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	04/30/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 15909 Based on observation, interview, and record review, the facility failed to promote a resident's dignity by telling Resident H to utilize an incontinence brief instead of a bedpan, and a staff member cursed within hearing distance of Resident F. This affected 2 of 3 residents reviewed for dignity. Findings include: 1. Resident F's record was reviewed on 4/26/24 at 11:03 a.m. The record indicated Resident F had diagnoses that included, but were not limited to, metabolic encephalopathy, heart disease, atrial fibrillation, type 2 diabetes, violent behavior, speech disturbances, and vascular dementia, severe, with psychotic disturbance. An Admission Minimum Data Set assessment, dated 1/19/24, indicated Resident F was severely cognitively impaired, is sometimes understood, rarely/never understood, had physical behavior symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days. Had other behavioral symptoms not directed toward others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) for 1 to 3 days. did not reject care, did not wander, was frequently incontinent of bowel and bladder, and was dependent on staff for toileting, hygiene, showers, and most activities of daily living. A State reportable incident, dated 3/14/24, indicated a brief description of incident: At approximately 4:30 pm an allegation was reported to the Executive Director that the employee was cursing while providing care to the resident. The employee has been suspended pending an investigation. Type of Injury: No injuries noted. Immediate Action Taken: Allegation reported to Executive Director, employee suspended, investigation, and the resident was assessed for potential injury, no injuries noted, and/or emotional distress noted. the resident's physician and responsible party were notified. Type of preventative measures added: This investigation is ongoing, employee will remain suspended during investigation, [resident] will be monitored for signs and symptoms of emotional distress. Follow Up: 3/20/24: Investigation concluded with no findings that CRCA (Certified Resident Care Assistant) [CRCA's initials] was verbally inappropriate while providing care to resident [resident's initials]. Employee may return to work. Resident [resident's initials] will continue to be followed by Social Services, family/POA has no requests for the facility at time of conclusion of this investigation. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/26/24, at 11:40 a.m., CRCA 3 indicated she usually didn't have any difficulty with Resident F's care. He would be agitated or aggressive at times, but would usually just let them take care of him, mainly when he was incontinent, and needed to go to the bathroom. He would refuse care, they would wait a few minutes and re-approach. She said she has not observed or been told that any staff had cursed at Resident F, nor became agitated with him. The investigative notes of the interviews were reviewed, as provided by the Administrator, on 4/26/24 at 1:35 p.m., as follows: A. The payroll coordinator, on 3/14/24, indicated I was assisting a resident back to their room and observed [CRCA 3] assisting the resident. The resident was sitting in the common area by the nurse's station and the employee was picking up pieces to an activity table. CRCA 3 reported the resident had pushed her causing her to fall onto the activity table to break. CRCA 3 stated 'I was attempting to assist him to his room to change his brief and clothes.' I heard CRCA 3 cursing in front of the resident. B. CRCA/CNA [3], on 3/14/24, indicated: I had just returned from break and observed the resident, [F], walking unassisted in the common area by the nurse's station. I attempted to redirect the resident to sit down. The resident then pushed me, causing me to fall onto his activity table resulting in the table breaking. At this time the resident had sat back down in his wheelchair, and I walked away to assist another resident. Once I had finished assisting the other resident, I returned to the common area and noticed the resident was attempting to stand and walk unassisted. I re-approached the resident and noticed the resident pooped. At this time, I attempted to redirect the resident to his wheelchair, explain to him that he had pooped and that I needed to change him. I said to the nurse, This man needs changed and needs his medicine. I do not remember if I had cussed but I would not cuss at a resident. I was frustrated but that is why I walked away to assist other residents and attempted to re-approach [Resident F]. C. Director of Nursing, on 3/19/24: I arrived at 1500 (3:00 p.m.). There was no aid at that time, she was on break. 3:45 she returned. [Resident F] was continuing to stand up. [CRCA 3] returned and assisted [Resident F] to his chair. It looked like [Resident F] shoved [CRCA 3] and she fell backwards onto the table and broke it into multiple pieces. Later on, [Resident F] was repeatedly trying to stand up. [CRCA 3] was asking [Resident F] to sit. [Payroll Coordinator] was present and [CRCA 3] was with [Resident F]. I didn't hear anything or see any forceful motions. They all disappeared and then the ED came down to talk to [CRCA 3]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, with the AP/Payroll Coordinator, on 4/26/24, at 2:31 p.m., she indicated she was taking a resident back to her room, as she was walking by, she saw CRCA 3, and heard her mumbling and grumbling while she was picking stuff off the floor. She asked CRCA 3 what was going on, and she said the resident had pushed her and she had fallen back. CRCA 3 said some curse words in front of the resident but not to the resident, she did not see the interactions, he was sitting on the couch and didn't act bothered at all. The CRCA had broken a table, and she said f***ing poop, but it wasn't directed toward the resident. Resident F was incontinent at the time, it was about a month before he passed. She said she did not feel it was abusive, it was not directed toward him. He didn't seem to notice anything. He acted like he could care less. No other residents or staff were present. A nurse was at the medication cart and might have heard, but the nurse heard her addressing it. The CRCA was talking in her normal voice and she has a loud personality. She said she saw it happened and reported it to her business office manager, and her BOM went to the Executive Director or the Director of Nursing about it, and the Executive Director talked to her before she left for the day. On 4/30/24, at 11:39 a.m., the Business Office Manager (BOM) indicated she had heard about it but did not see it, that the AP/Payroll Coordinator had reported it also, after it was reported the employee was suspended for investigation and said they knew to report it right away. 45291 2. The clinical record for Resident H was reviewed on 4/25/2024 at 1:55 p.m. The medical diagnosis included depression. No minimum data set assessment was available for Resident H. A baseline care plan, dated 4/19/2024, indicated to provide assistance to Resident H with toileting as needed. An interview with Resident H on 4/23/2024 at 1:52 p.m., indicated that she is continent of her bladder, but she had an ostomy from a complications from a procedure. Since she had been admitted to the facility, she utilized a bedpan due to not being able to transfer to the toilet. She indicated that there is often spillage, or she overfills the bedpan, resulting in a need to have her linens changed. This caused her to be upset at times due to her history with incontinence and the importance of her to be continent after the complications of her previous history that resulted in her having an ostomy for her bowel. An interview with CNA 3 on 4/26/2024 at 11:42 a.m., indicated she had cared for Resident H. Resident H was continent of her bladder and utilized a bedpan for toileting needs due to having a recent procedure to her foot and being non weight bearing. The morning on 4/25/2024, Resident H disclosed to her that the night shift nurse had instructed her to use her brief instead of a bedpan. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN 4 on 4/26/2024 at 1:45 p.m., indicated that Resident H disclosed to her the night shift nurse had told her to use her brief instead of the bedpan because she was going to have to change her anyway. Resident H appeared upset when she was talking about the interaction to LPN 4. LPN 4 indicated that Resident H was continent of her bladder and utilized a bed pan, but the bed pan was too small for Resident H so she would have spillage and need a linen change with peri-care after toileting. An interview with Resident H on 4/26/2024 at 3:15 p.m., indicated that early on the morning on 4/25/2024 she had requested to use the bedpan. The night shift nurse responded to her request with, Just go in your brief, I'm going to have to change you anyway. Resident H recalled that she told the nurse she was not going to do that, and they went back and forth for a few minutes before the nurse finally put her on the bedpan. The interaction made Resident H upset, frustrated, and disrespected. A policy, entitled Resident Rights Guidelines, was provided by the Executive Direction on 4/29/2024 at 2:49 p. m. the policy indicated, .Our residents have the right to .Be treated with dignity and respect .Be treated fairly, courteously and with respect by all staff This Federal tag relates to Complaint IN00431921. 3.1-3(t)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15909 Based on interview, and record review, the facility failed to provide showers as scheduled for 2 of 4 residents reviewed for activities of daily living. (Residents K and B) Findings include: 1. On 4/23/24, at 2:39 p.m., Resident K indicated she doesn't get her showers like she is supposed to, that she doesn't get her showers twice a week; staff will come in at 9 p.m. and she doesn't want one then. She is supposed to get showers on Wednesday and Saturday after 6 p.m. Resident K's record was reviewed, on 4/25/24, at 1:19. The record indicated Resident K was admitted with diagnoses that included, but were not limited to, metabolic encephalopathy, severe sepsis with septic shock, acute respiratory failure with hypoxia, acute kidney failure, chronic obstructive pulmonary disease, osteoarthritis, low heart rate, and high blood pressure. An Admission Minimum Data Set assessment, dated 2/20/24, indicated Resident K was cognitively intact, required substantial/maximal assistance for shower or bathing, and it was very important for her to choose between a tub bath, shower, bed bath or sponge bath. A care plan, with a start date of 3/01/2024, indicated a problem of Resident requires staff assistance to complete self-care and mobility functional tasks completely and safely. Goal: Resident will have functional needs met safely by staff Shower sheets, for 3/1/24 through 4/17/2024, were provided by the Director of Nursing, on 4/19/24 at 10:00 a.m., and indicated she had a shower on the following days: 3/9/24, 3/20/24, 3/23/24, 3/30/24, 4/6/24, 4/10/24, 4/13/24, 4/17/24. Resident K should have received 9 showers in March. 45291 2. The clinical record for Resident B was reviewed on 4/30/2024 on 11:20 a.m. The medical diagnosis included stroke. Resident B was admitted on [DATE], had a hospital stay from 8/27/2023 to 8/29/2023, and discharged on [DATE]. An Admission Minimum Data Set Assessment, dated 8/20/2023, indicated that Resident B was mildly cognitively impaired, did not reject care, and was dependent on staff for bathing. A care plan, dated 8/17/2023, indicated that Resident B would receive showers on Mondays and Thursdays. During a confidential interview on 4/29/2024 at 1:11 p.m., it was indicated in the two months that Resident B was at the facility that he had only received four showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Shower documentation for Resident B indicated he had a complete bed bath or shower on the following dates: 8/21/2023 - Shower 9/4/2023 - Complete bed bath 9/15/2023 - Complete bed bath 9/22/2023 - Shower 10/13/2023 - Shower 10/17/2023 - Shower A policy entitled, Guidelines for Bathing Preferences, was provided by the Nursing Support Services on 4/30/2024 at 1:50 p.m. The policy indicated, .Bathing shall occur at least twice a week unless resident preference states otherwise . This Federal tag relates to Complaint IN00419594. 3.1-38(a)(2)(A) 3.1-38(b)(1)