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	01/13/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35317 Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 4 of 24 residents reviewed for care plan meetings (Residents 24, 28, and 37), and the facility failed to ensure the resident and or the resident representative was present for an initial care plan meeting for 1 of 24 residents reviewed. (Resident 64). Findings include: 1. During an interview, on 1/8/25 at 10:12 a.m., Resident 24 indicated he did not remember being invited to or attending a care plan meeting recently. He thought maybe the last one was 6 months ago. Resident 24's record was reviewed on 1/9/25 at 10:42 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/12/24, indicated the resident had no cognitive impairment. Census information indicated the resident was admitted to the facility on [DATE]. A care plan summary note, dated 6/26/24 indicated a care plan meeting was conducted on this day for Resident 24. A care plan summary note, dated 10/30/24, indicated a care plan meeting was conducted on this day for Resident 24. Resident 24's record lacked documentation of quarterly care plan meetings being conducted for the last year, January 2024 to January 2025. 2. During an interview, on 1/7/24 at 11:46 a.m., Resident 28 indicated she did not remember being invited to or attending a care plan meeting. She could not recall when the last one was. Resident 28's record was reviewed on 1/9/25 at 11:42 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident had no cognitive impairment. Census information indicated that the resident was admitted to the facility on [DATE]. A care plan summary note, dated 6/4/24, indicated a care plan meeting was conducted on this day for Resident 28 (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Resident 28's record lacked documentation of quarterly care plan meeting being conducted from June 2024 to January 2025. 48226 2. On 1/07/25 at 12:07 p.m., during an interview, Resident 37 indicated she had not attended a care plan meeting. On 1/9/25 at 11:23 p.m., the medical record for resident 37 was reviewed. Diagnosis included but were not limited to nontraumatic intracerebral hemorrhage (bleeding in the brain that occurs without trauma or other known causes), dated 11/29/2023. Parkinsons disease (a brain disorder that causes movement problems, including tremors, stiffness, and difficulty with balance), dated 1/02/2025. A quarterly Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident was cognitively intact. The medical record documentation indicated a care plan summaries, dated 5/8/24 and 10/30/24, were completed. The meeting notes indicated the resident attended. The record lacked documentation of any disciplines attending. The record lacked evidence of additional care plan meetings before 5/8/24 or after 10/30/24. 34525 3. Resident 64's record was reviewed on 1/8/25 at 3:01 p.m. The profile indicated the resident had been admitted to the facility on [DATE]. The resident's diagnoses included, but were not limited to, type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and adult failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments). An admission Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the resident had severe cognitive deficit. A Road to Recovery meeting document (a document that summarizes a person's health conditions, care needs, and treatments), dated 12/16/24, lacked documentation that the resident and/or her representative were present and participated in the meeting or a reason why they had not attended. The document indicated Social Services were the only persons in attendance. A Social Services progress note, dated 1/2/25 at 2:04 p.m., indicated a meeting had taken place to discuss the resident's clinical information, goals, and discharge plan. The document indicated members of the Interdisciplinary Team (IDT-a group of health care professionals with various areas of expertise who work together toward the goals of their residents) and Social Services had attended the meeting. The note lacked documentation that the resident and/or her representative had attended or participated in the meeting or a reason why they had not attended. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 9:46 a.m., the Social Services Director (SSD) provided a document, with a postmark date of 12/16/24, and indicated it was a letter that had been sent to the resident's representative. The letter requested that her representative call to schedule a meeting to discuss her plan of care. The resident's record lacked documentation of any return contact from her representative about scheduling a meeting. The record lacked documentation of any follow-up attempt by the facility, to contact the resident's representative regarding the letter. During an interview, on 1/9/25 at 11:55 a.m., the Social Service Director (SSD) indicated he was hired in March 2024 to fill a vacant SSD position and completed his training in May 2024. He indicated the facility did not have a good system in place to keep track of the quarterly care plan meetings and he was now working on that and they had an action plan in place. He was unable to provide documentation that the care plan meetings were conducted quarterly for the above residents. The SSD indicated that a post card was mailed out or handed to the residents and/or resident representatives to remind them to call the facility to schedule a care plan meeting, but he had noticed that they were not calling the facility to schedule the care plan meetings, and they were getting missed. On 1/9/25 at 12:51 p.m., the Executive Director (ED) provided a document, with a revision dated of 8/2023, titled, IDT Comprehensive Care Plan Policy, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: Care plan review will be interdisciplinary and should include, to the extent possible, nursing, social services, activities, dietary, therapy, pharmacy, physician, direct care staff, and hospice (if indicated). Resident, resident representative, or others as designated by the resident will be invited to the care plan review. The care plan review will be conducted face-to-face, via phone conference, video conference, or through written communication per resident and/or representative preference. Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each MDS assessment 3.1-35(a)(2)(C) 3.1-35(e)

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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. 48226 Based on interview and record review, the facility failed to ensure residents who were dependent on staff for shaving facial hair, received the service for 1 of 24 residents reviewed for Activities of Daily Living (ADL) assistance (activities related to personal care). (Resident 65) Findings include: On 1/07/25 at 11:54 a.m., during an observation, Resident 65 was observed in his room with extensive beard growth. The resident indicated he wanted to be shaved. He indicated the staff had shaved him before and needed to do it again. He did not like to have facial hair. On 1/8/25 at 10:45 a.m., observed Resident 65 in his room with facial hair. He indicated the staff had not offered to shave him. On 1/9/24 at 10:30 a.m., observed Resident 65 in the hall with extensive facial hair. On 1/9/25 at 11:35 a.m., during an interview, Certified Nurse Aide (CNA) (15) indicated she shaved residents on their designated shower day. On 1/9/24 at 11:38 a.m., during an interview CNA (13) indicated residents were to be shaved on shower days. On 1/9/24 at 2:30 p.m., during an interview the Director of Nursing Services (DNS) indicated Resident 65 often refused showers and those were the days he would have been shaved. The DON provided shower records indicated the resident had refused showers and records indicated the resident had been shaved on other days. On 1/9/24 at 2:45 p.m., the medical record of Resident 65 was reviewed. The resident was admitted to the facility with diagnoses including but not limited to, Type 2 diabetes mellitus (a disease that occurs when your blood glucose, also called blood sugar, is too high), with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems) and need for assistance with personal care, dated 10/23/24. An admission Minimum Data Set (MDS) assessment, dated 10/29/24, indicated the resident was cognitively intact and required assistance from the staff for activities of daily living (ADL) care. A care plan, dated 10/24/24, indicated the resident required assistance and monitoring for a.m. and p.m., care. Interventions included but were not limited to, a.m. and p.m. care tasks included bathing, dressing, hair combing, and oral care. On 1/9/2025 at 12:51 p.m., the DNS provided a document, titled, AM Care, dated, and indicated it was the policy currently being used by the facility. The policy indicated, .8. Shave resident, if needed or requested (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(a)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48226 Based on observation, interview, and record review, the facility failed to ensure that 1of 1 residents observed for transfers and reviewed for accidents had adequate assistance devices and interventions in place to prevent potential for accidents (Resident 8). Findings include: On 1/7/25 at 1:00 p.m., observed Certified Nurse Aide (CNA) 16 transfer Resident (8) from bed to chair. CNA failed to apply a gait belt, nor shoes or non-skid socks prior to assisting to transfer from the bed to a chair next to the resident's bed. The CNA assisted the resident by lifting under the resident's left arm, stood and transferred the resident to the chair. The resident required extensive assistance to transfer and was unsteady when standing. On 1/7/25 at 1:07 p.m., during an interview, CNA 16 indicated the resident refused to wear shoes or socks and indicated sometimes she used a gait belt to transfer a resident. On 1/7/25 at 1:10 p.m., during an interview, Resident 8 indicated the staff always made her wear her shoes when transferring her. She could not recall if the CNA had offered to apply shoes or non-skid socks. On 1/9/24 at 11:40 a.m., during an interview, CNA 14 indicated she placed shoes and or non-skid socks on residents before assisting to transfer. On 1/9/25 at 1:00 p.m., the medical record of Resident 8 was reviewed. The resident was admitted with diagnoses including but not limited to vascular dementia, unspecified severity, (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain), chronic congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and hypertension (high blood pressure). The record indicated the resident had multiple falls since admission and was identified as high fall risk. An annual Minimum Data Set (MDS) assessment, dated 11/5/24, indicated the resident was cognitively intact and required staff assistance with transfers. A care plan, dated 1/30/24, indicated Resident was a high fall risk for falls per a John Hopkins score of 25 points due to: age, one or more falls in the last 6 months, incontinence, on 2 or more high fall risk drugs, unsteady gait, impulsive, lack of understanding of one's physical and cognitive limitations, and requires assist/supervision with mobility/transfers or ambulation. Interventions included but were not limited to, shoes to be placed next to bed and non-skid footwear, dated 12/16/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/2025 at 12:51 p.m., the Director of Nursing Services (DNS) provided a document, titled, Transfer to Wheelchair, dated 9/2023, and indicated it was the policy currently being used by the facility. The policy indicated, .9. put non-skid footwear on resident and securely fasten .11. Place gait belt around resident's waist. 12. Grab belt securely on both sides. 13. With legs on the outside of the resident's legs, brace resident's lower legs to prevent slipping. 14. Instruct resident on count of three to slowly rise and stand 3.1-45(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48226 Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 1 of 3 residents (Resident 172) observed during the medication pass when 2 medication errors were observed during 29 opportunities for error in medication administration resulting in a medication error rate of 6.9%. Findings include: On 1/10/25 at 8:51 a.m., during an observation of the medication pass, Licensed Practical Nurse (LPN) 17 was observed to prepare medications for Resident 172. The LPN was observed administering Timolol 5% eye drops (a medication used to treat the pressure within the eye caused by glaucoma) one drop into each eye of Resident 172. At 8:52 a.m., the LPN administered Dorzolamide HCL 2% (a medication used to treat the pressure within the eye caused by glaucoma) one drop into each eye. The LPN failed to wait a specific time period between administering the eye drops. On 1/10/25 at 8:55 a.m., during interview LPN 17 indicated she would normally wait five minutes between eye drops but the physician order did not indicate to wait between drops. On 1/10/25 at 9:05 a.m., the medical record of Resident 172 was reviewed. The resident was admitted with diagnosis of Glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve.) Physician orders included but not limited to, Timolol 5% eye drops administer one drop into each eye two times daily for diagnosis of glaucoma. Dorzolamide HCL 2% administer one drop into each eye two times daily for diagnosis of glaucoma. On 1/10/2025 at 10:41 a.m., the Director of Nursing (DNS) provided a document, titled, Medication Administration (Medication Pass Procedure), dated 07/2023, and indicated it was the policy currently being used by the facility. The policy indicated, .15. Eye drops separated 3 minutes, when using multiple medications to allow proper absorption 3.1-48(c)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35317 Based on observation, interview, and record review, the facility failed to ensure the scoop used to place ice into residents drink glasses was maintained in a safe and sanitary fashion, and to ensure proper hand hygiene was used when assisting residents in eating their meals for 2 of 2 dining observations. Findings include: 1. During an observation in the main dining room, on 1/7/25 at 11:59 a.m., the Activity Director was preparing a drink for a resident. She scooped ice into the glass and returned the scoop into the ice bucket. The Activity Director served the juice to a male resident. The ice scoop remained in the ice bucket until 12:12 p.m., the Marketing and Admission Director walked over to the drinks and prepared a lemonade for a resident. She scooped the ice into a glass and returned the scoop into the ice bucket. She then served the lemonade to a female resident. The ice scoop remained in the ice bucket until 12:20 p.m. During an interview, om 1/13/25 at 8:30 a.m., Registered Nurse (RN) 19 indicated staff were not to leave the ice scoop in the ice bucket. They were to return it to the empty container by the ice bucket. On 1/13/25 at 8:43 a.m., the Executive Director (ED) provided a document, dated 02/10, titled, Passing Fresh Ice Water, and indicated it was the policy currently being used by the facility. The policy indicated, . 4. Replace ice scoop in proper covered container or cover it with a clean towel or plastic bag to prevent contamination 34525 2. During the initial dining observation in the west unit dining room, on 1/7/25 at 12:00 p.m., the following was observed: a. On 1/7/25 at 12:26 p.m., Qualified Medication Aide (QMA) 10 was observed assisting Resident 47 and Resident 27 with their lunch meals. The QMA failed to perform hand hygiene between residents while assisting them. b. On 1/7/25 at 12:27 p.m., Certified Nursing Assistant (CNA) 11 was observed assisting Resident 221, Resident 40, and Resident 63 with their lunch meals. The CNA failed to perform hand hygiene between residents while assisting them. 3. During a follow-up dining observation, on 1/10/25 at 12:15 p.m., Certified Nursing Assistant (CNA) 12 was observed assisting Resident 27 and Resident 221 with their lunch meals. The CNA was observed touching the residents to help them with their positioning while assisting the residents to eat their meal. She was moving back-and-forth between the residents while assisting them. The CNA failed to perform hand hygiene while assisting the residents with their meals. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/10/25 at 1:45 p.m., the Director of Nursing (DON) indicated the staff should always perform hand hygiene when assisting residents with their meals. If they were assisting more than one resident, hand hygiene should be done between residents. On 1/10/25 at 3:24 p.m., the DON provided a document, with a revised date of 9/2023, titled, Nursing Skills Competency .Feeding a Resident, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure Steps: .17. Perform hand hygiene 3.1-21(i)(3)