STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155154		05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

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F 000 Bldg. 00	This visit was a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00173085. Complaint IN00173085-Substantiated. Federal deficiencies related to allegations are cited at F 312 and F 242. Survey dates: May 6, 7, 8, 11, 12, 13 and 14, 2015 Facility number: 000074 Provider number: 155154 AIM number: 100290050 Census bed type: SNF: 11 SNF/NF: 93 Total : 104 Census payor type: Medicare: 16 Medicaid: 63 Other: 25 Total: 104 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 000	June 5, 2015 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian St Indianapolis, IN 46204 Dear Ms Rhoades, On May 14th, a recertificationsurvey was conducted at Spring Mill Meadows. We respectfully request a paper IDR for F465as the facility disagrees with the scope and severity. Spring Mill Meadows then respectfullyrequests this document be submitted as the Plan of Correction and be consideredfor desk review by the staff of your division. If any questions arise regarding this request or attacheddocuments, please feel free to contact me at your earliest convenience. Respectfully submitted, Austin Steele, HFA Cc: BernieMcGuinness, VP of Operations	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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			SueHornstein, Director of Compliance MarthaHerron, Director of Clinical Services File	
F 223 SS=A Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent verbal abuse from occurring for 1 of 3 residents who were reviewed for abuse allegations. (Resident #45) Findings include: A review of reportable occurrences on 3/9/15 at 2:25 p.m., indicated "Res. [Resident] asked staff member to put bed control on bed. I put it on the bed. She asked me to put it some where else. I said you just asked me to put it there. Then the Res said No I didn't say that. Then I said yes you did + [and] that's when we started arguing. I then told her I would move it one more time. Staff member stated she was wrong for arguing." The statement was signed by	F 223	**F223 FREE FROMABUSE/INVOLUNATARY SECLUSION** **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?** * Employment of Housekeeping Aide was terminated whenoriginal investigation was completed. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** *All residents have the potential to be affected by the alleged deficientpractice. * All resident will be interviewed using QIS questions toidentify if verbal abuse has occurred. If identified, investigation will be initiated per policy.	06/10/2015

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	Housekeeping Aide #1. A undated statement, indicated "On this day this writer spoke with resident concerning a altercation that she had with a staff member (housekeeper). Resident 'stated' that the staff member was cleaning her room and rearrange items in her room that she didn't want touch. Res 'stated' that she also told housekeeper stop moving so fast d/t [due/to] housekeeper throwing things around in her room. Housekeeper responded back by arguing with resident. Resident 'stated' that she was ok." The statement was signed by LPN #3. An Incident Form dated 3/13/15, indicated this report was the Follow-up Report. The report indicated the incident occurred on 3/9/15 at 2:15 p.m. The report indicated Housekeeping Aide #1 was overheard speaking loudly with Resident #45. The report indicated Housekeeping Aide #1 was immediately suspended pending investigation and Resident #45 was interviewed with no concerns and indicated she was fine. The report indicated an investigation was started and Housekeeping Aide #1 was disciplined per company policy. An Employee Communication Form dated 3/11/15, indicated on 3/9/15 at 2:15		*IDT completed a review of all residents that may have beeninvolved in staff to resident abuse since March 1, 2015 to ensure appropriatemeasures have been put in place. **What measures will be putinto place or what systemic changes you will make to ensure the deficientpractice does not recur?** * Director of Nursing Services or designee will educatestaff by 6/5/15 on the Abuse Prohibition policy. * The Executive Director or designee will be notifiedimmediately if there is suspected staff to resident abuse and start aninvestigation. **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * To ensure compliance theDirector of Nursing Services or designeeis responsible for completion of the Abuse Prohibition and Investigation CQIweekly x 4 weeks, monthly x 2 months, and quarterlythereafter for one year with results reported to the Continuous QualityImprovement Committee overseen by the Executive Director * If threshold of 95% is not achievedan action plan will be developed to ensure compliance	

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	p.m., the Resident Abuse/Inconsiderate Treatment policy/procedure was violated. The form indicated Housekeeping Aide #1 was overheard arguing in a loud tone with a resident and the investigation was completed on 3/11/15. Housekeeping Aide #1 was suspended on 3/9/15 and terminated via telephone on 3/13/15 at 9 a.m., related to inconsiderate treatment of a resident. During an interview on 5/13/15 at 9:45 a.m., the Executive Director (ED) indicated he terminated Housekeeping Aide #1 related to the way she talked to Resident #45. He indicated he had substantiated the alleged abuse allegation. Resident #45's record was reviewed on 5/13/15 at 11:49 a.m. Diagnoses included, but were not limited to personality disorder, myasthenia gravis, depressive disorder and cerebrovascular disease. A current policy titled "Abuse Prohibition, Reporting and Investigation" dated 02/2010 and revised 10/2013, was provided by the ED on 5/7/15 at 1:00 p.m., indicated "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental			

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	abuse, neglect, involuntary seclusion and misappropriation of resident property and/or funds...Verbal Abuse-defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance...or scolding and /or speaking to them in harsh voice tones...Policy/Procedure: 1. [Name of Company] will not permit residents to be subjected to abuse by anyone...." 3.1-27(b)			
F 242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to honor a resident's preferences in regards to bathing choices for 1 of 1 residents interviewed for choices. (Resident E) Findings include: On 5/11/15 at 10:48 a.m., the record	F 242	**F 242 SELF-DETERMINATION –RIGHT TO MAKE CHOICES** **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?_** * Resident E bathing preference, profile, and care planupdated to indicate bed bath/shower twice a week and is	06/10/2015

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	review for Resident E was completed. Diagnoses included, but were not limited to, dementia, acute respiratory failure, status post gastric perforation with gastrostomy closure, questionable reopening, stroke, history of diabetes and seizures. The Preferences for Daily Customary Routines document, dated 4/7/15, indicated the resident felt it was very important for him to choose the type of bathing. He indicated he wanted a bed bath in the evenings twice a week. On 5/8/15 at 10:36 a.m., the resident indicated he was supposed to be bathed two times a week and sometimes it did not get done. On 5/12/15 at 10:48 a.m., the resident had dry flaky skin around ears and hairline when observed and hair was oily. The Director of Nursing Services provided documentation regarding bathing on 5/12/15 at 11:50 a.m. The Activities of Daily Living documentation indicated the resident had not received bathing twice a week per his preference for: The first week of April 5th-11th the		receiving bathing perschedule. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** *All residents have the potential to be affected by thealleged deficient practice. * All residents were interviewed by Customer Care Reps ordesignee for resident preferences related to bathing. * All residents preference, profiles, and care plans wereupdated as needed with resident preferred schedule for bathing. * Staff was in-serviced by Director of Nursing Services by 6/5/15or designee on following resident preference, profile, and care plan related topreferred bathing schedule. **What measures will be putinto place or what systemic changes you will make to ensure the deficientpractice does not recur?** * Daily audits willbe completed by Unit Manager or designee to verify residents are receivingbathing per resident preference. * Activities Directoror designee will update resident preference, profile, and care plans related tobathing on a quarterly basis and per resident request. * Staff wasin-serviced by Director of Nursing or designee by 6/5/15 on following residentpreference related to bathing and documentation of resident bathing **How the corrective actionwill be**	

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	resident documentation indicated: 4/7/15: 1:57 a.m. Complete bed bath The first week of May 3rd-9th the resident documentation indicated: 5/8/15 : 10:52 a.m. Complete bed bath 3:33 p.m. Shower As of the exit conference on 5/13/15 at 3:10 p.m., The DNS indicated that residents usually get bathed twice a week. This Federal tag relates to Complaint # IN00173085. 3.1-3(u)(1)		**monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * Toensure compliance, the DNS/Designee is responsible for the completion of theAccommodation of Needs CQI tool weekly times 4 weeks, monthly times 6 monthsand quarterly thereafter for one year with results reported to the ContinuousQuality Improvement Committee overseen by the Executive Director * If threshold of 95% is not achievedan action plan will be developed to ensure compliance	
F 312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living services for bathing, oral care and perineal care for 3 of 4 residents reviewed for Activities of Daily Living (ADL). (Resident E, L, and J)	F 312	**F312 ADL CARE PROVIDED FOR DEPENDENTRESIDENTS** **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?_** * Resident E bathing preference,	06/10/2015

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	Findings include: 1. On 5/11/15 at 10:48 a.m., the record review for Resident E was completed. Diagnoses included, but were not limited to, dementia, acute respiratory failure, status post gastric perforation with gastrostomy closure, questionable reopening, stroke, history of diabetes and seizures. On 5/8/15 at 10:36 a.m., the resident indicated he was supposed to be bathed two times a week and sometimes it did not get done. On 5/12/15 at 10:48 a.m., the resident had dry flaky skin around ears and hairline when observed and hair was oily. The Director of Nursing Services (DNS) provided documentation regarding bathing on 5/12/15 at 11:50 a.m. The Activities of Daily Living documentation indicated the resident had not received bathing twice a week for: The first week of April 5th-11th the resident documentation indicated: 4/7/15: 1:57 a.m. Complete bed bath The first week of May 3rd-9th the resident documentation indicated:		profile, and care planupdated to indicate bed bath/shower twice a week and is receiving bathing perschedule. * Resident L isreceiving oral care per care plan. * Resident J isreceiving pericare per policy. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** * All residents whoare dependent with bathing, oral care and perineal care have the potential tobe affected by the alleged deficient practice. * All residents that are dependent withbathing, oral care, and perineal care were reviewed by Unit Managers ordesignee for bathing preference, oral care per care plan, and perineal care perpolicy to ensure that resident care plans and profiles were updatedaccordingly. * Staff was in-serviced by Director ofNursing by 6/5/15 or designee onfollowing resident preference, profile and care plans related to bathing, providing oral care per care plan, andperforming perineal care per policy. **What measures will be put intoplace or what systemic changes you will make to ensure the deficient practicedoes not recur?** * Staff was in-serviced by	

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	5/8/15 : 10:52 a.m. Complete bed bath 3:33 p.m. Shower On 5/13/15 at 3:10 p.m., The DNS indicated that residents usually gets bathed twice a week.		Director of Nursingor designee by 6/5/15 on following resident preference, profile and care plansrelated to bathing, providing oral careper care plan, and performing perineal care per policy. * Director of Nursing or designee will reviewbathing documentation and oral care documentation in Point of Care daily to ensure showers wereoffered and oral care performed and appropriate documentation occurred perresident preference. * Director of Nursing or designee will perform roundsevery shift to ensure perineal care, oral care, and bathing for dependentresidents performed per care plan and/or policy using the nurse rounds audittool. **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * To ensure compliance, theDNS/Designee is responsible for the completion of the Accommodation of NeedsCQI, tool weekly times 4 weeks, monthlytimes 6 months and then until continued compliance is maintained for 2consecutive quarters. The results of these audits will be reviewed by the CQIcommittee overseen by the	

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			Director of Nursing, Executive Director, and MedicalDirector * If threshold of 95%is not achieved an action plan will be developed to ensure compliance	
F 329 SS=E Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to ensure residents receiving antispychotic medications had appropriate diagnoses for use, appropriate targeted behaviors monitored, and failed to monitor for side effects of the	F 329	**F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive	06/10/2015

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	medication for 5 of 5 residents reviewed for unnecessary (Residents #100, #105, #125, #53 and E) Findings include: 1. Resident #100's record was reviewed on 5/12/15 at 10:13 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, episodic mood disorder and debility. The resident's Physician Order Report dated May 2015, included, but were not limited to, the following orders: 2/25/15--Trazodone (an antidepressant medication) 50 mg (milligrams) at bedtime for Aftercare. 3/20/15--Risperdal (an antipsychotic medication) 0.25 mg by mouth daily for episodic mood disorder. a. A Behavior Symptom Monthly Summary Form dated 4/20/15, indicated the supporting diagnosis for Risperdal 0.25 mg by mouth daily was dementia with psychosis, agitation and aggression. Behavior Symptom Monthly Summary Forms dated 7/24/14 to 2/9/15, included, but were not limited to, the following monitored behaviors: The resident used the restroom in inappropriate places, was at risk for elopement due to being exit seeking and		duration; or without adequate monitoring;or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above **What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?** · Resident #100- has appropriate diagnosesfor Trazodone and Risperdal, has appropriate target behaviors on behavior flowsheets, care plans have been update and appropriate behaviors are being monitored. · Resident #105- has appropriate diagnosesfor Risperdal, care plans have been updated and appropriate behaviors are being monitored. · Resident #125- has appropriate diagnosesfor Buspirone and Citalopram, has appropriate target behaviors on behavior flowsheet, care plans have been updated and appropriate behaviors are beingmonitored. · Resident#53- Resident has supporting dxfor the use of Risperdal. Has appropriate target behavior on flowsheet and appropriate behavior are being monitored. · Resident E: Seroquel medication was discontinued. **How will you identify other residents having the potential to be affected by the same deficient practice and**	

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	she pulled on doors, pushed key pad buttons, and stood by doors waiting for them to be opened. She displayed physical aggression toward the staff by slapping and hitting them. She had a diagnosis of dementia and was administered antipsychotic medications. Behavior Symptom Monthly Summary Forms dated 3/14/15 to 4/20/15, included, but were not limited, the following monitored behaviors: The resident was at risk for elopement due to exit seeking because she pulled on doors, pushed key pad buttons and stood by doors waiting for them to be opened, she displayed physical aggression toward the staff by slapping and hitting them and she had a diagnosis of dementia and utilized anti-psychotic medications. Behavior Flowsheets dated March 2015 to May 2015, included, but were not limited to, the following monitored behaviors: The resident may express verbal agitation by yelling in a language other than English, waved hands to protect her personal space, exit seeking and pulled on unit doors, pushed key pad buttons, attempted to unlock doors, stood by doors waiting for them to be opened, and she had been physically aggressive with staff by slapping them when they		**what correctiveaction will be taken?** · All residents who receive an antipsychotic,anti-anxiety, and antidepressant medications have the potential to be affected by thealleged deficient practice · The IDT team will be in-serviced on the Psychoactive Medication Management and Behavior Management Programs by theDNS/designee by June 5, 2015 · The IDT team will review all physician'sorders in the clinical meeting to identify all residents receiving antipsychotic, anti-anxiety, and antidepressant medications to ensure careplanis updated and that the diagnosis is appropriate and that side effect monitoring is in place. · Social Services/designee will audit all residents receiving anti-psychotic, anti-anxiety, and antidepressant medications to ensure that all medications have an appropriate diagnosis for use, and that there is resident specific behavior monitoring in place. · The DNS/designee will audit all residents receiving anti-psychotic, anti-anxiety, and antidepressant medications to ensure that there is monitoring present in the medication administration record for side effects of the medications **What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?** · The IDT team will be in-serviced on	

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	attempted to redirect her. The above behaviors were not indicated for the use of an anti-psychotic medication. There was no behavior tracking related to the diagnosis of psychosis. b. A Behavior Symptom Monthly Summary Form dated 4/20/15, indicated the supporting diagnosis for Trazodone 25 mg at bedtime by mouth was insomnia. Behavior Flowsheets dated March 2015 to May 2015, included, but were not limited to, the following monitored behaviors: The resident has a diagnosis of insomnia. Behavior Symptom Monthly Summary Forms dated 3/14/15 to 4/20/15, included, but were not limited, the following monitored behaviors: The resident had insomnia. During an interview on 5/13/15 at 5:02 p.m., the the Activity Director/Social Service Assistant (AD/SSA) #9 with Social Service Assistant (SSA) #8 in attendance indicated Resident #100's diagnosis for Risperdal was episodic mood disorder and the Trazodone diagnosis was aftercare. She indicated		the Psychoactive Medication Management and Behavior Management Programs by theDNS/designee by June 5, 2015 · The IDT team will review all physician's orders in the clinical meeting to identify all residents receiving antipsychotic,anti-anxiety, and antidepressant medications · Social Services/designee will audit all residents receiving anti-psychotic, anti-anxiety, and antidepressant medications to ensure that all medications have an appropriate diagnosis for use, and that there is resident specific behavior monitoring in place · The DNS/designee will audit all residents receiving anti-psychotic, anti-anxiety, and antidepressant medications to ensure that there is monitoring present in the medication administration record for side effects of the medications · The IDT team or designee will review daily any new orders for anti-psychotic, anti-anxiety, and antidepressant medications to ensure that side effect monitoring is placed in the medication administration record, there is an appropriate diagnosis for use. The IDT team or designee will review physician's orders Monday through Friday to identify that appropriate targeted behaviors are monitored using behavior monitoring flow sheet **How the corrective action(s) will be monitoredto ensure the deficient practice will not recur,**	

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	she understood these were not appropriate diagnoses for these medications and she was unable to find any additional documentation why the resident had these diagnoses. She indicated the behavior monitoring for Risperdal was agitation, aggression and dementia with psychosis. She indicated she was unable to find any behavior monitoring in the resident's records for the Trazodone. During an interview on 5/13/15 at 5:50 p.m., the Director of Nursing Services (DNS) with the Executive Director (ED) in attendance indicated the facility was aware there were problems with the behavior monitoring program and they had developed a plan of correction for it. 2. Resident #105's record was reviewed on 5/13/15 at 10:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, insomnia, senile psychosis and depressive disorder. The resident's Physician Order Report dated May 2015, included, but were not limited to, the following physician orders: 4/24/14--Mirtazapine (an antidepressant medication) 15 mg by mouth at bedtime for depressive disorder. 3/14/15--Trazodone (an antidepressant		**i.e., what quality assurance program will be put into place?** · Behavior Management and Unnecessary Medications CQI tools will be utilized weekly x 4 weeks, monthly x 6months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. · If 95% a threshold is not achieved, an action plan will be developed to ensure compliance.	

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	medication) 50 mg by mouth at bedtime for insomnia. 4/15/15--Risperdal 0.25 mg by mouth daily for Alzheimer's disease. 4/15/15--Risperdal 0.5 mg by mouth at bedtime for Alzheimer's disease. a. A Behavior Symptom Monthly Summary Form dated 3/14/15, indicated the supporting diagnosis for Risperidone (Risperdal) 0.5 mg by mouth twice a day was dementia with psychosis. Behavior Symptom Monthly Summary Forms dated May 2014 to 3/14/15, included, but were not limited to, the following monitored behaviors: The resident intrusively wandered into other resident's rooms, was combative with care at times and had increased agitation on the night shift. Behavior Flowsheets dated April 2015 to May 2015, included, but were not limited to, the following monitored behaviors: The resident intrusively wandered into other resident's rooms, hovered around the dining room bathroom when other residents attempted to use it and attempted to redirect other residents, was combative with care at times, had increased agitation and combativeness on the night shift and refused to rest in the bed.			

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	The above behaviors were not indicated for the use of an anti-psychotic medication. There was no behavior tracking related to the diagnosis of psychosis. b. A Behavior Symptom Monthly Summary Form dated 3/14/15, indicated the supporting diagnosis for Trazodone 50 mg in the evening was insomnia. Behavior Flowsheets dated April 2015 to May 2015, included, but were not limited to, the following monitored behaviors: The resident had signs and symptoms of sleeplessness and had a diagnosis of insomnia. Behavior Symptom Monthly Summary Forms dated June 2014 to 3/14/15, included, but were not limited to, the following monitored behaviors: The resident had insomnia. There were no behaviors being tracked for the medication Mirtazapine or the diagnosis depressive disorder. During an interview on 5/13/15 at 5:29 p.m., the AD/SSA #9 with the SSA #8 present indicated Resident #105's Trazodone diagnosis was insomnia, Risperidal diagnosis was Alzheimer's			

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	disease and his Mirtazapine diagnosis was depressive disorder. She indicated the behaviors he was being monitored for was intrusively wandering into other resident's rooms and being combative with care at times. 3. Resident 125's record was reviewed on 5/12/15 at 11:53 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances and delusional disorder. The resident's Physician Order Report dated May 2015, included, but were not limited to, the following orders: 4/10/14--Olanzapine (Zyprexa) (an anti-psychotic medication) 5 mg by mouth at bedtime for delusional disorder. 12/19/14--Zyprexa 2.5 mg by mouth for delusional disorder. 2/6/15--Remeron (an antidepressant medication) 15 mg tablet give 7.5 mg at bedtime for poor appetite. 2/7/15--Buspirone (an anti-anxiety medication) 5 mg by mouth twice a day for dementia with behavior disturbances. 2/7/15--Citalopram (an antidepressant medication) 20 mg by mouth daily for aftercare. a. A Behavior Symptom Monthly Summary Form dated 3/14/15, indicated the supporting diagnosis for Zyprexa 5			

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	mg at bedtime and 2.5 mg every morning was dementia with psychosis. Behavior Flowsheets dated April 2015 to May 2015, included, but were not limited to, the following monitored behaviors: The resident exhibited grandiose delusions such as; she had cancer, she had an upcoming surgery scheduled or she was waiting on a family member to finish building her house, so she could move. She exhibited paranoid behaviors such as; she fixated on personal belongings and thought they had been taken even when she originally did not have the items. Behavior Symptom Monthly Summary Forms dated May 2014 to 3/14/15, included, but were not limited to, the following monitored behaviors: The resident invaded other resident's personal space, she exhibited paranoid behaviors such as; she fixated on her personal belongings being taken even then she did not have the items originally. She believed other residents had been her family and friends for many years and she needed to care for them. She had grandiose delusions such as; she had cancer, she had an upcoming surgery scheduled and she was waiting on a family member to build her house, so she could move.			

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	The above behaviors were not indicated for the use of an anti-psychotic medication. There was no behavior tracking related to the diagnosis of psychosis. b. A Behavior Symptom Monthly Summary Form dated 3/14/15, indicated the supporting diagnosis for Celexa (Citalopram) 20 mg daily was depressive disorder. There were no behaviors being tracked for the medication Celexa or the diagnosis depressive disorder. c. A Behavior Symptom Monthly Summary Form dated 3/14/15, indicated the supporting diagnosis for Buspar (Buspirone) 5 mg twice daily was anxiety. There was no behaviors being tracked for the medication Buspar or the diagnosis anxiety. During an interview on 5/13/15 at 5:18 p.m., the AD/SSA #9 with the SSA #8 present indicated the diagnosis for Resident #125's Zyprexa was for disorder and delusional. The diagnosis for Remeron was appetite. The diagnosis for Celexa was aftercare and the diagnosis			

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	for Buspar was anxiety and dementia with unspecified behavioral disturbances. She indicated the behavior being monitored for Zyprexa was dementia with psychosis. The behavior being monitored for Celexa was depressive disorder. The behavior being monitored for Buspar was anxiety. 4. On 5/11/15 at 10:48 a.m. record review for Resident E was completed. Diagnoses included, but were not limited to, dementia, acute respiratory failure, COPD, status post gastric perforation with gastrostomy closure, questionable reopening, stroke, history of diabetes and seizures. The physician's orders dated 1/8/15, indicated the resident was on Seroquel (an antipsychotic medication) 50 milligrams 1 tablet by mouth at night. The Initial Assessment document signed by the physician, dated 1/5/15, indicated the resident was on Seroquel for dementia. There was MAR (Medication Administration Record) documentation for April 2015 which indicated the monitoring for side effects of medications. There was no documentation found for side effects of the antipsychotic medication.			

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	There were no behavior documentation flow sheets found in the chart related to the use of the Seroquel. On 5/12/15 at 11:53 a.m., the Director of Nursing Services (DNS) indicated there was no side effect monitoring for Seroquel. She indicated she believed the resident was put on Seroquel at the hospital and had not been reassessed as to why he needed the medication. She indicated the facility had no behavior tracking for the Seroquel as there was no diagnosis as to why the resident was on the medication. As of the exit conference on 5/14/15 at 10:15 a.m., no other documentation was provided for indication for the use of the Seroquel. 5. On 5/11/2015 at 1:21 p.m., the record review was completed for Resident #53. Diagnoses included, but were not limited to, depression, diabetes, renal disease, depression and bipolar disorder. The physician's orders dated 4/15/15, indicated the resident was receiving Risperidone 1.5 mg by mouth twice daily for bipolar disorder. The March 2015 physician's order report			

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	indicated the resident was on Risperdal 1 milligram twice daily for shared psychotic disorder. The April 2015 physician's order report indicated the resident was on Risperdal 1 milligram twice daily for shared psychotic disorder. The May 2015 physician order report indicated Risperidone 1.5 milligrams twice daily for bipolar disorder. There were behavior flowsheets for February, March and April 2015. The Behavior Flowsheets indicated the resident becomes verbally aggressive towards others and argumentative. On 5/11/15 at 5:36 p.m. the DNS indicated they do not have the behavior monitoring to match the diagnosis of why the resident was on the medication as the behavior documentation indicated aggressiveness and cussing, and diagnosis for use of medication was bipolar. 3.1-48(6)			
F 371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -			

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	(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 Based on observation, interview and record review, the facility failed to ensure cooking appliances and kitchen equipment were maintained in sanitary conditions and failed to ensure food being served from the kitchen was stored in sanitary conditions for 1 of 1 kitchens reviewed for safe food handling practices. This deficient practice had the potential to affect 104 of 104 residents being served from the kitchen. Findings include: The kitchen tour began on 5/6/15 at 10:27 a.m., with the Dietary Manager (DM) in attendance. 1. On 5/6/15 at 10:32 a.m., the following metal pans were observed to have a clear liquid on them, identified as water by the DM: a. Two medium rectangular shaped metal pans had beads of water between each pan, which ran down the side of the second pan when the first pan was lifted up. b. Three small rectangular shaped metal pans had beads of water between each pan, which ran down the sides of the	F 371	**F371 FOOD PROCURE,STORAGE/PREPARE/SERVE – SANITARY** **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?_** * All residents have thepotential to be affected by the alleged deficient practice. * All pans were completely air dried prior touse * The splashguard behind the stove was cleaned. * The screens for the hood over the stove topwere cleaned. * The two dented cans of applesauce were thrownout *The dented can of cranberryjuice was thrown out * The two 8 pound bottles of spicy brownmustard were thrown out * The two ounces of sodium beef base was thrownout. * The ten pound tube of ground beef was thrownout. * The two tubes of ten pounds of ground beefsitting on tray were thrown out. * The Chef salad was thrown out * The 15 scoops of ice	06/10/2015

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	pans when each pan was lifted up. c. Three large rectangular shaped metal pans had beads of water between each pan, which ran down the sides of the pans when the pans were lifted up. d. Nine long flat rectangular shaped metal pans had beads of water between each pan, which ran down the sides of the pans when the pans were lifted up. e. During an interview at that time, the DM indicated the water was not suppose to be between the pans. She indicated the staff should have left the pans in the drying station to air dry before putting them away or the pans should have been inverted on the racks to allow them to air dry individually. 2. On 5/6/15 at 10:45 a.m., the Splashguard behind the stove top was observed to have a rust colored debris along the bottom half of it. The DM indicated at that time, the rust colored debris was carbon from the open flame. She indicated the carbon was burnt on the Splashguard was cleaned weekly by staff, but they were unable to remove all of it. 3. On 5/6/15 at 10:48 a.m., the screens for the hood over the stove top, grill and ovens were partially covered with a gray colored debris. At that time, the DM indicated the screens were ran through the dishwasher once a month. She		cream were thrown out. * The 5 pound bag of crinkle cut carrots werethrown out. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** * All residents have the potential to beaffected by the alleged deficient practice. * Cleaning schedule will be modified to includecleaning of splashguard and Hood/Vents. * Dietary staff willbe in-serviced by Dietary Manager or designee by 6/5/15 on drying pans, foodstorage and labeling, protocol for dented cans, cleaning equipment andfollowing cleaning schedules. *Dietary Manager or designee will audited to ensure dryingpans, food storage and labeling, protocol for dented cans, cleaning equipmentand following cleaning schedules. **What measureswill be put into place or what systemic changes you will make to ensure thedeficient practice does not recur?** * Cleaning schedule will be modified to includecleaning of splashguard and Hood/Vents. * Dietary staff willbe in-serviced by Dietary Manager or designee by 6/5/15 on drying pans,	

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	indicated she thought the last time the screens were ran through the dishwasher was three weeks ago. She indicated the inside of the hood system was cleaned once every six months professionally by a company and that was completed in January 2015. 4. On 5/6/15 at 11:02 a.m., the following items were observed in the dry storeroom area: a. Two 104 oz (ounce) dented cans of Applesauce. b. One 117 oz dented can of jellied Cranberry sauce. c. Two 8 pound bottles of spicy brown Mustard with a best if used by date 3/19/15, and a received date 12/3/14. d. The DM indicated at that time, the dented cans should not have been on the shelves. She indicated they were to be placed in her office and she returned them and received credit for them from the distributor. She indicated the Mustard bottles were expired and she did not know why they were on the shelf. 5. On 5/6/15 at 11:12 a.m., the following food items were observed in the walk-in cooler and identified by the DM: a. Two ounces of sodium Beef base had an open date of 4/30/15. b. A ten pound tube of ground beef cut in half was sitting on a metal flat tray,		foodstorage and labeling, protocol for dented cans, cleaning equipment andfollowing cleaning schedules. * RegisteredDietician or designee will monitor kitchen processes each meal by completingthe Dietary Quick Sanitation to ensure proper drying of pans, food storage andlabeling, protocol for dented cans, cleaning equipment and following cleaningschedules follows protocol. * A full sanitation audit will be conducted by the RDConsultant or designee monthly. **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * To ensure compliance the Registered Dietician or designeeis responsible for completion of the Kitchen Sanitation/Environmental Review Toolweekly x 4 weeks, monthly x 6, and quarterly thereafter for one year withresults reported to the Continuous Quality Improvement Committee overseen bythe Executive Director * If threshold of 95% is not achieved an action plan will bedeveloped to ensure compliance	

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	which was a dark brown color. The ground beef tube was opened and uncovered at the opened end with no label or open date. c. Two tubes of ten pounds of ground beef was sitting on a flat metal tray along side the open tube of ground beef with no pull date marked on the meat or tray to indicate when it was removed from the freezer to be thawed. d. One entree Chef salad was sitting on a flat metal tray with no label or prep date. e. At that time, the DM indicated the staff should have fully wrapped, labeled and dated the opened tube of ground beef. She indicated the unopened tubes of ground beef should have had a pull date and label. She indicated the Chef salad should have had a label and prep date. She indicated the beef base was expired and should have been thrown out. The DM discarded the ground beef and salad at that time. 6. On 5/6/15 at 11:25 a.m., the following food items were observed in the walk-in freezer and identified by the DM: a. 15 scoops of vanilla flavored ice cream were in plastic bowls on a flat metal tray dated 5/5/15. b. 5 pounds of crinkle cut carrots were in a blue bag with the top of the bag twisted, but not securely closed. There			

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	was no label or date on the bag. c. The DM indicated the vanilla ice creams were from last night's dinner and should have been covered with parchment paper. She indicated the carrots should have been securely closed, dated and labeled when opened. 7. The cleaning schedules were provided by the Dietary Manager: a. The a.m. and p.m., cleaning schedule dated March 2015, indicated there was no documentation the Hood/Vents had been cleaned for the month of March 2015. The Splashguard was not found on the weekly cleaning schedule for that month. b. The a.m. and p.m., cleaning schedule dated April 2015, was not provided by the DM. c. The a.m. and p.m., cleaning schedule dated May 2015, indicated the Splashguard was not found on the weekly cleaning schedule for that month. d. At that time, the DM indicated if March 2015, a.m. and p.m., cleaning schedules was not documented for the cleaning of the Hood/Vents monthly, then they had not been cleaned. She indicated she had not placed the Splashguard for the back of the stovetop on the weekly cleaning sheet. A current policy titled "Labeling and			

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SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

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	Dating" dated 8/2014, was provided by the Executive Director (ED) on 5/6/15 at 2:17 p.m., indicated "All opened and left over items need to be labeled with the date of opening/date stored and a discard /use-by date... 3 Days:.. Label with the date of storage and the date of discard-add 2 to today's date* Examples:..chicken breasts, ham, bologna, salami... These are guidelines and should not be used in place of good judgement. When in Doubt, Throw it Out!" A current policy titled "Cleaning Hoods and Filters" dated 2/2002 and revised 4/2011, provided by the ED on 5/6/15 at 2:17 p.m., indicated "Policy: Stove hoods and filters will be cleaned according to the cleaning schedule. Procedure:...2. Remove screens from hood. 3. Place in soapy water in the sink. Scrub thoroughly. Rinse. May run through the dish machine if appropriate. 4. Remove and let screens dry...6. To clean interior and exterior of hood, a clean dry cloth soaked in soapy detergent water is used... A more abrasive cleaning agent may be needed in some cases...." A current policy titled "Food Storage" dated 2/2002 and revised 7/2013, provided by the ED on 5/6/15 at 2:17 p.m., indicated "Policy:...Food is stored,			

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	prepared and transported at an appropriate temperature and by methods designed to prevent contamination... Procedure:... 5. Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods...14. Leftover prepared foods are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 F [Fahrenheit] or less for no more than 3 days. The day the food was prepared shall be counted as Day 1. 15. Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors, shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held at 41 F or less for no more than 7 days and the date marked may not exceed the manufacturer's use-by-date. The day the original container is opened shall be counted as Day 1... 18. Refrigeration:... f) All foods should be covered, labeled and dated. 19. Frozen foods:...Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24-48 hours... d) Foods should be covered,			

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	labeled and dated...." 3.1-21(i)(3)			
F 431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package			

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	drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observations and interviews, the facility failed to ensure medications were labeled for 1 of 5 medication carts reviewed for medication storage. Findings include: During observations of medication storage, on 5/12/15 at 12:17 p.m., with LPN #4, three boxes containing seven tablets each of Myrbetriq (used to treat overactive bladder) was stored in medication cart #2, on the second floor. The three boxes of Myrbetriq were not dated and were not labeled with a resident name and were without administration instructions. LPN #4 indicated she did not know why there was not a label and did not know to whom the medication belonged. She indicated all medications should be dated and labeled with the patients name, the route of administration, and administration instructions from the physician. 3.1-25(k)(1) 3.1-25(k)(5)	F 431	F431 DRUGRECORDS, LABEL/STORE DRUGS & BIOLOGICALS **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?** * Unlabeled medication in Cart#2 was removed and destroyed. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** *All residents have the potential to be affected by the alleged deficientpractice. * All Med carts were audited by unit managers and thepharmacy to ensure that all medication is labeled with date received, patientname, and administration instructions. * Director of Nursing Services or designee will in-serviceLicensed Nurses by 6/5/15 on Labeling of Medication and proper storage. **What measures will be putinto place or what systemic changes you will make to ensure the deficientpractice does not recur?** * Medications stored inmedication carts will be audited daily by the Director of Nursing Services	06/10/2015

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			ordesignee to ensure that medication is labeled with date received patient name,and administration instructions. *Each licensed nurse will complete every shift the nurserounds audit tool to ensure that medication is labeled with date received, patientname, and administration instructions. * Director of Nursing Services or designee will in-serviceLicensed Nurses by 6/5/15 on Labeling of Medication. *Director of Nursing Services or designee will audit weeklyto ensure medications have proper labeling using an audit tool. **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * To ensure compliance the Director of Nursing Services or designee is responsible for completion ofthe Medication Storage CQI weekly x 4 weeks, monthly x 2 months, and quarterlythereafter for one year with results reported to the Continuous QualityImprovement Committee overseen by the Executive Director * If threshold of 95% is not achievedan action plan will be developed to ensure compliance	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT			

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Bldg. 00	SPREAD, LINENS 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. (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. (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 lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interview, the facility failed to maintain infection control practices by failing to remove	F 441	**F441 INFECTION CONTROL,PREVENT SPREAD, LINENS** **What corrective action(s)will be**	06/10/2015

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	furniture soiled with bowel movement from a hallway and failed to ensure staff food items were not stored in a medication refrigerator. This deficient practice had the potential to affect of 17 (Moving Forward Unit) of 108 residents residing in the building. Findings include: During an observation, on 5/07/15 at 9:55 a.m., on the east hallway of the Moving Forward unit, a light colored straight back chair had formed and soft-formed, foul smelling feces on the seat. The chair was placed at the intersection of the east hall and north hall, near room 110. At that time, an unidentified therapist was knocking the door (room 110). The therapist indicated the speech therapist was working with Resident 118, at that time. The speech therapist was heard indicating to the therapist, she would be finished in 15 - 30 minutes. The soiled chair was brought to the attention of the ADNS on 5/7/15 at 10:04 a.m. The ADNS removed the chair and took it outside to the garbage dumpster. The ADNS indicated it should not have been left in the hall, like that. She did not know which room the chair came from or who put it there.		**accomplished for those residents found to have been affected by thedeficient practice?_** * Soiled chair was removed from facility and discarded * Food in Moving Forwardmedication refrigerator was discarded **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** * All residents have the potential to be affected by thealleged deficient practice * Housekeeping Supervisor or designee audited furniture incommon area for soilage and clean and disinfect as needed. *Unit Mangers or designee auditedmedication refrigerators for storage of food. * Director of Nursing Services or designee will in-service staffby 6/5/15 on Infection Control Policy and Procedures including storing food inmedication refrigerator and removal and disinfecting of soiled furniture **What measures will be putinto place or what systemic changes you will make to ensure the deficientpractice does not recur?** * Housekeeping Supervisor or designee will audit furniturein	

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	On 5/13/15 at 2:35 p.m., during an interview, the Rehabilitation Services Manager indicated she was in charge of the occupational therapists (OT), physical therapists (PT), speech therapy (ST). She indicated she expected OT, PT, and ST to notify a CNA or a nurse and housekeeping staff, if they went into a residents room to provide therapy services and noticed soiled furniture. She indicated she would expect them to put a towel over it, at least, and depending on the size of the furniture, remove it from the room and take it to a place for cleaning or disposal. She indicated leaving it in the hallway, uncovered, was not the right thing to do. 2. On 5/12/15 at 5:26 p.m., during an observation of a medication storage room on the Moving Forward unit, with LPN #5, an open, clear, plastic, square container was stored in a medication refrigerator used to store nutritional supplements. Six grapes and a partially eaten Thai chicken wrap were in the open container. The container of food was not labeled or dated. LPN #5 indicated the staff's personal food was not to be stored with medications or with nutritional supplements. 3.1-19(a)		common areas weekly for soilage and clean and disinfected as needed. *Unit Manger or designee willaudit Medication refrigerators daily for storage of food . * Director of Nursing Services or designee will in-servicestaff by 6/5/15 on Infection Control Policy and Procedures including storingfood in medication refrigerator and removal and disinfecting of soiledfurniture **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * To ensure compliance the HouskeepingSupervisor or designee is responsiblefor completion of the Environmental Safety CQI x 4 weeks, monthly x 6 months,and quarterly thereafter for one year with results reported to the ContinuousQuality Improvement Committee overseen by the Executive Director * If threshold of 95% is not achievedan action plan will be developed to ensure compliance	

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F 465 SS=F Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations and interviews, the facility failed to maintain an orderly, clean, and homelike interior for residents, visitors, and staff 3 of 3 environmental tours. (Room 206, 118, 119, 121, 217, 130, 110) Findings include: 1. During an observation, on 5/07/15 at 9:55 a.m., on the east hallway of the Moving Forward unit, a light colored straight back chair had formed and soft-formed, foul smelling feces on the seat. The chair was placed at the intersection of the east hall and north hall, near room 110. At that time, an unidentified therapist was knocking the door (room 110). The therapist indicated the speech therapist was working with Resident 118, at that time. The speech therapist was heard indicating to the therapist, she would be finished in 15 - 30 minutes.	F 465	**F465 SAFE/FUNCTIONAL/SANITARY/COMFRTABLE ENVIRONMENT** Spring Mill Meadows respectfully requests additional evidentiaryinformation be considered to reduce the scope and severity of F 465 from the 2567. The current statement ofdeficiencies on the 2567 omits significant facility information and thereforemisrepresents the care and services administered by the provider to itsresidents. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice?** *The soiled chair in Moving Forward hallway was thrown out * The box fan in room 206 wascleaned * The floors at baseboards on 2ndfloor were cleaned. * The floor at the fire doors onthe northeast hall were cleaned * The P-TAC unit at thesoutheast window in front of room 231 was cleaned and painted. * The P-TAC unit in room 217 was cleaned and painted and thedrywall below the P-TAC unit was fixed and painted. * The P-TAC units at thesouthwest and northwest corner were cleaned	06/10/2015

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	The soiled chair was brought to the attention of the ADNS on 5/7/15 at 10:04 a.m. The ADNS removed the chair and took it outside to the garbage dumpster. The ADNS indicated it should not have been left in the hall, like that. She did not know which room the chair came from or who put it there. On 5/13/15 at 2:35 p.m., during an interview, the Rehabilitation Services Manager indicated she was in charge of the occupational therapists (OT), physical therapists (PT), speech therapy (ST). She indicated she expected OT, PT, and ST to notify a CNA or a nurse and housekeeping staff, if they went into a residents room to provide therapy services and noticed soiled furniture. She indicated she would expect them to put a towel over it, at least, and depending on the size of the furniture, remove it from the room and take it to a place for cleaning or disposal. 2. At 12:11 p.m., on 5/12/15, during a medication pass observation in room 206, a box fan on the floor had a covering of dust bunnies on the fan cover. LPN #4 indicated the fan was the property of the facility. She indicated housekeeping staff was in charge of cleaning, and the room was deep cleaned, earlier that day, and the fan was not cleaned.		and painted. * The transition strips for rooms 118, 119, 121, 127, and130 were cleaned and wax build up was removed. * The closet door for room 206 was sanded and painted. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** * All residents have the potential to be affected by thealleged deficient practice * All furniture in common areas will be audited to ensure nosoilage and cleaned and disinfected as needed. * All P-TAC units will becleaned and painted as needed. * All floors, baseboards, transitions strips and closetdoors will be audited for dirt, debris and wax buildup and clean and/or paintas needed. * All box fans were audited and cleaned as needed. * Director of NursingServices or designee will educate housekeeping and maintenance staff by 6/15/15 on environmental cleaning, includingP-TAC units, floors, baseboards, transitions strips, closet doors and box fans. **What measures will be putinto place or what systemic changes you will make to ensure the deficientpractice does not recur?** * Furniture in common areas will be audited daily forsoilage and cleaned and disinfected as needed by housekeeping supervisor ordesignee. * Maintenance	

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	3. During an environmental tour with the Maintenance Director on 5/13/15 at 3:40 p.m., the following was observed on the second floor: a.) The floors were noted with debris and dirt at the baseboards throughout the second floor. b.) The fire doors at the northeast hall were noted with wax build up and dirt/debris where the floor meets the door frame. c.) The P-TAC (Packaged Terminal Air Conditioner) unit at the southeast window, (in front of room 231) had chipped paint, rust, visible metal on the vent, and an overly accumulation of dust and dust bunnies. During an interview with the maintenance director, during the tour, he indicated the air conditioning does not work on this unit, and it was only used for the fan, at times. He indicated the facility staff could paint over it, if needed. d.) The P-TAC unit in room 217 was observed with dust, dirt, rust, and something was hanging from the bottom. During the tour, the maintenance director indicated dirty drywall was hanging from the bottom of the unit. e.) The P-TAC unit's at the southwest corner and the northwest corner were		Supervisor ordesignee will audit P-TAC units monthly and clean and paint as needed. * Housekeeping Supervisor or designee will audit floors,baseboards, transitions strips and closet doors weekly for dirt, debris and waxbuildup and clean and/or paint as needed. * Housekeeping Supervisor or designee will audit residentroom box fans for cleanliness weekly and clean as needed. * Director of NursingServices or designee will educate housekeeping and maintenance staff by 6/5/15 on environmental cleaning, includingP-TAC units, floors, baseboards, transitions strips, closet doors and box fans. **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** * To ensure compliance theMaintenance Director or designee isresponsible for completion of the Environmental Safety CQI x 4 weeks, monthly x6 months, and quarterly thereafter for one year with results reported to theContinuous Quality Improvement Committee overseen by the Executive Director * If threshold of 95% is not achievedan action plan will be developed to ensure compliance **F223 FREE FROMABUSE/INVOLUNATARY SECLUSION What corrective action(s)will be accomplished**	

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	dirty, dusty, and rusty, especially at the vents and control knobs. 4. During observations on the memory care unit on 5/13/15 at 4:10 p.m., with the ED, transition strips at the resident room doorways were noted with black debris and wax build up, to the following rooms: 118, 119, 121, 127, and 130. 5. On 5/13/15 at 4:20 p.m., during observations with ED and maintenance director, the closet door in room 206 was noted with hardened clumps of plaster attempting to cover two holes. The ED indicated the two areas needed sanded. 3.1-19(f)		**for those residents found to have been affected by thedeficient practice?** * Employment of Housekeeping Aide was terminated whenoriginal investigation was completed. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** *All residents have the potential to be affected by the alleged deficientpractice. * All resident will be interviewed using QIS questions toidentify if verbal abuse has occurred. If identified, investigation will be initiated per policy. *IDT completed a review of all residents that may have beeninvolved in staff to resident abuse since March 1, 2015 to ensure appropriatemeasures have been put in place. **What measures will be putinto place or what systemic changes you will make to ensure the deficientpractice does not recur?** * Director of Nursing Services or designee will educatestaff by 6/5/15 on the Abuse Prohibition policy. * The Executive Director or designee will be notifiedimmediately if there is suspected staff to resident abuse and start aninvestigation. **How the corrective actionwill be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?**	

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			* To ensure compliance theDirector of Nursing Services or designeeis responsible for completion of the Abuse Prohibition and Investigation CQIweekly x 4 weeks, monthly x 2 months, and quarterlythereafter for one year with results reported to the Continuous QualityImprovement Committee overseen by the Executive Director * If threshold of 95% is not achievedan action plan will be developed to ensure compliance **Informal Dispute Resolution forSpring Mill Meadows Annual Survey 5-14-15 SpringMill Meadows is requesting a paper review IDR** Spring Mill Meadows respectfully requests additional evidentiaryinformation be considered to reduce the scope and severity of F 465 from the 2567. The current statement ofdeficiencies on the 2567 omits significant facility information and thereforemisrepresents the care and services administered by the provider to itsresidents. **F 465 Safe/Functional/Sanitary/Comf ortableEnvironment FederalRegulation states: §483.70 (h) The facility must provide a safe, functional,sanitary, and comfortable environment for residents, staff and the public. StateOperations Manual definition of scope:** "Scope has three levels: isolated; pattern; and widespread. Thescope levels are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/14/2015

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			defined accordingly: Scope is a pattern whenmore than a very limited number of residents are affected, and/or more than avery limited number of staff is involved, and/or the situation has occurred inseveral locations, and/or the same resident(s) have been affected by repeatedoccurrences of the same deficient practice. The effect of the deficientpractice is not found to be pervasive throughout the facility. Scope is widespread whenthe problems causing the deficiencies are pervasive in the facility and/orrepresent systemic failure that affected or has the potential to affect a largeportion or all of the facility's residents. Widespread scope refers to theentire facility population, not a subset of residents or one unit of afacility. In addition, widespread scope may be identified if a systemic failurein the facility (e.g., failure to maintain food at safe temperatures) would belikely to affect a large number of residents and is, therefore, pervasive inthe facility. " **State OperationsManual definition of severity:** B. Guidance on Severity Levels There are four severity levels. Level 1, no actual harm withpotential for minimal harm; Level 2, no actual harm with potential for morethan minimal harm that is not immediate jeopardy; Level 3, actual harm that isnot immediate jeopardy; Level 4, immediate	

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			jeopardy to resident health orsafety. These four levels are defined accordingly: 1. Level 1 is a deficiency that has the potential forcausing no more than a minor negative impact on the resident(s). **DeficientPractice Statement** Based on observations and interviews, the facility failed tomaintain an orderly, clean, and homelike interior for residents, visitors, andstaff 3 of 3 environmental tours. (Room 206, 118, 119, 121, 217, 130 and 110). **Evidence toRefute the Finding:** The Straight back chair that had feces on the cushion, was removed and discarded immediately. Thereis no evidence that any resident sat on the chair when it was soiled or therewere other chairs. There are no rooms identified on the second floor regarding dirtybaseboards. There is one observation. The base boards are on a daily cleaning schedule. (attachment 1) The floors by the fire doors on the hallway are on a cleaning schedule. There is one observation madeby the surveyors regarding these floors. (attachment 1) One vent was noted to not be clean. There are multiple vents ineach hall. Vents are on a cleaning schedule. There was one observation. (attachment1) One box fan was noted to be dirty. There are multiple box fanswhich were clean in the facility. There was	

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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260	

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			one observation. Two PTAC units were noted to not be clean. There are PTAC units inevery room. There was one observation. (PTACs are on a cleaning schedule. (attachment1) Transition strips are cleaned daily – 5 out of 77 rooms wereidentified. There was one observation. There are many additional rooms, halls etc which were not identifiedin the 2567. (attachment 2 facility floor plan) Resident Council meets every month, there are no concerns voicedregarding the environment of the facility and resident council minutes on5/6/15 indicate the residents complemented the floors of the facility.(attachment 3) **Conclusion:** The regulations state the facility must provide a safe,functional, sanitary and comfortable environment. The facility had received nocomplaints regarding the environment from residents or families. State Operations Manual states: Scope is widespread when theproblems causing the deficiencies are pervasive in the facility and/orrepresent systemic failure that affected or has the potential to affect a largeportion or all of the facility's residents. Widespread scope refers to theentire facility population, not a subset of residents or one unit of afacility. The Scope is a pattern when more than a very limited number ofresidents are affected, and/or more than a very limited	

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			number of staff isinvolved, and/or the situation has occurred in several locations, and/or thesame resident(s) have been affected by repeated occurrences of the samedeficient practice. The effect of the deficient practice is not found to bepervasive throughout the facility. One soiled chair, which was removed and thrown awayimmediately, does not equate to all the chairs the residents use. Seven listed rooms does not equate to a widespread concern. There are a total of 77 rooms. One hallway out of 12 does not equate to all of the hallways Two PTAC units out of 79 does not equate to all of the PTAC units. The above environmental issues do not equate to scope of widespread. The listed items has not produced a negative impact to theresidents. These environmental issues should be considered severity of Level1 - a deficiency that has the potentialfor causing no more than a minor negative impact on the resident(s). SpringMill Meadows did not receive any environmental complaints/griveances within thepast year. Therefore, Spring Mill Meadows is requesting the deficiency bereduced in scope and severity from an F level deficiency to a B leveldeficiency. Thank you for your consideration.	