

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2016
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NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey. This visit included the Investigation of Complaint IN00189420.</p> <p>Complaint IN00189420-Substantiated. Federal/State deficiencies related to the allegations are cited at F157.</p> <p>Survey dates: January 19, 20, 21, 22, 23, 24, 25, &amp; 26, 2016</p> <p>Facility number: 010739 Provider number: 155764 AIM number: 200856890</p> <p>Census bed type: SNF/NF: 45 Residential: 58 Total: 103</p> <p>Census payor type: Medicare: 30 Medicaid: 8 Other: 65 Total: 103</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on January 19 -26, 2016. Please accept this Plan of Correction as Spring Mill Healthcare credible allegation of compliance effective February 25, 2016 Spring Mill respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview,</p>	F 0157	F 157 notification of change 1.	02/25/2016
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	<p>the facility failed to ensure the Physician was notified in a timely manner related to a family request for a medication change for 1 of 2 residents (Resident #B). In addition, the facility failed to notify the Physician of blood glucose results for 1 of 2 residents reviewed for Notification of Change. (Resident #C)</p> <p>Findings include:</p> <p>1. The Closed record for Resident #B was reviewed on 1/21/16 at 1:48 p.m. The resident's diagnoses included, but were not limited to, dementia and anxiety.</p> <p>Physician's orders, dated 10/17/15, indicated the resident was to receive Aricept (a medication used to treat dementia) 5 milligrams (mg) at bedtime. The resident was also receiving Zoloft (an antidepressant) 50 mg daily.</p> <p>The 10/27/15 "Resident First Conference" notes, indicated in the comments section: "does not have Alzheimer's disease or depression per family and history. Family wants Aricept and Zoloft discontinued too."</p> <p>A Physician's order, dated 11/9/15, indicated to decrease Zoloft 50 mg daily to Zoloft 25 mg daily times one week,</p>		<p>Resident B has been discharged</p> <p>2. Resident first meeting notes have been reviewed any concerns noted were corrected at that time. 3. Resident first meeting participants were reinserviced regarding follow up with family concerns. Audit will be performed twice a week on resident first meetings notes by MDS department to insure concerns are being addressed. MDS manager or designee will report monthly to QAA for 90 days or until 100% compliance is obtained. 4 QAA will monitor for any trends and make recommendations to the plan of correction as needed. QA&amp;A will monitor for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F157 will be completed by 2/25/16.</p> <p>1. Resident C abnormal blood sugars above 400 were notified to MD and family. 2. Current residents were reviewed for significant changes in condition. Any deficiencies noted were corrected at that time 3. Licensed nurses will be reinserviced on notification of Physician and Family of changes in condition. An audit by the HC manager/designee will be performed 2 x a week to insure notification of changes in condition has occurred. Unit manager or designee will report findings to QAA monthly for 90 days or until 100% compliance is obtained. 4. QAA will monitor for</p>	

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	<p>then 12.5 mg every other day times one week, then discontinue.</p> <p>An entry in the Nursing progress notes, dated 11/9/15 at 4:30 p.m., indicated family (POA/Power of Attorney) requested resident to be taken off of Zoloft and Aricept. Writer notified Physician and he ordered to decrease the Zoloft 50 mg daily to Zoloft 25 mg daily times one week, then 12.5 mg every other day times one week, then discontinue. The Physician stated to leave the Aricept in place until after caregivers could see how the resident did with the reduction and discontinuing of Zoloft. Resident and POA were aware.</p> <p>A Physician's order, dated 11/20/15, indicated to discontinue the Aricept and Zoloft per family request.</p> <p>Interview with the Director of Nursing on 1/26/16 at 9:00 a.m., indicated there was no documentation to indicate if the resident's Physician had been notified of the family request for the medication change prior to 11/9/15.</p> <p>2. The record for Resident #C was reviewed on 1/20/16 at 2:10 p.m. The resident's diagnoses included, but were not limited to, sepsis, high blood pressure, prostate cancer, Parkinson's disease, diabetes, acute renal failure, and</p>		<p>any trends and make recommendations to the plan of correction as needed. QA&amp;A will monitor for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F157 will be completed by 2/25/16.</p>				

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	<p>dementia without behaviors.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 11/27/15, indicated the resident received an Insulin injection for 7 days.</p> <p>Physician Orders, dated 11/22/15 and on the current 1/2016 recap, indicated "Humulin Regular Insulin per sliding scale. Accucheck before meals and at night time. Call the Physician if blood sugar less than 60 or greater than 400."</p> <p>The 12/2015 Medication Administration Record (MAR) was reviewed. The resident's blood sugar was 415 at night time on 12/3/15. On 12/10/15 at supper, the blood sugar was 417. On 12/28/15 at night time, the resident's blood sugar was 422.</p> <p>Nursing Progress Notes, for the mentioned dates, indicated there was no documentation the resident's Physician had been notified of the blood sugar greater than 400.</p> <p>The 1/2016 MAR was reviewed. On 1/1/16 the resident's blood sugar was 405 at supper.</p> <p>Nursing Progress Notes, for the mentioned date, indicated there was no</p>			

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F 0159 SS=B Bldg. 00	<p>documentation the resident's Physician had been notified of the blood sugar greater than 400.</p> <p>Interview with the Director of Nursing, on 1/22/16 at 1:30 p.m., indicated there was no documentation the resident's Physician had been notified on the mentioned dates.</p> <p>This Federal Tag relates to Complaint IN00189420</p> <p>3.1-3(a)(3)</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a</p>			

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	<p>non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on observation and interview, the facility failed to ensure "banking hours" were posted in the facility. This had the potential to affect the 9 residents who had a current balance in their personal funds account.</p> <p>Finding includes:  Interview with Resident #94, on 1/19/16</p>	F 0159	<p><b>F 159: Facility Management of Personal Funds</b> 1. Resident 94 was informed of the facility banking hours including weekend accessibility 2. Residents currently residing in the facility were hand delivered &amp; mailed a notice of facility banking hours including weekend accessibility 3. Business office Employees were re-inserviced on Facility Banking hours including weekend</p>	02/25/2016

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F 0241 SS=D Bldg. 00	<p>at 11:43 a.m., indicated she did not have access to the money in her personal funds account on the weekend.</p> <p>Interview with Guest Relations Employee #1, on 1/21/16 at 11:07 a.m., indicated there were no posted banking hours.</p> <p>Interview with the Business Office Manager, on 1/21/16 at 11:15 a.m., indicated the residents had access to their funds 24 hours a day seven days a week. When asked about the weekend, the Business Office Manager indicated the funds were accessible through the Central Nurses' Station in case a resident would need any money. When asked where the facility banking hours were posted, the Business Office Manager indicated, she was not aware if any hours were posted.</p> <p>Observation of the lobby area, on 1/21/15 at 11:25 a.m., indicated there were no posted banking hours nor was there any information posted to inform the residents how they could obtain money from their personal funds account.</p> <p>3.1-6(f)(1)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents</p>		<p>accessibility. Facility Banking hours were posted at the main entrances of the campus. Business Office Manager or designee will perform an audit of 5 Residents to ensure there are no concerns regarding accessibility of funds for 90 days and report findings monthly to QAA for 90 days or until 100% compliance is obtained. 4. QAA will monitor for any trends and make recommendations to the plan of correction as needed. QAA will monitor for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F159 will be completed by 2/25/16.</p>				

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	<p>in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to promote each resident's dignity related to a catheter drainage bag not in a dignity bag and a resident's name on the back of his wheelchair for 1 of 3 residents reviewed for dignity of the 3 residents who met the criteria for dignity. (Resident #132)</p> <p>Finding includes:</p> <p>On 1/19/16 at 12:17 p.m., Resident #132 was observed sitting in his wheelchair in the dining room. At that time, his catheter drainage bag was not covered and his urine was visible in the bag.</p> <p>On 1/19/16 at 3:16 p.m., the resident was observed in his room. At that time, the resident's catheter drainage bag was not covered and the urine was visible in the bag.</p> <p>On 1/20/16 at 10:43 a.m., the resident was observed seated in a wheelchair in the therapy room. At that time, his catheter drainage bag was not covered and the resident's urine was observed from the hallway.</p>	F 0241	<p>F241 Dignity and respect of individual</p> <ol style="list-style-type: none"> <li>Resident #132 urinary catheter bag has been covered and name has been removed from the wheelchair</li> <li>All Residents with urinary catheters have been assessed for coverage of their urine. All residents wheelchairs have been assessed for names on chairs. Any deficiencies noted were corrected at that time.</li> <li>Licensed nurse and aides will be re inserviced on dignity. Social Service/designee will monitor by auditing 2 times a week 5 residents to insure dignity issues are not present. Social service or designee will report monthly finding to QAA for 90 days or until 100% compliance.</li> <li>QAA will monitor for any trends and make recommendations to the plan of correction as needed. QA&amp;A will monitor for monthly for 90 days or until 100% compliance is obtained.</li> <li>Correction of F241 will be completed by 2/25/16.</li> </ol>	02/25/2016

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	<p>On 1/21/16 at 8:22 a.m., the resident was observed seated in his wheelchair in the dining room. At that time, his catheter drainage bag was not covered and the urine was visible. The resident's name was printed on a white sheet of paper in big black marker letters and taped to the back of his wheelchair. There were staff around the resident, however, no staff removed the paper.</p> <p>On 1/21/16 at 9:00 a.m., a therapy assistant took the resident downstairs by the way of his wheelchair. At that time, the resident's name was still on the back of the wheelchair and the catheter drainage bag was not covered.</p> <p>On 1/21/16 at 12:45 p.m., the resident was observed seated in the wheelchair in the dining room. At that time, the resident's name was still on the back of the wheelchair and the catheter drainage bag was not covered.</p> <p>On 1/21/16 at 1:57 p.m., the resident was observed in bed. The catheter drainage bag was hanging on the side of the bed. At that time, the bag was not covered and the resident's urine was visible from the hallway.</p> <p>The record for Resident #132 was reviewed on 1/21/16 at 8:49 a.m. The</p>			

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	<p>resident's diagnoses included, but were not limited to, Parkinson's disease, and sacral pressure ulcer.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 1/14/16, indicated the resident was moderately impaired for decision making and was not alert and oriented.</p> <p>Physician Orders, dated 1/11/16, indicated "Ok to use Texas Catheter (an external condom type catheter)."</p> <p>The current, 1/7/14, Guidelines for Preserving Dignity with Indwelling Catheter policy provided by the Nurse Consultant on 1/26/16 at 9:30 a.m., indicated "Keep drainage bag covered with an appropriate device."</p> <p>Interview with the Healthcare 2 Unit Manager, on 1/22/16 at 8:19 a.m., indicated the external drainage bag should have been covered and in some type of dignity bag. She further indicated the piece of paper with the resident's name on it should not have been on the back of the wheelchair.</p> <p>3.1-3(t)</p>			

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure an ongoing activity program was provided for a dependent resident for 1 of 1 Hospice residents reviewed. (Resident #40)</p> <p>Finding includes:</p> <p>On 1/20/16 at 2:09 p.m., Resident #40 was observed in his room in bed. The resident was awake at this time. The privacy curtain was pulled between the resident and his roommate. The resident did not have a television or radio in his side of the room. The roommate's television was on at this time but out of the resident's view.</p> <p>On 1/21/16 at 10:45 a.m. and 12:50 p.m., the resident remained in room in his bed. Again the privacy curtain was pulled between the resident and his roommate. There was no television or radio present on the resident's side of the room.</p> <p>At 7:20 a.m. on 1/22/16, the resident was</p>	F 0248	<p><b>F248: Activities Meet Interests/Needs of each Resident</b></p> <ol style="list-style-type: none"> <li>1. Resident #40 was discharged from the facility. At the initial observation of the concern facility immediately provided Resident #40 with a radio.</li> <li>2. Current Residents have the potential to be effected. Resident care plans were updated to reflect individual interest.</li> <li>3. Life Enrichment Associates were re-inserviced on Meeting the interest/needs of each Resident based on the residents individual plan of care. Life Enrichment Director or designee will perform an audit of 5 random Resident plans of care weekly to ensure the interest/needs of the residents are being met. Life Enrichment Director or designee will report findings monthly to QAA for 90 days or until 100% compliance is obtained.</li> <li>4. QAA will monitor for any trends and make recommendations to the plan of correction as needed. QAA</li> </ol>	02/25/2016

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	<p>in his room in bed. The resident was awake and asking if a Nurse was available. The privacy curtain was pulled between the resident and his roommate. No television or radio was present on the resident's side of the room. At 9:45 a.m., the resident remained in bed. The privacy curtain was pulled. The roommate's television was on and out of the resident's view. At 1:11 p.m., the resident was seated in a broda chair in the lounge area in front of the television. This was the first time the resident was observed out of his room since 1/19/16.</p> <p>The record for Resident #40 was reviewed on 1/20/16 at 2:51 p.m. The resident's diagnoses included, but were not limited to, depression, weakness, dementia, difficulty ambulating, and decubitus ulcer.</p> <p>The Significant Change Minimum Data Set assessment, dated 9/16/15, indicated it was somewhat important for the resident to have books, newspapers and magazines to read as well as listen to music that he liked. It was very important to him to keep up with the news and do his favorite activities.</p> <p>The Individual Plan Report, dated 12/21/15, indicated the resident enjoyed listening to country and western music.</p>		<p>will monitor for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F248 will be completed by 2/25/16</p>	

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F 0309 SS=D Bldg. 00	<p>There were no current Activity progress notes in the resident's record.</p> <p>Interview with the Director of Nursing, on 1/25/16 at 2:40 p.m., indicated there were no current activity notes for the resident. The Administrator and Director of Nursing were informed at this time that there was no television nor radio on the resident's side of the room. They were also informed about the privacy curtain being pulled between the resident and his roommate. The Administrator indicated he would get a radio for the resident.</p> <p>3.1-33(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident's Arteriovenous (AV) Shunt was assessed</p>	F 0309	<p>F309 Quality of care</p> <p>1. Resident #70 was assessed and</p>	02/25/2016

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	<p>every day for 1 of 1 residents reviewed for dialysis. (Resident #70)</p> <p>Finding includes:</p> <p>Interview with Resident #70 on 1/19/16 at 2:10 p.m., indicated he went to dialysis three times a week on Monday, Wednesday and Friday. He further indicated he had a shunt in his upper left arm.</p> <p>The record for Resident #70 was reviewed on 1/21/16 at 10:39 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease and hemodialysis.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 12/28/15, indicated the resident was alert and oriented with a Brief Interview for Mental Status score of 13. The resident was receiving dialysis while a resident at the facility.</p> <p>The current care plan, dated 12/11/15 and updated 12/28/15, indicated the resident went to dialysis on Monday, Wednesday, and Friday and had a left AVG (Arterial Ventricular Graft) shunt. The Nursing Approaches were to "check my graft for good thrill and bruit."</p>		<p>orders placed for monitoring AV fistula.</p> <p>2. All other residents with fistulas were assessed for orders and monitoring in place.</p> <p>3. Licensed nurses will be re inserviced on monitoring and assessing shunts. Unit manager/designee will monitor documentation regarding shunt assessment is occurring and document on audit sheet. Unit manager will report monthly finding to QAA for 90 days or until 100% compliance.</p> <p>4. QAA will monitor for any trends and make recommendations to the plan of correction as needed. QA&amp;A will monitor for monthly for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of F309 will be completed by 2/25/16.</p>	

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	<p>Nursing Notes, dated 1/1/16-1/21/16, indicated there was no documentation of an assessment of the resident's AV shunt nor was there any documentation the bruit and thrill were assessed.</p> <p>The 1/2016 Medication Administration Record (MAR) and the Treatment Administration Record (TAR) were reviewed. There was no documentation the resident's bruit and thrill were assessed every day on the MAR or the TAR.</p> <p>Interview with LPN #1, on 1/22/16 at 9:12 a.m., indicated the assessment of the bruit and thrill should be documented on every shift in the Treatment book or the Medication book. She further indicated after looking, there was no documentation the resident's bruit and thrill had been assessed every shift.</p> <p>The current, 1/2014, Guidelines for Monitoring Shunt policy provided by the Director of Nursing (DoN) on 1/22/16 at 12:15 p.m., indicated the AV shunt was to be monitored daily and the documentation of the assessment was to be completed in the medical record or on the TAR.</p> <p>Interview with the DoN on 1/22/16 at 12:22 p.m., indicated the resident's AV</p>			

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F 0325 SS=D Bldg. 00	<p>shunt was to be assessed every day.</p> <p>3.1-37(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's nutritional needs were met related to serving fortified food at meals for 1 of 2 residents reviewed for tube feeding of the 2 residents who met the criteria for tube feeding. (Resident #C)</p> <p>Finding includes:</p> <p>On 1/21/16 at 8:20 a.m., Resident #C was observed sitting at a table in the dining room. At that time, the resident was asked by staff if he would like a bowl of oatmeal, the resident indicated he did not want any oatmeal. At 8:39 a.m., the resident received his breakfast. He was served 1 pancake, scrambled eggs and ground meat. The resident had apple</p>	F 0325	<p><b>F325: Maintain Nutrition Status Unless Unavoidable</b></p> <p>1. Resident C was offered fortified food. No adverse side effects noted from not receiving fortified food.</p> <p>2. All Residents receiving fortified foods were assessed and any deficiencies noted were corrected at that time</p> <p>3. Dietary Employees were re-inserviced on serving fortified food.. Dietary Manager or designee will perform an audit of 5 Residents three per week (to include all meal times) for 90 days to ensure fortified foods are being offered to Residents per their preference. Dietary Manager or designee will report</p>	02/25/2016
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	<p>juice to drink. The resident was not offered or served any type of fortified foods.</p> <p>On 1/22/15 at 8:18 a.m., the resident was observed seated at the table in the dining room. At that time, the resident was asked if he would like oatmeal, the resident declined. At 8:31 a.m., the resident was served his breakfast. He was served 1 pancake, ground meat and scrambled eggs. The resident was given apple juice to drink. The resident was not offered or served any type of fortified foods.</p> <p>Interview with Dietary Aide #1, on 1/22/16 at 8:56 a.m., indicated cream of wheat was a fortified food she was to serve to the residents that morning. She further indicated that was all she had to offer the residents regarding fortified foods. She was unaware of any other kinds of fortified foods to be served to the residents.</p> <p>The record for Resident #C was reviewed on 1/20/16 at 2:10 p.m. The resident's diagnoses included, but were not limited to, sepsis, high blood pressure, prostate cancer, Parkinson's disease, diabetes, acute renal failure, and dementia without behaviors.</p>		<p>findings monthly for 90 days to QAA or until 100% compliance is obtained.</p> <p>4. QAA will monitor for any trends and make recommendations to the plan of correction as needed. QAA will monitor for monthly for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of F325 will be completed by 2/25/16.</p>	

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	<p>The Admission Minimum Data Set (MDS) assessment, dated 11/27/15, indicated the resident's weight was 171 pounds and he had no history of weight loss. The resident was receiving a mechanically altered diet as well as enteral feeding (liquid food through a tube in the resident's stomach).</p> <p>Physician Orders, dated 12/16/15, indicated to discontinue the enteral feedings related to a good oral intake.</p> <p>Physician Orders, dated 1/6/16, indicated add fortified foods three times a day for weight stability.</p> <p>A Dietary Progress Note documented by the Registered Dietitian (RD), dated 1/6/16, indicated the resident's weight was 172 pounds, a 9.8 pound loss (5.7%) in 30 days. Resident received a mechanical soft diet and the intake was 100%, which appeared to not meet his needs. Resident had a history of Parkinson's and prostate cancer, and had high demand for calories. The note indicated a recommendation to add fortified foods three times a day for weight stability.</p> <p>Review of the weight record indicated weights as follows: December 4, 2015 - 182 pounds; January 1, 2016 - 172</p>			

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F 0363 SS=D Bldg. 00	<p>pounds; the most current weight, dated January 20, 2016, for the resident was 166 pounds another 6 pound weight loss since the Dietary Progress Note on 1/6/16.</p> <p>Interview with the Health Care 2 Unit Manager, on 1/22/16 at 9:01 a.m., indicated there was a list of fortified foods to be given to the resident, however, she was unaware of what was on that list and would have to find out. She indicated Nursing staff should be aware of the fortified foods and if the resident refused them what other foods could be offered.</p> <p>3.1-46(a)(2)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to ensure the menu was followed related to serving the</p>	F 0363	<b>F363: Menus Meet Resident Needs/Prep in Advance/Followed</b>	02/25/2016	

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	<p>correct portion size for mechanically altered diets (ground meat and pureed) for 1 of 3 meals observed on the Healthcare 2 Unit.</p> <p>Finding includes:</p> <p>On 1/19/16 at 12:20 p.m., Dietary Aide #2 was observed serving the lunch meal to the residents in the Healthcare 2 Unit dining room. At that time, he was observed to use a set of tongs to serve the ground meat out of the pan and placed it on the resident's meal plate. He placed 2 to 3 servings on each plate. The Dietary Aide did not measure ground meat to obtain the correct portion size. He proceeded to use the tongs to serve the ground meat for all four mechanical soft diets.</p> <p>On 1/19/16 at 12:41 p.m., Dietary Aide #2 was observed serving the pureed diets to the residents. He used a scoop to serve the pureed meat onto the resident's plate. The scoop was observed to be only 1/4 full of the pureed food. He continued to prepare the two pureed diets that way.</p> <p>Interview with Dietary Aide #2 at that time, indicated he was unaware of the correct portion he was to serve to the residents related to the ground pork and the pureed pork. He indicated he had no</p>		<ol style="list-style-type: none"> <li>1. Dietary Aide #2 was re-inserviced on proper use of portions.</li> <li>2. All Residents had the potential to be effected. Any deficiencies found were corrected at that time.</li> <li>3. Dietary Employees were re-inserviced on the proper use of portion. Dietary Manager or designee will perform an audit of 5 Residents being served appropriate portions weekly during random meal services (to include all meal times) for 90 days to ensure that correct portioning of food is being served. Dietary Manager or designee will report findings monthly for 90 days to QAA or until 100% compliance is obtained.</li> <li>4. QAA will monitor for any trends and make recommendations to the plan of correction as needed. QAA will monitor for monthly for 90 days or until 100% compliance is obtained.</li> <li>5. Correction of F363 will be completed by 2/25/16.</li> </ol>	

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F 0371	<p>spread sheet of the meal breakdown with portion sizes for all the diets. The Dietary Aide stated, "He told me it was just a couple of helpings of pork with the tongs." The Dietary Aide indicated the "He" was the previous Food Service Manager that no longer worked at the facility. The Dietary Aide further indicated he did not know what scoop size he was serving the pureed meat with. He indicated he was always told not to serve a full scoop, because that was too much.</p> <p>The spread sheet was reviewed for the 1/19/16 lunch meal. The Mechanical Soft and pureed diets were to receive a portion of the ground meat (pork chop) with the #8 serving scoop.</p> <p>Interview with the Assistant Food Service Manager, on 1/22/16 at 1:03 p.m., indicated the Dietary Aide was supposed to use the #8 scoop to serve ground meat for the mechanical soft diets. She further indicated he was to obtain a full scoop of the pureed meat, not just a 1/4 of one.</p> <p>3.1-20(i)(1) 3.1-20(i)(4)</p> <p>483.35(i)</p>			

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SS=E Bldg. 00	<p><b>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b> The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions, related to food not dated in the prep refrigerator, salad prep refrigerator, food left open to air in the freezer, and the high temperature dishwasher not reaching the correct temperature during the wash cycle for 1 of 2 dish machines.</p> <p>Findings include:</p> <p>1. During the initial Kitchen Sanitation tour on 1/19/16 at 9:20 a.m. with the Assistant Food Service Manager, the following was observed:</p> <p>a. A plastic container in the prep refrigerator with 2 1/2 liters of eggs was covered with plastic wrap, and not dated.</p> <p>b. A salad bowl and fruit plate in the prep salad refrigerator both were covered with plastic wrap and not dated.</p> <p>c. In the walk in freezer, a box of breaded fish fillets (26 pieces) were in a plastic</p>	F 0371	<p><b>F371: Food Procure, Store/Prepare/Serve-Sanitary</b></p> <p>1. All food that was not covered were disposed of on 1/19/2016. Dish Machine was serviced on 1/19/2016 and had appropriated temperature readings.</p> <p>2. Kitchen area was inspected on 1/19/2016 to ensure food was stored appropriately. Not other deficiencies were noted at that time</p> <p>3. Dietary staff was re-inserviced on sanitation and dish machine temperatures. Dietary Manager or designee will perform an audit of the kitchen area three times per week for 90 days to ensure that food items are dated, stored correctly and that the dish machine is operating within the proper guidelines of the facility policy. Dietary Manager or designee will report findings monthly to QAA for 90 days or until 100% compliance is obtained.</p> <p>4. QAA will monitor for any trends and make recommendations to the</p>	02/25/2016

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	<p>bag open to air.</p> <p>Interview at that time with the Assistant Food Service Manager indicated the food should be dated, and the bag of fish should have not been open to air.</p> <p>2. On 1/19/16 at 9:35 a.m., the Assistant Food Service Manager ran the dishwasher. The wash temperature registered 142 degrees. At that time, the Food Service Manager indicated the temperature should have registered 150 degrees or higher, and she would notify the Contractor to look at it.</p> <p>On 1/19/16 at 2:29 p.m., interview with the Dish Washer Contractor indicated the dishwasher's heat switch had debris which was keeping it from heating to the correct temperature. He removed the debris and now the machine was heating up to 150 degrees. He further indicated the machine was serviced monthly.</p> <p>On 1/22/16 at 10:00 a.m., interview with Corporate Dining Support Employee indicated the dishwashing machine was a high temperature dishwasher, and according to their "Dishmachine Guidelines...page 126...High Temp-Wash Temp should be between 150 to 160 degrees." He further indicated this was the most current policy regarding the</p>		<p>plan of correction as needed. QAA will monitor for monthly for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of F371 will be completed by 2/25/16.</p>	

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F 0441 SS=D Bldg. 00	<p>dishwasher.</p> <p>On 1/22/16 at 10:20 a.m., interview with the Food Service Manager indicated, the dishwasher should have been washing at 150 to 160 degrees according to the guidelines.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin</p>			

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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control was maintained related to a catheter drainage bag observed on the floor for 1 of 3 residents reviewed for dignity of the 3 residents who met the criteria for dignity. (Resident #132)</p> <p>Finding includes:</p> <p>On 1/20/16 at 10:43 a.m., Resident #132 was observed seated in a wheelchair in the therapy room. At that time, three therapy assistants assisted the resident to a standing positioning from his wheelchair to the parallel bars. One of the therapy aides reached under the resident's chair and unhooked the catheter drainage bag and placed it on the floor. The drainage bag was not covered and the resident's urine was observed from the hallway. The bag remained on the floor while the resident was standing and holding onto the bars. At that time, another therapy aide moved the bag with</p>	F 0441	<p>F441 Infection Control</p> <ol style="list-style-type: none"> <li>Resident #132 urinary bag was placed in proper position</li> <li>All other residents with urinary bags were reviewed to insure proper placement.</li> <li>Licensed nurse, aides and therapists were re inserviced on proper placement of catheter bag.</li> </ol> <p>Therapy manager will monitor by documented audits of 3 residents, two times a week for correct placement and transfer of bag.</p> <p>Therapy manager will report finding to QA&amp;A monthly for 90 days or until 100% compliance is obtained</p> <ol style="list-style-type: none"> <li>QAA will monitor for any trends and make recommendations to the plan of correction as needed. QA&amp;A will monitor for monthly for 90 days or until 100% compliance is obtained.</li> </ol>	02/25/2016

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NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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R 0000 Bldg. 00	<p>her foot while it was still on the floor.</p> <p>Interview with the Director of Nursing on 1/22/16 at 11:10 a.m. indicated therapy staff should not have placed the drainage bag on the floor and they should not have used their feet to move the bag.</p> <p>The current, 1/7/14, Guidelines for Preserving Dignity with Indwelling Catheter policy provided by the Nurse Consultant on 1/26/16 at 9:30 a.m., indicated "Urinary drainage bags and catheter tubing should be kept from touching the floor surface."</p> <p>3.1-18(b)(1)</p> <p>This visit was for a State Residential Licensure Survey. This visit included an annual Recertification and State Licensure Survey.</p> <p>Residential Census: 58</p> <p>Residential Sample: 9</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>5. Correction of F441 will be completed by 2/25/16.</p> <p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the</p>	

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R 0117  Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.  Based on record review and interview,	R 0117	Annual Recertification and State Licensure Survey on January 19 -26, 2016. Please accept this Plan of Correction as Spring Mill Healthcare credible allegation of compliance effective February 25, 2016 Spring Mill respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance	02/25/2016	

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R 0273 Bldg. 00	<p>the facility failed to ensure at least one first aid certified employee was on site at all times for the week of January 18, 2016 for 2 of 2 units. (Assisted Living and Legacy)</p> <p>Finding includes:</p> <p>Review of the Assisted Living and Legacy staffing schedule for January 18-January 25, 2016 on 1/25/16 at 11:00 a.m., indicated there was at least one CPR (cardiopulmonary resuscitation) certified employee working each shift. However, there was no employee that was certified in first aid.</p> <p>Interview with the Director of Nursing indicated the staff who were certified in CPR were not certified in first aid. She indicated a first aid certification class was scheduled for February, 2016.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions,</p>	R 0273	<p>R117</p> <ol style="list-style-type: none"> <li>no assisted living resident was harmed by lack of first aid training</li> <li>All residents were reviewed for harm due to lack of first aid training, none were identified. Employees files were reviewed for First aide training and has been completed on which employees need first aide training.</li> <li>Classes for First aid were scheduled for February 16 and Feb 23,2016. Staff development or designee will track certificates for first aid and report finding to QA&amp;A monthly</li> <li>QA&amp;A will monitor monthly any trends or recommendation to the plan of correction as needed. QA&amp;A will monitor for 90 days or until 100% completion is obtained.</li> <li>Correction of R117 will be completed by Feb 25, 2016</li> </ol> <p><b>R273: Food and Nutrition Services-Deficiency</b></p>	02/25/2016	

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	<p>related to food not dated in the prep refrigerator, salad prep refrigerator, food left open to air in the freezer, and the high temperature dishwasher not reaching the correct temperature during the wash cycle for 1 of 2 dish machines.</p> <p>Findings include:</p> <p>1. During the initial Kitchen Sanitation tour on 1/19/16 at 9:20 a.m. with the Assistant Food Service Manager, the following was observed:</p> <p>a. A plastic container in the prep refrigerator with 2 1/2 liters of eggs was covered with plastic wrap, and not dated.</p> <p>b. A salad bowl and fruit plate in the prep salad refrigerator both were covered with plastic wrap and not dated.</p> <p>c. In the walk in freezer, a box of breaded fish fillets (26 pieces) were in a plastic bag open to air.</p> <p>Interview at that time with the Assistant Food Service Manager, indicated the food should be dated, and the bag of fish should have not been open to air.</p> <p>2. On 1/19/16 at 9:35 a.m., the Assistant Food Service Manager ran the dishwasher. The wash temperature</p>		<p>1. All food that was not covered were disposed of on 1/19/2016. Dish Machine was serviced on 1/19/2016 and had appropriated temperature readings.</p> <p>2. Kitchen area was inspected on 1/19/2016 to ensure food was stored appropriately. Not other deficiencies were noted at that time</p> <p>3. Dietary staff was re-inserviced on sanitation and dish machine temperatures. Dietary Manager or designee will perform an audit of the kitchen area three times per week for 90 days to ensure that food items are dated, stored correctly and that the dish machine is operating within the proper guidelines of the facility policy. Dietary Manager or designee will report findings monthly to QAA for 90 days or until 100% compliance is obtained.</p> <p>4. QAA will monitor for any trends and make recommendations to the plan of correction as needed. QAA will monitor for monthly for 90 days or until 100% compliance is obtained.</p> <p>5. Correction of F371 will be completed by 2/25/16.</p>	

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	<p>registered 142 degrees. At that time, the Food Service Manager indicated the temperature should have registered 150 degrees or higher, and she would notify the Contractor to look at it.</p> <p>On 1/19/16 at 2:29 p.m., interview with the Dish Washer Contractor, indicated the dishwasher's heat switch had debris which was keeping it from heating to the correct temperature. He removed the debris and now the machine was heating up to 150 degrees. He further indicated, the machine was serviced monthly.</p> <p>On 1/22/16 at 10:00 a.m., interview with Corporate Dining Support Employee, indicated the dishwashing machine was a high temperature dishwasher, and according to their "Dishmachine Guidelines...page 126...High Temp-Wash Temp should be between 150 to 160 degrees." He further indicated this was the most current policy regarding the dishwasher.</p> <p>On 1/22/16 at 10:20 a.m., interview with the Food Service Manager indicated the dishwasher should have been washing at 150 to 160 degrees according to the guidelines.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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