility failed to provide written bed hold information for of 2 residents reviewed for hospitalization. (Resident 15)."</li> <li>1: What corrective action(s) v be accomplished for those residents found to have affected by the deficient practice?</li> <li>Residents 15 was affect by the alleged deficient practic with no adverse effects noted.</li> <li>2: How other residents having the potential to be affected by the same deficient practice w be identified and what corrective action will be taken - One of two residents were affected by the alleged deficient practice.</li> <li>IDT and nursing staff war reeducated on the Bed Hold pot and procedure.</li> <li>All discharges within the past 30 days were audited for hold notification. No residents required bed hold notification. Education provided: o Bed Hold Policy</li> </ul>	, vill ted e vg y rill n. ere plicy e bed	04/01/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QYO711 Facility ID: 005954

If continuation sheet Page 6 of 56

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	COMI	<ul> <li>X3) DATE SURVEY</li> <li>COMPLETED</li> <li>02/27/2023</li> </ul>	
	PROVIDER OR SUPPLIE		628 N	T ADDRESS, CITY, STATE, ZIP COD			
SPRING	HURST HEALTH (	CAMPUS	GREE	ENFIELD, IN 46140			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	DN	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
		Services indicated she could					
	not find any docur	nentation that a bed hold notice		3: What measures will be	put		
	had been issued.			into place or what system	ic		
				changes will be made to			
		Hold Notification" was		ensure that the deficient			
		irector of Health Services on		practice does not recur?			
		n. The policy included, but was		- DHS/designee will e			
		verview: Residents and		monitoring of all discharged			
	_	es have a right to be notified		residents through the clinic			
	-	iting on reserve bed payment		meeting to ensure discharg			
		e plan when someone goes out		residents have appropriate			
	_	on a therapeutic leave. Before a		hold documentation weekly			
		nsfers a resident to a hospital or		weeks, biweekly for 8 week			
	-	on a therapeutic leave, the		monitored monthly in QAPI	for 6		
		ast provide written information		months.			
		esident representative that		4. 11			
	-	ion of the state bed hold policy,		4: How the corrective acti			
		ch the resident is permitted to residence in the nursing		will be monitored to ensu			
		e bed payment policy in the		deficient practice will not			
		he nursing facility's policies		i.e., what quality assurance program will be put into p			
		d periods permitting a resident		- DHS/Designee will b			
	0 0	me of transfer of a resident for		responsible for the for ongo			
		therapeutic leave, a nursing		compliance and monitoring	-		
	-	de to the resident and the		months. The results of thes			
		ative written notice which		audits will be reviewed by t			
	-	ion of the bed hold policy"		committee overseen by the			
		* 2		Executive Director. If a three			
				of 100% is not achieved, a			
	3.1-12(a)(6)(A)			plan will be developed. Th			
				facility through the QAPI pr			
				will review, update, and ma	-		
				changes to the POC as need	eded for		
				sustaining substantial com	oliance		
				for no less than 6 months.			

Event ID: QYO711 Facility ID: 005954

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If continuation sheet

	R MEDICARE & MEDI		1		<b>I</b>	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	~ <i>^</i>	E CONSTRUCTION	· /	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	3 <u>00</u>		LETED
		155767	B. WING		_ 02/27	7/2023
			STRE	ET ADDRESS, CITY, STATE, ZIP C	OD	
NAME OF	PROVIDER OR SUPPLIE	2R	628	N MERIDIAN RD		
SPRING	HURST HEALTH (	CAMPUS	GRE	EENFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE A		COMPLETION
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
F 0657	483.21(b)(2)(i)-(ii	i)				
SS=D	Care Plan Timing	g and Revision				
Bldg. 00	§483.21(b) Com	orehensive Care Plans				
	§483.21(b)(2) A	comprehensive care plan				
	must be-					
	(i) Developed wit	hin 7 days after completion				
		nsive assessment.				
		an interdisciplinary team, that				
	includes but is no					
	(A) The attending					
		nurse with responsibility for				
	the resident.					
		with responsibility for the				
	resident.					
		food and nutrition services				
		lood and nutrition services				
	staff.	ana stie shield the				
	(E) To the extent	-				
		ne resident and the resident's				
		. An explanation must be				
		dent's medical record if the				
		e resident and their resident				
		determined not practicable				
	for the developm	ent of the resident's care				
	plan.					
		riate staff or professionals in				
		termined by the resident's				
		ested by the resident.				
	(iii)Reviewed and	l revised by the				
	interdisciplinary t	eam after each assessment,				
	including both the	e comprehensive and				
	quarterly review	assessments.				
	Based on interview	v and record review the facility	F 0657	F657 – Care Plan Timi	ng and	04/01/202
	failed to complete	a care plan meeting for 1 of 1		Revision		
	_	l for care plan meetings		"Facility failed to compl	lete a care	
	(Resident 43).			plan meeting for 1 of 1 reviewed for care plan	resident's	
	Finding include:			(Resident 43)." 1: What corrective act	-	
	During an intervie	w with Resident 43 on 2/20/23 at		be accomplished for t		
	-	ed he had not had care plan		residents found to have		
	1 2.07 P.m., mulcale	a ne nau not nau care pian				1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	JLTIPLE CO ILDING	ONSTRUCTION	` <i>`</i>	E SURVEY LETED
IND PLAN	OF CORRECTION	155767	A. BU B. WI		00		7/2023
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD	_	
SPRING	HURST HEALTH (	CAMPUS			NFIELD, IN 46140		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION	_	TAG			DATE
	-	facility talked to him about his			affected by the deficient		
	goals and needs.				practice?		
	D Cd	1 (D 1 42 2/22/22 4			- Residents 43 was affe		
		ord of Resident 43 on 2/23/23 at			by the alleged deficient pract	ice.	
		ted the resident's diagnoses not limited to, severe sepsis			Meeting was immediately	milu	
		acute kidney failure, pulmonary			scheduled as per resident/fail availability.	illy	
	-	a disease, hypertension, type					
		tus, low back pain, right and left			2: How other residents hav	ina	
		prostate cancer, chronic pain,			the potential to be affected	-	
		weakness and urinary retention.			the same deficient practice	-	
	msomma, musere	weakiess and armary recention.			be identified and what	WIII	
	The Annual Minin	num Data Set (MDS)			corrective action will be tak	en	
		sident 43, dated 11/11/22,			- All residents have the	-	
		ent was cognitively intact for			potential to be affected by the		
	daily decision mak			alleged deficient practice.	-		
		c			- Social Service		
	During an intervie	w with the Director Of Health			Representative was reeduca	ted on	
	Services (DHS) or	n 2/23/23 at 11:55 a.m., indicated			the Resident Care Plan Mee		
	Resident 43 had no	ot had a care plan meeting since			(Resident First Meetings).	•	
	April 2022. The D	HS indicated she was unsure			- All inhouse residents		
	how the resident's	care plan meeting got missed			audited on 3.10.2023 by SSF	R for	
	and the standard o	f the facility was resident's			appropriate and timely care p	olan	
	were suppose to ha	ave a care plan meeting			meetings. Further care plan		
	quarterly.				meetings were scheduled if		
					qualified.		
		neeting guidelines provided by			Education provided:		
	* *	n 2/23/23 at 1:30 p.m., indicated			o Resident First Meeting		
	· ·	facilitate communication and			Guidelines		
		ding the resident's plan of care,					
		and care needs between the			3: What measures will be pr		
	-	esident representative and care			into place or what systemic		
		rst meetings should be nimum of quarterly.			changes will be made to		
		minum of quarterry.			ensure that the deficient practice does not recur?		
					- DHS/SSR/designee w	/ill	
	3.1-35(C)(2)(B)				ensure weekly monitoring du		
	J.1-JJ(C)(Z)(D)				clinical care meeting (CCM)	-	
					ensure that any residents wh		
					needs a care plan meeting is		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		628 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD		
SPRING	HURST HEALTH C	AMPUS	GREE	NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				<ul> <li>scheduled to do so, weekly for weeks, biweekly for 8 weeks, a monitored monthly in QAPI for months, refusals are being documented when applicable.</li> <li>4: How the corrective action</li> </ul>	and 6	
				will be monitored to ensure to deficient practice will not reco- i.e., what quality assurance program will be put into place - DHS/SSR/designee will responsible for the for ongoing compliance and monitoring for months. The results of these audits will be reviewed by the committee overseen by the Executive Director. If a thresho of 100% is not achieved, an ac plan will be developed. The facility through the QAPI progr will review, update, and make changes to the POC as needed sustaining substantial complia for no less than 6 months.	e? I be G G QA Dd ction ram, d for	
<sup>=</sup> 0677 SS=D Bldg. 00	§483.24(a)(2) A r carry out activitie necessary servic nutrition, groomir hygiene;	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good ig, and personal and oral				
	review the facility scheduled for depe	on, interview and record failed to provide showers as ndent residents for 2 of 2 ities Of Daily Living (ADL) ( esident 9).	F 0677	F677 – ADL Care Provided for Dependent Residents "Facility failed to provide show as scheduled for dependent residents for 2 of 2 reviewed for Activities of Daily Living (ADL) (Resident 30 and Resident 9).	ers pr	

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULT A. BUILD B. WING	ple construction ing <u>00</u>	СОМ	(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		6	TREET ADDRESS, CITY, STATE, ZIP CO 28 N MERIDIAN RD REENFIELD, IN 46140	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D PROVIDER'S PLAN OF CORF FIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE	
IAG	<ol> <li>During an inter 2/20/23 at 11:46 a. was not receiving t was suppose to. Th wipes to clean hers resident indicated a washed for seven of During an intervier 1:58 p.m., the resid home she took at heresident indicated was able to give here burden on the staff Monday.</li> <li>Review of the record 2:10 p.m., indicated included, but were heart disease, occh vascular disease, c disease, lack of coo in right knee, must osteoporosis and le The profile care gu 1/19/23, indicated shower two times a Thursday.</li> <li>The Admission Mi assessment for Resi indicated the resid- daily decision mak extensive assistant The resident was to for bathing. It was</li> </ol>	view with Resident 30 on m., the resident indicated she two showers a week like she he resident indicated she used self the best she could. The she had not had her hair lays. w with Resident 30 on 2/23/23 at dent indicated when she was east three showers a week. The she would be glad when she erself a shower so she wasn't a C. I did get a shower on ord of Resident 30 on 2/23/23 at d the resident's diagnoses not limited to, hypertensive usion of arteries, peripheral hronic obstructive pulmonary ordination, unspecified fall, pain cle weakness, age related		1: What corrective act be accomplished for the residents found to have affected by the deficient practice? <ul> <li>Resident 30 and was affected by the deficient practice.</li> <li>Residents were immediately approaches shower. Refusals docu- applicable.</li> </ul> 2: How other resident the potential to be affected the same deficient practice of the same deficient practice alleged deficient practice alleged deficient practice alleged deficient practice assessed for appropria and documentation of sepreference. <ul> <li>Nursing staff war reeducated on assessing implementation of show including but not limited resident shower prefere Additional education war for documentation practice additional education war for documentation practice and for documentation practice <ul> <li>Guidelines for Bathin Preference</li> <li>Standard documentation practices r/t refusals of</li> </ul></li></ul>	hose ve int I resident 9 eged ed for a imented as is having ected by ictice will by the ce. re te orders shower is nents and vers, I to, the ence. as provider tices and ent ing ation	DATE	

Event ID: QYO711 Facility ID: 005954

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION (X3 00	) DATE SURVEY COMPLETED
		155767	B. WING		02/27/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD	
SPRING	GHURST HEALTH C	CAMPUS		NFIELD, IN 46140	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		wers/bathing for Resident 30		3: What measures will be put	
		t 37 days the resident had		into place or what systemic	
	received 4 showers	5.		changes will be made to	
				ensure that the deficient	
	,	rvation on 2/21/23 at 11:02 a.m.,		practice does not recur?	
		ing in her wheelchair. The		- DHS/designee will ensure	
		greasy and dirty. The		random weekly monitoring to	
	resident's fingernal	ils were long and jagged.		ensure that residents are receiving	1g
	During on chaoryou	tion on 2/23/23 at 11:10 a.m.,		their bathing preference, or	
	-	ting in her wheelchair in the		documentation of refusal of bathing, twice a week for 4 week	
		resident's hair was greasy and		weekly for 8 weeks, and	5,
	-	's fingernails were long and		bi-monthly for 2 months and	
	jagged.	s migemans were long and		monitored monthly in QAPI for 6	
	Jugged.			months.	
	Review of the reco	ord of Resident 9 on 2/22/23 at			
	11:56 a.m., indicat	ed the resident's diagnoses		4: How the corrective action	
		not limited to, dementia,		will be monitored to ensure the	
		y, difficulty walking, abnormal		deficient practice will not recur	
	posture, repeated f	alls, lack of coordination,		i.e., what quality assurance	
	muscle weakness a	and chronic pain.		program will be put into place?	
				- DHS/designee will be	
	· ·	iimum Data Set (MDS)		responsible for the for ongoing	
	assessment for Res	sident 9, dated 11/17/22,		compliance and monitoring for 6	
		ent was severely cognitively		months. The results of these	
		decision making. The resident		audits will be reviewed by the QA	<b>N</b>
		of rejecting care. The resident		committee overseen by the	
		of physical aggression or verbal		Executive Director. If a threshold	
		sident required extensive		of 100% is not achieved, an action	n
		beople for personal hygiene and		plan will be developed. The	
	total dependent for	oaunng.		facility through the QAPI program	1,
	The profile care ~	iide for Resident 9, dated		will review, update, and make	or
		the resident was to receive a		changes to the POC as needed f sustaining substantial compliance	
	shower twice a we			for no less than 6 months.	-
	Review of the show	wer/bathing for Resident 9,			
	dated 11/22/23 to 2	2/22/23, the resident received			
	two showers and two	wo complete bed baths in the			
	past three months.				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155767	A. BUILDING <u>00</u> B. WING		02/27/2023	
	PROVIDER OR SUPPLIE		628 N M	ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O During an intervie Services (DHS) or it was the responsi residents with thei refuses then the pr later time and if th the CNA was to re nurse would attem shower. The bathing policy	<sup>7</sup> STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> w with the Director Of Health 2/23/23 at 11:50 a.m., indicated bility of the CNA to provide r showers/baths, if the resident otocol was to reproach at a e resident continues to refuse port it to the nurse and the pt to provide the resident with a	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE	
<sup>=</sup> 0684 SS=D Bldg. 00	applies to all treat facility residents. comprehensive a facility must ensu- treatment and ca professional stan comprehensive p and the residents Based on observat review the facility with a hospice pro care related to labo changes, wound as Dietitian (RD) reco reviewed for hospi residents reviewed	a fundamental principle that tment and care provided to Based on the ssessment of a resident, the tre that residents receive re in accordance with dards of practice, the erson-centered care plan,	F 0684	<b>F684 – Quality of Care</b> <i>"Facility failed to ensure</i> <i>collaboration with a hospice</i> <i>provider regarding coordinatior</i> <i>care related to laboratory work</i> , <i>medication form changes, wou</i> <i>assessments, and Registered</i> <i>Dietitian (RD) recommendation</i> <i>for 1 of 1 resident reviewed for</i> <i>hospice services (Resident 17)</i>	nd Is	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	î î	ILDING	DNSTRUCTION 00	COMP	DATE SURVEY OMPLETED <b>2/27/2023</b>	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD			
SPRING	HURST HEALTH (	CAMPUS	GREENFIE		NFIELD, IN 46140			
X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	(Resident 26). The	e facility also failed to ensure a			of 5 residents reviewed for			
	device was in plac	e, per physician orders, in			pressure ulcers (Resident 22)	, and		
	regard to limited ra	ange of motion (ROM) for 1 of 1			1 of 1 resident reviewed for			
	resident reviewed	for impaired mobility (Resident			nutrition (Resident 26). The fa	cility		
	22).				also failed to ensure a device	was		
					in place, per physician orders	,		
	Findings include:				regarding limited range of mo			
	-				(ROM) for 1 of 1 resident revie			
	1a. The clinical re	cord for Resident 17 was			for impaired mobility (Residen			
	reviewed on 2/24/2	23 at 11:26 a.m. The diagnoses			22)."			
		e not limited to, Alzheimer's			1: What corrective action(s)	will		
		anxiety disorder, chronic			be accomplished for those			
		d unspecified convulsions.			residents found to have			
	5	1			affected by the deficient			
	A safety care plan			practice?				
		t risk for seizures related to			- Residents 17, 22, and	26		
		cified convulsions. The			was affected by the alleged	20		
		ed to do any laboratory work per			deficient practice.			
		nd give medication per			- Hospice was immediat	elv		
	physician orders.				contacted for collaboration	ory		
	F,				regarding Resident 22 pressu	re		
	A fall care plan, re	evised 2/17/23, indicated			ulcers, Resident 26 nutrition, a			
	-	t risk for falls due to history of			resident 17 for laboratory work			
		reased mobility, increased			and medication changes would			
		istance needed with activities			assessments and RD			
	of daily living.				recommendations.			
	or anny mong.				- ROM device was			
	A physician order	, dated 3/18/22, was noted for			immediately retrieved for Resi	ident		
		re medication/anticonvulsant			22 and implemented.	GOIL		
	medication)							
					2: How other residents havi	na		
	A fall event dated	2/1/23, indicated Resident 17			the potential to be affected b	-		
		broda chair and appeared			the same deficient practice v	-		
	-	17 slid assisted from the broda			be identified and what			
		use was listed as Resident 17			corrective action will be take	'n		
		f being cold and shivering. The			- All residents receiving	,		
		o offer a blanket when up in			hospice services or ROM dev	ices		
		e to reported seizure-like			have the potential to be affect			
		y was to inquire with hospice			by the alleged deficient practic			
		Keppra level to ensure			- IDT was reeducated or			
	about obtaining a	Keppra level to ensure			<ul> <li>IDT was reeducated or</li> </ul>	า		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION C	X3) DATE SURVEY COMPLETED
IND PLAN	OF CORRECTION	155767	B. WING	00	02/27/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD	
SPRING	HURST HEALTH C	CAMPUS	GREE		
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	therapeutic level.			Hospice services communication	on
	There was no prov	ious physician order for		with concentration on, but not	ior.
	-	a Keppra level for Resident 17 in		limited to, assessing residents f	or
	the clinical record.			medication appropriateness,	
	the chinear record.			wound measurements, ROM	
	1h A prograss not	e, dated 2/15/23, indicated the		devices, RD recommendations, adhering to orders by the	
		pice in to see residentalso		physician, and laboratory work.	
	-	ssed to change resident to		- All inhouse residents	
		cations]; resident does not take		currently receiving Hospice	
		and tends to spit or not take		services were audited on	
		re crushed; per hospice nurse		3.10.2023 by the DHS/designed	-
	-	edical Director] review		Residents receiving Hospice	J.
	-	ee about changing meds to		services were discussed with	
		lent taking liquids better than		Hospice representative.	
	-	rse will call and discuss with		Education provided:	
	-	in earlier and this nurse had		o Hospice Communication.	
		er as well; daughter stated		o Following physician orders for	or
		vould be fine with her"""		ROM devices.	
	There was no follo	w up in the clinical record in		3: What measures will be put	
	regard to changing	Resident 17's medications from		into place or what systemic	
	pills/capsules to lie	quid.		changes will be made to	
				ensure that the deficient	
		t for Resident 17, dated 2/14/23		practice does not recur?	
		cated orders for medications by		- DHS/designee will ensur	re
		ot liquid. These medications		weekly monitoring for Hospice	
		sodium capsule, Keppra tablet,		communication adherence for	
	-	sule (antibiotic), buspirone		residents including, but not limit	ted
	· ·	dication), hydroxyzine tablet		to, wound assessments,	
		etaminophen capsule, and		medication reviews, RD	
	Ativan (anxiety mo	edication) tablet.		recommendations, ROM device and laboratory work. Proper	es
	An interview cond	ucted with the Director of		monitoring will occur weekly for	4
		DHS), on 2/24/23 at 12:18 p.m.,		weeks, biweekly for 8 weeks, a	
		ty requested another Keppra		monitored monthly in QAPI for 6	
		s one taken, in 2022, was within		months.	-
	-	DHS had made a call out to			
		g to hear back from one of the		4: How the corrective action	
	-	ut the request for a Keppra	1	will be monitored to ensure th	

Event ID: QYO711 Facility ID: 005954

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	СОМ	e survey pleted <b>7/2023</b>
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, Z 628 N MERIDIAN RD GREENFIELD, IN 46140		COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETIC DATE
	level. She also reading in the second state of	ched out about the request for The floor nurse was supposed and obtain an order for the ell as a request for the liquid cord for Resident 22 was 23 at 11:23 a.m. The diagnoses in not limited to, dementia, t hand, dysphagia, and pain. gement Detail Report, dated that Resident 22 had a pressure ig toe that was identified on coccyx that was identified on seessments were conducted, per gement Detail Report, but there ap with a delay in obtaining essments from 12/27/22 to lucted with the DHS, on 2/24/23 ated she had reached out to about the weekly wound the weeks that appear to be Wound Management Detail Assistant Director of Health being ill during that time period. der, dated 10/14/22, indicated utilize a carrot in right hand at or hygiene or if causing s tolerated.		deficient practice will i.e., what quality assu program will be put in - DHS/designee responsible for the for compliance and monit months. The results of audits will be reviewed committee overseen b Executive Director. If a of 100% is not achieve plan will be developed facility through the QA will review, update, an changes to the POC a sustaining substantial for no less than 6 mon	urance nto place? will be ongoing oring for 6 f these d by the QA y the a threshold ed, an action l. The PI program, d make as needed for compliance	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155767 B. WING 02/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE The following observations were conducted to where Resident 22 did not have a carrot or device to her right hand: 2/22/23 at 11:06 a.m., 2/22/23 at 11:36 a.m., 2/22/23 at 2:30 p.m., & 2/22/23 at 3:36 p.m. An interview conducted with the DHS, on 2/24/23at 12:40 p.m., indicated the expectations are for staff to following physician orders and the residents care plans as written. 3. The clinical record for Resident 26 was reviewed on 2/22/23 at 12:44 p.m. The diagnoses included, but were not limited to, history of COVID-19, history of pneumonia, congestive heart failure (CHF), dysphagia, anemia, and cerebrovascular disease. A care plan for nutritional status, revised 2/18/23, indicated Resident 26 was malnourished and/or at risk for malnutrition related to diagnoses, inadequate nutrient/energy intakes, and/or metabolic demands. The approach was to have the Dietitian to re-evaluate as indicated and provide diet, supplements, medications, and adaptive equipment as ordered. A Registered Dietitian (RD) note, dated 2/21/23 at 3:26 p.m., indicated the following, "...Noted COVID+ [positive] on 2/6/23 with decline. Noted significant weight loss since 2/6/23 with poor meal intake. Noted new impairments to coccyx and bilateral buttocks on 2/20/23. Dxs [diagnoses]: CHF, CKD 3 [chronic kidney disease; stage 3], dysphagia, lymphedema. Noted recent weight history: 2/21/23: 165.8 lbs, 2/20/23: 167.2 lbs, Event ID: QY0711 Facility ID: 005954 Page 17 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/27/2023 155767 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2/19/23: 169.2 lbs, 2/18/23: 170.2 lbs, 2/6/23: 182.2 lbs, 2/1/23: 186 lbs, IBW: 136 lbs, BMI: 26.76. Weighed daily per order. Continues Lasix 40 mg qday [daily] with no changes since 1/4/23. Receiving regular diet with food preferences honored as requested. Ordered protein drink qday and ProStat AWC Sugar Free TID [three times a day]. Will recommend d/c [discontinue] protein drink and giving Ensure supplement TID between meals and fortified shakes at meals. Will recommend MVI [multivitamin] with minerals 1 po[by mouth] qday[every day] to aid in skin integrity. Careplan initiated [sic] .... " As of 2/24/23 at 11:11 a.m., there were no physician order for an Ensure supplement in Resident 26's clinical record. An interview conducted with the DHS, on 2/24/23 at 2:40 p.m., indicated she was going to follow up with hospice in regard to the RD recommendation. A policy titled "Guidelines for Weight Tracking", revised 1/16/21, was provided by Clinical Support on 2/24/23 at 2:57 p.m. The policy indicated the facility dietitian or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted. It also stated residents with a significant weight change can be added to Clinically At Risk. A Hospice Services Agreement, dated 6/12/17, was provided by the DHS on 2/24/23 at 3:20 p.m. The document indicated the following, "...Plan of Care [POC]: a written individualized Plan of Care and services necessary to meet the patient-specific needs. It includes all patient care physician orders, and planned interventions for problems identified during patient assessments, to Event ID: QY0711 Facility ID: 005954 Page 18 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155767 B. WING 02/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE ensure that care and services are appropriate to the severity level of each patient and family needs...TERMS AND CONDITIONS...1.2 Plan of Care...The Plan of Care will be written in collaboration with the Hospice IDT [interdisciplinary team], the Facility Staff, the Hospice Patient or the Hospice Patient's Representative and the physician, based on the needs of the Hospice Patient. Any change in the POC will be discussed with the Hospice Patient or the Hospice Patient's representative, and the Facility representatives, and must be approved by Hospice before implementation .... " 3.1-37(a) F 0686 483.25(b)(1)(i)(ii) SS=D Treatment/Svcs to Prevent/Heal Pressure Bldg. 00 Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. F 0686 F686 - Treatment/Svcs to 04/01/2023 Based on observation, interview, and record **Prevent/Heal Pressure Ulcer** review, the facility failed to ensure weekly "Facility failed to ensure weekly measurements were conducted of pressure ulcers, measurements were conducted of provide treatment as ordered by the physician, pressure ulcers, provide treatment and ensure a resident with a history of pressure as ordered by the physician, and Page 19 of 56 Event ID: QY0711 Facility ID: 005954 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI		00	COMPL	
	of condenion	155767	B. WING		<u> </u>	02/27/	
		100101				02/21/	2020
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP COD		
	HURST HEALTH (				IERIDIAN RD FIELD, IN 46140		
SFRING		JAMPUS	6		FIELD, IN 40140		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	IĽ	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	Ξ	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
	-	n the same position for an			ensure a resident with a history	' of	
	-	f time for 2 of 5 residents			pressure ulcers didn't stay in the	е	
	reviewed for press	ure ulcers. (Resident 17 and			same position for an extended		
	Resident 22)				period of time for 2 of 5 resident	ts	
					reviewed for pressure ulcers.		
	Findings include:				(Resident 17 and Resident 22).	"	
					1: What corrective action(s) w	rill	
	1. The clinical rec	ord for Resident 17 was reviewed			be accomplished for those		
	on 2/22/23 at 10:5	0 a.m. The diagnoses included,			residents found to have		
	but were not limited	ed to, Alzheimer's disease,			affected by the deficient		
	dementia, unspeci	fied protein-calorie malnutrition,			practice?		
	anxiety disorder, a	nd unspecified convulsions.			- Residents 17 and 22 was	S	
					affected by the alleged deficient	t	
	A progress note, d	ated 2/15/23 at 3:44 p.m.,			practice.		
	indicated Resident	t 17 had an area to the left hip			- Resident 17 was		
	that appears to loo	k like an old scar. A new red			immediately repositioned.		
	blanchable area wa	as noted on her right hip.			- Resident 22 had her		
	Resident was very	thin and has multiple bony			wound treatment completed.		
	prominences noted	d. The hospice nurse was					
	present and verbal	ized to continue to change			2: How other residents having	g	
	position.				the potential to be affected by	,	
					the same deficient practice wi	ill	
	A care plan for ski	in integrity, revised 2/21/23,			be identified and what		
	indicated Resident	t 17 was at risk for pressure			corrective action will be taken	<b>.</b>	
	ulcers related to de	ecreased mobility and			- All residents with skin		
	incontinent of bow	vel and bladder. The approach			impairment have the potential to	0	
	was to conduct a s	ystematic skin inspection by			be affected by the alleged defic		
	nurse weekly, kee	p bony prominences from direct			practice.		
	contact with one a	nother, and turn and reposition			- Nursing staff was		
	frequency.				reeducated on preventative		
					measures and order sets for ski	in	
	An observation co	nducted on 2/22/23 at 11:12			conditions with concentration or	n,	
	a.m. of Resident 1	7 sitting in her broda chair with			but not limited to, repositioning		
	the head lowered w	with appearance of sleep.			and weekly documentation of		
					wound treatments.		
	An observation co	nducted on 2/22/23 at 2:35 p.m.			- All inhouse residents we	ere	
		ing in the same position in her			audited on 3.10.2023 by the		
		ppeared to be attempting to			DHS/designee. Preventative		
		de down in her broda chair.			interventions were placed where	е	
					applicable and measurements		

Event ID: QYO711 Facility ID: 005954

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	· · · · · · · · · · · · · · · · · · ·	3) DATE SURVEY COMPLETED	
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER 155767	A. BUILDING B. WING	<u>00</u>	02/27/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
SPRING	HURST HEALTH (	CAMPUS		MERIDIAN RD NFIELD, IN 46140		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		nducted on 2/22/23 at 3:35 p.m.		entered as appropriate.		
		l in the same position in her		Education provided:		
	-	yes were closed, and she		o Guidelines for General Wound	d	
	appeared to be slee	eping.		and Skin Care.		
				o Preventative skin order set		
	An interview cond	ucted with the Director of				
		DHS), on 2/24/23 at 12:40 p.m.,		3: What measures will be put		
	indicated her expe	ctations are for staff to follow		into place or what systemic		
	the plan of care an	d follow physician orders as		changes will be made to		
	written.			ensure that the deficient		
				practice does not recur?		
	2a. The clinical rec	cord for Resident 22 was		- DHS/designee will ensure	e	
	reviewed on 2/22/2	23 at 11:23 a.m. The diagnoses		weekly monitoring new		
	included, but was i	not limited to, dementia,		admissions with risk for skin		
	contracture of righ	t hand, anxiety disorder,		breakdown and implementation of	of	
	dysphagia, and mu			preventive skin interventions		
				including, but not limited to,		
	A care plan for pre	essure, dated 12/6/22, indicated		reposition, float heels, and		
		ulcer to her coccyx. The		pressure reducing mattress.		
		ssess the wound, include		Proper monitoring will occur 3		
		observation of the pressure		times a week for 4 weeks,		
		and provide treatment as		biweekly for 8 weeks, and		
	ordered.	F		bimonthly for 12 weeks. Then		
				monitored monthly in QAPI for 6		
	A physician order.	dated 1/24/23, indicated to		months.		
		th normal saline or wound				
	-	apply Medihoney to area, and		4: How the corrective action		
		ressing. Change every 5 days		will be monitored to ensure the		
		ed) for soilage. The special		deficient practice will not recur		
		e physician order was "to be		i.e., what quality assurance		
		e nurse 1 day a week and		program will be put into place?		
		ays a week". The order was		- DHS/designee will be		
	discontinued on 2/	-		responsible for the for ongoing		
				compliance and monitoring for 6		
	The electronic me	dication administration record		months. The results of these		
		ry of 2023 and February of 2023		audits will be reviewed by the QA		
		ician order for Medihoney to		committee overseen by the	`	
		yx was signed off, as		Executive Director. If a threshold		
		ne following day(s):		of 100% is not achieved, an action		
		ie ionowing day(s).				
			1	plan will be developed. The		

EACH DEFICIE CGULATORY ( 23, 1/29/23, 23. /sician order f Medihoney hange every he Wound N ent 22's coccurements fro 1/31/23. terview concurence h Services (1	CAMPUS EY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION 2/3/23, 2/8/23, 2/13/23, and r, dated 2/20/23, indicated the y to coccyx, cover with foam, y 3 days. Management Detail Report for recyx indicated there were no om the assessment on 12/27/22 educted with the Director of DHS), on 2/24/23 at 2:40 p.m.,	ì í	JILDING NG STREET A 628 N M	ONSTRUCTION         00         ADDRESS, CITY, STATE, ZIP COD         MERIDIAN RD         NFIELD, IN 46140         PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)         facility through the QAPI pro- will review, update, and mak changes to the POC as need sustaining substantial compli for no less than 6 months.	gram, e ded for	
THEALTH SUMMAR SACH DEFICIE COLLATORY ( 23, 1/29/23, 23. //sician order f Medihoney hange every he Wound N ent 22's coccurements fro 1/31/23. terview concurences (1	155767         IER         CAMPUS         XY STATEMENT OF DEFICIENCIE         ENCY MUST BE PRECEDED BY FULL         OR LSC IDENTIFYING INFORMATION         2/3/23, 2/8/23, 2/13/23, and         r, dated 2/20/23, indicated the         y to coccyx, cover with foam,         y 3 days.         Management Detail Report for         rcyx indicated there were no         om the assessment on 12/27/22         dducted with the Director of         DHS), on 2/24/23 at 2:40 p.m.,		STREET 4 628 N M GREEN ID PREFIX	ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD NFIELD, IN 46140 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY) facility through the QAPI pro- will review, update, and mak changes to the POC as need sustaining substantial compl	02/27 NATE gram, e ded for	(X5) COMPLETIO
HEALTH SUMMAR SUMMAR EACH DEFICIE GULATORY (23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 24, 1/23, 24,	CAMPUS EY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION 2/3/23, 2/8/23, 2/13/23, and r, dated 2/20/23, indicated the y to coccyx, cover with foam, y 3 days. Management Detail Report for recyx indicated there were no om the assessment on 12/27/22 educted with the Director of DHS), on 2/24/23 at 2:40 p.m.,		628 N M GREEN ID PREFIX	MERIDIAN RD NFIELD, IN 46140 PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) facility through the QAPI pro- will review, update, and mak changes to the POC as need sustaining substantial compl	gram, e ded for	COMPLETIO
HEALTH SUMMAR SUMMAR EACH DEFICIE GULATORY (23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 23, 1/29/23, 24, 1/23, 24,	CAMPUS EY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION 2/3/23, 2/8/23, 2/13/23, and r, dated 2/20/23, indicated the y to coccyx, cover with foam, y 3 days. Management Detail Report for recyx indicated there were no om the assessment on 12/27/22 educted with the Director of DHS), on 2/24/23 at 2:40 p.m.,		GREEN ID PREFIX	NFIELD, IN 46140  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  facility through the QAPI prov will review, update, and mak changes to the POC as need sustaining substantial compl	gram, e ded for	COMPLETIO
SUMMAR SACH DEFICIE GULATORY ( 23, 1/29/23, 23. 23. 23. 23. 23. 23. 23. 23. 23. 23.	AY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION 2/3/23, 2/8/23, 2/13/23, and r, dated 2/20/23, indicated the y to coccyx, cover with foam, y 3 days. Management Detail Report for recyx indicated there were no om the assessment on 12/27/22 ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) facility through the QAPI pro- will review, update, and mak changes to the POC as need sustaining substantial compl	gram, e ded for	COMPLETIO
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23, 1/29/23, 23. 23. 23. 23. 23. 23. 23. 23. 23. 23.	2/3/23, 2/8/23, 2/13/23, and r, dated 2/20/23, indicated the y to coccyx, cover with foam, y 3 days. Management Detail Report for wyx indicated there were no om the assessment on 12/27/22 iducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,		TAG	facility through the QAPI pro- will review, update, and mak changes to the POC as need sustaining substantial compl	gram, e ded for	DATE
23. /sician order f Medihoney hange every he Wound N ent 22's coco urements fro 1/31/23. terview cono h Services (1	r, dated 2/20/23, indicated the y to coccyx, cover with foam, y 3 days. Management Detail Report for cyx indicated there were no om the assessment on 12/27/22 ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,			will review, update, and mak changes to the POC as need sustaining substantial compl	e ded for	
vsician order f Medihoney hange every he Wound N ent 22's coco urements fro 1/31/23. terview cono h Services (1	y to coccyx, cover with foam, 7 3 days. Management Detail Report for reyx indicated there were no om the assessment on 12/27/22 ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,			changes to the POC as need sustaining substantial compl	ded for	
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f Medihoney hange every he Wound M ent 22's coor arements fro 1/31/23. terview cont h Services (1	y to coccyx, cover with foam, 7 3 days. Management Detail Report for reyx indicated there were no om the assessment on 12/27/22 ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,					
hange every he Wound M ent 22's coco arements fro 1/31/23. terview cono h Services (1	Anagement Detail Report for wyx indicated there were no om the assessment on 12/27/22 ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,					
ent 22's cocc arements fro 1/31/23. terview conc h Services (1	bey were no born the assessment on 12/27/22 aducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,					
ent 22's cocc arements fro 1/31/23. terview conc h Services (1	bey were no born the assessment on 12/27/22 aducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,					
arements fro 1/31/23. terview cond h Services (1	ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,					
1/31/23. terview cond h Services (l	ducted with the Director of DHS), on 2/24/23 at 2:40 p.m.,					
terview con h Services (l	DHS), on 2/24/23 at 2:40 p.m.,					
h Services (l	DHS), on 2/24/23 at 2:40 p.m.,					
neu sile was	s following up with hospice on					
	sessments due to the Assistant					
-	h Services (ADHS) being ill					
	eriod of late December to late					
	pice nurse was conducting					
	ring that time period.					
icv titled "G	Guidelines for General Wound					
•	lated 12/31/22, was provided by					
	on 2/23/23 at 1:30 p.m. The policy					
	owing, "PROCEDURE2.					
	esidents who are immobile					
-	r care plan requirements14.					
	nd treatmentReevaluate the					
	e to the prescribed treatment20.					
-	f wound, location, stage (if					
	h, width, depth in centimeters,					
mannage, pe						
ound weekly	JUL					
ound weekly						
ound weekly						
ound weekly nent flowshe						
ound weekly nent flowshe D(a)(2)	t					
d	and weekly ant flowshe		a)(2) (d)(1)(2) f Accident	a)(2) (d)(1)(2) f Accident	and weekly using the wound/skin ant flowsheet" a)(2) (d)(1)(2)	a)(2) (d)(1)(2) f Accident

PRINTED: 05/08/2023 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	r í	JILDING	00	3) DATE S COMPLI 02/27/2	ETED
	PROVIDER OR SUPPLIE HURST HEALTH (			628 N	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR 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
	remains as free of possible; and §483.25(d)(2)Ea adequate supervito prevent accided Based on observative of prevent accided Based on observative of prevent accided Based on observative of the facility interventions were ensure a fall follow neurological check for accidents. (Rest Findings include: 1a. The clinical re- reviewed on 2/22/ included, but were disease, dementia, and unspecified co A fall care plan, re- Resident 17 was a approach to provid- up in broda chair a after meals. An observation co- p.m., of Resident member in her bro- chair in the comm she resided in fror chair was not posi Resident 17 was s	ensure that - ne resident environment of accident hazards as is ch resident receives vision and assistance devices ents. tion, interview, and record y failed to ensure fall e in place per the care plan and w-up included completed ks for 3 of 4 residents reviewed sident 17, 31, and 9) cord for Resident 17 was 23 at 10:50 a.m. The diagnoses e not limited to, Alzheimer's , malnutrition, anxiety disorder, onvulsions. evised 2/17/23, indicated t risk for falling with the de resident with a blanket while and staff to recline broda chair onducted, on 2/23/23 at 12:35 17 being assisted by a staff oda chair and set her in her broda ion area on the hallway where at of the television. The broda tioned in a recline position and	F 04	589	<ul> <li>F689 – Free of Accidents</li> <li>Hazards/Supervision/Devices</li> <li>"Facility failed to ensure fall interventions were in place per to care plan and ensure a fall follow-up included completed neurological checks for 3 of 4 residents reviewed for accidents (Resident 17, 31, and 9)."</li> <li>1: What corrective action(s) wib be accomplished for those residents found to have affected by the deficient practice?</li> <li>Residents 17, 31, and 9 was affected by the alleged deficient practice.</li> <li>Resident 31 immediately had her Broda chair positioned i a reclining position.</li> <li>Resident 31 immediately was transferred to recliner.</li> <li>Resident 9 was assessed for neurological impairment. No noted.</li> <li>2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.</li> </ul>	n II ne	04/01/202

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

PRINTED:	05/08/2023
FORM APP	PROVED

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION (X: 00	DATE SURVEY COMPLETED 02/27/2023
	PROVIDER OR SUPPLIE HURST HEALTH C		628 N	f address, city, state, zip cod MERIDIAN RD ENFIELD, IN 46140	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		7 up in her broda chair, reclined		- Residents with fall	
		et nor cover was in place while		interventions have the potential t	
	she was up in her b	broda chair.		be affected by the alleged deficie	ent
	1h A fall avant de	ated 12/26/22 indicated		practice.	
		ated 12/26/22, indicated to floor in		- Nursing staff was reeducated on fall interventions	
		fall was unwitnessed. There		and neurological checks with	
		cal checks conducted for two		concentration on, but not limited to, repositioning, transferring residents to recliner, and	
	-	ups, four 30-minute follow ups,			
		ups, and three 4 hour follow			
	ups after the fall ev	-		neurological checks as indicated	
	•			after unwitnessed fall.	
	2. The clinical reco	ord for Resident 31 was reviewed		- All inhouse residents were	e
	on 2/23/23 at 11:48	8 a.m. The diagnoses included,		audited on 3.10.2023 by the	
	but were not limite	ed to, dementia, heart disease,		DHS/designee. Fall interventions	i
		nemia, and major depressive		were placed if applicable.	
	disorder.			Education provided:	
				o Falls Management Program	
	-	vised 2/20/23, indicated		Guidelines	
		risk for falling with the		o Guidelines for Neurological	
	approach to place i	resident in recliner after meals.		Checks 3: What measures will be put	
		nducted of Resident 31, on			
		n. of him sitting up in his		into place or what systemic	
	wheelchair with ap	opearance of sleep.		changes will be made to	
	An observation as	nduated of Pasidant 21 on		ensure that the deficient	
		nducted of Resident 31, on n., of him sitting up in his		<ul> <li>practice does not recur?</li> <li>DHS/designee will ensure</li> </ul>	
	· ·	eview of the record of Resident 9		random weekly monitoring of	
		6 a.m., indicated the resident's		implementation of fall	
		l, but were not limited to,		interventions. Proper monitoring	
	-	on, anxiety, difficulty walking,		will occur 3 times a week for 4	
		repeated falls, lack of		weeks, biweekly for 8 weeks, and	t l
	-	cle weakness and chronic pain.		bimonthly for 12 weeks. Then	
		-		monitored monthly in QAPI for 6	
	The Quarterly Min	imum Data Set (MDS)		months.	
	assessment for Res	sident 9, dated 11/17/22,			
	indicated the reside	ent was severely cognitively		4: How the corrective action	
	impaired for daily	decision making. The resident		will be monitored to ensure the	
	has had one fall wi	th injury since the last		deficient practice will not recur	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QYO711 Facility ID: 005954

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COM	PLETED
		155767	B. WING		02/27/2023	
NAME OF 1	PROVIDER OR SUPPLIE	ER		EET ADDRESS, CITY, STATE, ZIP	COD	
SPRING	HURST HEALTH (	CAMPUS		N MERIDIAN RD EENFIELD, IN 46140		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFL	CROSS-REFERENCED TO TH	E APPROPRIATE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG			DATE
	assessment.			i.e., what quality ass	surance	
				program will be put	into place?	
	The fall event for	Resident 9, dated 11/2/22,		- DHS/designee	e will be	
	indicated the resid	ent had an unwitnessed fall in		responsible for the fo	or ongoing	
	the bathroom. The	resident had an moderate		compliance and mon	itoring for 6	
	amount of pain in	her right knee. The resident's		months. The results	of these	
	neurological check	ks were not complete for the last		audits will be reviewe	ed by the QA	
	4 neurological che	ecks required.		committee overseen Executive Director. If		
	The fall event for	Resident 9, dated 12/27/22,		of 100% is not achiev		
		ent had an unwitnessed fall out		plan will be develope		
		sident only received on		facility through the Q		
	neurological check	-		will review, update, a		
	incuroiogical check	cutter the full.		changes to the POC		
	The fall event for	Resident 9, dated 2/6/23,		sustaining substantia		
		ent had an unwitnessed fall		for no less than 6 mo		
		air in the dining room. The			niuis.	
		hip pain. The resident only				
	-	blogical check after the fall.				
		singlear encert arter the fam.				
		lucted with the Director of				
		DHS), on 2/24/23 at 12:40 p.m.,				
	-	ectations are for staff to follow				
	the care plan and/o	or physician orders as written.				
		lls Management Program				
		w date of 3/16/22, was provided				
		rt on 2/23/23 at 1:30 p.m. The				
	policy indicated th	e following, "4. Any orders				
	received from the	physician should be noted and				
	carried out5. The	e resident care plan should be				
	-	any new change in				
	interventions6. N	Nursing staff will monitor and				
	document continue	ed resident response and				
	effectiveness of in	terventions for 72 hours"				
		uidelines for Neurological				
		ate of 12/31/22, was provided by				
		23 at 12:17 p.m. The policy				
	indicated the follo	wing, "PURPOSETo				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155767	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/27/2023
	PROVIDER OR SUPPLIE		628 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD NFIELD, IN 46140	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION
= 0692 SS=D Bldg. 00	pupil response, mo that may alert staff seizure activityP for 24 hours shoul Event Form" 3.1-45(a)(1) 3.1-45(a)(2) 483.25(g)(1)-(3) Nutrition/Hydratio §483.25(g) Assis (Includes naso-g tubes, both percu- gastrostomy and jejunostomy, and resident's compre- facility must ensu- §483.25(g)(1) Ma parameters of nu- usual body weigh range and electror resident's clinical that this is not po- preferences indic §483.25(g)(2) Is to maintain proper §483.25(g)(3) Is when there is a r health care provi Based on interview failed to follow up recommendations	of consciousness, evaluate otor function, and vital signs f for potential for head injury or ROCEDURES3. Neuro-checks d be completed within the Fall on Status Maintenance sted nutrition and hydration. astric and gastrostomy utaneous endoscopic percutaneous endoscopic l enteral fluids). Based on a ehensive assessment, the ure that a resident- aintains acceptable stritional status, such as nt or desirable body weight olyte balance, unless the l condition demonstrates ossible or resident cate otherwise; offered sufficient fluid intake er hydration and health; offered a therapeutic diet nutritional problem and the der orders a therapeutic diet. v and record review, the facility o with a Registered Dietitian (RD) for a supplement for a resident significant weight loss for 1 of 1	F 0692	F692 – Nutritional/Hydration Status Maintenance "Facility failed to follow up wi Registered Dietitian (RD) recommendations for a	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED 02/27/2023	
		155767	B. WING			02/27	/2023
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD		
SPRING	HURST HEALTH (	CAMPUS	Ċ	GREE	NFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	<u>`</u>	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	1	'AG	experienced significant weight	1055	DATE
	Findings include:				for 1 of 1 resident reviewed for		
	C				nutrition. (Resident 26)."		
	The clinical record	l for Resident 26 was reviewed			1: What corrective action(s)	will	
	on 2/22/23 at 12:4	4 p.m. The diagnoses included,			be accomplished for those		
	but were not limite	ed to, history of COVID-19,			residents found to have		
	history of pneumo			affected by the deficient			
	(CHF), dysphagia,	anemia, and cerebrovascular			practice?		
	disease.				- Resident 26 was affect		
					by the alleged deficient practic	e.	
	-	tritional status, revised 2/18/23,			- Resident 26 was		
		26 was malnourished and/or at			immediately referred to Hospic	ce	
		on related to diagnoses,			for RD recommendation.		
	_	t/energy intakes, and/or					
		s. The approach was to have evaluate as indicated and			2: How other residents having	-	
		lements, medications, and			the potential to be affected b	-	
	adaptive equipmer				the same deficient practice v be identified and what	/111	
	adaptive equipmen	it as ordered.			corrective action will be take	n	
	A Registered Dieti	itian (RD) note, dated 2/21/23 at			- Residents with RD		
	-	ed the following, "Noted			recommendations have the		
	-	] on 2/6/23 with decline. Noted			potential to be affected by the		
		loss since $2/6/23$ with poor meal			alleged deficient practice.		
		impairments to coccyx and			- IDT was reeducated or	RD	
	bilateral buttocks of	on 2/20/23. Dxs [diagnoses]:			recommendations with		
	-	onic kidney disease; stage 3],			concentration on, but not limite		
		edema. Noted recent weight			to, supplements, multivitamins	;	
		65.8 lbs, 2/20/23: 167.2 lbs,			and desirable body weight.		
		, 2/18/23: 170.2 lbs, 2/6/23: 182.2			- All inhouse residents w	ere	
		s, IBW: 136 lbs, BMI: 26.76.			audited on 3.10.2023 by the		
		order. Continues Lasix 40 mg			DHS/designee for RD		
		no changes since 1/4/23.			recommendations and addres	sed	
		diet with food preferences			as appropriate.		
	-	ted. Ordered protein drink qday Sugar Free TID [three times a			Education provided:	king	
		nend d/c [discontinue] protein			o Guidelines for Weight Trac	ĸing	
		Insure supplement TID between			3: What measures will be put	•	
		l shakes at meals. Will			into place or what systemic	•	
		multivitamin] with minerals 1			changes will be made to		
		y[every day] to aid in skin			ensure that the deficient		

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	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER 155767		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		628 N	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION DATE
	integrity. Careplan As of 2/24/23 at 1 physician order for Resident 26's clini An interview cond at 2:40 p.m., indica with hospice in reg A policy titled "Gu revised 1/16/21, w on 2/24/23 at 2:57 facility dietitian or resident's nutrition and current weight program when war	initiated [sic]" 1:11 a.m., there were no r an Ensure supplement in cal record. ucted with the DHS, on 2/24/23 ated she was going to follow up gard to the RD recommendation. didelines for Weight Tracking", as provided by Clinical Support p.m. The policy indicated the representative will review the al status, usual body weight to implement a nutritional tranted. It also stated residents weight change can be added to		<ul> <li>practice does not recur?</li> <li>DHS/designee will evekly monitoring of RD recommendations in morning meeting. Proper monitoring occur 3 times a week for 4 biweekly for 8 weeks, and bimonthly for 12 weeks. The monitored monthly in QAPI months.</li> <li>4: How the corrective active active will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into p - DHS/designee will be responsible for the for ongo compliance and monitoring months. The results of thes audits will be reviewed by the Executive Director. If a three of 100% is not achieved, ar plan will be developed. The facility through the QAPI pr will review, update, and marchanges to the POC as needs sustaining substantial compliance in the months.</li> </ul>	ng CCM g will weeks, en for 6 on re the recur ce lace? be joing for 6 se he QA c shold n action he ogram, ike eded for	
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Resp tracheostomy can The facility must needs respiratory tracheostomy can	heostomy Care and iratory care, including re and tracheal suctioning. ensure that a resident who / care, including re and tracheal suctioning, care, consistent with				

TERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>00</u>	COMPLETED	
		155767	B. WING		02/27/2023	
AME OF	PROVIDER OR SUPPLIE	2		ADDRESS, CITY, STATE, ZIP COD		
PRING	HURST HEALTH C	AMPUS		MERIDIAN RD NFIELD, IN 46140		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
REFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
		dards of practice, the				
		erson-centered care plan,				
		Is and preferences, and				
	483.65 of this sub	-				
		on, interview and record	F 0695	F695 –	04/01/202	
		failed to store oxygen nasal	1 0095			
		P mask in a bag for infection		Respiratory/Tracheostomy C		
		Id failed to date oxygen tubing		and Suctioning		
				"Facility failed to store oxygen	- 1-	
		2 of 2 residents reviewed for respiratory care ident 45 and Resident 163).		nasal cannula and C- PAP ma	SK	
	(Resident 45 and R	esident 163).		in a bag for infection control		
				purposes and failed to date		
	Findings include:			oxygen tubing for 2 of 2 reside	nts	
				reviewed for respiratory care		
		at 11:03 a.m., Resident 45 was		(Resident 45 and Resident 163	3)."	
	sitting in her wheelchair with oxygen on via oxygen concentrator with a nasal cannula. The			1: What corrective action(s) w	vill	
				be accomplished for those		
	resident's C - pap m	nask was not in a bag and not		residents found to have		
	dated. oxygen conc	entrator on 2 liters tubing on		affected by the deficient		
	either one was not o	dated. The portable oxygen on		practice?		
	back of wheelchair	ck of wheelchair nasal cannula not bagged and		- Resident 45 and 163 wa	as	
	touching the back of	on the wheelchair, the tubing		affected by the alleged deficier	nt	
	was not dated.			practice.		
				- Resident 45 immediate	v	
	During an observat	ion and interview on 2/22/23 at		had CPAP mask placed in bag	•	
	-	nt 45 indicated the staff do not		and oxygen tubing dated.		
	,	AP mask in a bag, it depended		- Resident 163 immediate	elv	
		ng. The resident's oxygen nasal		had oxygen tubing dated.		
		on the floor from her portable				
	oxygen tank, not in	-		2: How other residents havin	a	
				the potential to be affected by	-	
	Review of the reco	rd of Resident 45 on 2/24/23 at		the same deficient practice w		
		d the resident's diagnoses		be identified and what		
	_			corrective action will be take		
	included, but were not limited to, acute respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease, obstructive sleep					
				- Residents receiving	the	
	-	-		respiratory interventions have	ine	
	apnea and dependent	nce on supplemental oxygen.		potential to be affected by the		
				alleged deficient practice.		
		nimum Data Set (MDS)		- IDT was reeducated on		
		ident 45, dated 12/14/22,		proper respiratory dating and		
	indicated the reside	ent was cognitively intact for		storage with concentration on,	hut	

Event ID: QYO711 Facility ID: 005954

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155767	B. WING		02/27/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
SPRING	HURST HEALTH C	CAMPUS	GREE	NFIELD, IN 46140	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	ing. The resident received		not limited to, oxygen tubing,	
	oxygen therapy.			nasal cannulas, and CPAP/BiP	ар
	2) During on alog	2/20/22 at 11.17 a m		devices.	
		rvation on 2/20/23 at 11:17 a.m., sitting in her wheelchair with		- All inhouse residents	
		a nasal cannula, oxygen		receiving respiratory intervention were audited on 3.10.2023 by t	
		g was not dated. The resident		DHS/designee for proper storage	
		gen tank on the back of her		and dating of as appropriate.	90
		ygen tubing was not dated and		Education provided:	
		not in bag and was laying in		o Administration of Oxygen	
	the back of wheeld			Policy	
	Review of the reco	rd of Resident 163 on 2/23/23 at		3: What measures will be put	
	11:30 a.m., indica	ted the resident's diagnoses		into place or what systemic	
	included, but were	not limited to, chronic		changes will be made to	
	obstructive pulmor	nary disease, chronic		ensure that the deficient	
		with hypoxia and dependence		practice does not recur?	
	on supplemental of	xygen.		- DHS/designee will ensu	re
				random weekly monitoring of	
		nimum Data Set (MDS)		respiratory interventions. Prop	er
		sident 163, dated 2/9/23,		monitoring will occur 3 times a	
		ent was moderately impaired for		week for 4 weeks, biweekly for	8
		ing. The resident received		weeks, and bimonthly for 12	
	oxygen therapy.			weeks. Then monitored monthl QAPI for 6 months.	y in
	During an interview	w with the Director Of Health			
	-	2/24/23 at 12:35 p.m., indicated		4: How the corrective action	
		ere that residents oxygen nasal		will be monitored to ensure th	e
	-	P mask would be stored in a		deficient practice will not recu	-
		ot in use for infection control		i.e., what quality assurance	
		S indicated it was the nurses		program will be put into place	?
	responsibility to da	ate the oxygen tubing when it		- DHS/designee will be	
	was changed.			responsible for the for ongoing	
				compliance and monitoring for	6
		of oxygen policy provided by		months. The results of these	
	**	n 2/23/23 at 1:30 p.m., indicated		audits will be reviewed by the C	QA
		ald be dated with the day it was		committee overseen by the	
	initiated and chang	ged monthly.		Executive Director. If a thresho	
				of 100% is not achieved, an ac	tion
			1	plan will be developed. The	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155767	A. BUILDING <u>00</u> B. WING		COMPLETED 02/27/2023		
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD				
SPRING	HURST HEALTH C	AMPUS	GREE	ENFIELD, IN 46140			
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION	
TAG	3.1-47(6)	R LSC IDENTIFYING INFORMATION	TAG	facility through the QA will review, update, an changes to the POC a sustaining substantial for no less than 6 mo	API program, nd make as needed for l compliance	DATE	
= 0756 SS=D Bldg. 00	On §483.45(c) Drug §483.45(c)(1) The resident must be month by a licens §483.45(c)(2) Thi review of the resi §483.45(c)(4) The any irregularities and the facility's r of nursing, and the upon. (i) Irregularities in to, any drug that in paragraph (d) of unnecessary drug (ii) Any irregularit during this review separate, written attending physicia director and direct minimum, the resi drug, and the irrefidentified. (iii) The attending in the resident's r identified irregular what, if any, action address it. If therefilter	eview, Report Irregular, Act Regimen Review. e drug regimen of each reviewed at least once a sed pharmacist. s review must include a dent's medical chart. e pharmacist must report to the attending physician medical director and director ese reports must be acted include, but are not limited meets the criteria set forth of this section for an					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CO A. BUILDING B. WING	00	3) DATE SURVEY COMPLETED 02/27/2023
	PROVIDER OR SUPPLIEI		628 N I	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	REGULATORY OF document his or h medical record. §483.45(c)(5) The maintain policies monthly drug regi are not limited to, steps in the proce pharmacist must identifies an irregi action to protect t Based on interview failed to ensure a p followed up with ti reviewed for unnec 31 and Resident 9) Findings include: 1. The clinical reco on 2/23/23 at 1:53 but were not limite atrial fibrillation, an disorder. A physician order, Acetaminophen PM (diphenhydramine- milligrams at bedti	A LSC IDENTIFYING INFORMATION her rationale in the resident's and procedures for the men review that include, but time frames for the different less and steps the take when he or she ularity that requires urgent he resident. and record review, the facility harmacy recommendation was mely for 2 of 5 residents lessary medications. (Resident actions) (Resident 31 was reviewed p.m. The diagnoses included, d to, dementia, heart disease, nemia, and major depressive dated 1/13/22, was noted for 4 acetaminophen) tablet 25-500 me. mendation, dated 9/22/22, ving, "He is receiving Tylenol		F756 – Drug Regimen Review, Report Irregular, Act On "Facility failed to ensure a pharmacy recommendation was followed up with timely for 2 of 5 residents reviewed for unnecessary medications. (Resident 31 and Resident 9)." 1: What corrective action(s) wi be accomplished for those residents found to have affected by the deficient practice? - Resident 31 and 9 was affected by the alleged deficient practice. - Resident 31 was immediately addressed for pharmacy recommendation regarding nighttime medication. - Resident 9 immediately had nighttime medication chang	DATE
	Diphenhydramine i potentially inappro elderly due to the a Would it be possib Trazodone 50mg [r	is included in the Beers list for priate medications in the nticholinergic properties. le to replace this with nilligrams] QHS?" The I the physician agreed with all		to morning per pharmacy recommendation. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		· · ·	PLETED	
		155767	B. WING	<u></u>		02/27/2023	
NAME OF	PROVIDER OR SUPPLIE	ËR		EET ADDRESS, CITY, STATE, ZIP COD N MERIDIAN RD			
SPRING	HURST HEALTH (			EENFIELD, IN 46140			
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPR	OPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE	
	recommendations.			corrective action will be			
		1 1 . 1		- Residents with pharm	•		
		recommendation, dated		recommendations have th			
		d the following, "The		potential to be affected by	rine		
		om 9/22 was closed out with the		alleged deficient practice.	-l	1	
		t the NP [Nurse Practitioner]		- IDT was reeducate			
	-	s change. Please review as he is		pharmacy recommendation			
	-	taminophen PM" The		concentration on, but not		1	
		d the physician agreed with all		to, medication review, and	1	1	
	recommendations.			medication change.			
		1.4 1.1		- All inhouse resider			
		recommendation, dated		audited on 3.10.2023 by t			
		d the following, "He is		DHS/designee for pharma	•		
		PM QHS for insomnia.		recommendations and ad	dressed		
		is included in the Beers list for		as appropriate.			
		opriate medications in the		Education provided:			
	-	anticholinergic properties.		o Consultant Pharmacist	•		
	-	ble to replace this with		o Pharmacy recommend	ations		
		QHS?" The document indicated					
		oner does not agree with		3: What measures will be	•		
		endation and will continue with		into place or what syster	nic		
	-	n. 2.) Review of the record of		changes will be made to			
		2/23 at 11:56 a.m., indicated the		ensure that the deficient			
	e	es included, but were not		practice does not recur?			
	· · · · · ·	ia, depression, anxiety, difficulty		- DHS/designee will		1	
	-	l posture, repeated falls, lack of		weekly monitoring of phar			
	coordination, mus	cle weakness and chronic pain.		recommendations during	-	1	
				CCM meeting. Proper mo	-		
		nimum Data Set (MDS)		will occur 3 times a week			
		sident 9, dated 11/17/22,		weeks, biweekly for 8 wee			
		ent was severely cognitively		bimonthly for 12 weeks. T			
		decision making. The resident		monitored monthly in QAF	'l for 6	1	
		pressant for the past 7 days.		months.			
		ad one fall with injury since the				1	
	last assessment.			4: How the corrective act			
				will be monitored to ensu			
		ommendation for Resident 9,		deficient practice will no			
		dicated the pharmacist		i.e., what quality assurar		1	
		nging zoloft to be giving in the		program will be put into	-		
	morning. The phar	macist indicated zoloft could be		- DHS/designee will	be		

Event ID: QYO711 Facility ID: 005954

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD GREENFIELD, IN 46140				
X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY O a stimulating and c restlessness and inst to falls. The Physician Rec 9, dated February 2 received zoloft (an for anxiety and dep bedtime. During an interview Services (DHS) on was the DHS and t Services (ADHS) t recommendations of the Nurse Practitio morning time today A policy titled "Co revised 11/18, was Health Services (D The policy indicate "MEDICATION medication regime: evaluating the resid therapy to determin the highest practica preventing or minin related to medication and the pure Medical Director a AdministratorPro-	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ontribute to nighttime somnia which also contributes apitulation (Recap) for Resident 2023, indicated the resident tidepressant) 25 milligrams (mg) pression one time a day at w with the Director Of Health 2/24/23 at 3:00 p.m., indicated it he Assistant Director Of o follow up on the pharmacy on 12/28/22. The DHS indicated ner changed the zoloft to y. nsultant Pharmacist Reports", provided by the Director of HS), on 2/24/23 at 11:15 a.m. ed the following, REGIMEN REVIEWThe n review (MRR) includes lent's response to medication ne that the resident maintains able level of functioning and mizing adverse consequences on therapy. Findings and are reported to the Director of escriber, and if appropriate, the nd/or the preceduresE. Recommendations documented by the facility	GREEI	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY) responsible for the for ong compliance and monitorin months. The results of the audits will be reviewed by committee overseen by th Executive Director. If a thr of 100% is not achieved, a plan will be developed. T facility through the QAPI p will review, update, and m changes to the POC as ne sustaining substantial com for no less than 6 months.	oing g for 6 se the QA e eshold an action he rogram, ake eeded for apliance	(X5) COMPLETION DATE	
	3.1-23(1) 3.1-25(i)						

QYO711 Facility ID: 005954

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X:	X3) DATE SURVEY COMPLETED 02/27/2023	
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD GREENFIELD, IN 46140			COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AFFROFRIATE	DATE
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emerger §483.55 Dental s The facility must routine and 24-hd §483.55(a) Skille A facility- §483.55(a)(1) Mu outside resource §483.70(g) of this emergency denta of each resident; §483.55(a)(2) Ma resident an addit emergency denta §483.55(a)(2) Ma resident an addit emergency denta §483.55(a)(3) Mu those circumstan damage of dentu responsibility and for the loss or da determined in ac to be the facility's §483.55(a)(4) Mu requested, assist (i) In making app (ii) By arranging f the dental service	ncy Dental Srvcs in SNFs ervices. assist residents in obtaining our emergency dental care. d Nursing Facilities ust provide or obtain from an , in accordance with with s part, routine and al services to meet the needs ay charge a Medicare ional amount for routine and al services; ust have a policy identifying ices when the loss or res is the facility's d may not charge a resident mage of dentures cordance with facility policy a responsibility; ust if necessary or if the resident; ointments; and for transportation to and from es location; and					DATE
	refer residents w for dental service within 3 days, the documentation or resident could sti	ust promptly, within 3 days, ith lost or damaged dentures es. If a referral does not occur e facility must provide f what they did to ensure the II eat and drink adequately ental services and the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/27/2023 155767 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE extenuating circumstances that led to the delay. F 0790 F790 – Routine/Emergency 04/01/2023 Based on observation, interview and record **Dental Srvcs in SNFs** review the facility failed to provide routine dental "Facility failed to provide routine services for a resident who had missing or broken dental services for a resident who teeth and difficulty chewing, for 1 of 2 residents had missing or broken teeth and reviewed for dental status (Resident 15). difficulty chewing, for 1 of 2 residents reviewed for dental Findings include: status (Resident 15)." 1: What corrective action(s) will During an interview, on 2/21/23, Resident 15 be accomplished for those indicated he has several teeth that are broken or residents found to have worn down and he has trouble eating, especially affected by the deficient meat. Observation of the resident's teeth practice? indicated he had several missing or broken upper Resident 15 was affected and lower teeth. by the alleged deficient practice. Resident 15 was Resident 15's record was reviewed on 2/22/23 at immediately scheduled for dental 1:23 p.m. The record indicated Resident 15 had services. diagnoses that included, but were not limited to, liver disease, type 2 diabetes mellitus, heart 2: How other residents having failure, heart disease, anxiety and depression. the potential to be affected by the same deficient practice will A Quarterly Minimum Data Set (MDS) be identified and what assessment, dated 1/4/2023, indicated Resident 15 corrective action will be taken. was cognitively intact. Residents with dental needs have the potential to be affected A care plan, dated 12/8/22 indicated a problem for by the alleged deficient practice. potential for mouth pain related to missing teeth. IDT was reeducated on His goal was not to exhibit mouth pain or dental services with concentration infection. Interventions included, but were not on, but not limited to, scheduling limited to, dental evaluation and intervention as residents for dental services. needed All inhouse residents were assessed on 3.10.2023 by the Current Physician's orders indicated Resident 15 DHS/designee for needing dental could see an audiologist, dentist, podiatrist, services. psychologies, or an optometrist as needed, dated Education provided: 12/30/22. o Dental Services Including Repair, Replacement Policy

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Event ID:

QYO711 Facility

Facility ID: 005954

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00	COMPI	
		155767	B. WING			02/27/2023	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEI				MERIDIAN RD		
SPRING	HURST HEALTH C	AMPUS		GREEN	IFIELD, IN 46140		-
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	Assessment, dated 12/06/2022,					
	-	ted Resident 15's diet is a			3: What measures will be pu	t	
		controlled carbohydrate diet with regular thin liquids, and MDS documentation, noted he had			into place or what systemic		
	-				changes will be made to		
		culty chewing/swallowing.			ensure that the deficient		
		mendation to inform Speech			practice does not recur?		
	Therapy.				- DHS/designee will ens	ure	
					random weekly monitoring of		
		note, dated 1/03/2023 at 11:57			residents in need of dental		
		et clarification for a controlled			services. Proper monitoring w		
		vith mechanical soft texture,			occur 3 times a week for 4 we	eks,	
	ground meats, and	thin liquids.			biweekly for 8 weeks, and		
	A.5.1	. 1 1.1/00/2022			bimonthly for 12 weeks. Then		
		ssessment, dated 1/09/2023 at			monitored monthly in QAPI for	r 6	
		l Resident 15's diet was			months.		
		drate with mechanical soft					
	-	liquids, had average intakes of			4: How the corrective action		
		orking with speech, has			will be monitored to ensure t		
	coughing at meals	-			deficient practice will not rec	cur	
	cnewing/swallowin	g per resident report.			i.e., what quality assurance	- 0	
	Dunin a an interview	$x_{1} = \frac{2}{2} \frac{1}{2} \frac{1}{2} \frac{1}{2} = \frac{1}{2} $			program will be put into plac	e?	
		v, on 2/24/23 at 2:43 p.m., the Services indicated she could			- DHS/designee will be		
		entation of dental visits, that			responsible for the for ongoing		
		sident who said he didn't feel it			compliance and monitoring for months. The results of these	10	
		said he would like to go in the			audits will be reviewed by the	04	
		e talked to the Social Service			committee overseen by the	QA	
		t have any documentation of			Executive Director. If a thresh	old	
	Resident 15 refusin				of 100% is not achieved, an a		
	Resident 15 Terusin	ig dentar visits.			plan will be developed. The	Clion	
	On $2/24/23$ at $3.00$	p.m., the Director of Health			facility through the QAPI prog	ram	
		she spoke with the resident's			will review, update, and make		
		vices, and they are going to			changes to the POC as neede		
	have him seen by the				sustaining substantial complia		
		ile dentifit.			for no less than 6 months.		
	A policy for "Dent	al Services Including Repair,					
		provided by the Director of					
	-	2/24/23 at 3:12 p.m. The policy					
		not limited to, "Overview: It is					
		ogy Health Services to assist					
					1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155767 B. WING 02/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS **GREENFIELD, IN 46140** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE residents in obtaining routine and emergency dental care, per the resident request. The facility will assist by making appointments and/or by arranging for transportation to and from the dental services location. Procedure: 1. Clinical staff will assess teeth and gums upon admission, with each comprehensive assessment and as needed to identify pain, lost or broken teeth, visible signs of tooth decay and other chewing and swallowing problems. 2. The facility will ensure the delivery of emergency dental services to meet the resident needs .... " 3.1-24(a)(1) F 0880 483.80(a)(1)(2)(4)(e)(f) SS=D Infection Prevention & Control Bldg. 00 §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 diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment Event ID: QY0711 Facility ID: 005954 Page 38 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 02/27/2023		
	NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD GREENFIELD, IN 46140				
(X4) ID PREFIX	SUMMARY	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE		
		ding to §483.70(e) and ed national standards;						
	and procedures f include, but are r (i) A system of su identify possible infections before persons in the fa (ii) When and to communicable di be reported; (iii) Standard and precautions to be of infections; (iv)When and hor for a resident; ind (A) The type and depending upon organism involve (B) A requirement the least restriction under the circums (v) The circumstant must prohibit em communicable di lesions from direct their food, if direct disease; and (vi)The hand hyg followed by staff contact. §483.80(a)(4) A se incidents identified and the corrective facility.	urveillance designed to communicable diseases or they can spread to other cility; whom possible incidents of sease or infections should a transmission-based e followed to prevent spread w isolation should be used cluding but not limited to: duration of the isolation, the infectious agent or d, and at that the isolation should be we possible for the resident stances. ances under which the facility ployees with a sease or infected skin ct contact with residents or et contact will transmit the iene procedures to be involved in direct resident system for recording ed under the facility's IPCP e actions taken by the						
	§483.80(e) Linen	IS.						

05/08/2023 PRINTED: FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/27/2023 155767 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. F 0880 F880 – Infection Prevention & 04/01/2023 Control Based on observation, interview, and record "Facility failed to ensure review, the facility failed to ensure medications medications were not handled by were not handled by bare hands during a bare hands during a medication medication administration observation. This administration observation. This affected 1 of 3 residents observed for a medication affected 1 of 3 residents observed pass. (Resident 45) for a medication pass. (Resident 45)." Findings include: 1: What corrective action(s) will be accomplished for those During a medication administration observation, residents found to have on 2/20/23 at 7:25 a.m. RN 1 was observed as she affected by the deficient prepared Resident 45's morning medications. The practice? following medications were set up for Resident 45: Resident 45 was affected amiodarone 200 milligrams (mg) 1 tablet, aspirin 81 by the alleged deficient practice. mg 1 tablet, Eliquis 5 mg 1 tablet, Ferrous sulfate Resident 45 was 325 mg 1 tablet, hydroxychloroquine 200 mg 1 immediately assessed for adverse tablet, Mucinex 600 mg 1 tablet, pantoprazole 40 effects. None noted. mg 1 tablet, potassium chloride 20 milieu, 2 tablets given to equal 40 mg, sildenafil 20 mg 1, torsemide 2: How other residents having 20 mg 1, Prednisone 10 mg 1, and oyster shell the potential to be affected by calcium 500 mg with vitamin D 200 units, 1 tablet. the same deficient practice will RN 1 was observed to pop the pills out of the be identified and what package onto her ungloved hands before she corrective action will be taken. placed them in a medication cup, then crushed the All residents that have pills and placed them in applesauce. A capsule medications administered by for Keflex 500 milligrams, and a capsule for facility staff have the potential to cardizem 180 milligrams, were opened and be affected by the alleged deficient sprinkled on top of the applesauce with ungloved practice. hands prior to administering the medications to IDT and nursing staff was Resident 45. reeducated on infection control

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AND PLAN OF CORRECTION IDEN		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 02/27/2023			
	NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD GREENFIELD, IN 46140				
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IAG	During an intervie Director of Health expectation to place med cup when pass A policy for "Med Guidelines" was p Health Services or policy undiluted, b "PolicyPreparati only by licensed n other licensed pers and regulations to medications. 2) Ha Sanitization: The p medications adher	w, on 2/20/23 at 9:13 a.m., the Services said it is an ee medications directly into a sing medications. ication Administration General rovided by the Director of a 2/27/23 at 11:27 a.m. The but was not limited to: on: 1) Medications are prepared ursing, medical, pharmacy or sonnel authorized by state laws prepare and administer andwashing and Hand berson administering es to good hand hygiene, a medication pass, prior to		<ul> <li>practices with concentration of but not limited to, hand hygie practices.</li> <li>Education provided: <ul> <li>Medication Administration General Guidelines</li> </ul> </li> <li>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? <ul> <li>DHS/designee will ensuration general guidelines</li> </ul> </li> <li>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? <ul> <li>DHS/designee will ensuration generation administration. Provided: and weekly monitoring of medication administration. Provide for 4 weeks, biweekly for weeks, and bimonthly for 12 weeks. Then monitored mont QAPI for 6 months.</li> </ul> </li> <li>4: How the corrective action will be monitored to ensure deficient practice will not refile., what quality assurance program will be put into pla</li> <li>DHS/designee will be responsible for the for ongoin compliance and monitoring for months. The results of these audits will be reviewed by the committee overseen by the Executive Director. If a thresh of 100% is not achieved, an a plan will be developed. The facility through the QAPI program is not achieved, an a plan will be developed. The facility through the QAPI program is not achieved, an a plan will be developed. The facility through the QAPI program is not achieved, and plan will be developed. The facility through the QAPI program is not achieved, and plan will be developed. The facility through the QAPI program is not achieved, and plan will be developed. The facility through the QAPI program is not achieved, and plan will be developed. The facility through the QAPI program is not achieved, and plan will be developed. The facility through the QAPI program is not achieved, and plan will be developed. The facility through the QAPI program is not achieved and plan will be developed. The facility through the QAPI program is not achieved and plan will be developed. The facility through t</li></ul>	on, ne ut sure roper a or 8 chly in the cur ce? lg or 6 e QA hold action gram, e ed for			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		628 N	T ADDRESS, CITY, STATE, ZIP COD I MERIDIAN RD ENFIELD, IN 46140		
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(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE		DATE
= 9999						
Bldg. 00	Based on interviev	v and record review, the facility	F 9999	F9999 – Final Observation "Facility failed to complete	S	04/01/202
		required pre-employment		required pre-employment		
	· ·	ion, and training for 10 of 10		screening, orientation, and	trainina	
	-	ewed for employee records.		for 10 of 10 staff members	Ū.	
	The diameter day			reviewed for employee reco		
	Findings include:			1: What corrective action(	,	
	Employee records	were reviewed on 2/27/2023 at		be accomplished for those	9	
	10:15 a.m.	were reviewed on 2/2//2025 at		residents found to have affected by the deficient		
				practice?		
		at 3 was hired on 8/31/2021. No		- 10 of 10 employees	were	
		al tuberculosis risk assessment,		found to be missing part of		
		est, or education for resident		requirements for employme	ent.	
	-	r abuse in the last 12 months		- Employees were		
	were present in the			immediately notified and ar		
		istant 4 (RCA) was hired on dication of general orientation,		required to provide docume	ents.	
	specific orientation	n, or dementia training present		2: How other residents ha	iving	
	in the employee re	cord.		the potential to be affected	d by	
				the same deficient practic	e will	
		Care Assistant 5 (CRCA) was		be identified and what		
		22. No indication of		corrective action will be ta		
	· ·	nal references, general		<ul> <li>All newly hired employ</li> </ul>		
	· •	c orientation, or education for		have the potential to be affe		
	on the employee re	hts, or dementia were present ecord.		by the alleged deficient pra - ED/designee were	ctice.	
				reeducated on hiring proce	ss with	
		8/18/2018. No indication of		concentration on, but not lir	nited	
		s risk assessment, annual		to, background checks,		
		ducation for resident rights,		tuberculosis risk assessme		
	· · · · ·	in the last 12 months were		general orientation, referen	ces,	
	present in the emp	loyee record.		and/or education. Education provided:		
	Cook 7 was hired	on 10/19/2017. No indication of		o New Employee Onboard	lina	
		s risk assessment, annual		Workflow/Checklist		
		ducation for resident rights,		o State File Checklist		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		628 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD NFIELD, IN 46140		
SPRING (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C dementia, or abuse present in the emp Licensed Practical 8/23/2021. No ind risk assessment, an education for resid in the last 12 mont record. CRCA 9 was hired personal/professio orientation, specifi abuse, resident rig on the employee re RCA 10 was hired a criminal backgro personal/professio examination prior orientation, specifi resident rights, abu on the employee re CRCA 11 was hired of job description, dementia training record. Environmental Sec 1/10/2023. No firs job description, ge orientation, or edu	Y STATEMENT OF DEFICIENCIE         NCY MUST BE PRECEDED BY FULL         R LSC IDENTIFYING INFORMATION         e in the last 12 months were         loyee record.         Nurse 8 (LPN) was hired on         ication of annual tuberculosis         mual Mantoux test, or         ent rights, dementia, or abuse         hs were present in the employee         I on 11/22/2022. No indication of         nal references, general         c orientation, or education for         hts, or dementia were present         ecord.         on 11/22/2022. No indication of         und check,         nal references physical         to hire, job description, general         c orientation, or education for         use, or dementia were present         ecord.         ed on 12/21/2022. No indication         specific orientation, or         were present on the employee         vices Assistant 12 was hired on         t and second step Mantoux test,         neral orientation, specific         cation for resident rights,		<ul> <li>NFIELD, IN 46140</li> <li>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)</li> <li>3: What measures will be puinto place or what systemic changes will be made to ensure that the deficient practice does not recur?</li> <li>ED/AP Payroll/Design will ensure monitoring of all m hires weekly for 4 weeks, biw for 8 weeks, and monitored monthly in QAPI for 6 months</li> <li>4: How the corrective action will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla</li> <li>Designee will be responsible for monitoring compliance of the weekly pro- for 6 months. The results of t audits will be reviewed by the committee overseen by the Executive Director. If a thresh of 100% is not achieved, an a plan will be developed. The facility through the QAPI prog- will review, update, and make changes to the POC as need sustaining substantial compliance for no less than 6 months.</li> </ul>	ut eee lew reekly s. hthe fcur ce? ce? ce? cess hese e QA hold action gram, e ed for	(X5) OMPLETIO DATE
	employee record. An interview with 2/27/2023 at 10:24 in the employee re	the Executive Direction on a.m. indicated there were lapses cords requested and that they g quality compliance audits on				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155767 B. WING 02/27/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE all employee records. An interview with the Executive Director on 2/27/2023 at 11:19 a.m. indicated they were unable to provide any further information for the requested employees. A document entitled, "New Employee Onboarding Workflow/Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. It indicated prior to extending an offer of employment, the prospective employee should complete resident rights and abuse education. Within 24 hours of accepting a job offer, the following should be schedule/completed: Mantoux testing, physical examination. Within 1 week prior to employment, the facility should initiate the background check and reference checks. A document entitled "State File Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. He indicated it is the expectation to have this completed for every employee. This document included: criminal background check, two reference checks, employee health exam, 1st step tuberculosis testing, 2nd step tuberculosis testing, annual tuberculosis, general orientation checklist, job specific checklist, resident rights training for the current year, abuse training for the current year, job description to be signed during onboarding, and three hours of dementia certification and/or current year three hours of dementia training. 410 IAC 16.2-3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall Event ID: QY0711 Facility ID: 005954 Page 44 of 56 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2023				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD					
SPRING	HURST HEALTH (	JAMPUS	GREEN	NFIELD, IN 46140				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)		
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TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
		e limited to, the following:						
	(1) Residents' righ							
	(2) Prevention and	l control of infection.						
	(3) Fire prevention	1.						
	(4) Safety and acc	ident prevention.						
	(5) Needs of speci	alized populations served.						
	(6) Care of cogniti	ively impaired residents.						
	(l) The frequency	and content of inservice						
	education and train	ning programs shall be in						
	accordance with th	ne skills and						
	knowledge of the	facility personnel as follows. For						
	-	, this shall include at least						
		of inservice per calendar year						
		of inservice per calendar year for						
	nonnursing person							
		ion of all staff must be						
	<b>a</b> .)	cumented and shall include the						
	following:							
	e	the needs of the specialized						
		ulations served in the facility,						
	for example:	alations served in the facility,						
	(A) aged;							
	(B) developmental	llv disabled:						
	(C) mentally ill;	ny albaoloa,						
	(D) children; or							
		vely impaired; residents.						
		sidents' rights and other						
		of the facility's policy manual.						
		irst aid, emergency procedures,						
		er preparedness, including						
		ures and universal precautions.						
	-	ew of the appropriate job						
	-	ling a demonstration of						
		ocedures required of the specific						
	-	the employee will be assigned.						
		cal considerations and						
		resident care and records.						
		staff, instruction in the						
	-	f each resident to whom the						
	employee will be	providing care.	1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023		
NAME OF	PROVIDER OR SUPPLIE	ER		r address, city, state, zip MERIDIAN RD	COD		
SPRING	HURST HEALTH (	CAMPUS		ENFIELD, IN 46140			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		COMPLETI	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	(q) Each facility sl	hall maintain current and					
	accurate personnel	l records for all employees. The					
	personnel records	for all					
	employees shall in	clude the following:					
	(1) The name and	address of the employee.					
	(2) Social Security						
	(3) Date of beginn						
		ent, experience, and education if					
	applicable.	· • •					
		censure, certification, or					
		er or dining assistant certificate					
	or letter of comple	-					
	applicable.						
		facility and job description.					
		n of orientation to the facility					
	and to the specific						
	-	vledgement of orientation to					
	residents' rights.	reagement of orientation to					
	-	valuations in accordance with					
	the facility's policy						
	(10) Date and reas						
		mination shall be required for					
		a facility within one (1) month					
		ent. The examination shall					
		in skin test, using the Mantoux					
		D), administered by persons					
	-	tion of training from a					
		ved course of instruction in					
		ulin skin testing, reading, and					
		previously positive reaction					
		d. The result shall be recorded					
		nduration with the date given,					
		whom administered. The					
		t must be read prior to the					
	employee starting the following:	work. The facility must assure					
	(1) At the time of	employment, or within one (1)					
		ployment, and at least annually					
	_	ees and nonpaid personnel of					
		creened for tuberculosis. For					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/27/2023 155767 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 628 N MERIDIAN RD SPRINGHURST HEALTH CAMPUS GREENFIELD, IN 46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days fo personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. R 0000 Bldg. 00 This visit was for a State Residential Licensure R 0000 Preparation or execution of this Facility ID: 005954 QYO711 Page 47 of 56 Event ID: If continuation sheet State Form

05/08/2023

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155767	B. WING		02/2	02/27/2023	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP ( MERIDIAN RD	COD		
SPRING	HURST HEALTH (	CAMPUS		NFIELD, IN 46140			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE	
		included a Recertification and		plan of correction doe			
	State Licensure Su	irvey.		constitute admission of	-		
	Survey date: Febr	North 27, 2022		of provider of the truth			
	Survey date. Febr	uary 27, 2025		alleged or conclusions the Statement of Defic			
	Facility number: (	005954		Plan of Correction is p			
	i denity number.	505751		executed solely becau	-		
	Residential Census	s: 51		required by the position			
				and State Law. The P			
	These State Reside	ential Findings are cited in		Correction is submitte			
	accordance with 4	-		to the allegation of nor			
				cited during the Annua			
	Quality review con	npleted on February 28, 2023		conducted February 2	20 – 27,		
				2023.			
				Please accept this Pla			
				Correction as the prov			
				credible allegation of o			
				as of April 1, 2023. Th			
				respectfully requests o			
				with paper compliance			
				considered in establis	•		
				provider is in substant compliance.	liai		
R 0119	410 100 16 2 5 1	.4(d)(1)(A-E)(2)(A-D)(3-					
10115	Personnel - None						
Bldg. 00		ng independently, each					
2.49.00		e given an orientation to the					
		pervisor (or his or her					
		department in which the					
		rk. Orientation of all					
	employees shall	include the following:					
	· · /	n the needs of the					
	specialized popu	lations:					
	(A) aged;						
	(B) development	ally disabled;					
	(C) mentally ill;						
	(D) dementia; or						
	(E) children;	114.7					
	served in the faci	iiity.					

· /		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023		
	ROVIDER OR SUPPLIE			628 N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e facility's policy manual and		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	employees; and (D) residents' rigi (3) Instruction in procedures, and preparedness, in procedures. (4) Review of eth confidentiality in (5) For direct car- to, and instruction each resident to providing care. (6) Documentation employee's person supervising the on Based on interview failed to complete employee records Findings include: Employee records 10:15 a.m. Resident Care Ass 11/22/2022. No im- orientation was pro- Certified Resident hired on 11/22/202 specific orientation record.	chart; licies; and grooming policies for hts. first aid, emergency fire and disaster cluding evacuation ical considerations and resident care and records. e staff, personal introduction n in, the particular needs of whom the employee will be on of the orientation in the onnel record by the person rientation.	R 0.	119	R119 – Personnel - Noncompliance "Facility failed to complete a complete orientation for 2 of employee records reviewed." 1: What corrective action(s) be accomplished for those residents found to have affected by the deficient practice? - 2 of 5 employees were found to be missing complete orientation. - Employees were immediately notified and are required to provide documents/orientation. 2: How other residents hav the potential to be affected	" e e	04/01/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTI A. BUILDI B. WING	ple construction ing <u>00</u>	COMI	(X3) DATE SURVEY COMPLETED 02/27/2023	
				TREET ADDRESS, CITY, STATE, ZI		7/2023	
	PROVIDER OR SUPPLIE			28 N MERIDIAN RD			
SPRING	HURST HEALTH C	CAMPUS	G	REENFIELD, IN 46140		-	
X4) ID PREFIX	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	II PRE	FIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	17	10		DATE	
		cords requested and that they		the same deficient be identified and w	-		
		g quality compliance audits on		corrective action w			
	all employee recor			- All newly hired			
				have the potential to			
	An interview with	the Executive Director on		by the alleged defici			
	2/27/2023 at 11:19	a.m. indicated they were unable		- ED/designee	-		
	to provide any furt	her information for the		reeducated on hiring	process with		
	requested employe	ees.		concentration on, bu	it not limited		
				to, general orientation			
		ed "State File Checklist", was		Education provided:			
	-	ecutive Director on $2/27/2023$ at		o State File Checkl			
	have this complete	cated it is the expectation to d for every employee. This d: general orientation checklist		o General orientation and job specific cheory			
	and job specific ch			3: What measures v	vill be put		
	JF			into place or what s	-		
				changes will be ma	-		
				ensure that the defi			
				practice does not re	ecur?		
				- ED/AP Payro	ll/Designee		
				will ensure monitorin	ng of newly		
				hired employees for			
				biweekly for 8 weeks			
				monitored monthly in	n QAPI for 6		
				months.			
				4: How the corrective	ve action		
				will be monitored to			
				deficient practice w			
				i.e., what quality as			
				program will be put			
				- Designee will	=		
				responsible for moni	itoring		
				compliance of the w	• •		
				for 6 months. The re			
				audits will be review	•		
				committee overseen	-		
				Executive Director. I			
				of 100% is not achie	eved, an action		

State Form

Event ID: QYO711 Facility ID: 005954

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155767	B. WING		_	7/2023
			STREET	ADDRESS, CITY, STATE, ZIP CO	DD	
	PROVIDER OR SUPPLIE			MERIDIAN RD		
SPRING	HURST HEALTH (	CAMPUS	GREE	NFIELD, IN 46140		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORF		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE PPROPRIATE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				plan will be developed.		
				facility through the QAF		
				will review, update, and		
				changes to the POC as		
				sustaining substantial of		
				for no less than 6 mont	hs.	
R 0120	410 IAC 16.2-5-1	1/(p)(1-3)				
0120	Personnel - None					
Bldg. 00		e an organized inservice				
Blug. 00		aining program planned in				
		ersonnel in all departments				
		Training shall include, but				
		residents' rights, prevention				
		ection, fire prevention,				
		prevention, the needs of				
		lations served, medication				
		nd nursing care, when				
	appropriate, as fo	-				
		y and content of inservice				
		aining programs shall be in				
		the skills and knowledge of				
		nnel. For nursing personnel,				
		at least eight (8) hours of				
		endar year and four (4) hours				
		alendar year for nonnursing				
	personnel.	alendar year for nonnarsing				
		the above required inservice				
		have contact with residents				
		mum of six (6) hours of				
		c training within six (6)				
		e (3) hours annually				
		et the needs or preferences,				
		ively impaired residents				
	-	gain understanding of the				
	-	s of care for residents with				
	dementia.					
		orde shall be maintained and				
		ords shall be maintained and				
	shall indicate the (A) The time, dat	-				
	LIALINE IIME dat	e, and location.		1		1

PRINTED: 05/08/2023 FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/27/2023	
	PROVIDER OR SUPPLIE		628 N	t address, city, state, zip cod I MERIDIAN RD ENFIELD, IN 46140		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	<ul> <li>(B) The name of</li> <li>(C) The title of th</li> <li>(D) The names o</li> <li>(E) The program</li> <li>The employee wide</li> <li>by written signate</li> <li>Based on interview</li> <li>failed to have require</li> <li>employee records</li> <li>Findings include:</li> <li>Employee records</li> <li>10:15 a.m.</li> <li>Resident Care Ass</li> <li>5/23/2012. No dentite the last 12 months</li> <li>RCA 10 was hired</li> <li>dementia training</li> <li>employee record a</li> <li>Certified Resident</li> <li>hired on 1/16/2013</li> <li>indicated in the last</li> <li>record.</li> <li>CRCA 9 was hired</li> <li>dementia training</li> <li>employee record a</li> <li>Licensed Practical</li> <li>1/29/2008. No dentite</li> <li>hard interview with</li> <li>2/27/2023 at 10:24</li> </ul>	the instructor. e instructor. f the participants. content of inservice. Ill acknowledge attendance ure. v and record review, the facility ired dementia training for 5 of 5 reviewed. were reviewed on 2/27/2023 at istant 13 (RCA) was hired on mentia training was indicated in on the employee record. on 11/22/2022. Six hours of was not completed on the fter hire. Care Assistant 14 (CRCA) was 3. No dementia training was at 12 months on the employee d on 11/22/2022. Six hours of was not completed on the	R 0120	<ul> <li>R120 - Personnel - Noncompliance</li> <li><i>"Facility failed to have required dementia training for 5 of 5 employee records reviewed."</i></li> <li>1: What corrective action(s) we be accomplished for those residents found to have affected by the deficient practice?</li> <li>5 of 5 employees were found to be missing dementia training.</li> <li>Employees were immediately notified and are required to provide documents complete training.</li> <li>2: How other residents having the potential to be affected by the same deficient practice we be identified and what corrective action will be takener. All newly hired employees have the potential to be affected by the alleged deficient practice.</li> <li>ED/designee were reeducated on hiring process we concentration on, but not limite to, dementia training.</li> <li>Education provided:</li> <li>State File Checklist</li> <li>Dementia Training</li> </ul>	or 9 / / / / / / / / / / / / /	

If continuation sheet Page 52 of 56

ENTERS FOR MEDICARE & MEDI- STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023	
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 628 N MERIDIAN RD GREENFIELD, IN 46140				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	all employee record An interview with 2/27/2023 at 11:19 to provide any furt requested employee A document entitle provided by the Ex 11:45 a.m. He indit have this complete document included	the Executive Director on a.m. indicated they were unable her information for the		<ul> <li>3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? <ul> <li>ED/AP Payroll/Designee</li> <li>ED/AP Payroll/Designee</li> <li>will ensure monitoring of newly hired employees for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months.</li> </ul> </li> <li>4: How the corrective action will be monitored to ensure the deficient practice will not recurie., what quality assurance program will be put into place <ul> <li>Designee will be</li> <li>responsible for monitoring</li> <li>compliance of the weekly process for 6 months. The results of the audits will be reviewed by the Committee overseen by the Executive Director. If a threshol of 100% is not achieved, an act plan will be developed. The facility through the QAPI program will review, update, and make changes to the POC as needed sustaining substantial compliant for no less than 6 months.</li> </ul></li></ul>	6 <b>r</b> <b>r</b> <b>r</b> <b>r</b> <b>r</b> <b>r</b> <b>r</b> <b>r</b>	
R 0121	410 IAC 16.2-5-1 Personnel - Nond	compliance				
Bldg. 00	employee of a fa	n shall be required for each cility prior to resident een shall include a tuberculin				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155767	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED <b>02/27/2023</b>	
	PROVIDER OR SUPPLIE		628 N	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	PPD), unless a p can be document recorded in millin date given, date administered. Th following: (1) At the time of (1) month prior to annually thereaft personnel of facil tuberculosis. The must be read prior work. For health had a documente test result during months, the base should employ th first step is negat performed one (1 first step. The fre depend on the ris tuberculosis. (2) All employees reaction to the sk have a chest x-ra laboratory exami a diagnosis. (3) The facility sh of each employee employment-rela (4) An employee active disease, (s active tuberculos to, cough, fever,	the Mantoux method (5 TU, reviously positive reaction reed. The result shall be heters of induration with the read, and by whom e facility must assure the employment, or within one e employment, and at least er, employees and nonpaid ities shall be screened for first tuberculin skin test or to the employee starting care workers who have not ed negative tuberculin skin the preceding twelve (12) line tuberculin skin testing e two-step method. If the ive, a second test should be ) to three (3) weeks after the quency of repeat testing will ik of infection with s who have a positive in test shall be required to y and other physical and nations in order to complete all maintain a health record e that includes reports of all ted health screenings. with symptoms or signs of symptoms suggestive of is, including, but not limited hight sweats, and weight permitted to work until led out.				
		and record review, the facility f had an annual Mantoux test	R 0121	R121 – Personnel - Noncompliance <i>"Facility failed to ensure staff I</i>	04/01/20	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155767		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED 02/27/2023	
		B. WING				
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ER		MERIDIAN RD		
SPRING	HURST HEALTH (	CAMPUS	GREEI	NFIELD, IN 46140		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	and/or tuberculosi	s risk assessment for 3 of 5		an annual Mantoux test and/o	r	
	employee records	reviewed.		tuberculosis risk assessment	for	
				3 of 5 employee records revie	wed."	
	Findings include:			1: What corrective action(s)	will	
				be accomplished for those		
	Employee records	were reviewed on 2/27/2023 at		residents found to have		
	10:15 a.m.			affected by the deficient		
				practice?		
	Resident Care Ass	istant 13 (RCA) was hired on		- 3 of 5 employees were		
	5/23/2012. No ann	ual Mantoux test and/or		found to be missing tuberculo		
	tuberculosis risk a	ssessment were completed in		risk assessment.		
	the last 12 months	-		- Employees were		
				immediately notified and are		
	Certified Resident	Care Assistant 14 (CRCA) was		required to provide documents	s or	
		3. No annual Mantoux test		complete risk assessment.		
	and/or tuberculosi	s risk assessment were				
	completed in the la	ast 12 months.		2: How other residents havi	na	
	1			the potential to be affected b	-	
	Licensed Practical	Nurse 15 (LPN) was hired on		the same deficient practice v	-	
		nual Mantoux test and/or		be identified and what		
	tuberculosis risk a	ssessment were completed in		corrective action will be take	en.	
	the last 12 months	-		- All newly hired employee		
				have the potential to be affect		
	An interview with	the Executive Direction on		by the alleged deficient practic		
		a.m. indicated there were lapses		- ED/designee were		
		cords requested and that they		reeducated on hiring process	with	
		g quality compliance audits on		concentration on, but not limit		
	all employee recon			to, tuberculosis risk assessme		
				Education provided:		
	An interview with	the Executive Director on		o State File Checklist.		
	2/27/2023 at 11:19	a.m. indicated they were unable		o Annual Tuberculosis Risk		
		ther information for the		Assessments.		
	requested employe					
				3: What measures will be pu	t	
	A document entitle	ed "State File Checklist", was		into place or what systemic		
		xecutive Director on 2/27/2023 at		changes will be made to		
		icated it is the expectation to		ensure that the deficient		
		ed for every employee. This		practice does not recur?		
	-	d annual tuberculosis.		- ED/AP Payroll/Designe	e	
				will ensure monitoring of newl		

Event ID: QYO711 Facility ID: 005954 Page 55 of 56 If continuation sheet

PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155767		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 02/27/2023		
	ROVIDER OR SUPPLIE		628 N 1	address, city, state, zip cod MERIDIAN RD NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) hired employees for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for months. 4: How the corrective action will be monitored to ensure the deficient practice will not rece i.e., what quality assurance program will be put into place - Designee will be responsible for monitoring compliance of the weekly proce for 6 months. The results of the audits will be reviewed by the 6 committee overseen by the Executive Director. If a threshop of 100% is not achieved, an action	6 he ur e? ess ese QA old	
				plan will be developed. The facility through the QAPI progr will review, update, and make changes to the POC as neede sustaining substantial complian for no less than 6 months.	d for	

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If continuation sheet

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