

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 4, 5, 6, 7, 8, and 11, 2013</p> <p>Facility number: 000074 Provider number: 155154 Aim number: 100290050</p> <p>Survey team: Donna M. Smith, RN-TC Mary Jane Fischer, RN Maureen Newton, RN Courtney Mujic, RN Karina Gates, SS Cynthia Stramel, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 103 Total: 122</p> <p>Census payor type: Medicare: 26 Medicaid: 87 Other: 9 Total: 122</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	Please accept this 2567 Plan of Correction for the Health Survey ending March 11, 2013 as the Provider's Letter of Credible Allegation. This Provider respectfully requests consideration for paper compliance in lieu of a revisit survey for this Plan of Correction with a completion date of April 7, 2013. We respectfully request a face-to-face IDR to dispute F242, F250, F318, F323, F463, F465, F520.	

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.

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality Review was completed by Tammy Alley RN on March 18, 2013.			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to ensure a Medicare beneficiary resident was timely notified of the effective date skilled nursing services would end and the potential liability amount for non-covered stay in the facility. This affected 1 of 4 Medicare beneficiaries discharged in the past 6 months who were reviewed for appropriate liability and appeal notices. (Resident #35)</p> <p>Findings include:</p> <p>The Notice of Medicare Non-Coverage for Resident #35 was reviewed on 3/6/13 at 2:00 p.m. The notice indicated, "The Effective Date Coverage of Your Current Skilled Nursing Services Will End: 2-13-13." The notice included Resident #35's signature dated 2/13/13 and did not indicate the specific potential liability amount.</p> <p>During an interview with the Business Office Manager on 3/6/13 at 2:23 p.m., she indicated the resident was admitted to the facility on 12/27/12 and her Medicare services ended 2/13/13 for a total of 49 days of Medicare services.</p>	F000156	<p>F156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #35 no longer resides in this facility <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents currently receiving services under their Medicare benefits at this facility have the potential to be affected ·Business Office Manager or designee will audit current residents receiving services under their Medicare benefit to identify any resident with the potential for non-coverage of services and notify Social Services accordingly ·Executive Director or designee will in-service Social Services staff according to the Checklist/Instructions for issuing a Notice of Medicare Non Coverage (NOMNC)/Determination on Continued Stay including appropriate and timely documentation <p>What measures will be put into place or what systemic changes you will make to</p>	04/07/2013

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>During an interview with the Social Services Director on 3/6/13 at 2:30 p.m., she indicated she issued the notice to Resident #35 on 2/11/13, but that Resident #35 wanted to review it with her family, so she signed the notice on 2/13/13. No further information was provided to indicate Resident #35 was given the notice on 2/11/13.</p> <p>The Checklist/Instructions for issuing a Notice of Medicare Non-Coverage (NOMNC)/Determination on Continued Stay was provided by the Nursing Consultant on 3/11/13 at 11:10 a.m. It indicated, "At the signature line, the resident or authorized representative must sign. Bottom of page 2. The resident or authorized representative must fill in the date that he/she signs the document. (This is critical to demonstrating the 2-day notice requirement.)"</p> <p>3.1-4(f)(3)</p>		<p>ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Executive Director or designee will in-service Social Services staff according to the Checklist/Instructions for issuing a Notice of Medicare Non Coverage (NOMNC)/Determination on Continued Stay including appropriate and timely documentation · Interdisciplinary Team will meet weekly to review all residents receiving services under the Medicare benefit to ensure timely notification of The Notice of Medicare Non Coverage <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Notice of Medicare Non-Coverage Letters (NOMNC) CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, 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 		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observations, record review, and interview, the facility failed to ensure residents were assessed for self medication administration for 2 of 2 randomly observed residents. (Resident #116 and #7)</p> <p>Findings include:</p> <p>1. On 3/6/13 at 2:10 p.m., Resident #116 was observed in his bed receiving a masked nebulizer treatment. No supervision was observed in the resident's room. The resident was observed to move the mask around but did not take it off during this observation.</p>	F000176	<p>F 176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #116 no longer resides in this facility · Resident #7 will be assessed for self-administration of medication by the Interdisciplinary Team and documented accordingly How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents receiving nebulizer treatments have the potential to be affected by the alleged deficient practice · All residents receiving nebulizer treatments will be assessed for self-administration of medication by the Interdisciplinary Team and documented accordingly · Licensed Nurses will be in-serviced on Self-Administration of Medication policy and Medication Administration of Nebulizer Treatments by the Staff Development Coordinator or designee by April 7 th , 2013</p>	04/07/2013

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Licensed Nurses will be in-serviced on Self-Administration of Medication policy and Medication Administration of Nebulizer Treatments by the Staff Development Coordinator or designee by April 7 th , 2013 · Director of Nursing or designee will conduct rounds on all shifts to ensure residents who are not approved to self administer medication receive the necessary supervision for nebulizer treatment · Licensed Nurses will have a Nebulizer skills validation completed by the Staff Development Coordinator or designee by April 7 th , 2013, annually thereafter and as needed based on nursing rounds observation How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Nebulizer CQI will be completed weekly x 4 weeks, monthly x 2 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>	

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 3/7/13 at 11:20 a.m., resident #116 was observed in his room receiving a mask nebulizer treatment with no supervision. LPN #9 was down the hall preparing medications at the medication cart.</p> <p>On 3/8/13 at 2:37 p.m. during an interview, LPN #21 stated Resident #116 was not to self administer medication, and there is no such paperwork to say he can.</p> <p>Resident #116 record was reviewed on 3/11/13 at 9:30 a.m. No information was indicated the resident may self administer medications. The physicians's order, originally ordered 10/18/12 was ipratropium bromide albuteral inhalation solution (respiratory medication) use 1 vial per nebulizer every 4 hours.</p> <p>2. On 3/7/13 at 11:11 a.m., Resident #7 was observed in her room receiving a mask nebulizer treatment with no supervision. LPN #9 was observed down the hall preparing medications at the medication cart.</p> <p>On 3/8/13 at 2:37 p.m., during an interview, LPN # 21 indicated Resident #7 was not to self administer medication.</p>				

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Resident #7's record was reviewed on 3/11/13 at 9:30 a.m. No information was indicated the resident may self administer medications. The physician's order, originally ordered 01/12/12, was ipratropium bromide albuterol inhalation solution use 1 vial per nebulizer every 4 hours as needed .</p> <p>3. The "Self Administration of Medications " policy was provided by the Administrator on 3/11/13 at 10:30 a.m. This current policy indicated the following: "...PROCEDURE ...If a resident desires to participate in self-administration, the Interdisciplinary Team (that includes the Pharmacist and attending physician) will assess the competence of the resident to participate by completing the "Self-Administration of Medication Assessment form". * A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self administration plan...."</p> <p>3.1-11(a)</p>						

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 03/11/2013
---	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents 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 and interview the facility failed to ensure residents were treated with respect and dignity during meal service by not serving all residents at the same table at the same time, long wait times, talking over the residents, (#45, # 91, # 186, # 5, # 102) and failed to ensure names of resident were not being announced in an overhead page and failed to address a resident by proper name (# 67) for 6 of 6 random observations for dignity.</p> <p>Findings include:</p> <p>1. During an observation on 03-04-13 at 12:20 p.m., in the Rehabilitation Dining room, 11 residents were seated at a table waiting for the noon meal.</p> <p>Certified Nurses Aide # 4 was observed to provide a meal tray to Resident #91. Resident's #45 and #186 continued to wait for their noon meal, while other residents in the Rehabilitation Dining Room had been</p>	F000241	<p>F241 DIGNITY AND RESPECT OF INDIVIDUALITY What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #91 will be served at the same time as all other residents at the same table; resident will only be provided a clothing protector when resident responds accordingly · Resident #45 will be served at the same time as all other residents at their same table · Resident #186 will be served at the same time as all other residents at their same table · Resident #5 will be served at the same time as all other residents at their same table · Resident #102 will be attended to and talked with during meal service · Resident #67 will be addressed by her preferred name by staff · Resident #178 no longer resides at this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who reside in this facility have the potential to be affected</p>	04/07/2013			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>served.</p> <p>After approximately 10 minutes, Certified Nurse Aide #4 served the meal to Resident's #45 and #186.</p> <p>During the continued observation of the noon meal on 03-04-13, the Social Service Assistant #16, served a meal tray to 1 of 3 residents seated at a table at the far end of the dining room. This staff member served a subsequent meal tray to the other resident seated at this table. The staff member returned to the food cart, picked up another tray and served this tray to a resident seated in another area of the dining area. This sequence continued, until almost all trays had been served from the cart. When interviewed if this resident received a meal tray, the certified nurses aide #4 returned to the food cart, left the dining room, and returned with a meal tray for the resident who was with the 2 other resident's who had been served.</p> <p>The certified nurses aide addressed the resident and indicated, "Sorry about that (name of resident #178) that your tray was late."</p> <p>During this observation, the other two residents had completed half of their</p>		<p>by the alleged deficient practice · Registered Dietitian or designee will utilize Meal Service Observation tool at each meal to evaluate the dining services including dignity practices during meal service to include serving all residents at the same table at the same time, long wait times, talking over residents and addressing residents by proper name · Corrections will be made accordingly based on observation · Staff will be in-serviced by April 7 th , 2013 by Staff Development Coordinator or designee on meal service and resident rights including dignity and respect to ensure that o All residents are being served at the same table at the same time o Meals are served promptly o Staff is not talking over residents o Staff is addressing residents by their preferred name o Residents names are not being paged overhead via speaker intercom</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Staff will be in-serviced by April 7 th , 2013 by Staff Development Coordinator or designee on meal service and resident rights including dignity and respect to ensure that o All residents are being served at the same table at the same time o Meals are served promptly o Staff is not talking over residents o Staff is</p>		

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>meal.</p> <p>2. During an observation on 03-04-13 at 12:20 p.m., Certified Nurses Aide #4 approached Resident #91 and stated, "Here's a clothing protector for you - you don't want to get food on you do you?"</p> <p>The resident did not respond, and the Certified Nurses Aide placed the clothing protector across the front of the resident and attached the protector behind the resident's neck.</p> <p>3. During an observation on 03-04-13 at 10:35 a.m., an announcement was made over the facility intercom system, announcing the first and last name of a resident and indicated "there's a road to recovery meeting in the ED (executive director) office for (resident name)."</p> <p>4. During an observation on 03-04-13 at 10:40 a.m., Licensed Nurse #9 prepared medications for Resident #67. After the nurse prepared the medication, the nurse entered the resident room, and addressed the resident as "Hi sweetie, are you feeling ok?" The resident did not respond and the licensed nurse made the determination to transfer the resident to bed with the assistance of</p>		<p>addressing residents by their preferred name o Residents names are not being paged overhead via speaker intercom · Director of Nursing or designee will conduct rounds on all shifts to ensure that o All residents are being served at the same table at the same time o Meals are served promptly o Staff is not talking over residents o Staff is addressing residents by their preferred name o Residents names are not being paged overhead via speaker intercom · Registered Dietitian or designee will utilize Meal Service Observation tool at each meal to evaluate the dining services including dignity practices during meal service to include serving all residents at the same table at the same time, long wait times, talking over residents and addressing residents by proper name How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Dignity and Privacy CQI tool and Meal Service Observation CQI tool will be completed weekly x 4 weeks, monthly x 2 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure</p>				

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>a certified nurses aide. After the resident had been transferred to bed the licensed nurse attempted to take the resident's blood pressure and indicated to the resident, "I'm going to lift your arm darling...alright sweetheart ?"</p> <p>5. During an observation on 3/4/2013 at 12:39 p.m., Resident #5 was served his lunch meal tray by CNA #25 and then immediately after the lunch tray was placed in front of the resident, the Social Services Director came over indicated, "no, he can't eat yet." When the resident asked why, the Social Services Director indicated, "because the man is in the house today," and then took his tray away from him. Resident #5 was re-served his lunch meal tray at 1:04 p.m.</p> <p>During an interview with the Dietary Manager on 3/8/2013 at 4:05 p.m., he indicated he didn't know exactly about this particular situation, but generally they try to serve everyone at each table at the same time.</p> <p>6. On 3/7/13 at 8:33 a.m., during breakfast in the second floor assisted dining room, LPN #9 was observed assisting resident #102 with her meal. During this observation LPN #9 and CNA #22 were observed talking to each other excluding the resident in the conversation.</p>		compliance				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-3(t)			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to ensure a resident received medically related social service needs, in that when the social service assistant arranged audiology services for a resident, the assistant failed to follow up in additional required medically related needs for 1 of 1 residents reviewed for social service needs. (Resident #178).</p> <p>Findings include:</p> <p>The record for resident #178 was reviewed on 03-05-13 at 2:00 p.m. Diagnoses included, but were not limited to, fractured femur, constipation, gout, anemia, hypertension, atrial fibrillation, esophageal reflux, pain, and glaucoma. These diagnoses remained current at the time of the record review.</p> <p>Review of the Resident's Minimum Data Set assessment, dated 01-23-13 indicated the resident had no cognitive impairment and had minimal hearing impairment.</p>	F000250	<p>F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>We respectfully request a face-to-face IDR to dispute the citation of this finding. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> -Resident #178 no longer resides in facility <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> -All residents who receive in house audiology services have the potential to be affected by the alleged deficient practice -Social Services or designee will audit clinical records of all residents who have received an in house audiology visit within the last three months to ensure all follow up measures have been addressed by the appropriate department -Social Services and Licensed Nurses will be in-serviced by April 7 th , 2013 by the Staff Development 	04/07/2013	

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The resident was scheduled for an Audiogram with a local contractor on 02-08-13. The results of this exam indicated the resident's "physical exam" indicated the resident's ears were "occluded" and the resident had "moderate difficulty" with ability to hear. The "comment" section of the audiologist report instructed the facility "Refer to PCP [primary care physician] for bilateral wax removal. Will follow up with the [name of local hospital] when [resident] has hearing benefits."</p> <p>During an interview on 03-08-13 at 1:55 p.m., the Social Service assistant indicated she had not seen the recommendation on the above report.</p> <p>3.1-34(a)(3)</p>		<p>Coordinator and/or designee on Vision and Hearing Services Policy and Procedures including recommendation follow up</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Social Services and Licensed Nurses will be in-serviced by April 7 th , 2013 by the Staff Development Coordinator and/or designee on Vision and Hearing Services Policy and Procedures including recommendation follow up ·Social Services Director or designee will request that after each facility visit, the Audiologist provide a copy of recommendations for residents seen to ensure necessary follow up is completed ·Director of Nursing or designee will review recommendations from the audiologist to ensure necessary follow up completed and documented in the clinical record <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Hearing and Vision Services CQI tool will be completed by Social Services or designee weekly x 4 weeks, monthly x 2 		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			months, and quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance		

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate reflecting the fall with a fracture prior to admission for 1 of 3 residents reviewed for falls who met the QCLI ([criteria for quality of life and care)</p>	F000278	<p>F278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #178 no longer resides in facility ·Resident #170 will be reviewed 	04/07/2013			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(Resident #178) and failed to correctly code an MDS assessment for urinary incontinence for 1 of 3 residents reviewed for urinary incontinence of the 7 who met the QCLI criteria for urinary incontinence. (Resident #170)</p> <p>Findings include:</p> <p>1. The record for Resident #178 was reviewed on 03-05-13 at 9:00 a.m. Diagnoses included but were not limited to a right fractured femur after a fall on the ice at home. The resident was admitted to the facility on 01-11-13.</p> <p>A pre-admission assessment, dated 01-01-13 indicated the resident was "admitted [in reference to the hospital] after slipping on the ice and falling."</p> <p>The initial Fall Risk Assessment, dated 01-11-13, lacked identification the resident had a "history of fall(s) within the past 3 months."</p> <p>Review of the Minimum Data Set Assessment, dated 01-23-13, section related to Fall History prior to Admission was blank.</p> <p>2. Resident #170's clinical record</p>		<p>by Interdisciplinary Team to evaluate current plan of care and check for accuracy as compared to current MDS</p> <ul style="list-style-type: none"> ·In addition, a new bladder continence assessment will be performed for resident #170 <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice ·Company RAI Specialist or designee will perform a validation audit on site on new admissions in the last 30 days related to falls and incontinence to compare the coded MDS document to the clinical record to ensure coding is accurate ·MDS Coordinator and MDS Assistant will be in-serviced by April 7 th , 2013 by the company RAI Specialist or designee on accuracy of MDS related to falls and incontinence ·Licensed Nurses will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on supplemental assessments and accuracy of assessments <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·MDS Coordinator and MDS Assistant will be in-serviced by 		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>was reviewed on 3/7/2013 at 2 p.m.</p> <p>Diagnoses included, but were not limited to, benign brain tumor, hemiplegia, constipation, aphasia, benign prostatic hypertension, glaucoma, hypertension and epilepsy.</p> <p>An Admission MDS Assessment dated 12/24/2012, indicated, "Frequently incontinent", which is defined as 7 or more episodes of urinary incontinence, but at least one episode of continent voiding.</p> <p>A "Significant Change in status assessment Readmission/return assessment", dated, 1/21/2013, indicated, "Always incontinent", which is defined as no episodes of continent voiding.</p> <p>During an interview with MDS LPN #26 on 3/8/2013 at 3 p.m., she indicated the 1/21/13 MDS was correctly coded, he was always incontinent. The 12/24/12 MDS had 5 instances of incontinence for the 7 day look back per the point of care charting, which just based on this alone looked like it wouldn't be coded correctly, but they (the previous employees who completed the MDS) may have pulled information from somewhere else in order to get the 7</p>		<p>April 7 th , 2013 by the company RAI Specialist or designee on accuracy of MDS related to falls and incontinence</p> <ul style="list-style-type: none"> ·RAI Specialist or designee will conduct a weekly audit to ensure MDS is coded correctly for residents who have had a fall and/or incontinence. ·Licensed Nurses will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on supplemental assessments and accuracy of assessments ·Interdisciplinary Team will review all new admissions' and readmissions' admission, quarterly, annual and significant change supplemental assessments in the clinical meeting to verify accuracy of assessments <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Assessments (Admission, Quarterly, Significant Change) CQI tool will be completed by MDS Coordinator or designee weekly x 4 weeks, monthly x 2 months, and quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>or more in order to code it as frequently. They could've gotten more times he was frequently incontinent from the "matrix" vitals, or in the progress notes. She indicated she had to rely on their MDS as being accurate, because she wasn't here at the time, but based on just this information, with only 5 occurrences documented as incontinent of urine, not the required 7, it looks like it was coded wrong.</p> <p>A "Matrix" vitals report, provided by the Medical Records RN on 3/8/2013 at 3:20 p.m., indicated Resident #170 was incontinent of urine on the following dates and times between the 1/15/2013 through 1/21/2013 look back period; 1/17/2013 at 1:47 p.m., and 1/21/2013 at 6:30 p.m. There are further occurrences during this time frame which indicate "urine" but did not specify incontinence. Review of the resident's progress notes did not provide further occurrences of urinary incontinence. This information was not enough information to code the 1/21/13 MDS as always incontinent.</p> <p>3.1-31(d)(3)</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to ensure a plan of care was developed that identified the resident problem, contained measurable goals and had specific interventions/approaches to enhance a resident's ability to meet those goals for 2 of 29 residents reviewed for development of care plans. (Residents #178 and #107)</p> <p>Findings include:</p> <p>1. The record for Resident #178 was reviewed on 03-05-13 at 9:00 a.m.</p>	F000279	<p>F 279 DEVELOP COMPREHENSIVE CARE PLANS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #178 no longer resides at this facility · Resident #107 will have Care Plan updated to reflect depression and diabetes How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who take</p>	04/07/2013	

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Diagnoses included but were not limited to a right fractured femur after a fall on the ice at home. Additional diagnoses included a history of MRSA (methycillian resident staphylococcus aurous), hypertension, diabetes, peripheral vascular disease, and atrial fibrillation. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 02-15-13, which indicated "Change Trazodone [an antidepressant] to read Trazodone 50 mg [milligrams] P.O. [by mouth] QHS [at bedtime] PRN [as needed] insomnia times 14 d [days] then re-eval."</p> <p>The medication administration record for February 2013 indicated the resident received the medication on February 14, 15, 19, 21, 23, 24, 27, 28 and march 1, 2013.</p> <p>The record lacked a plan of care related to the resident's need for the antidepressant at bedtime for insomnia.</p> <p>The resident also received the services of a local audiologist on 02-08-13 for hearing impairment.</p>		<p>antidepressant medications, hearing impairment and/or receive accuchecks and insulin that reside in this facility have the potential to be affected by the alleged deficient practice</p> <ul style="list-style-type: none"> The Interdisciplinary Team will review all new admissions and re-admissions in the clinical meeting utilizing the IDT admission/readmission review form to identify residents with hearing impairments, physicians orders for antidepressants, insulin and accuchecks to ensure appropriate Care Plans are developed Licensed nurses will be in-serviced by April 7 th , 2013 by the Staff Development Coordinator or designee on admissions and temporary care plans What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses will be in-serviced by April 7 th , 2013 by the Staff Development Coordinator or designee on admissions and temporary care plans The Interdisciplinary Team will review all new admissions and re-admissions in the clinical meeting utilizing the IDT admission/readmission review form to identify residents with hearing impairments, physicians orders for antidepressants, insulin and accuchecks to ensure 				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Although the results of this exam indicated the residents ears were "occluded." and the resident had "moderate difficulty" with ability to hear," with instructions to "Refer to PCP [primary care physician] for bilateral wax removal."</p> <p>The facility failed to implement a plan of care in regard to the resident's impairment, with measurable goals and specific interventions.</p> <p>2. The clinical record for Resident #107 was reviewed on 3/8/13 at 11:00 a.m.</p> <p>The diagnoses for Resident #107 included, but were not limited to, Diabetes Mellitus and depression.</p> <p>The March, 2013 Physician's Orders for Resident #107 indicated Accuchecks were to be done twice daily effective 1/7/13 and sliding scale insulin was to be given accordingly</p>		<p>appropriate Care Plans are developed</p> <ul style="list-style-type: none"> All residents found without appropriate care plans for antidepressant medications and/or hearing impairment and those residents receiving accuchecks and insulin will have appropriate care plans put in place How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Care Plan Updating CQI tool will be completed weekly x 4 weeks, monthly x 2 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 		

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>effective 1/4/13. The orders also indicated Escitalopram (an antidepressant medication) 10 mg tab to be given once daily for depression.</p> <p>During review of Resident #107's care plans, no depression or diabetic care plans could be found.</p> <p>During an interview with the DON (Director of Nursing) on 3/8/13 at 3:26 p.m., she indicated the resident should have a care plan for depression. As she looked through Resident #107's care plans in the computer, she stated, "I don't see a diabetic care plan in here. She should have one."</p> <p>3.1-35(a)</p>						

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to ensure physician orders and plans of care were followed for 3 of 29 residents reviewed for to physician orders and plans of care. (Residents #178, #104, and #16)</p> <p>Findings include:</p> <p>1. The record for resident #178 was reviewed on 03-05-13 at 2:00 p.m. Diagnoses included but were not limited to fractured femur, constipation, gout anemia, hypertension, atrial fibrillation, esophageal reflux, pain, and glaucoma. These diagnoses remained current at the time of the record review.</p> <p>Review of the Resident's Minimum Data Set assessment, dated 01-23-13 indicated the resident had no cognitive impairment and had minimal hearing impairment.</p> <p>The resident was scheduled for an Audiogram with a local contractor on</p>	F000282	<p>F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #178 no longer resides in this facility · Resident #104 will receive accuchecks according to the physician order · Resident #16 no longer resides in this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents that receive in-house audiology services, Physical Therapy, PRN antidepressants, accuchecks and PRN narcotic medication have the potential to be affected by the alleged deficient practice · Care Plans for all residents identified will be reviewed and updated if needed by the Interdisciplinary Team according to physician orders · Staff will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on Hearing and Vision Services, Physical Therapy nursing to therapy communication forms,</p>	04/07/2013			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>02-08-13. The results of this exam indicated the residents "physical exam" indicated the resident's ears were "occluded." and the resident had "moderate difficulty" with ability to hear. The "comment" section of the audiologist report instructed the facility "Refer to PCP [primary care physician] for bilateral wax removal. Will follow up with the [name of local hospital] when [resident] has hearing benefits."</p> <p>Interview on 03-08-13 at 1:55 p.m., the Social Service assistant indicated [in regard to the report] "I didn't see this. To be honest I don't know that I saw the order for the wax removal."</p> <p>In addition, the pre-admission assessment, dated 01-01-13 indicated the resident was "admitted [in reference to the hospital] after slipping on the ice and falling. The resident was found to have a right femur fracture, was non weight bearing on the right lower leg, and "speciality equipment" needed included a "bed alarm, and a vertical lift for transfers."</p> <p>Review of the Therapy notations on 03-08-13 at approximately 9:15 a.m., indicated the following:</p>		<p>PRN Medication Administration and Documentation, Blood Glucose Monitoring Policy and Pain Management Policy · MAR/TAR audits will be completed and reviewed by Director of Nursing or designee daily to ensure that prn medications have an indication for use and are evaluated for effectiveness and that accuchecks are done per physician orders · The Interdisciplinary Team will review all physicians orders, therapy and in-house audiology recommendations and facility activity report in clinical meeting to ensure that services are provided according to physician orders and plan of care What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Staff will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on Hearing and Vision Services, Physical Therapy nursing to therapy communication forms, PRN Medication Administration and Documentation, Blood Glucose Monitoring Policy and Pain Management Policy · Physical Therapy to provide Director of Nursing with copies of therapy communication forms. Interdisciplinary Team will review communication forms to ensure appropriate follow up is completed and documented</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"Physical Therapy"</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-01-13 - Patient continues to have functional deficits including NWB [non weight bearing] R [right] LE [lower extremity], right hip decreased strength, decreased safety awareness."</p> <p>"Impact on Burden of Care / Daily Life. Due to safety reasons, the patient requires supervision and 10 % cues for transfers, toileting, gait...Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-08-13 - Patient continues to have functional deficits include NWB, R, LE and decreased safety awareness, frequently forgetting to lock brakes."</p> <p>"Impact on Burden of Care / Daily Life. Due to safety reasons, the patient requires supervision and 5% verbal cues for transfer...Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-11-13 - Patient continues to have functional deficits including muscle weakness, NWB precautions (R) LE and decreased safety awareness."</p> <p>"Impact on Burden of Care / Daily Life. Due to safety reasons, the</p>		<p>accordingly · Director of Nursing and/or designee will conduct rounds on all shifts to ensure care plans and physician orders are followed related to audiology services, physical therapy, antidepressant medications, accuchecks and prn narcotic medication · MAR/TAR audits will be completed and reviewed by Director of Nursing or designee daily to ensure that prn medications have an indication for use and are evaluated for effectiveness and that accuchecks are done per physician orders · The Interdisciplinary Team will review all physicians orders, therapy and in-house audiology recommendations and facility activity report in clinical meeting to ensure that services are provided according to physician orders and plan of care How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>· MAR/TAR audit tool, Hearing and Vision, Unnecessary Medications, Blood Glucose and Pain Management CQI tools will be completed weekly x 4 weeks, monthly x 2 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will</p>	

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>patient requires verbal cues for safe transfer...Precautions Fall risk. Bed alarm."</p> <p>"Occupational Therapy"</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-01-13 - patient continues to have deficits in strength and standing balance which limit ability to perform self care tasks."</p> <p>"Impact on Burden of Care / Daily Life. The patient has shown gains in strength which allowed for improved performance in self care tasks...Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-08-13 - Has continued deficits in standing tolerance, endurance, strength, functional transfers and ADLs [activities of daily living]."</p> <p>"Impact on Burden of Care / Daily Life. Patient presenting with [blank]. Due to safety reason, the patient requires initiation cue and verbal cues to maintain FFWB status on R LE...Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-11-13 - Has continue <sic> deficits in standing tolerance, endurance,</p>		be developed to ensure compliance		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>strength, functional transfers and ADLs [activities of daily living]." "Impact on Burden of Care / Daily Life. Due to safety reasons, patient requires initiation cues to adhere to FFWB status on R LE." "Precautions Fall risk. Bed alarm."</p> <p>Although the therapy departments continued to refer to the use of a bed alarm, and the resident's cognitive deficits, the facility failed to ensure the plan of care was followed to alert the nursing staff of unassisted ambulation or transfer.</p> <p>Interview on 03-08-13 at 2:20 p.m., LPN # 3 indicated the resident did not utilize an alarm. She indicated "We don't use alarms here, if there is something we need to be aware of therapy would tell us."</p> <p>In addition, the resident had physician order dated 02-15-13, which indicated "Change Trazodone [an antidepressant] to read "Trazodone 50 mg [milligrams] P.O. [by mouth] QHS [at bedtime] PRN [as needed] insomnia times 14 d [days] then re-eval."</p> <p>The medication administration record for February 2013 indicated the resident received the medication on</p>			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>February 14, 15, 19, 21, 23, 24, 27, 28 and March 1, 2013.</p> <p>When interviewed on 03-08-13 at 2:20 p.m., in regard to the re-evaluation of the use of the medication, licensed nurse #3 reviewed the resident progress notes and indicated "if it is not documented [resident] is having insomnia problems, then we only chart by exception. I guess [resident] doesn't need it because there is nothing charted." When further interviewed if the evaluation was completed, the licensed nurse indicated, "no."</p> <p>2. The clinical record for Resident #104 was reviewed on 3/7/13 at 1:00 p.m.</p> <p>The diagnoses for Resident #104 included, but were not limited to, Diabetes Mellitus.</p> <p>The 2/8/13 diabetic care plan for Resident #104 indicated an approach was to monitor blood sugars as ordered.</p> <p>The March, 2013 Physician's Orders for Resident #104 indicated Accuchecks 4 times daily effective 3/19/12.</p> <p>The February, 2013 Capillary Blood</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Glucose Monitoring Tool for Resident #104 indicated Accuchecks were conducted 3 times daily from 2/6/13 through 2/26/13 at 6 a.m., 4 p.m., and 9 p.m. The form indicated Accuchecks were conducted 3 times daily on 2/27/13 and 2/28/13 at 6 a.m., 4 p.m. and 8 p.m.</p> <p>During an interview with the Nursing Consultant on 3/8/13 at 1:47 p.m. regarding why Accuchecks were only done 3 times daily on the above dates, she indicated, "The person who filled out the flow sheet probably documented times incorrectly."</p> <p>During an interview with the DON (Director of Nursing) on 1:58 p.m., on 3/8/13, she indicated the Unit Manager noticed that Accuchecks printed out 3 times daily instead of 4 times daily and was looking for the 11 a.m. diabetic flowsheet to indicate Accuchecks were in fact done 4 times daily as ordered. Neither the flow sheet nor any other information was provided to indicate Accuchecks were done 4 times daily for Resident #104 from 2/6/13 to 2/28/13.</p> <p>3. The clinical record for Resident #16 was reviewed on 3/8/13 at 10:00 a.m.</p>				

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The diagnoses for Resident #16 included, but were not limited to, end stage renal disease and chronic back pain.</p> <p>The March, 2013 Physician's Orders indicated 8 mg of Dilaudid (pain medication) to be taken every 4 hours as needed.</p> <p>The 1/23/13 pain care plan for Resident #16 indicated an approach was to document the effectiveness of prn (as needed) medications.</p> <p>The March, 2013 MAR (medication administration record) indicated prn Dilaudid was given to Resident #16 as follows:</p> <p>3/1/13 - 3 times 3/4/13 - 1 time 3/6/13 - 3 times</p> <p>There was no documentation in the clinical record to indicate the effectiveness of the prn pain medication at all on 3/1/13 or 3/4/13 and only twice on 3/6/13.</p> <p>During an interview with RN #12 on 3/8/13 at 10:43 a.m., she indicated if the documentation of the prn pain medication effectiveness was not on the MAR, it was probably not</p>						

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>anywhere. She indicated she did not see it anywhere in Resident #16's clinical record for the three 3/1/13 administrations, the one 3/4/13 administration and only twice for the three 3/6/13 administrations.</p> <p>The Pain Management policy was provided by the Medical Records Staffperson on 3/8/13 at 10:55 a.m. It indicated, "...effectiveness of pain medication will be documented on the back of the Medication Administration (MAR), or on the facility specific pain management flow sheet."</p> <p>3.1-35(g)(2)</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 observation, record review, and interview, the facility failed to coordinate with the dialysis company in order to have a dialysis care policy in place for 1 of 2 residents who received dialysis services in the facility (Resident #185) and to evaluate and monitor a resident's skin condition with a history of breakdown for 1 of 3 residents reviewed with skin condition (Resident #122).</p> <p>Findings include:</p> <p>1. Resident #185's clinical record was reviewed on 3/7/2013 at 3 p.m. The resident was admitted on 2/27/2013. Diagnoses included, but were not limited to, muscle weakness, end stage renal disease, hypertension, and hypopotassemia.</p> <p>A care plan dated 2/27/2012, indicated, "Problem: Resident receives dialysis: Potential for complications. Goal: Resident will have no complications due to</p>	F000309	<p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The facility will be in possession of a current Policy and Procedure pertaining to Peritoneal Dialysis for Resident #185 · Resident #122 had a skin assessment completed on 3/22/2013 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents that receive Peritoneal Dialysis and/or have actual skin impairment have the potential to be affected by the alleged deficient practice · Currently all Peritoneal Dialysis residents that reside in this facility have a Policy and Procedure for care of residents with Peritoneal Dialysis · Facility skin sweep will be conducted by April 7 th , 2013. All impairments in skin integrity will be evaluated by a</p>	04/07/2013	

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dialysis."</p> <p>A copy of "skilled nursing facility/nursing home agreement for certain home peritoneal dialysis related services" was provided by the Administrator on 3/4/2013 at 1 p.m. The contract indicated, "This agreement is made by and between Spring Mill Meadows and [name of dialysis company] effective February 15, 2013...D. Mutual Obligations: 1. Written Protocols. Company or ESRD (end stage renal disease) facility and nursing facility shall develop written protocols governing policies and procedures to be used in rendering home peritoneal dialysis services to ESRD residents at the nursing facility."</p> <p>An interview with the Administrator on 3/6/2013 at 10 a.m., indicated she does not have a policy, she thinks the dialysis company should have a copy of this. She does have the care plan for the resident, and the dialyses company nurses come to the facility and write orders pertaining to the dialysis that are followed by the facility nurses.</p> <p>A policy provided by the Administrator on 3/8/2013 at 1:45 p.m., indicated, "[Name of dialysis company] "Setting</p>		<p>Licensed Nurse and reported to Physician for appropriate treatment and interventions · Licensed Nurses will be in-serviced by April 7 th , 2013 by the Staff Development Coordinator or designee on Skin Management Program and Peritoneal Dialysis Policy and Procedures What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Licensed Nurses will be in-serviced by April 7 th , 2013 by the Staff Development Coordinator or designee on Skin Management Program and Peritoneal Dialysis Policy and Procedures · The Interdisciplinary Team will review all new admissions, re-admissions, physician orders and Facility Activity Report to identify residents with actual skin impairment for evaluation, intervention and monitoring · Skin sweeps will be held monthly and Director of Nursing or designee will ensure that appropriate evaluation, interventions and monitoring occur</p> <p>·Residents with wound/potential of wounds will be monitored by wound nurse/designee weekly to ensure physician orders and care plans are followed</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>up the [name of dialysis machine] cycler. Purpose: The purpose of this procedure is to provide a guide for setting up the [name of dialysis machine cycler]. Responsibility: Home therapies nurse, patients, and/or caregivers. Policy: The [name of dialysis machine] cycler will be set up as recommended by the manufacturer's guidelines. Always refer to the instructions for use of device for description of use, warnings, hazards, contraindications, side effects, and precautions."</p> <p>During an interview with the Administrator at this time, indicated she just got the policy faxed to her today.</p> <p>2. On 3/8/13 at 9:25 a.m., Resident #122's personal care was observed. During this observation with the Director of Nursing (DON), the resident's buttock's were observed. On the left buttock a nickel to quarter sized irregular reddened area was observed with a white cream substance over it. Also, the inner areas of the buttocks were observed with irregular reddened areas throughout with a white substance over the area. At this same time during an interview, the DON identified the white substance as Calmoseptine cream, which she</p>		<p>i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Skin Management Program CQI tool will be completed weekly x 4 weeks, monthly x 2 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated was applied after incontinent episodes. The DON also indicated her buttock areas were pink and when the family would change her, they would wipe off the calmoseptine lotion causing the shearing. She indicated she had educated the family member about this. As CNA #20 then started to apply more calmoseptine cream to the buttock areas, he indicated she had been incontinent of bowel movement (BM). As CNA #20 was observed to cleanse the buttock areas of incontinent brown BM and the cream, the resident cried out and tried to move her hips (buttocks) away. The top area of the inner left buttock was observed bright red at this time. After completing the incontinent care, CNA #20 applied the Calmoseptine cream to the inner and upper outer areas of the buttocks. The resident's brief was reapplied, and the resident was repositioned in the bed. CNA #20 indicated he would let her rest in bed until lunch.</p> <p>Resident #122's record was reviewed on 3/8/13 at 7:35 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, Alzheimer's disease, dementia, and hypertension. The quarterly MDS(Minimum Data Set) assessment</p>			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dated 12/17/12, indicated the resident required extensive to total assist of 1 to 2 persons for transfers and activities of daily living and transfers. She was frequently incontinent of urine and was always incontinent of BM's. The resident did not have any history or present skin issues.</p> <p>The "Event Report," dated 1/10/13, related to "Non-Pressure Wound Skin Evaluation Report" indicated the following: On the right buttock a new area was present measuring in centimeters 2 x 0.1 x 0.1. This same area was indicated as shearing and pink in color with no drainage. On the left buttock a new area was present measuring in centimeters 0.1 x 0.1 x 0.1. This same area was indicated as shearing and pink in color with no drainage. The treatment for both areas was indicated as Calmoseptine (protective cream).</p> <p>The "Event Report," dated 2/15/13, related to "Non-Pressure Wound Skin Evaluation Report" indicated the following 3 areas with calmoseptine as the treatment for all 3 areas. On the right buttock a new area was present measuring in centimeters 0.5 x 0.5 x 0.1. This same area was</p>						

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated as shearing and pink in color with no drainage. On the left superior buttock a new area was present measuring in centimeters 0.2 x 0.2 x 0.1. This same area was indicated as shearing and pink in color with no drainage. On the left inferior buttocks a new area was present measuring in centimeters 1 x 1 x 0.1. This same area was indicated as shearing and pink in color with no drainage. The treatment for the 3 areas was indicated as Calmoseptine.</p> <p>The "Event Report," dated 3/08/13, related to "Non-Pressure Wound Skin Evaluation Report" indicated a new area on the left buttocks measuring in centimeters 6.1 x 0.8 x 0.1. This area was indicated with 40% slough, 30% granulation and 30% epithelialization with small serosanguineous drainage. The area was indicated as dermatologic. The current treatment per the wound nurse was medihoney moistened fluffed gauze.</p> <p>The resident's progress notes indicated the following: On 1/18/13 at 9:34 p.m., the resident continued to have shearing to bilateral buttocks with Calmoseptine applied every shift as orders. On 1/21/13 at 11:14 p.m., during the</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>son's visit he had expressed concern with the wound on the resident's buttock.</p> <p>On 2/13/13 at 9:09 p.m., during the residents' son visit he had indicated concerns about the resident's excoriated bottom showing staff. The nurse had explained staff were applying barrier cream and repositioning the resident to enhance healing "but in vein."</p> <p>No further information was indicated related to the resident's improving and/or worsening of skin condition in the "Event Report" or in the resident's progress notes.</p> <p>On 2/22/13 at 3:50 p.m., the Interdisciplinary team (IDT) indicated a skin review. This skin review indicated the area to her bilateral buttocks presented with 100% epithelial tissue with the root cause indicated as incontinent associated dermatitis. The area present was indicated as superficial dermatitis with no drainage or no pain and had received an outcome of resolved with the current treatment of Calmoseptine.</p> <p>On 2/25/13 at 11:43 p.m., the resident's treatment to her buttocks was completed with no pain or drainage indicated from "sores" to her buttocks.</p> <p>On 3/1/13 at 10:53 p.m., treatment to</p>			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the resident's buttocks was completed and were indicated as "sores" to her buttocks.</p> <p>On 3/4/13 at 11:38 p.m., the resident's treatment to her buttocks was completed with no pain or drainage indicated from "sores" to her buttocks.</p> <p>On 3/6/13 at 11:12 p.m., the treatment to the resident's "sores" was completed with no drainage or pain indicated.</p> <p>No further information was indicated related to the resident's improving and/or worsening of skin condition in the "Event Report" or in the resident's progress notes.</p> <p>On 3/8/13 at 3:10 p.m., during an interview, RN #61, the wound nurse/nurse practitioner, indicated when a resident had a skin breakdown, the resident should not wear a brief while in bed.</p> <p>3.1-37(a)</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000313 SS=D	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on record review and interview the facility failed to ensure a resident received hearing services which included referral to a primary care physician, in that when a resident had an audiology exam, the facility failed to ensure the resident received the additional services recommended for 1 of 1 resident resident reviewed for hearing needs. (Resident #178)</p> <p>Findings include:</p> <p>The record for resident #178 was reviewed on 03-05-13 at 2:00 p.m. Diagnoses included, but were not limited to, fractured femur, constipation, gout anemia, hypertension, atrial fibrillation, esophageal reflux, pain, and glaucoma. These diagnoses remained current at the time of the record review.</p>	F000313	<p>F313 TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #178 no longer resides in facility <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who receive audiology services have the potential to be affected by the alleged deficient practice ·Social Services or designee will audit clinical records of all residents who have received an in house audiology visit within the last three months to ensure all follow up measures have been addressed by the appropriate department ·Social Services and Licensed Nurses will be in-serviced by April 7 th , 2013 by the Staff 	04/07/2013			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Review of the resident's Minimum Data Set assessment, dated 01-23-13 indicated the resident had no cognitive impairment and had minimal hearing impairment.</p> <p>The resident was scheduled for an Audiogram with a local contractor on 02-08-13. The results of this exam indicated the residents "physical exam" indicated the resident's ears were "occluded." and the resident had "moderate difficulty" with ability to hear. The "comment" section of the audiologist report instructed the facility "Refer to PCP [primary care physician] for bilateral wax removal. Will follow up with the [name of local hospital] when [resident] has hearing benefits."</p> <p>Interview on 03-08-13 at 1:55 p.m., the Social Service assistant indicated she had not seen the follow-up recommendations.</p> <p>3.1-39(a)(1) 3.1-39(a)(2)</p>		<p>Development Coordinator and/or designee on Vision and Hearing Services Policy and Procedures including recommendation follow up</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Social Services and Licensed Nurses will be in-serviced by April 7 th , 2013 by the Staff <p>Development Coordinator and/or designee on Vision and Hearing Services Policy and Procedures including recommendation follow up</p> <ul style="list-style-type: none"> ·Social Services Director or designee will request that after each facility visit, the Audiologist provide a copy of recommendations for residents seen to ensure necessary follow up is completed ·Director of Nursing or designee will review recommendations from the audiologist to ensure necessary follow up completed and documented in the clinical record <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Hearing and Vision Services CQI tool will be completed by Social Services or designee weekly x 4 weeks, monthly x 2 months, and quarterly for one 		

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 03/11/2013
---	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director</p> <p>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>	

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident admitted with a pressure sore received necessary treatment and services to promote healing, and prevent new sores from developing for 1 of 2 residents reviewed for pressure ulcers of the 2 who met the QCLI (Quality Care /Life indicators) for pressure ulcers. (Resident # 168)</p> <p>Findings include:</p> <p>On 3/5/13 8:50 a.m., during an interview, Resident #168 indicated upon admission to the facility her buttocks were sore but not opened.</p> <p>On 3/7/13 at 9:30 a.m., Resident #168's dressing change to her sacrum was observed. LPN #60 completed the wound care. During</p>	F000314	<p>F 314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #168 no longer resides at this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be effected by the alleged deficient practice ·Facility skin sweep will be conducted by April 7 th , 2013 by Nurse Management Team to ensure all interventions are in place to promote healing, all skin conditions are identified, physician is notified and plan of care is developed ·Nursing staff will be in-serviced on Skin Management Program by 	04/07/2013
-----------------	---	---------	--	------------

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>this observation 2 open areas were observed and was as follows: 1-in sacral area, approximately 2 cm (centimeters) long x .5 cm wide, long, narrow, slit-like. No slough (yellowish, fibrous tissue) or necrotic tissue (black, hard), no exudate (drainage) noted. 2- Left buttock, approximately 1 cm round, pink wound base; no exudate, no slough or necrotic tissue. Surrounding skin was intact, no erythema (redness). Both wounds involve underlying tissue.</p> <p>During an interview while observing wound care on 3/7/13 at 9:30 a.m., LPN #60 stated wound " looks worse today." After the wound care observation at 9:50 a.m., LPN #60 was queried regarding the protocol if a wound looks worse. She then stated she would notify the physician.</p> <p>On 3/7/13 at 3:10 p.m., during an interview Resident #168 indicated she was incontinent of urine at times and did wear a pull-up depend. She indicated she spent most of her time when up sitting in her recliner or going to therapy.</p> <p>Resident #168's record was reviewed on 3/7/13 at 11 a.m.</p>		<p>the Staff Development Coordinator or designee by April 7 th , 2013</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Nursing staff will be in-serviced on Skin Management Program by the Staff Development Coordinator or designee by April 7 th , 2013 ·Skin sweeps will be conducted by Nurse Management Team monthly ·All residents will have a skin assessment done weekly ·Medical Records Director of designee will complete a weekly audit to ensure that skin assessments have been done per schedule ·Director of Nursing or designee will monitor physician orders regarding pressure ulcers to ensure physician orders are followed by conducting rounds on all shifts <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·A Skin Management Program CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director 		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Current diagnoses included included, but were not limited to, hypertonic bladder, fracture lumbar vertebrae, closed, and pain.</p> <p>The initial admission skin assessment, dated 11/29/12, indicated a bruise to left hip and a rash to the sacrum. There was no notation of open pressure sore.</p> <p>The Minimum Data Set assessment, dated 12/6/12, indicated a BIMS (Brief Interview of Mental Status) score of 11 with a score of 8 to 15 as interviewable.</p> <p>The 12/7/12 assessment by wound care nurse, NP (Nurse Practitioner) #61, indicated "Pressure ulcer lower back, sacrum, unstageable". Treatment plan included "upgrade mattress to LAL" (low air loss).</p> <p>A 12/7/12 Care Plan problems and approaches included, but were not limited to: " Resident has impaired skin integrity: pressure ulcer on sacrum. Approach: Assess wound weekly documenting measurements and description Approach: Incontinent care as needed. Approach: Encourage resident to eat</p>		<p>If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</p>		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>75% of meals. Approach: Turn and reposition every 2 hr (hours). Approach: Incontinent care as needed. Approach: Notify MD [physician] of worsening or no change in wound or for signs of infection. Approach: Wound healing vitamins as ordered.</p> <p>Problem: Resident at risk for further skin breakdown due to wound on sacrum; impaired mobility; DM [Diabetes Mellitus], memory loss. Approach: assess and document skin condition weekly and as needed; notify MD of abnormal findings. Approach: Assist resident with toileting. Approach: Turn and reposition at least every 2 hr. Approach: Incontinent care as needed using periwash and moisture barrier."</p> <p>There was no order located for Low Air-loss Mattress as indicated on 12/7/12 plan by wound care nurse.</p> <p>Progress Notes, include but were not limited to: 12/28/12 IDT (interdisciplinary team) note "...current interventions...Air overlay mattress, moisture barrier,</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>turn and reposition frequently." 1/18/13 IDT note "...current interventions...Air overlay mattress, moisture barrier, turn and reposition frequently." 2/1/13- IDT note "...current interventions...moisture barrier, turn and reposition frequently..." 2/15/13- Weekly skin assessment: "Resident noted to have IAD (incontinence associated dermatitis) on R (right) and L (left) Buttock." The Plan included, but was not limited to, continued use of moisture barrier, turn and reposition frequently. 2/22/13- Weekly skin assessment: " IAD both resolved. 100% epithelial tissue ". The Plan included, but was not limited to, continued use of moisture barrier, turn and reposition frequently. 2/22/13- IDT note "...Current interventions:...moisture barrier, turn and reposition freq [frequently]". 3/1/13- Interdisciplinary team meeting note: " nursing has shared that there have been no new changes. Back brace has been dc/d " 3/1/13 -Event Report: Notes a stage 2 wound to L buttock 1 cm x .5 cm. Wound was described as 75% slough. 3/8/13- Weekly skin assessment: " L buttock area presents as re-opened IAD " .</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/8/13 at 11:45 a.m., during an interview the DON indicated she was unaware of the Nurse Practitioner requesting an upgrade of a mattress as indicated on the progress note, dated 12/7/12.</p> <p>3.1-40(a)(2)</p>			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation and record review the facility failed to ensure appropriate treatment and services related to the patency of a gastrostomy feeding tube, in that when a nurse prepared to administer medications through a gastrostomy feeding tube, the licensed nurse failed to check for placement or patency prior to the instillation of the medications for 1 of 2 residents observed for gastrostomy tube placement. (Resident #165)</p> <p>Findings include: The record for Resident # 165 was reviewed on 03-08-13 at 12:00 p.m. Diagnoses included but were not</p>	F000322	<p>F322 NG TREATMENT/SERVICES – RESTORE EATING SKILLS</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #165 Gastrostomy Tube is now patent and placement is checked prior to administration of any substance</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents with gastrostomy tubes that reside in this facility have the potential to be effected by the alleged deficient practice</p> <p>· Licensed nursing staff will be in-serviced by Staff Development</p>	04/07/2013	

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>limited to cerebral vascular accident, right hemiparesis, vascular dementia, diabetes mellitus, hypertension and dysphagia. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 02-20-13 for Glucerna (a specific formula) 1.2 at 52 ml (milliliters) per hour continuously. During an observation on 03-07-13 at 9:50 a.m., licensed nurse #13 prepared to administer medications to Resident #165. The licensed nurse indicated she would administer the following medications via the gastrostomy feeding tube: Aspirin 81 mg (milligrams) and Norvasc (a medication used for hypertension) 10 mg.</p> <p>The licensed nurse crushed the medications, poured the medications into a plastic cup, entered the resident's room, and turned the feeding tube pump dial selection to the off/hold position.</p> <p>The licensed nurse disconnected the gastrostomy tubing from the pump tubing. The licensed nurse placed the barrel of a syringe into the end of</p>		<p>Coordinator and/or designee by April 7 th , 2013 pertaining to Policy and Procedures for Gastrostomy tube medication administration · Gastrostomy tube medication administration skills validation will be completed for all Licensed Nurses by April 7 th , 2013 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Licensed nursing staff will be in-serviced by Staff Development Coordinator and/or designee by April 7 th , 2013 pertaining to Policy and Procedures for Gastrostomy tube medication administration · Gastrostomy tube medication administration skills validation will be completed for all Licensed Nurses by April 7 th , 2013 · Director of Nursing or designee will conduct rounds during Gastrostomy Tube medication administration to ensure Gastrostomy Tube medication administration policy is followed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Enteral Therapy CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the gastrostomy tubing and poured 120 ml. of water into the barrel of the syringe. During this observation, the water did not flow by gravity. The licensed nurse then placed the syringe onto the end of the barrel and depressed the syringe with force, in order for the water to flow by gravity. The water began to flow and the licensed nurse added additional water prior to administering the medications to the resident.</p> <p>Review of facility policy on 03-07-13 at 12:50 p.m., titled " Enteral Tube (Gastrostomy / Jejunostomy) Procedure - (Position, Gastric Content, Patency, Dressing & Re-Insertion), dated as " reviewed 09-2012, " indicated the following: " ...Procedure Steps: B. Enteral Tube - Gastric Content & Patency Procedure: 8. Place stethoscope on stomach area, attach syringe to end of enteral tube, slowly inject 20 - 30 cc of air into the enteral tube. Listen to detect a whooshing , bubbling or gurgling sound to confirm tube placement and patency. " 3.1-44(a)(2)</p>		<p>Director · If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</p>		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure assisted devices to alert the nursing staff of unassisted ambulation and transfer were utilized (Resident #178), for 4 of 4 residents reviewed for safety precautions in a sample of 10</p> <p>B. Based on observation and interview the facility failed to supervise a hot coffee dispenser for 1 of 1 resident randomly observed in the 2nd floor dining area. (Resident # 45, 91, 186, 178, 6, 50, 76, 14, 93, 19, 55.) This deficit practice had the potential to affect 7 of 7 of the cognitively impaired and mobile residents residing on the 2nd floor.</p> <p>Finding include:</p> <p>A1. The record for Resident #178 was reviewed on 03-05-13 at 9:00 a.m. Diagnoses included but were not limited to a right fractured femur after a fall on the ice at home.</p>	F000323	<p>F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES We respectfully request a face-to-face IDR to dispute a portion of this citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #186 will receive appropriate supervision during meal service as noted by the dietary instruction; resident will be supervised while hot coffee dispenser is in dining area · Resident #178 no longer resides in this facility · Resident #45 will receive appropriate supervision during meal service as noted by the dietary instruction; resident will be supervised while hot coffee dispenser is in dining area · Resident #91 will receive appropriate supervision during meal service as noted by the dietary instruction; resident will be supervised while hot coffee dispenser is in dining area · Resident #6 will be supervised while hot coffee dispenser is in dining area · Resident #50 will be supervised while hot coffee dispenser is in dining area 	04/07/2013

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The pre-admission assessment, dated 01-01-13 indicated the resident was "admitted [in reference to the hospital] after slipping on the ice and falling. The resident was found to have a right femur fracture, was non weight bearing on the right lower leg, and "speciality equipment" needed included a "bed alarm, and a vertical lift for transfers."</p> <p>Review of the Resident's Minimum Data Set (MDS) assessment, dated 01-23-13 indicated the resident had no cognitive impairment and had minimal hearing impairment and required extensive assistance with bed mobility, transfer, dressing, toileting and hygiene.</p> <p>The resident's plan of care dated 01-22-13 indicated "Problem - Falls - resident is at risk for fall due to "new environment, advanced age, recent fractured right femur, receives laxative, narcotics, hypnotics, incontinent impaired gait/balance, uses w/c [wheelchair] and walker for mobility." The "goal" indicated "resident will be free from fall related injury." Interventions included "labs as ordered, assist with all transfers <sic> / waling <sic>, call light in reach, non skid foot wear, observe for fall factors</p>		<p>Resident #76 will be supervised while hot coffee dispenser is in dining area · Resident #14 will be supervised while hot coffee dispenser is in dining area · Resident #93 will be supervised while hot coffee dispenser is in dining area · Resident #19 will be supervised while hot coffee dispenser is in dining area · Resident #55 will be supervised while hot coffee dispenser is in dining area How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents that reside in the facility that can ambulate or propel themselves in a wheelchair and have a BIMS of 8 or less, receive mechanically altered diets and require assistive devices to alert nursing staff of unassisted ambulation have the potential to be affected by the alleged deficient practice</p> <p>·Staff will be in-serviced by Staff Development Coordinator and/or designee by April 7 th , 2013 regarding Meal Service Observation, Environmental Safety, Licensed Staff Resident Care Rounds Policy and Fall Management Program</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Staff will be in-serviced by Staff</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and remove if possible, personal items in reach, therapy screen."</p> <p>The "Resident Care Sheet" cautioned the staff that the resident was a "fall risk."</p> <p>The admission "Fall Risk Assessment," dated 01-11-13, lacked identification the resident had a "history of fall(s) within the past 3 months," and failed to identify the resident received antihypertensive medications.</p> <p>The 14 day MDS assessment, dated 01-23-13 indicated the resident had not had a fall prior to admission.</p> <p>Review of the Therapy notations on 03-08-13 at approximately 9:15 a.m., indicated the following:</p> <p>"Physical Therapy" "Remaining Functional Deficits / Underlying Impairments. 02-01-13 - Patient continues to have functional deficits including NWB [non weight bearing] R [right] LE [lower extremity], right hip decreased strength, decreased safety awareness." "Impact on Burden of Care / Daily Life. Due to safety reasons, the patient requires supervision and 10 % cues for transfers, toileting, gait."</p>		<p>Development Coordinator and/or designee by April 7 th , 2013 regarding Meal Service Observation, Environmental Safety, Licensed Staff Resident Care Rounds Policy and Fall Management Program</p> <ul style="list-style-type: none"> ·Interdisciplinary Team will review all physicians orders and facility activity report in the clinical meeting to ensure that fall interventions and mechanically altered diets are added to the care plans and resident care sheets ·Designated manager will observe the dining services daily and ensure coffee dispenser removed after dining services are complete and ensure supervision present at the start of dining services ·Director of Nursing or designee to conduct rounds on all three shifts to ensure that fall interventions are in place per plan of care, residents with mechanically altered diets are being supervised during meals, and for environmental safety issues ·Therapy will utilize a therapy to nursing communication form to notify nursing of safe transfers/positioning and IDT will update Care Plan and Resident Care Sheets accordingly ·If resident is at risk for falls, nursing will implement fall interventions and update Care Plan and Resident Car Sheets accordingly 		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-08-13 - Patient continues to have functional deficits include NWB, R, LE and decreased safety awareness, frequently forgetting to lock brakes." "Impact on Burden of Care / Daily Life. Due to safety reasons, the patient requires supervision and 5% verbal cues for transfer." "Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-11-13 - Patient continues to have functional deficits including muscle weakness, NWB precautions (R) LE and decreased safety awareness." "Impact on Burden of Care / Daily Life. Due to safety reasons, the patient requires verbal cues for safe transfer." "Precautions Fall risk. Bed alarm."</p> <p>"Occupational Therapy" "Remaining Functional Deficits / Underlying Impairments. 02-01-13 - patient continues to have deficits in strength and standing balance which limit ability to perform self care tasks." "Impact on Burden of Care / Daily Life. The patient has shown gains in strength which allowed for improved</p>		<p>·Therapy team has access to Care Plans through electronic medical records</p> <p>·Staff will be in-serviced on therapy to nursing communication forms by April 7 th , 2013 by the Staff Development Coordinator</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Environmental Safety, Fall Management and Meal Observation CQI tools will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</p> <p>·If 95% a threshold is not achieved, an action plan will be developed</p>		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>performance in self care tasks." "Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-08-13 - Has continued deficits in standing tolerance, endurance, strength, functional transfers and ADLs [activities of daily living]." "Impact on Burden of Care / Daily Life. Patient presenting with [blank]. Due to safety reason, the patient requires initiation cue and verbal cues to maintain FFWB [Flat foot weight bearing] status on R LE." "Precautions Fall risk. Bed alarm."</p> <p>"Remaining Functional Deficits / Underlying Impairments. 02-11-13 - Has continue <sic> deficits in standing tolerance, endurance, strength, functional transfers and ADLs [activities of daily living]." "Impact on Burden of Care / Daily Life. Due to safety reasons, patient requires initiation cues to adhere to FFWB status on R LE." "Precautions Fall risk. Bed alarm."</p> <p>Review of the facility "Event Report," dated 02-12-13 at 7:08 p.m., indicated the resident had an unwitnessed fall, with no injuries." Review of the IDT [interdisciplinary team] report indicated the time of the</p>			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>fall was inconsistent with the original event report and indicated "unwitnessed fall on 02-12-13 at approximately 6:45 a.m. Resident found on floor in room sitting on floor with legs in front of [resident]. Per resident transferred self onto side of bed and slid off. call light was in reach. Root: cause" un-assisted transfer, res. [resident] noted to be confused stating they took the red cake, spoke of red button on call light. Current interventions: personal items and call light in reach non skid footwear, observe for fall factors and remove if possible, assist with transfers, therapy scrn [screen]. New interventions: Labs d/t [due to] increased confusion. Care plan reviewed and updated."</p> <p>During an interview on 03-08-13 at 2:20 p.m., LPN # 3 indicated "We don't use alarms here, if there is something we need to be aware of therapy would tell us."</p> <p>B1. During an observation on 3/4/2013 at 10:04 a.m., in the 2nd floor main dining room, there was a hot coffee dispenser, located on the edge of the counter on the far left side of the room. This dispenser was completely out of view of any staff members. One unidentified resident</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was present in the room at the time of the observation.,</p> <p>During an observation on 3/5/2013 at 2:23 p.m., in the above dining room indicated the coffee maker was on, plugged in and sitting on the edge of the counter. There were no residents observed to be in the dining room at this time.</p> <p>During an observation and interview with the Administrator on 3/8/2013 at 2:00 p.m., she indicated the hot coffee dispenser was on and plugged in. The Administrator unplugged the machine and indicated it should be taken downstairs to the kitchen at the end of each meal service. It should not remain in the room and on for much longer than it takes for them to clean the room after meals.</p> <p>A list of residents was provided by the Administrator on 3/7/2013 at 12:05 p.m. The list indicated residents who lived on the 2nd floor who could ambulate (walk) or could propel themselves in a wheelchair and their BIMS (Brief Interview of Mental Status) score was 8 or less. Residents #'s; 6, 50, 76, 14, 93, 19, 55 fit this criteria and was at risk for accidents.</p>			

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-45(a)(1) 3.1-45(a)(2)			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>Based on record review and interview the facility failed to ensure resident's were free from unnecessary medications, without the use of excessive dosage, or without adequate monitoring or indications for use for 2 of 10 residents reviewed for unnecessary medications. [Resident #178 and #85]</p> <p>Findings include:</p> <p>1. The record for resident #178 was</p>	F000329	<p>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #178 no longer resides in this facility · Resident #85 will receive accuchecks and insulin according to physician order How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>	04/07/2013			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed on 03-05-13 at 2:00 p.m. Diagnoses included but were not limited to fractured femur, constipation, gout anemia, hypertension, atrial fibrillation, esophageal reflux, pain, and glaucoma. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician order dated 02-15-13, which indicated "Change Trazodone [an antidepressant] to read "Trazodone 50 mg [milligrams] P.O. [by mouth] QHS [at bedtime] PRN [as needed] insomnia times 14 d [days] then re-eval."</p> <p>The medication administration record for February 2013 indicated the resident received the medication on February 14, 15, 19, 21, 23, 24, 27, 28 and March 1, 2013.</p> <p>Further review of the record lacked assessment/evaluation of the resident's need as instructed by the physician.</p> <p>When interviewed on 03-08-13 at 2:20 p.m., in regard to the re-evaluation of the use of the medication, licensed nurse #3 reviewed the resident progress notes</p>		<p>taken? · All residents residing in the facility that receive a PRN antidepressant and/or physician orders for accuchecks and/or insulin have the potential to be affected by the alleged deficient practice</p> <p>· Director of Nursing and/or designee will complete MAR/TAR audits daily to ensure that physicians orders are followed for administration of insulin, accuchecks and prn medication administration as per physician orders</p> <p>· Licensed Nurses will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on Medication Administration Policy as it relates to documentation of pre/post assessment and evaluation of residents' need and effectiveness</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>· Director of Nursing and/or designee will complete MAR/TAR audits daily to ensure that physicians orders are followed for administration of insulin, accuchecks and prn medication administration as per physician orders</p> <p>· Licensed Nurses will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on Medication Administration Policy as it relates to documentation of pre/post</p>		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and indicated "if it is not documented [resident] is having insomnia problems, then we only chart by exception. I guess [resident] doesn't need it because there is nothing charted." When further interviewed if the evaluation was completed, the licensed nurse indicated, "no."</p> <p>2. The clinical record for Resident #85 was reviewed on 3/7/13 at 10:00 a.m.</p> <p>The diagnoses for Resident #85 included, but were not limited to, dementia with mood disorder and Diabetes Mellitus.</p> <p>The 2/25/13 Physician Telephone Order for Resident #85 indicated, "schedule 5 units Novolog [insulin] TID [3 times daily] AC [accuchecks] + [plus] sliding scale amount.</p> <p>The March, 2013 Physician's Orders indicated Accuchecks three times daily effective 2/8/13 and Novolog per sliding scale before meals effective 2/8/13 at the following scale:</p>		<p>assessment and evaluation of residents' need and effectiveness</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Blood Glucose CQI and Unnecessary Medications CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, 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 		

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>131-150= 1 Unit 151-200= 2 Units 201-250=4 Units 251-300=6 Units</p> <p>The March, 2013 Capillary Blood Glucose Monitoring Tool for Resident #85 indicated the following:</p> <p>3/1/13 at 6 a.m. = 165, 0 units given, should have received 2 units. 3/1/13 at 4 p.m. = 199, 0 units given, should have received 2 units. 3/1/13 at 9 p.m. = 284, 0 units given, should not have had an accucheck at this time.</p> <p>3/2/13 at 6 a.m. = 246, 0 units given, should have received 4 units. 3/2/13 at 9 p.m. = 256, 6 units given, should not have received insulin.</p> <p>3/3/13 at 9 p.m. = 196, 2 units given, should not have received insulin.</p> <p>3/4/13 at 9 p.m. = 164, 0 units given, should no have had an accucheck at this time.</p> <p>During an interview with LPN #3 on 3/7/13 at 10:45 a.m., she indicated it was her understanding that Resident #85 was to receive the sliding scale insulin before meals which was 4 times daily because he received a</p>						

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>snack at night before bedtime. She stated, "I'll call (Name of Physician #24) and get a clarification."</p> <p>During a telephone interview with Physician #24 on 3/7/13 at 11:15 a.m., he indicated the sliding scale insulin orders indicated on the March, 2013 Physician Orders were correct. He indicated Resident #85 should have accuchecks 3 times daily before meals and sliding scale insulin administered accordingly. He stated, "He should not be getting them at 9 p.m."</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation and record review the facility failed to ensure the medications error rate was less than 5 %. There were 54 opportunities for errors with 6 errors observed which resulted in a medication error rate of 11.11%. (Resident # 67, # 80, # 185, # 19, # 7, # 187)</p> <p>Findings include:</p> <p>1. The following was observed during medication pass observation on 3-4-13</p> <p>During the medication observation on 03-04-13 at 10:54 a.m., licensed nurse #9 provided medications to resident #67. The licensed nurse prepared Amlodipine (a medication for hypertension) 5 mg for the resident. A review of the physician order dated 01-03-13 indicated the medication needed to be dispensed twice daily, and was scheduled for 8:00 a.m. and again later at 8:00 p.m.</p> <p>Licensed nurse #11 prepared medications for Resident #80 at 1:46 p.m.</p>	F000332	<p>F332 FREE OF MEDICATION ERROR RATES OF 5% OR MORE What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #67 will receive medication at scheduled time · Resident #80 resident no longer resides here · Resident #185 will receive medication at scheduled time with meals and snacks · Resident #19 will receive medication at scheduled time with meals · Resident #7 does not have an order for Divalproex 50mg ph BID or a diagnoses of schizophrenia · Resident #187 has a current physician order for Miralax 17g PO daily How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents that reside in this facility have the potential to be effected by the alleged deficient practice</p> <p>·Licensed Nurses will be in-serviced on Medication Administration Policy by Staff Development Coordinator or designee by April 7 th , 2013</p>	04/07/2013

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The nurse prepared Hydroco/Acetamin (a pain medication) 7.5/325 tab. The physician order, dated 12-27-12 indicated the scheduled times included 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m.</p> <p>Licensed nurse #11 prepared medications for Resident #185 at 2:14 p.m.</p> <p>The nurse prepared Renvela (a medication used for residents with end stage renal disease). The physician order dated 02-27-13 instructed the nurse to provide 800 mg - take 4 tablets (3200 mg) by mouth 4 times daily with meals and snack. The medication administration record indicated the scheduled times included 8:00 a.m., 12:00 p.m., 6:00 p.m. and 10:00 p.m.</p> <p>Licensed nurse #9 prepared medications for Resident #19 at 2:49 p.m. The nurse prepared Renvela 800 mg for the resident. The physician order dated 03-28-11 indicated the resident takes 3 tablets (2400 mg) by mouth three times daily with meals. The scheduled times included 8:00 a.m., 12:00 p.m., and 6:00 p.m.</p> <p>Licensed nurse #13 prepared</p>		<ul style="list-style-type: none"> · Medication Pass skills validation to be conducted on Licensed Nurses by Staff Development Coordinator or designee by April 7 th , 2013 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Medication Pass skills validation will be conducted on Licensed Nurses upon hire · Licensed Nurses will be in-serviced on Medication Administration Policy by Staff Development Coordinator or designee by April 7 th , 2013 · Medication Pass skills validation to be conducted on Licensed Nurses by Staff Development Coordinator or designee by April 7 th , 2013 · Director of Nursing or designee will conduct rounds to monitor medication administration to ensure medications are dispensed as prescribed by the physician and are administered in the proper time frame · A copy of the Pharmacy Policy and Procedure is available at the nurses' stations for review and reference by the licensed nurses · Pharmacy Consultant will conduct medication pass observation audits once a month to ensure physician orders are being followed How the corrective action(s) will be monitored to ensure the deficient practice will not recur, 				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medications for Resident #7 on 3/7/13 at 9:30 a.m. The physician ordered included the medication Divalproex 50 mg [a medication for schizophrenia] take 1 tablet by mouth twice daily (10 a.m. and 10 p.m.). During the observation of the medication administration pass, this resident did not receive this medication. During the reconciliation of the medications, the physician order was dated 03-28-11 for this medication, and the omission was found.</p> <p>Licensed nurse #12 prepared medications for Resident #187 on 3/7/13 at 9:15 a.m. The nurse prepared the medication polyethylene glycol 3350 powder - 17 grams (a medication used for constipation). A reconciliation of the resident's medications were completed and the original hospital orders instructed the nurse to provide this medication "as needed for constipation." The current physician re-write transcribed from the hospital physician orders instructed the nurse to provide the medications at 10:00 a.m. daily.</p> <p>2. Review of the facility Medication Administration Guidelines, on</p>		<p>i.e., what quality assurance program will be put into place? · Pharmacy Services CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, 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</p>		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>03-07-13 at 12:50 p.m., indicated the following:</p> <p>"Purpose: [bold type] to ensure that the right resident gets the right medication at the right time, in the right dosage, via the right route. To ensure medications are dispensed in a sanitary manner. To comply with State and Federal Guidelines for administration of medications."</p> <p>"Procedure: Medication Pass: [bold type] Medications can be administered within a two hour time frame (one hour before to one hour after the time prescribed) with the exception of: medications that are schedule to be administered a given number of minutes before meals (ac) or after meals (pc).</p> <p>Administering medications too early or too late is considered a medication error and must be followed by an incident report per facility policy.</p> <p>Medications specifically ordered AC or PC must be administered as such or will be considered a medication error."</p> <p>The nursing staff failed to ensure medications were provided to the resident's in a timely manner thus medications that were scheduled</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>were provided later to the resident than the scheduled time.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 Based on observations, interview, and record review, the facility failed to ensure a safe and sanitary kitchen related to the storage of ready-to-use dishes, coverage of prepared food for a meal, drying and sanitizing of pans and equipment for food preparation, and the condition of spatulas for 2 of 2 kitchen observation days. This had the potential to impact 117 of 122 residents residing in the facility. (March 4 and 7, 2013)</p> <p>Findings include:</p> <p>1. On 3/4/13 at 10:00 a.m., during initial tour of the kitchen, the following was observed:</p> <p>The 3 compartment sink was observed in use. The sanitizer sink was observed overflowing with dishes with a large drink pitcher 1/2 way out of the sanitation solution and a large cooking pan with only 1/3 of the pan immersed in the sanitizing solution. An unidentified kitchen personnel was</p>	F000371	<p>F371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · All residents have the potential to be affected by the alleged deficient practice · All serving and food preparation utensils will be inspected by Certified Dietary Manager and disposed of accordingly · All dishes will be completely air dried prior to use · Dishes will be sanitized following facility policy · All food in the freezer will be covered at all times How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All residents have the potential to be effected by the alleged deficient practice ·All serving and food preparation utensils will be inspected by Certified Dietary Manager and disposed of accordingly ·Dietary staff will be in-serviced on proper sanitizing protocol,</p>	04/07/2013			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>observed to remove the drink pitcher and immerse it briefly into the sanitizing solution and place it on the drying side of the sink. Next, she removed the cooking pan and briefly immersed it into the sanitizing solution placing it on the side of the sink to dry.</p> <p>The posted instructions for washing and sanitizing read- "Step 4- After rinsing ware, submerge into sanitizer sink for at least 1 minute"</p> <p>There was large sheet pan with jello observed in the walk in freezer uncovered. At this time, employee #64 agreed the pan should be covered and instructed staff to do so.</p> <p>2. On 3/7/13 at 10:05 a.m., the kitchen was observed. Four of four spatulas were observed with pieces missing from the edges of these spatulas resulting in a chewed-like appearance. At this same time during an interview, Cook #63 indicated dishes should be immersed for 30 seconds before being removed from the sanitizing solution.</p> <p>During an interview 3/7/13 at 10:30 a.m., kitchen staff #63, #64 and #62, were queried regarding the procedure</p>		<p>cleaning dishes and food storage by the Certified Dietary Manager or designee by April 7 th , 2013</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Dietary staff will be in-serviced on proper sanitizing protocol, cleaning dishes and food storage by the Certified Dietary Manager or designee by April 7 th , 2013 ·Registered Dietitian or designee will monitor kitchen processes to ensure proper sanitizing of dishes is followed, cleaning dishes and food storage follows protocol <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·A Kitchen Sanitation/Environmental Review tool will be utilized weekly X 4 weeks, monthly x 2 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·In addition, a full sanitation audit will be conducted by RD Consultant monthly ·If 95% a threshold is not achieved, an action plan will be developed to ensure compliance 				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>for sanitizing pans in 3 compartment sink. Employee #62 and #64 did not know.</p> <p>3. During a kitchen observation on 3/7/13 at 10:40 a.m., the following was observed:</p> <p>3 of 4 cups inspected and identified by employee #65 as clean and ready to use, were noted to contain moisture on the inside surface. Employee #64 agreed the cups contained moisture and removed trays containing cups back to drying area. At this time during interview with employee #65, she demonstrated where cups were put after washing to dry. After they were dry, the cups were moved onto carts for use. The cart she indicated is where the cups with moisture on the inside were located.</p> <p>Employee #63 prepared pureed tomatoes for lunch. He obtained puree machine bottom and lid from the clean dish drying area. The lid was observed to have moisture on the inside. The pureed tomatoes came into contact with moisture on lid. At this time during interview, employee #63 indicated he had not noticed moisture on lid. Employee #63 agreed that equipment should be</p>				

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dry prior to use.</p> <p>A Policy and Procedure for Cleaning Dishes and Dish Machine was provided by employee #62 on 3/7/13 at 12:45 p.m. The policy indicated "...Air dry all items. Towels may contaminate items...."</p> <p>A Policy and Procedure for Food Storage was provided by employee #62 at 3/7/13 at 12:45 p.m. The policy indicated "...All foods should be covered, labeled and dated...."</p> <p>On 3/11/13 at 9:58 a.m. during an interview, the Dietary Manager #64 indicated 117 residents were served meals from the kitchen as 5 residents presently were not receiving any meal trays.</p> <p>3.1-21(i)(3)</p>						

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to follow up timely in regards to specialized services for a resident with a developmental disability for 1 of 1 resident reviewed with developmental disabilities. (Resident #5)</p> <p>Findings include:</p> <p>The clinical record for Resident #5 was reviewed on 3/8/13 at 1:30 p.m.</p> <p>The diagnoses for Resident #5 included, but were not limited to, mild intellectual disability.</p> <p>Review of Resident #5's 11/12/12 PASSR II (Pre-Admission Screening/Annual Resident Review Certification for Nursing Facility</p>	F000406	<p>F406 PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Social Services Director or designee will reach out to Noble of Indiana and request services for Resident #5 and will stress the urgency and document response How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who "require specialized services for a developmental disability" as outlined on a Level II have the potential to be affected by the alleged deficient practice ·There are currently no other residents who reside at this facility that meet that requirement</p>	04/07/2013

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Services) indicated Resident #5 "Requires Specialized Services for a developmental disability: Provided by: (Name of specialized services provider)."</p> <p>During an interview with the Social Services Director on 3/8/13 at 2:55 p.m., regarding the status of Resident #5's specialized services to be provided, she indicated, "I've sent in all his paperwork for him to begin services on 1/11/13. I haven't heard anything since. I need to give him a call back. I haven't been in contact with (Name of Intake Coordinator for specialized services provider) since 1/11/13. He didn't give me any time frame for hearing back. It usually takes 30-45 days." Regarding the fact that 30-45 days from 1/11/13 was sometime between 2/10/13 and 2/25/13, she responded, "I plan on doing it at his (Resident #5's) next assessment, probably sometime in March or April. My process is to review quarterly." Resident #5's last quarterly assessment was 1/30/13 indicating his next assessment was not due until approximately 4/30/13.</p> <p>Resident #5's PASSR II also indicated, "(Name of Resident #5) is not pleased with his loss of freedom and expressed dissatisfaction having</p>		<ul style="list-style-type: none"> · Social Services Director or designee will reach out to Noble of Indiana and request services for Resident #5 and will stress the urgency and document response What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Social Services Director or designee will review all new admissions to identify Level II requirements for a developmental disability and which services need to be obtained · The Interdisciplinary Team will meet to review which services need to be obtained and update plan of care accordingly · Executive Director of designee will follow up with Social Services weekly to ensure referrals to applicable community agencies is made and response is documented in the resident medical record How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Specialized Rehab Services CQI tool will be utilized weekly X 4 weeks, monthly x 2 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If 95% a threshold is not achieved, an action plan will be 		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to be in a nursing facility. (Name of Resident #5) looks forward to community outings with his family and going to church outside the facility."</p> <p>Resident #5 had a care plan dated 8/14/12 that indicated the problem was "Resident displaying signs and symptoms of mood distress as evidenced by finding little interest or pleasure in doing things, at risk for mood decline." The approaches were "Acknowledge to the resident that the current situation must be difficult. Encourage family and church to continue visits and support, ask for their input (sic) in regards to coping skills. Encourage resident to verbalize feelings, concerns, fears, etc. Clarify misconceptions. Establish a trusting relationship with the resident. Explore with resident past effective and ineffective coping mechanisms i.e. family and church support. Talk to resident about his traveling across the U.S., encourage reminisce (sic)."</p> <p>3.1-23(a)(2)</p>		developed to ensure compliance	

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to provide a resident with dental services as desired, for 1 of 3 residents reviewed of 4 who met the criteria for dental status and services. (Resident #85)</p> <p>Findings include:</p> <p>The clinical record for Resident #85 was reviewed on 3/7/13 at 10:00 a.m.</p> <p>The diagnoses for Resident #85 included, but were not limited to: dementia with mood disorder and diabetes.</p> <p>During an interview with Resident #85 on 3/4/13 at 3:26 p.m., he indicated</p>	F000411	<p>F411 ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Dental consult will be scheduled for Resident #85 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All residents who require dental services have the potential to be affected by the alleged deficient practice ·Residents/family will be asked by April 7 th , 2013 during customer care rounds if the resident has any dental needs and if the resident would like to see a dentist</p>	04/07/2013

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>he had no teeth, which made it hard to chew, and would like dentures. An observation of Resident #85's oral cavity was made at this time. No teeth or dentures were observed in his mouth.</p> <p>Resident #85's 2/8/13 dental care plan indicated, "Resident has some or all of natural teeth lost. Does not have or use dentures or partials related to resident preference." A 2/20/13 approach was, "Obtain dental consult as needed."</p> <p>During another Interview with Resident #85 on 3/7/13 at 12:30 p.m., he stated, "They didn't ask me if I wanted dentures or to see a dentist. The care plan is not accurate. It is not my preference to not have dentures or partials. I went to my last care plan meeting not too long ago. They didn't talk about my teeth. I have no teeth, roots or anything. Yes, I sure would like a dental appointment."</p> <p>During an interview on 3/7/13 at 12:48 p.m., with the Medical Records Staff person from whom Resident #85's last dental consult was requested, she indicated, "He has no dental consults. They only get seen if there is a problem." She indicated</p>		<p>·Staff will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on Dental Services Policy</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Social Services Director/Designee will review the results of the customer care rounds to make appropriate referrals to the dentist of the resident's choice.</p> <p>·Interdisciplinary Team will review resident dental requests and referrals to ensure there is appropriate follow-up</p> <p>·Staff will be in-serviced by Staff Development Coordinator or designee by April 7 th , 2013 on Dental Services Policy</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Accommodation of Needs and Dental Services CQI tools will be utilized weekly X 4 weeks, monthly x 2 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director</p> <p>·If 95% a threshold is not achieved, an action plan will be developed to ensure compliance</p>				

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Social Services would have to be asked if a resident having no teeth or dentures was a problem.</p> <p>During an interview with the Social Services Assistant on 3/7/13 at 12:47 p.m., she indicated, "We didn't talk about dental at the care plan meeting. I don't know why we didn't proceed to get dentures."</p> <p>During another interview with the Social Services Assistant on 3/7/13 at 2:29 p.m., she stated, "I talked to him and he told me he would like dentures. I made an appointment for him for next week to be fitted for dentures." She indicated she had never asked Resident #85 since his 2/8/13 admission if he wanted dentures and that she had no idea why his dental care plan indicated it was his preference to not have dentures or partials.</p> <p>The Dental Services policy was provided by the Administrator on 3/11/13 at 10:30 a.m. It indicated, "The facility provides dental services to meet the oral health needs of each resident...."</p> <p>3.1-24(a)(1)</p>						

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observations and record review, the facility failed to ensure opened tuberculosis vials were dated for 2 of 3 medication rooms and</p>	F000431	F431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS What corrective action(s) will be accomplished for those residents found to	04/07/2013	

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>failed to ensure a clean and sanitary medication room for 3 of 3 medication rooms observed. (Second floor medication room, Moving Forward medication room and Memory Care medication room)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/6/13 at 11:15 a.m., the medication room on second floor was observed with LPN#15. The 4 foot refrigerator was observed with 2 inches of frost in the freezer section. The refrigerator door was observed with brown splashed dried substance on it. Two of five Tuberculosis (TB) vials were open with no open date marked. On 3/8/13 at 2:50 p.m., the Moving Forward medication room on first floor was observed with the Assistant Director of Nursing (ADON). One of the three TB vials opened were observed with no open date. The two small refrigerators were observed with a buildup of 2 inches thick of frost in each freezer section. One food item in the bottom second refrigerator was observed with no date or name on it. At the same time during an interview, the ADON indicated the second refrigerator on bottom was for the residents' food. 		<p>have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Medication refrigerators will be cleaned and defrosted Tuberculin vials with no open dates marked will be destroyed and any unmarked food will be disposed of <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice Medications stored in the refrigerator will be audited to ensure that medication is labeled with a date when opened and undated medications will be destroyed All refrigerators in medication rooms will be cleaned and defrosted and food items removed Staff Development Coordinator or designee will in-service Licensed Nurses by April 7 th , 2013 on Medication Storage and Expired Medication Policy <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staff Development Coordinator or designee will in-service Licensed Nurses by April 7 th , 2013 on Medication Storage and Expired Medication Policy Director of Nursing and/or designee will make rounds daily to ensure medications have 	

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>3. On 3/8/13 at 3:05 p.m., the Memory Care medication room was observed with the ADON. One four foot refrigerator was observed with frost on the freezer section 2 1/2 inches thick. A plastic container with food was observed not marked with name or date sitting on top of medication, at the same time during an interview, the ADON removed the plastic container and indicated it should not be in there. She also indicated the freezer needed to be defrosted.</p> <p>3.1-25(j)</p>		<p>proper dating and storage area is clean and sanitary · Pharmacy consultant will audit refrigerated medications monthly for proper dating and storage · Licensed Nurses will defrost freezers monthly and clean as needed for spillage · Signs will be posted on refrigerators that no food is to be stored in medication refrigerators How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Medication Storage CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, 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</p>		

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT 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.</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 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review, observation and interview, the facility failed to</p>	F000441	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS	04/07/2013			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>follow their infection control policy related to isolation procedures for 2 of 2 resident's observed in isolation (Resident # 182 and #119), failed to ensure contaminated items were stored and disposed of in a manner to prevent the possibility of contamination, failed to ensure an anchored catheter was positioned in a manner to prevent the possibility of infection for 1 of 1 resident observed with an anchored catheter (Resident #102), and failed to ensure handwashing was completed when and how indicated for 2 of 4 care observations. (Resident # 122 and ????)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 03-04-13 at 10:00 a.m., pink signage was observed adjacent to a resident's room. During interview on 03-04-13 at 10:30 a.m., licensed nurse #3 identified a resident with influenza and was currently being treated, and the resident's roommate, who was identified by the nurse as asymptomatic was also on medications prophylactically. The pink signage instructed staff and visitors to report to the nurses station prior to entering the resident's room.</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident #182 is no longer in isolation · Resident #119 no longer resides in this facility · Resident #102 will have catheter positioned in a manner to prevent the possibility of infection · Resident #122 will only receive care after proper handwashing technique is performed and infection control practices are followed How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents who reside in this facility have the potential to be affected by the alleged deficient practice · The Interdisciplinary Team will review physician orders and facility activity report in clinical meeting to identify residents with signs and symptoms requiring isolation, positive lab results, diagnosed infections and newly placed foley catheters to ensure proper infection control practices are initiated and maintained · Staff will be in-serviced by Staff Development Coordinator and/or designee by April 7 th , 2013 on Infection Control Policies and Procedures including transmission based precaution guidelines, handwashing, catheter positioning, tray service, linen transport and handling,</p>				

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>An interview was requested of the resident's room mate (#119), and the licensed nurse indicated a mask was to be used when entering the resident's room.</p> <p>An interview was conducted with resident #119 who expressed displeasure of being exposed to influenza, and indicated concern, when staff entered the room, crossed over the contaminated area and entered behind the curtain to that section of the room. The resident indicated she was upset about the "conditions she has had to deal with since last Friday [March 1, 2013]. I'm in here and it wasn't until today that the Director of nurses came to talk to me about it. For me - and I'm a nurse - this is cross contamination. They have to go by [name of room mate] to get to me."</p> <p>Both residents were placed in isolation on 03-02-13.</p> <p>2. During an observation on 03-04-13 at 12:38 p.m., room trays were delivered to the Moving Forward Unit. Licensed Nurse #3 and certified nurses aide #5 were observed taking trays from the food cart and delivering the lunch meal to the residents.</p>		<p>disposal of Peritoneal Dialysis Dialysate and personal grooming of staff What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Staff will be in-serviced by Staff Development Coordinator and/or designee by April 7 th , 2013 on Infection Control Policies and Procedures including transmission based precaution guidelines, handwashing, catheter positioning, tray service, linen transport and handling, disposal of Peritoneal Dialysis Dialysate and personal grooming of staff · The Interdisciplinary Team will review physician orders and facility activity report in clinical meeting to identify residents with signs and symptoms requiring isolation, positive lab results, diagnosed infections and newly placed foley catheters to ensure proper infection control practices are initiated and maintained</p> <ul style="list-style-type: none"> ·Skills validations will be performed on all staff on handwashing by April 7 th , 2013 ·Director of Nursing or designee will conduct daily rounds on all shifts to ensure infection control practices are being followed including proper foley catheter bag positioning, disposal of Peritoneal Dialysis Dialysate, proper handwashing, isolation procedures, linen transport and handling, proper grooming of staff 				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Certified nurses aide #5 obtained the tray for the resident identified with the flu. The certified nurses aide, while holding the tray with her forearm and hand, knocked on the resident's door and while entering the room, picked up a mask and wrapped the elastic band behind her left ear. The certified nurses aide placed the tray on the resident's overbed table, closed the door and then exited the room. With the mask hanging from her ear, the certified nurses aide went to the food cart, poured a beverage and returned to the resident's room without attaching the mask fully across her face. When interviewed, the certified nurses aide indicated "I think [resident] has the flu."</p> <p>Without sanitizing or washing her hands the certified nurses aide, bent over and took a resident tray from the food cart. While the certified nurses aide was bent over her hair fell into the resident's salad.</p> <p>3. During an observation on 03-05-13 at 11:00 a.m., a visitor was seated on the resident's bed visiting with the resident identified with influenza. The visitor had a mask on.</p> <p>Interview on 03-06-13 at 10:00 a.m., a housekeeper who was working on</p>		<p>and that residents, visitors and staff are following posted signage and precautions</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Infection Control Review CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, 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 		

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the Moving Forward Unit indicated she was unaware the resident's were being kept in isolation until that morning. "That's when I first saw the purple sign."</p> <p>On 03-08-13 at 10:21 a.m., the Staff Development Coordinator and the Director of Nurses were interviewed regarding precautions that should be taken when a resident had been identified with influenza. The Director of Nurses indicated the resident "wasn't feeling well and had symptoms of an upper respiratory infection with a productive cough, runny nose on 02-28-12. The MD [medical doctor] was informed and ordered Robitussin and a nasal swab on the 28th. The resident was placed in isolation immediately and the the physician wrote the order for isolation on 03-01-13. When a resident had the Flu, droplet precautions should be used. Visitors are limited by not allowing children in the room, they should all report to the nurses station and then be told to gown, glove and mask in order to go in the room. Staff should be wearing gown, glove, mask when also on the room mates side of the room." In addition the Director of Nurses indicated she observed the "pink" sign the nurses made over the weekend and changed it to the</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>laminare purple sign. Knowing the resident had been admitted to the facility from the local area hospital, the Director of Nurses nor the Staff Development Coordinator responded when interviewed if the hospital had been notified of a confirmed case of influenza.</p> <p>4. During an observation on 03-05-13 at 7:30 a.m., a licensed nurse #7 carried bags of spent dialysate to the soiled utility room. When interviewed the licensed nurse indicated she would dispose of the dialysate in the sink in the soiled utility room. The nurse did not have gloves on while handling the bags of dialysate.</p> <p>5. During an observation on 03-06-13 at 9:00 a.m., a linen barrel was observed adjacent to the service elevator on the second floor. Linens were observed spewing from all sides of the barrel. The lid to the barrel indicated "soiled linen" was placed over the top, however unable to close due to the amount of soiled linen therefore lack of containment.</p> <p>Review of the facility policy on 03-11-13 at 10:30 a.m., dated as "reviewed 02-2012," and titled "<u>LAUNDRY/LINEN</u> [bold type and underscored], indicated the following:</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"Policy: [bold type and underscored] The laundry staff shall handle, store, process, and transport linen appropriately to prevent the spread of infection, in resident care areas and in the laundry facility."</p> <p>"Purpose [bold type and underscored] To ensure the proper care of linen and laundry to prevent the spread of infection."</p> <p>"Components [bold type and underscored] Note: all linen is contaminated. All linen, including that from a resident with a diagnosed infection is treated the same way. 1. Resident care areas: Soiled linen . a. Staff shall follow standard precautions, using gloves and/or aprons if direct contact with body fluids is likely. b. Place soiled linen in plastic bag. d. Soiled linen: carry away from body to prevent soiling uniform, and place in container in soiled linen room for holding until picked up by laundry. Containers in soiled linen room should be labeled, lined with well-fitted lids...." 6. On 3/8/13 at 9:25 am, Resident #122's personal care was observed. After CNA #19 placed a gait belt around the resident, CNA #20 arrived to assist with the transfer from the</p>				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>wheelchair to the bed. After the transfer was completed, CNA #19 was observed to handwash for 10 seconds before leaving the room. As CNA #20 donned a pair of gloves and applied calmoseptine cream onto his right gloved hand for the resident's open buttock areas, he indicated she had been incontinent of brown bowel movement (BM) and removed his gloves. He then exited the room and returned with linen. After handwashing, CNA #20 donned a new pair of gloves. As he cleansed the rectal area of the incontinent BM, he removed his gloves and indicated he needed more linen. CNA #20 was observed to exit the room and obtained more linen. Upon returning to the room, he was observed to handwash for 10 seconds and donned another pair of gloves. After he completed her incontinent BM care, he was observed to handwash for 15 seconds. At this same time during an interview, CNA #20 indicated one should handwash for the length of singing 2 birthday songs. He also indicated one should handwash after gloves were removed.</p> <p>On 3/11/13 at 9:53 am., LPN #11 indicated one should handwash for 2 minutes and should handwash before</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and after gloves and between residents.</p> <p>7. During an observation on 3/05/2013 at 10:51 a.m., Resident #102 was sitting in a wheelchair in the 2nd floor lounge, her urinary catheter bag, located under the wheelchair, was touching the floor.</p> <p>An interview on 3/8/2013 at 10:13 a.m., with the RN Clinical support specialist, indicated she believes that there is no policy related to keeping the urinary catheter bag up off the floor.</p> <p>An interview with the RN Clinical support specialist, on 3/8/2013 at 1:05 p.m., indicated there are no policies directly related to keeping a urinary catheter bag up off the floor, it is just a standard of practice.</p> <p>8. During an observation of a wound care treatment at 3/7/13 at 9:30 a.m., by LPN #60. She asked resident to stand, applied gloves, did not wash hands prior donning gloves. She cleansed the sacral wound area with saline and gauze, Removed her gloves, washed her hands 3-5 seconds without soap, and did not use a paper towel to turn off the water. She then applied clean gloves, applied cream to the wound.</p>			

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>She then placed the soiled gauze and gloves put in plastic bag. LPN #60 washed hands again 3-5 seconds without soap and did not use paper towel to turn off the water. The plastic bag was taken by the LPN to the soiled utility room.</p> <p>A policy titled Hand Washing Policy and Procedure was provided by RD (Registered Dietician) #62 on 3/7/13 at 12:45 p.m. The policy indicated: "Procedure: 1. Turn on faucet. 2. Wet hands and forearms with warm water and apply an antibacterial soap. 3. Scrub well with soap and additional water as needed, scrubbing all areas thoroughly. Pay close attention to fingernails. Wash for at least 20 seconds in water having a temperature of at least 100 degrees. 4. Rinse thoroughly. 5. Dry hands with paper towel, turn off faucet with towel and discard."</p> <p>3.1-18(l) 3.1-19(g)</p>				

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 03/11/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview the facility failed to ensure specific care practices were identified, policies/procedures developed and implemented, in that when the facility accepted residents who required the services of CAPD (continuous peritoneal dialysis), the facility failed to institute a program in which it created policy and procedures specific to the needs of a resident</p>	F000520	<p>F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>We respectfully request a face-to-face IDR to dispute the citation of this finding. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Policy and procedures have been obtained by dialysis company for both residents in the facility that receive Peritoneal</p>	04/07/2013			

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 03/11/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>with continuous peritoneal dialysis and infection control. This deficit practice had the potential to affect 2 of 2 residents receiving CAPD.</p> <p>Findings include:</p> <p>A copy of "skilled nursing facility/nursing home agreement for certain home peritoneal dialysis related services" was provided by the Administrator on 3/4/2013 at 1 p.m. The contract indicated, "This agreement is made by and between Spring Mill Meadows and [name of dialysis company] effective February 15, 2013...D. Mutual Obligations: 1. Written Protocols. Company or ESRD (end stage renal disease) facility and nursing facility shall develop written protocols governing policies and procedures to be used in rendering home peritoneal dialysis services to ESRD residents at the nursing facility."</p> <p>During an interview with the Administrator on 3/6/2013 at 10 a.m., she indicated she does not have a protocol in which policies or related procedures for continuous ambulatory peritoneal dialysis and believes the dialysis company should have a copy of this.</p> <p>During a subsequent interview on</p>		<p>Dialysis</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents who reside in this facility and receive Peritoneal Dialysis have the potential to be affected by the alleged deficient practice · Currently there are no residents residing in facility receiving Peritoneal Dialysis which require a new contract with new entity What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Executive Director will ensure facility obtains Policy and Procedures for any new residents receiving Peritoneal Dialysis with any new contract entered into with ESRD outside facility · Executive Director or designee will review any new Peritoneal Dialysis Policy and Procedures with CQI committee during the quarterly CQI committee meeting following admission of a new resident receiving this service <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · Executive Director or designee will review any new Peritoneal Dialysis Policy and Procedures with CQI committee during the 				

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 03/11/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>03-08-13 at 3:35 p.m., the Administrator was interviewed regarding the facility QA & A program (Quality Improvement) indicated the title of the meeting was CQI (Continuous Quality Improvement), which not only meets "monthly but also quarterly."</p> <p>The Administrator confirmed the facility currently had two residents who received CAPD, and policies, procedures, nor implementation of infection control measures had been addressed, instituted or implemented by the CQI committee.</p> <p>3.1-52(b)(1) 3.1-52(b)(2)</p>		<p>quarterly CQI committee meeting following admission of a new resident receiving this service</p>		