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	02/23/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the resident received notice of transfer and bed hold policy, and failed to notify the hospital of transfer or condition report for 2 of 24 residents reviewed for hospitalization (Residents 96 and 7). Findings include:1. On 2/23/26 at 9:52 a.m., the medical record of Resident 96 was reviewed. The resident was admitted to the facility on [DATE]. admission diagnoses included, but was not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and congestive heart failure (CHF) (a condition that develops when your heart doesn't pump enough blood for your body's needs). An admission Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was cognitively intact and required assistance with daily care needs. The medical record, indicated on 1/24/26 at 2:32 p.m., the resident was observed to have extensive swelling of the right side of the face. The physician was notified and an order was received to send the resident to the emergency department for evaluation. The nurse called the hospital on 1/24/26 at 4:44 p.m., to obtain report on the resident's condition. The resident was admitted to the hospital. The medical record lacked evidence of written notice of transfer information and bed hold policy being sent with the resident or transfer report called to the hospital at the time of transfer. On 2/23/26 at 1:00 p.m., during an interview, the Director of Nursing (DON) acknowledged the record lacked documentation to indicate the facility sent the bed hold policy or the notice of transfer information with the resident and failed to call transfer report to the hospital. 2. During a family interview, on 2/18/26 at 9:08 a.m., they indicated Resident 7 had been in and out of the hospital several times since admission. Resident 7's record was reviewed on 2/18/26 at 3:22 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic respiratory failure with hypoxia (lungs cannot properly transfer oxygen in the blood, leading to low oxygen levels) and chronic kidney disease, stage 3a (mild to moderate kidney damage). Facility census information indicated Resident 7 was admitted to the facility on [DATE] and was transferred to the hospital on 1/15/26. Review of progress note, dated 1/15/26 at 9:08 a.m., indicated Resident 7 was lethargic and had slurred speech. Vitals were obtained by the nurse, and the nurse practitioner came to evaluate the (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155776	A. Building B. Wing	02/23/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and the nurse practitioner indicated to send the resident to ER (emergency room) for further evaluation and abnormal labs. Emergency Medical Services (EMS) arrived to the facility to transfer the resident to the hospital at 9:48 p.m. The record lacked documentation the hospital was notified of the transfer and the condition of Resident 7 at the time of transfer. During an interview on 2/20/26 at 9:32 a.m., the Director of Nursing (DON) indicated she was unable to find documentation where staff had notified the hospital of the transfer and condition of Resident 7 prior to her leaving the facility. The staff should have called report to the hospital staff and documented it in the record. On 2/20/26 at 10:07 a.m., the DON provided a document with a revised date of 2/19, titled, Hospital Discharge/Transfer, and indicated it was the currently policy being used by the facility. The policy indicated, .Nursing will complete an Emergency transfer observation and attach copies of the following information form the resident medical record:.Notice of Transfer/Discharge, Bed hold policy.Bed hold policy/transfer notification will be reviewed with the responsible party at the time of notification and documented in the medical record.Nursing will provide a thorough report to receiving hospital nurse that will include: head to toe assessment, current skin condition, current medications, when medications last received, any non-compliance or care issues for the resident, and any other pertinent information that will assist admitting facility in how to care for that resident. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-12(a)(6)(a).

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	02/23/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to address a significant weight discrepancy and re-evaluate a resident's weight for 1of 2 residents reviewed for nutrition (Resident 57). Findings include:On 1/17/26 at 12:00 p.m., observed resident sitting in the activity lounge area with a noon meal. The resident did not have dentures in place and was attempting to eat a sandwich. She was very restless during the meal and refused to allow staff to assist her. On 1/18/26 at 9:00 a.m., the medical record of Resident 57 was reviewed. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and anxiety (a feeling of fear, dread, and uneasiness). According to documented weights the resident has lost 12.5% weight loss in 6 months and 1.14% weight loss in 30 days. The monthly weight record indicated on 8/6/23 the resident's weight was recorded as 100 pounds (lbs.), on 9/2/25 weight was recorded 102 lbs., on 10/9/25 weight was recorded as 94 lbs. A care plan, dated 8/25/23, indicated the resident was at risk for altered nutritional status due to but not limited to varied intake of diet and dementia. Interventions included, but were not limited to, regular diet, super cereal at breakfast, ice cream with lunch and dinner, and mighty shake with breakfast lunch and dinner. A physician order, dated 12/12/23, indicated to administer Ensure Plus 237 ml (milliliters) daily. An annual Minimum Data Set assessment (MDS), dated [DATE], indicated the resident was severely cognitively impaired and required extensive assistance from the staff with daily care needs. The MDS indicated the resident had not had a significant weight loss of more than 10% in 6 months. Review of the Medication Administration Records (MAR) for January and February 2026 indicated the Ensure amount the resident consumed was not recorded for 18 days. On 2/18/25 at 1:40 p.m., during an interview, Licensed Practical Nurse (LPN) (18) indicated Resident 57 would not keep her dentures in and she often took them out. She indicated the resident liked to snack and run. They had difficulty keeping her sitting still long enough for meals and the resident got ensure daily around 2 p.m., but she also got lots of snacks.On 2/20/26 at 1:55 p.m., during an interview Certified Nurse Aide (CNA) (21) indicated the resident ate all day and she liked to snack. She indicated she was very active and wandered around a lot. On 2/23/26 at 1:00 p.m., during an interview the Director of Nurses indicated the resident's weight had consistently been about the same. The resident was noted to have a significant weight variance for 4 dates, and she believed the weights were wrong and thus an incorrect weight loss percentage was triggered. However, a re-weight was not completed at the time to confirm weight loss, and the weight loss had not been addressed until this month. On 2/23/26 at 1:00 p.m., the Director of Nursing provided a document titled, Resident weight monitoring dated 9/2024, and indicated it was the policy currently being used by the facility. The policy indicated, .3. Monthly weights will be obtained, verified for accuracy. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-46.

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	02/23/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they implemented a policy to ensure proper storage of respiratory equipment for 3 of 4 residents reviewed for respiratory care (Residents 14, 1, and 34) and they failed to ensure a physician order was obtained for respiratory equipment for a resident's use for 1 of 4 residents reviewed for respiratory care (Resident 14). Findings include:1. During an interview, on 2/18/26 at 8:20 a.m., Resident 14 indicated she used a continuous positive airway pressure (CPAP- a method of respiratory therapy in which air is pumped through the nose or nose and mouth during spontaneous breathing) machine at night. The machine was hers that was brought from home to use. She indicated the facility could not get the equipment quick enough for her and she needed to have it because of her sleep apnea (a common, serous disorder where breathing repeatedly stops and starts during sleep, preventing restful sleep and reducing blood oxygen levels). During an observation on 2/18/26 at 8:26 a.m., Resident 14's unbagged CPAP mask was on the resident's nightstand table next to the CPAP machine. The resident was resting in bed, watching T.V. During an observation on 2/18/25 at 11:04 a.m., Resident 14's unbagged CPAP mask was on the resident's nightstand table on top of a clear plastic bag, next to the CPAP machine. The resident was resident in bed, watching T.V. During an observation on 2/19/26 at 8:30 a.m., Resident 14's unbagged CPAP mask was lying next to the resident on her bed. There was an empty clear plastic bag noted on the resident's nightstand table. During an observation on 2/19/26 at 10:34 a.m., Resident 14's unbagged CPAP mask was on the resident's side table next to the bed, the mask was next to a dirty paper towel, telephone, remote, and an aluminum can. There was an empty clear plastic bag hanging from the CPAP machine. Resident 14's record was reviewed on 2/19/26 at 10:16 a.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive sleep apnea (caused by throat muscles relaxing and blocking the airway) and generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday events, lasting for at least 6 months). Facility census information indicated Resident 14 was admitted to the facility on [DATE]. An admission Minimum Data Set (MDS) assessment, dated 2/11/26, indicated the resident was cognitively intact and was not marked as using a CPAP mask. Resident 14's record lacked a physician order was obtained for the use of the CPAP equipment. Resident 14's record lacked the implementation of a care plan for the use of CPAP equipment. Review of progress note, dated 1/30/26 at 6:58 p.m., indicated Resident 14 reported to the nurse she needed a CPAP and her significant other would bring it to the facility the next day. Review of physician progress note, with an encounter date of 2/3/26, indicated Resident 14 used a (continued on next page)

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	02/23/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CPAP machine and reported no problems with its use. Review of hospital discharge instructions, dated [DATE], indicated a nocturnal (occurring at night) CPAP was ordered. During an interview, on 2/19/26 at 8:38 a.m., Licensed Practical Nurse (LPN) 9 indicated staff should store respiratory equipment in the bag when not in use. During an interview, on 2/19/26 at 10:41 a.m., Licensed Practical Nurse (LPN) 10 indicated staff should obtain an order from the physician for the use of CPAP equipment The residents were allowed to use the equipment from home if necessary but there should be an order for its use. During an interview, on 2/19/25 at 1:21 p.m., the Executive Director (ED) indicated the facility did not have a specific policy related to respiratory equipment. During an interview, on 2/19/26 at 2:02 p.m., the Director of Nursing (DON) indicated she would have to verify if Resident 14 had an order for the use of CPAP equipment, she was aware she used one. During an interview, on 2/19/26 at 2:45 p.m., the DON indicated she was unable to find an order for the use of CPAP equipment for Resident 14, and indicated it had gotten missed. During a random observation on 2/19/26 at 2:12 p.m., LPN 10 and Registered Nurse (RN) 11 were walking down the 200 hallway with clear plastic bags and a black marker, LPN 10 indicated to RN 11 make sure everyone with respiratory equipment had a plastic bag in their room. 2. During an observation, on 2/18/26 at 9:39 a.m., Resident 1's CPAP (a method of respiratory therapy in which air is pumped through the nose or nose and mouth during spontaneous breathing) mask was observed setting on top of the resident's bedside table. The mask was unbagged. At the same time, Resident 1 indicated the facility had never provided a bag for the mask to be placed in. During a random observation, on 2/19/26 at 8:32 a.m., the resident was sitting on the side of his bed eating his breakfast. His CPAP mask was sitting on top of his bedside table unbagged. At the same time, he indicated he wears the CPAP at night. He had been up for about 2 hours, and no one had come in to do anything with it. During a random observation, on 2/19/26 at 1:50 p.m., the resident was observed in his bed. The CPAP mask was sitting unbagged on his bedside table. Resident 1's record was reviewed on 2/18/26 at 3:14 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a progressive, long-term lung disease that makes it hard to breathe due to damaged, inflamed, and narrowed airways) and obstructive sleep apnea (a common, serious sleep disorder where throat muscles relax too much during sleep, causing the airway to collapse and repeatedly block breathing). A care plan, dated 8/5/25, indicated the resident had the potential for impaired gas exchange related to COPD and experiences shortness of breath (SOB) with lying flat. Interventions included, but were not limited to, resident wears a CPAP at times. A significant change Minimum Data Set (MDS) assessment, dated 1/11/26, indicated the resident had (continued on next page)

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	02/23/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no cognitive deficit and required oxygen therapy. A physician's order, dated 1/5/26, indicated special instructions for the resident's CPAP to be placed on at bedtime and off when awake. The record lacked a physician's order for the storage of the CPAP mask when not in use. During an interview, on 2/19/27 at 1:50 p.m., Licensed Practical Nurse (LPN) 10 indicated CPAP masks and tubing should be cleaned once daily. The mask should be placed in a clean dated bag when not in use. 3. On 2/17/26 at 11:00 a.m., during initial observation noted nebulizer tubing and medication chamber lying on top of a clear storage bag dated 2/15/26 on a chair in the room of Resident 34. Observed bilevel positive airway pressure (BiPap, a non-invasive, mask-based ventilation device that helps people breathe by pushing pressurized air into the lungs with two distinct pressures: a higher pressure for inhaling and a lower pressure for exhaling) mask and tubing lying on top of a clear plastic bag on top of the resident's bedside table. On 2/18/26 at 9:04 a.m., observed nebulizer tubing and medication administration chamber lying on chair in Resident 34's room on top of a plastic storage bag. Observed the BiPap mask and tubing unbagged on top of bedside table. The resident indicated she administered nebulizer treatments herself. On 2/18/26 at 9:10 a.m., during an interview, RN 13 indicated she set up the nebulizer treatment for Resident 34 and stood by while the resident administered her own breathing treatment. She indicated she cleaned the equipment and hung it up to dry. On 2/18/26 at 9:23 a.m., during an interview, Licensed Practical Nurse (LPN) 10 indicated the nurse should assess the resident during and after the nebulizer treatment. Once completed the nurse should rinse out the nebulizer tubing and medication chamber and allow the equipment to air dry then place equipment in a bag. On 2/19/26 at 8:31 a.m., observed nebulizer tubing and medication administration chamber unbagged laying on top of dated bag in a chair in the resident's room. Observed BiPap mask and tubing unbagged on top of bedside table. On 2/23/26 at 12:58 p.m., the ED provided a document with a revised date of 9/23, titled, BIPAP/CPAP and indicated it was the currently policy being used by the facility. The policy indicated .1. Verify resident and physician's order 2. Physician's order should include: a. CPAP or BIPAP pressure b. oxygen therapy with sleep, if indicated. d. size and type of mask/prongs e. back up rate, if indicated. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-47(a)(6).

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	02/23/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were dated when opened for 1 of 2 medication carts. Findings include:On 2/20/26 at 8:43 a.m., observed the medication cart for 100 hall with Qualified Medication Aide (QMA) 19. Observed an insulin pen, Basaglar insulin100 units, with instructions to administer 15 units at bedtime for Resident 30. The insulin pen had been opened, and label was not dated with an opened date. Observed an insulin pen Lantus insulin 3 milliliter pen with instructions to administer 15 units daily, for Resident 73 opened and not dated with an opened date. On 2/20/26 at 8:50 a.m., during an interview Licensed Practical Nurse (LPN) 18 indicated the insulin pens must be dated when opened and discarded after 30 days. On 2/20/26 at 10:00 a.m., the Director of Nursing provided a document titled, Medication storage and expiration policy, and indicated it was the policy currently being used by the facility. The policy indicated, .9. Facility staff should record the date opened on the primary medication container.c. If a multidose vial of an injectable medication has been opened or accessed (e.g., needle punctured), the vial should be dated and discarded within 28 days. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-25(j).

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	02/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff donned (put on) personal protective equipment (PPE-wearable gear and clothing designed to protect individuals from workplace illnesses and infections) when entering a room of a resident who was COVID-19 (a highly contagious respiratory disease) for 1 of 1 hall tray pass observation (Resident 93). Findings include:On 2/17/26 at 12:52 p.m., the Activity Director (AD) was observed entering Resident 93's room to deliver his lunch tray. Through the open door, the AD was observed to set the resident's lunch tray on the overbed table (a table that can be placed over a resident in bed to allow the resident access to items, such as meal trays, etc.) which was set directly in front of the resident. The AD was observed to enter and exit the room without donning or doffing (removing) appropriate PPE. Signage on the resident's room door indicated the resident was in droplet precautions (measures designed to prevent the spread of germs transmitted through large respiratory droplets) and a PPE bin was setting outside of the room. At the same time, the AD indicated she was not aware that the resident was on droplet precautions. During an interview, on 2/17/26 at 12:59 p.m., Registered Nurse (RN) 5, indicated the Regional Clinical Nurse had notified her that Resident 93 had tested positive for COVID-19. She assumed that the information had been passed along to all staff on the hallway. During an interview, on 2/17/26 at 1:08 p.m., the AD indicated she had gone into the room to give the resident his lunch tray. She had set it in front of the resident on the overbed table which was next to his bed. She had not been told that he had COVID-19 and did not put on any PPE prior to entering the room. During an interview, on 2/17/26 at 2:27 p.m., the Executive Director (ED) indicated that the resident had tested COVID-19 positive. He had tested positive earlier that morning. The staff had just messed up, by not wearing PPE when entering the resident's room. She was unsure if all the staff who were passing the lunch trays had been made aware of the resident situation, prior to passing the hall trays. The staff should have worn proper PPE when entering the resident's room. During an interview, on 2/17/26 at 2:34 p.m., Qualified Medication Aide (QMA) 3 indicated she had been notified about the resident testing COVID-19 positive from another staff earlier in her shift. She was not sure if any of the other staff who were assisting with passing the hall trays had been told. During an interview, on 2/17/26 at 2:47 p.m., the Payroll Coordinator indicated she had assisted with hall trays on the hall during the lunch meal. No one had informed her about the resident being COVID-19 positive. She had noticed the signage outside the door and the PPE bin sitting in the hallway. During an interview, on 2/18/26 at 11:00 a.m., the Business Office Manager (BOM) indicated she had assisted with passing the hall lunch trays. She was not told that the resident was COVID-19 positive. She did not observe the signage for droplet precautions until she saw the AD coming out of his room. During an interview, on 2/18/26 at 11:10 a.m., Certified Nursing Assistant (CNA) 8 indicated that she had not been informed that the resident was COVID-19 positive. When she was passing trays, she noticed the droplet precautions signage and had to ask the nurse to find out the reason for the signage. (continued on next page)

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	02/23/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/26 at 11:43 a.m., a home healthcare representative was observed in the resident's room standing directly in front of the resident, without any PPE in place. At the same time, the representative was informed that the resident was COVID-19 positive. She indicated no one had made her aware of the resident being positive and she did not observe the signage on the door, prior to entering. 8/26 at 8:17 a.m., the ED provided an undated and untitled document, and indicated it was the policy for infections that required droplet precautions currently in use by the facility. The policy indicated, .Use of Personal Protective Equipment-Mask and face protection in addition to gown and gloves: Anyone who goes into a room should wear a mask/face protection.Remove mask/face protection and dispose of it before leaving room.Perform hand hygiene before leaving the room.Droplet/Contact Precautions.Covid-19 Positive Resident.Use of Personal Protective Equipment: health care personnel (HCP) should wear an N95 or higher-level respirator, eye protection (.that covers the front and sides of the face).when caring for these residents. This deficiency reflects State Findings cited in accordance with 410 Indiana Administrative Code (IAC) 16.2-3.1-18(b).