STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155776	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician had been notified of a resident's refusal of routine insulin injections, for 1 of 5 residents reviewed for unnecessary medications. (Resident 49) Finding includes: Resident 49's record was reviewed on 3/5/20 at 9:46 a.m. The resident had been admitted to the facility on [DATE]. The resident discharged from the facility back to her home on 3/6/20. The resident [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 2/10/20, indicated the resident had moderate cognitive impairment, had [DIAGNOSES REDACTED]. A care plan, dated 2/5/20, indicated the resident was at risk for adverse effects of [MEDICAL CONDITION] or [DIAGNOSES REDACTED] (low blood glucose) related to use of glucose lowering medication and/or [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Notify the physician if the blood glucose reading was below 70 or greater than 400. A physician's orders [REDACTED]. Administer: 20 units, subcutaneous (applied under the skin), three times a day before meals for [MEDICAL CONDITION] (high blood glucose). A physician's orders [REDACTED]. Administer 45 units subcutaneous every morning. Review of the resident's February 2020 Medication Administration Record [REDACTED] p.m., 2/28/20 at 8:56 a.m., and 5:14 p.m., and 2/29/20 at 4:58 p.m. A fax cover sheet, dated 2/8/20, indicated a fax had been sent to the resident's physician. The documented indicated, the resident had been refusing her insulin [MEDICATION NAME], 20 units at mealtime and would like to determine if she takes or not. The physician written response indicated OK. Review of the resident's March 2020 Medication Administration Record [REDACTED]. At home she was on a sliding scale (insulin amount determined by blood sugar levels) of her insulin before meals. She would only take as much as was based on her Accu check reading and what was indicated on the sliding scale. Since she had been at the facility, she had not been provided a sliding scale. The routine order for 20 units of [MEDICATION NAME] before meals, she believed, caused her blood glucose to drop too much. During an interview, on 3/5/20 at 1:41 p.m., the Director of Nursing Services (DNS) indicated the physician had been notified, via fax, about the resident's refusal of her [MEDICATION NAME]for the dates 2/5/20 through 2/8/20. She was not sure what the response of ok on the fax cover sheet sent to the resident's physician on 2/8/20 actually meant. To the best of her knowledge, the physician had never been asked about considering a sliding scale for the resident's [MEDICATION NAME] insulin. During an interview, on 3/5/20 at 1:20 p.m., Registered Nurse (RN) 7 indicated the resident refused her insulin [MEDICATION NAME] almost every time it was offered. The resident had [MEDICATION NAME] administered every morning. She had received the insulin [MEDICATION NAME] a couple times, when first admitted , and her blood glucose level dropped really fast. RN 7 believed that was why she refused the insulin [MEDICATION NAME]. The RN was not able to state that the physician had ever been questioned about a sliding scale for the resident's insulin [MEDICATION NAME]. On 3/5/20 at 2:00 p.m., the DNS provided a document, dated 2013 and titled, 2.0 Resident Medication Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure: .4. Facility should notify Physician/Prescriber of a resident's refusal of medications/treatment for [REDACTED].
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** Based on record review and interview, the facility failed to revise a resident's care plan to accurately reflect their cognitive status for 1 of 16 residents' care plans reviewed. (Resident 40) Finding includes: Resident 40's record was reviewed on 3/4/20 at 12:49 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/7/19, indicated the resident had a moderate cognitive impairment with a brief interview for mental status (BIMS) assessment (a test used to get a snapshot of how a person is functioning cognitively) score of eight. A Significant Change Minimum Data Set (MDS) assessment, dated 2/5/20, indicated the resident was cognitively intact with a BIMS (Brief Interview for Mental Status) assessment (a test used to get a snapshot of how a person is functioning cognitively) score of fifteen. A care plan, started 12/16/19 and last reviewed 2/21/20, indicated the resident exhibited cognitive impairment with a BIMS score of less than thirteen, moderate impairment. During an interview on 3/4/20 at 2:33 p.m., the Social Services Director (SSD) indicated the resident was alert and oriented, but her cognition level fluctuated. The care plan should have been updated to indicate the resident was cognitively intact with the BIMS score of fifteen, or to show the resident had fluctuations in her cognition. The care plans should have been reviewed and revised with the MDS assessments. On 3/4/20 at 3:12 p.m., the Director of Nursing Services (DNS) provided a document titled, IDT Comprehensive Care Plan Policy, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment .Procedure: .Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition 3.1-35(d)(2)(B)
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure behaviors were monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident 40) Finding includes: Resident 40's record was reviewed on 3/4/20 at 12:49 p.m. A Significant Change Minimum Data Set (MDS) assessment, dated 2/5/20, indicated the resident was cognitively intact. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A Medication Administration Record (MAR), dated 3/1/19 to 4/1/19, indicated the resident was monitored each shift for behaviors of physical aggression towards staff, episodes of anxiety, and episodes of hallucinations and delusions including seeing five to six foot tall ants in room and believed she was pregnant and giving birth. The MAR indicated the resident had no behaviors. Progress notes, dated 3/1/19 to 4/1/19, lacked documentation the resident had behaviors. A pharmacy consultation report, dated 4/1/19, indicated the resident received [MEDICATION NAME] 2 mg by mouth twice daily for [MEDICAL CONDITION] since October 2018, and requested a gradual dose reduction (GDR) of the medication. The physician declined the GDR, and indicated the resident was stable on the current dose and continued to have hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) and delusions (fixed, false beliefs). A psychiatry progress note, dated 4/2/19, indicated staff reported the resident was at her baseline regarding behaviors and cognition. resident had a history of [REDACTED]. A GDR of the [MEDICATION NAME] was contraindicated for this visit. The note lacked documentation of any specific times the resident

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

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) exhibited behaviors in the recent past. A behavior symptom monthly summary form, dated 4/2/19, indicated the resident was monitored for physical aggression towards staff, episodes of hallucinations and delusions, and anxiety. The resident had one episode of hallucinations and delusions for the month. The summary lacked documentation of what behavior the resident had, and what interventions were provided for the resident's behavior. A MAR, dated 6/1/19 to 7/2/19, indicated the resident was monitored each shift for behaviors of physical aggression towards staff, episodes of anxiety, and episodes of hallucinations and delusions including seeing five to six foot tall ants in room and believed she was pregnant and giving birth. The MAR indicated the resident had no behaviors. Progress notes, dated 6/1/19 to 7/2/19, lacked documentation the resident had behaviors. A pharmacy consultation report, dated 7/2/19, indicated the resident received [MEDICATION NAME] 2 mg by mouth twice daily for [MEDICAL CONDITION] since October 2018, and requested a GDR of the medication. The physician declined the GDR, and indicated a reduction was likely to impair the resident's function, and delusions continued. A behavior symptom monthly summary, dated 7/2/19, indicated the resident was monitored for episodes of physical aggression towards staff and episodes of hallucinations and delusions. The resident had no behaviors during the month. A psychiatry progress note, dated 7/3/19, indicated the resident was due for a GDR of the [MEDICATION NAME], but it was contraindicated this visit. The note lacked documentation of why the GDR was contraindicated or any specific times the resident exhibited behaviors in the recent past. A MAR, dated 12/1/19 to 1/6/20, indicated the resident was monitored each shift for behaviors of physical aggression towards staff, episodes of anxiety, and episodes of hallucinations and delusions including seeing five to six foot tall ants in room and believed she was pregnant and giving birth. The MAR indicated the resident had no behaviors. Progress notes, dated 12/1/19 to 1/6/20, lacked documentation the resident had behaviors. A pharmacy consultation report, dated 1/6/20, indicated the resident received [MEDICATION NAME] 2 mg by mouth twice daily since October 2018, and requested a GDR of the medication. The nurse practitioner (NP) declined the GDR, and indicated the resident continued to have distressing delusional behaviors, and a decreased dose would likely impair the resident's functional ability. A behavior symptom monthly summary form, dated 1/7/20, indicated the resident was monitored for episodes of physical aggression towards staff and episodes of hallucinations and delusions. The resident had no behaviors during the month. A psychiatry progress note, dated 1/8/20, indicated the resident was due for GDR of [MEDICATION NAME], and the resident's psychotic behaviors and hallucinations had continued. The resident had episodes in the past of thinking she was pregnant and having a baby. The note lacked documentation of any specific times the resident exhibited behaviors in the recent past. The GDR for the [MEDICATION NAME] was contraindicated. A care plan, goal target dated 5/9/20, indicated the resident had episodes of frightening hallucinations and delusions as evidenced by resident saw five to six foot tall ants in her room and believed she was pregnant and giving birth. A care plan, goal target dated 5/9/20, indicated the resident had episodes of anxiety as evidenced by restlessness and excessive worrying. A care plan, goal target dated 5/9/20, indicated the resident had episodes of physical aggression towards staff as evidenced by trying to hit staff with her hand. During an interview, on 3/5/20 at 11:16 a.m., the Social Services Director (SSD) indicated she was not able to find any further documentation to support the resident's behaviors were tracked. The resident had behaviors often, at least daily. She thought it was possible the nurses were so used to the resident's behavior, they would not document like they should have. When a resident had a behavior, it should have been documented on the MAR behavior monitoring, including the number of occurrences, interventions tried, and efficacy of the interventions. On 3/5/20 at 11:29 a.m., the SSD provided a document titled, Behavior Management Policy, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: It is the policy of .to provide behavior interventions for residents with problematic or distressing behaviors .Procedure: .2. When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior on the monitoring form, if the resident is being monitored for the behavior including what interventions were attempted during the episode and whether or not they were effective .5. All residents who are on the behavior monitoring program will have a summary monthly that includes a review of behaviors and interventions. 3.1-43(a)(1)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control procedures were followed for a resident on contact isolation for 1 of 1 resident's reviewed for infections (Resident 61), and failed to ensure expired bleach germicidal wipes were properly disposed of for 3 of 3 medication carts reviewed. (300 hall cart, 400 hall cart & 100 hall cart) Findings include: 1. During a random observation of Resident 61, on [DATE] at 10:16 a.m., isolation precautions were observed on the resident's door. Housekeeping Aide (HA) 5 was observed in Resident 61's room with gloves on and no gown. She had the resident's clothing (a shirt and blue jeans) placed against her clothing. She walked out of the resident's room with the resident's clothing un-bagged and gloves on. She proceeded to get a bag and walked back into the resident's room. HA 5 indicated the resident was on contact isolation and was told she only had to wear gloves in the resident's room, a gown was not required. She should have bagged the clothes up before she brought them out of the room. Resident 61's record was reviewed on [DATE] at 9:28 a.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Type of isolation: contact, related to [MEDICAL CONDITION]-resistant staphylococcus aureus (bacterium that causes infections in different parts of the body (MRSA)) of the right heel. A Laboratory Report, dated [DATE], indicated a final culture report [MEDICAL CONDITION] in the right heel. A care plan, initiated [DATE], indicated the resident was on isolation related [MEDICAL CONDITION] in the right heel. Interventions included, but were not limited to, resident's isolation would reduce the spread of the infectious agent and minimize the transmission of the infection and follow the facility's infection control policies/procedures when soiled or contaminated linen are handled. During an interview, on [DATE] at 10:21 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident 61 was on contact isolation precautions. Staff should have bagged the resident's clothing before it was brought out of the resident's room and proper personal protective equipment should have been used. 2. During a medication storage observation, on [DATE] at 11:05 a.m., the 300 hall medication cart had a bleach germicidal wipe (used to clean and disinfect and deodorize hard, nonporous surfaces) that expired on [DATE]. At this time, Registered Nurse (RN) 10 indicated the wipes were used to clean glucometers (devices used to check residents' blood sugar level) and should have been disposed of when expired. During a medication storage observation, on [DATE] at 11:07 a.m., the 100 hall medication cart had 15 bleach germicidal wipes which expired on [DATE]. During a medication storage observation, on [DATE] at 11:15 a.m., the 400 hall medication cart had 3 bleach germicidal wipes which expired on [DATE] and 7 bleach germicidal wipes which expired on [DATE]. At this time, RN 8 indicated expired bleach germicidal wipes should have been disposed of when they had expired. On [DATE] at 10:57 a.m., the Director of Nursing (DON) provided a document, last reviewed ,[DATE] and titled, Infection Prevention and Control Program Policy, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: The facility shall establish and maintain infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections .Goals: The goals of the infection prevention and control program are to: 1. Decrease the risk of infection to residents .2. Monitor and identify occurrence of infection and implement appropriate control measures to prevent outbreaks and cross-contamination On [DATE] at 11:52 a.m., the DON provided a document, last reviewed ,[DATE], and titled, Standard and Transmission-Based Precautions (Isolation) Policy, and indicated it was the policy currently being used by the facility. The policy indicated, Policy: The facility shall utilize the appropriate transmission-based precaution based on the means of transmission and the infectious agent or organism involved. The isolation precautions should be the least restrictive possible for the resident under the circumstances .Contact Precautions: refers to measures intended to prevent transmission of infectious agents by direct or indirect contact wither with the resident or with the resident's environment .Use of Personal Protective Equipment Gown and Gloves: Applies to anyone entering the room who may touch the resident or objects in the room should wear PPE Put on gown and gloves upon entry to room .PPE should be discarded prior to leaving the room and hand hygiene performed. Gloves: Wear gloves whenever touching resident's skin or surfaces close to resident. Perform hand hygiene prior to donning and after On [DATE] at 11:30 a.m., the DON provided a document, last reviewed ,[DATE], and titled, Glucose Meter Cleaning & Testing, and indicated it was the policy currently being used by the facility. The policy indicated, Procedure Steps: .5. Obtain a single-use germicidal wipe. 6. Wipe entire external surface of the blood glucose meter with wipe for 3 minutes .9. Dispose of used wipe and gloves in trash 3XXX,[DATE](a) 3XXX,[DATE](b)(2)