STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155776	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springhill Village	1001 E Springhill Dr Terre Haute, IN 47802

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48226 Based on record review and interview, the facility failed to ensure timely assessments and treatment for a resident with a change of condition in 1 of 6 residents reviewed for quality of care resulting in delayed treatment and hospitalization (Resident C). Findings include: On 11/26/24 at 10:00 a.m., the medical record of Resident C was reviewed. The most recent admission to the facility was on 7/29/24. Admitting diagnoses included, but not limited to, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), fracture of lower end of right femur (broken thigh bone), chronic congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and chronic pain. Physician orders included, but were not limited to, acetaminophen (Tylenol) tablet; 325 milligrams (mg) every 4 hours and as needed (PRN), Occupational therapy (OT) to treat 3 times week for 8 weeks for wheelchair (WC) positioning, generalized weakness, bilateral (both) LE (lower extremity) edema (swelling), physical therapy (PT) to evaluate and treat for transfers. A significant change Minimum Data Set (MDS) assessment, dated 7/13/24, indicated the resident was mildly cognitively impaired and required extensive assistance with daily care needs. A care plan, dated 4/16/2018, indicated the resident was at risk for impaired mobility related to weakness, debility, edema in bilateral lower extremities. Interventions included, but were not limited to, notify therapy of declines in mobility or improvement in mobility, observe for signs of pain. A care plan, dated 4/16/2018, indicated the resident was at risk for pain related to diagnosis of neuropathy (nerve pain). Interventions included, but were not limited to, administer medications as ordered, observe for nonverbal signs of pain, changes in breathing, vocalizations, mood/behavior changes, eyes change, expression, sad/worried face, crying, teeth clenched, and changes in posture. An Indiana State Department of Health (ISDH) Survey Report System report, dated 7/25/24 at 10:01 a.m., indicated Resident C had sustained a fracture of the right femur and the injury had occurred while being transferred with a mechanical lift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155776	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Springhill Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E Springhill Dr Terre Haute, IN 47802	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/26/24 at 10:40 a.m., during an interview, the Regional [NAME] President of Clinical Services (RNCS) indicated the ISDH report, submitted on 7/25/24 where the facility reported Resident C's injury had occurred during a transfer of Resident C with a mechanical lift, was a statement by the resident's family member. On 7/11/24 and 7/17/24 physical therapy notes indicated treatment was provided to Resident C. The treatment provided, on 7/11/24, indicated the resident was dependent for transfer using a mechanical lift. The physical therapy treatment note, dated 7/17/24, indicated the resident was repositioned in the wheelchair due to resident leaning to the left side, and the right hip was internally rotated. The record lacked documentation the physical therapist had notified the nurse of Resident C's internal rotation of the right leg. A nurse progress note, dated 7/18/24 at 2:55 p.m., indicated the resident's skin was dark with yellowish tint. The resident's right foot was contracted inward, and the right knee was very swollen where knee replacement scars were. Resident C required extensive assistance of two staff during mechanical lift. The record lacked documentation of detailed assessment of the right leg, physician notification of change in condition or additional observations or assessment of the right leg. On 7/25/24 the medical record indicated the resident was transferred to the hospital emergency room (ER) for evaluation and was admitted to the hospital for distal femur fracture. The hospital record indicated the right leg was bruised and swollen. The resident was able to minimally move the toes and foot and unable to actively mobilize any part of the leg. On 11/26/24 at 11:40 a.m., during an interview the RNCS indicated she did not know why there was a delay in resident assessment or notification of rotation of right hip and swollen knee to the physician from 7/17/24 to 7/25/24. On 11/26/24 at 3:35 p.m., during interview, the Physical Therapist indicated if a resident had a physical issue during a therapy treatment, depending on if it would affect the resident's function, she would document it in the therapy note. If there was an abnormality they would report it to the nurse. The therapist indicated she would talk to the nurse personally and record the conversation in the therapy notes. The therapist indicated she did not use a communication form to relay information to the nurse. On 11/26/24 at 3:40 p.m., during an interview, Registered Nurse (RN) 12 indicated if a resident had a swollen ankle or leg the RN would do an assessment and then call the physician and report the change in condition. The employee indicated when assessing for an injury the RN would look for redness and warmth and swelling. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155776	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER Springhill Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 E Springhill Dr Terre Haute, IN 47802	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/26/2024 at 2:16 p.m., the RDCS provided a document titled, Resident Change of Condition Policy, dated 11/2018, and indicated it was the policy currently being used by the facility. The policy indicated, . Policy .It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that all appropriate, timely, and effective intervention takes place . 2. Acute Medical Change .a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician .d. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met .3. Non-Urgent Medical Change .a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly b. The nurse in charge is responsible for notification of physician .prior to end of assigned shift .g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized This citation relates to Complaint IN00445095. 3.1-37