Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155767	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springhurst Health Campus	628 N Meridian Rd Greenfield, IN 46140

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to correctly transcribe the hospital's discharge orders for 1 of 3 residents reviewed for accuracy of physician orders for a newly admitted resident. This deficient practice resulted in a resident not having a diagnosis of diabetes identified and not receiving his hospital discharged ordered insulin for five (5) days, which contributed to the resident having elevated (high) blood glucose, diminished cognitive levels, lethargy and being sent out to the local hospital. The resident was sent out to the local hospital on 2-13-26, at the request of the family. He was subsequently admitted to the local hospital the same date for altered mental status, possibly related to dehydration, infection or diabetic ketoacidosis. (Resident B) The Immediate Jeopardy began on 2/6/26 when the facility failed to correctly transcribe the hospital's discharge orders for a resident resulting in the resident not having a diagnosis of diabetes identified and not receiving his hospital discharged ordered insulin for five (5) days resulting in hospitalization for five days, extreme elevated blood glucose levels, and altered mental status as a result of possible diabetic ketoacidosis. The Administrator and Regional Nurse Consultant were notified of the Immediate Jeopardy on 3/20/26 at 3:40 p.m. Findings include:The clinical record of Resident B was reviewed on 3-18-26 at 11:02 a.m. The resident's diagnoses included, but were not limited to type 2 diabetes, acute upper respiratory infection and unspecified dementia (mental decline). His 5-day Minimum Data Set (MDS) assessment, conducted on 2-11-26, indicated he was severely cognitively impaired. The resident received hypoglycemic medications (insulin, designed to lower blood glucose levels) and had received one (1) insulin injection since his admission on [DATE]. The MDS assessment indicated during a drug regimen review, an issue had been identified which had potentially clinically significant issues and the identified issue had been brought to the attention of the medical provider. A review of Resident B's clinical record indicated his hospital discharge orders, dated 2-6-26, specified he had a diagnosis of type 2 diabetes and was to receive glargine (also known as Lantus insulin, a long-acting insulin) 16 units subcutaneously (under the skin) twice daily and was ordered to receive blood glucose (BG) monitoring before meals (or three times daily). These orders were not entered into the resident's electronic health record until 2-12-26. He was not ordered to continue the sliding scale insulin (short-acting insulin administered as based on the results of the BG levels) as he had received in the hospital. Additionally, the discharge orders indicated Resident B was to have monitoring of his blood sugar levels twice daily. In an interview with the Director of Health Services (DHS) and Executive Director (ED) on 3-18-26 at 1:05 p.m., the DHS indicated during an initial care planning meeting with Resident B's family member on 2-11-26, a family member inquired about the resident's BG levels. The hospital discharge summary initial page did not specifically mention the diabetes diagnosis, as it was located further into the document. Multiple facility staff, including herself (DHS), the MDS staff, the Nurse Practitioner and two facility nurses originally reviewed the discharge and entered the orders into the facility's electronic health record. She indicated the facility staff failed to locate the information initially, but with further inspection on 2-11-26, the information was located and acted upon at that time by notifying the resident's responsible party and the attending physician of the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	situation and ensured updated medication and care orders were received and initiated the same date. During the interview with the DHS and ED, they shared a copy of a document dated 2-11-26, and entitled, Investigation Summary. which indicated Resident B was admitted to the facility on [DATE], for a short-term rehab stay due to upper respiratory infection, weakness, dehydration, and hydrocephalus. The resident had poorly controlled diabetes. Diabetes monitoring orders for Lantus insulin, were not transcribed at admission. The medication error was discovered on 2-11-26, during a family meeting. The attending physician was immediately notified as to the occurrence with new orders obtained. The document's Summary of Investigation, indicated, A transcription error at admission was identified as the root cause. The team notified the provider and responsible parties, obtained updated orders, developed an action plan, provided staff education, and initiated ongoing audits. In an interview with the DHS on 3-19-26 at 9:58 a.m., the DHS indicated the post-incident staff education, the staff were educated on the need to complete both Occurrence, and Event, documents regarding any incidents. Although both documents are technically a part of each resident's clinical record, only the Occurrence, was viewable to non-staff persons. She did complete a late entry under 'Occurrence,' to address the medication transcription omission for the resident. Review of Resident B's prior hospitalization records, indicated Resident B's BG results while hospitalized indicated the following: on 2-6-26 at 8:42 a.m., the resident's BG level was 99 and at 12:05 p.m. the resident BS level was 277 (normal fasting blood glucose levels range from 70 to 100). Review of Resident B's hospital records, beginning on 2-13-26, indicated he was initially seen in the emergency room and later admitted to the hospital. His medical records indicated he had an elevated white blood count (blood cells that help to fight infections) that were elevated at 19.0. Additionally, it indicated his hospital admission diagnoses, included but were not limited to, altered mental status, possibly related to dehydration, infection, or diabetic ketoacidosis (a serious life-threatening complication of diabetes occurring when the body breaks down fat too quickly for energy, producing toxic acidic substance called ketones resulting from lack of insulin, leading to high blood sugar levels). It identified his diabetes as being uncontrolled at that time. He did discharge on [DATE], to an area nursing facility. A review of Resident B's BG results, were as followed: on 2-11-26 at 8:04 p.m., the resident's BG level was 399; on 2-12-26 at 11:39 a.m., the resident's BG level was 451; on 2-12-26 at 4:04 p.m., the resident's BG level was 496; on 2-12-26 at 10:27 p.m., the resident's BG level was 316; on 2-13-26 at 5:27 a.m., the resident's BG level was 360; on 2-13-26 at 8:38 a.m., the resident's BG level was 356; on 2-13-26 at 11:58 a.m., the resident's BG level was 422; and on 2-13-26 at 4:34 p.m., the resident's BG level was 354 (normal fasting blood glucose levels range was from 70 to 100). On 3-19-26 at 8:40 a.m., the ED provided a copy of a policy, reviewed by the facility on 12-12-25, entitled, Guidelines for Medication Error Reporting. This policy indicated it purpose as, In the event of a medication error, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare. Notify the attending physician promptly of the error. Implement the physician orders. Notify the resident or responsible party. Initiate the appropriate Event form. Monitor the resident closely for 72 hours or as directed. Document the following in the resident's clinical record: A description of the error (brief); Name of the physician and time notified; Physician's subsequent orders. In an interview with the Corporate Nurse on 3-19-26 at 2:50 p.m., she indicated she could not locate any other policies related to medication errors. The past non-compliance Immediate Jeopardy began on 2-6-26. The Immediate Jeopardy was removed and the deficient practice corrected by 2-16-26, prior to the start of the survey, and was therefore past noncompliance after the facility implemented a systemic plan that included the following actions: immediate notification of the physician and the responsible party of the identified issues, obtaining updated physician orders, implementing those orders, educating the licensed nursing staff on the facility's policies related to transcribing physician orders and diagnoses from the discharging entity into the facility's electronic health record, initiated an audit system to ensure any resident admitted to the facility in the last 30 days, and ongoing, had accurately transcribed admission orders and diagnoses correctly documented (continued on next page)

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