STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155764		03/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(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
F 000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 16, 17, 18, 19, 20, and 23, 2015. Facility number: 010739 Provider number: 155764 AIM number: 200856890 Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN Janelyn Kulik, RN (3/20/15 and 3/23/2015) Census bed type: SNF: 41 SNF/NF: 10 Residential: 64 Total: 115 Census payor type: Medicare: 33 Medicaid: 8 Other: 74 Total: 115 Residential sample: 9	F 000	This plan of correction is submitted by Spring Mill Health Campus in order to respond to the alleged deficiencies sited during the Complaint survey which was conducted on March 16, 2015 . Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective April 22, 2015. The Facility is requesting a desk review.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 30, 2015, by Janelyn Kulik, RN.			
F 242 SS=D Bldg. 00	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure a resident's preferences were honored related to the number showers they received a week for 1 of 3 residents reviewed for choices of the 3 residents who met the criteria for choices. (Resident #152) Finding includes: Interview with Resident #152 on 3/17/15 at 9:27 a.m., indicated she would like to take more than just two showers a week. Continued interview with the resident on 3/18/15 at 3:44 p.m., indicated she had showered everyday while she was at	F 242	1. Resident (R152) bathing preferences have been updated. Resident (152) Care plan was updated to reflect changes. 2. All other residents were review for bathing preferences and care plans were updated. 3. Nursing were re-in-serviced on following the resident preferences by DHS or Designee. Life Enrichment will be responsible within 72 hours of admission to complete the resident's preference forms. This information will be communicated to the C.N.A. Via electronic Care Tracker. Unit Manager or designee will document audits of 5 residents per week to	04/22/2015

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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410	

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	home. She further indicated she would prefer to take at least four showers a week during her stay. The record for Resident #152 was reviewed on 3/18/15 at 3:22 p.m. The resident had just been admitted to the facility on 3/5/15. The resident's diagnoses included, but were not limited to, stroke, gait disturbance, anxiety, depression, and vascular dementia. Review of the shower book indicated the resident was supposed to receive a shower in the evening on Monday and Thursday. This determination was based on her room number. Review of the shower sheets indicated the resident had only received two showers since admit on 3/12 and 3/16/15. Review of the life enrichment assessment dated 3/6/15 indicated it was very important to choose between a shower or tub bath. The resident indicated she would prefer a shower in the evening. There were no questions regarding how many times a week she preferred to shower. Interview with the Assistant Director of Nursing (ADoN) on 3/20/15 at 9:30 a.m., indicated the resident was only receiving		ensure preference is being completed. Unit Manager or designee will report findings monthly to QAA monthly for 90 days or until 100% compliance is obtained. 4. QA&A will monitor monthly for 90 days or until 100% compliance is obtained for trends and makes recommendations to the Plan of Correction as needed. 5. Correction of F242 will be completed by 4/22/15	

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	two showers a week based on her room number. She further indicated she was unaware the resident preferred to take more showers a week. The ADoN indicated she had not asked the resident how many showers a week she would prefer. 3.1-3(v)(1)			
F 282 SS=E Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure sliding scale insulin was administered as ordered for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure areas of bruising were monitored for 3 of 3 residents reviewed for skin conditions (non-pressure related) of the 3 residents who met the criteria for skin conditions (non-pressure related). (Residents #38, #71, #95, and #155) Findings include: 1. The record for Resident #95 was reviewed on 3/18/15 at 10:48 a.m. The resident's diagnosis included, but was not	F 282	1. Resident (95) was assessed on 4/3/15 no adverse side effects noted related to sliding scale. Resident (71) & (38) skin was documented on bruise assessment sheet. Resident (155) has been discharged. 2. All other residents receiving sliding scale in the last 30 days were reviewed no adverse side effects noted. All residents were assessed for any bruising any resident noted with bruising were started on bruise assessment sheet. 3. Licensed Nurses will be re-in-serviced on following MD orders for sliding scales and documentation related to bruises. Unit Manager or designee will	04/22/2015

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	limited to, diabetes mellitus. A Physician's order dated 1/31/15 indicated the resident was to receive Novolog (a type of insulin) based on the following sliding scale three times a day: 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units over 400=12 units and call MD The February 2015 Medication Administration Record (MAR), indicated the resident's blood sugar upon rising on 2/13/15 was 140, the resident received two units of Novolog insulin. The resident's blood sugar upon rising on 2/25/15 was 191, the resident received four units of insulin rather than two units. The resident's blood sugar upon rising on 2/26/15 was 207. There was no documentation of insulin being given. The current plan of care indicated the resident had the potential for hypo/hyperglycemia (low or high blood sugar) related to diabetes. The interventions included, but were not limited to, administer insulin as ordered. Interview with the Assistant Director of		monitor via documented audits of 5 residents per week to ensure sliding scales is being followed per MD orders & bruise assessment being completed. Unit Manager or designee will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F282 will be completed by 4/22/15	

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	Nursing (ADON) on 3/23/15 at 9:15 a.m., indicated the resident did not receive his insulin as ordered. 2. On 3/17/15 at 11:20 a.m., Resident #71 was observed with multiple areas of bruising to his left forearm. A dark purple bruise was also observed to the resident's right antecubital area. The record for Resident #71 was reviewed on 3/19/15 at 9:13 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease on dialysis. The March 2015 Treatment Administration Record (TAR), indicated the resident was to have a weekly skin assessment on Thursday. There was no documentation to indicate if the weekly skin assessments had been completed. Also, there were no non-pressure skin sheets available for review. The current plan of care indicated the resident was to have a weekly skin check by a Licensed Nurse and document any news areas in the care tracker and report to the Nurse. Interview with the Assistant Director of Nursing (ADON) on 3/20/15 at 8:10 a.m., indicated that she would have to			

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	check and see if the resident had a non-pressure skin sheet for his bruises. Interview with LPN #3 on 3/20/15 at 9:31 a.m., indicated the resident had areas of discoloration to his left and right hands and bilateral forearms. The resident indicated the areas were from wheeling himself in the wheelchair and where he received the blood thinners. The LPN indicated there were no skin sheets initiated for the areas. 3. On 3/17/15 at 10:59 a.m., Resident #155 was observed with an area of dark purple discoloration to the top of his left hand. On 3/20/15 at 8:10 a.m., the area of reddish purple discoloration remained to the top of the resident's left hand. The record for Resident #155 was reviewed on 3/18/15 at 9:47 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and coronary artery disease. The March 2015 Treatment Administration Record (TAR), indicated the resident was to have a weekly skin assessment on Thursday. The weekly skin assessment for 3/12/15 had not been signed out as completed. There was also			

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	no non-pressure skin sheet related to the discoloration on the resident's left hand. The current plan of care indicated the resident was to have a weekly skin check by a Licensed Nurse and document any new areas in the care tracker and report to the Nurse. Interview with the Assistant Director of Nursing (ADON) on 3/20/15 at 8:10 a.m., indicated that she would have to check and see if the resident had a non-pressure skin sheet completed. 4. On 3/16/2015 at 12:24 p.m., Resident #38 was observed with an approximate nickel sized area of purple discoloration to the top of her right hand. On 3/18/2015 at 10:58 a.m., an approximate nickel sized area of purple discoloration was observed on the top of the resident's left hand. The nickel sized purple discoloration remained on the top of the resident's right hand. The record for Resident #38 was observed on 3/18/2015 at 10:33 a.m. The resident's diagnoses included, but were not limited to, anemia, dementia, and hypertension. Review of the Multiple Bruise Monitoring Sheets for March 2015			

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	indicated no forms had been completed related to the resident's bruising to the top of her right hand. Review of the Nursing progress notes dated 3/1/2015 through 3/18/2015, indicated there was no evidence of documentation related to the resident's bruising to the top of her right hand. Review of the March 2015 shower sheets, indicated the resident's skin was listed as being intact on shower days. No bruising was documented. The resident was documented as receiving a shower on 3/14/2015 and her skin was listed as having no new areas of bruising. Review of the individual plan report indicated the resident had fragile skin and would occasionally get skin tears and bruising as she propelled herself in her wheelchair and bumped into things. The interventions included, but were not limited to, observe skin daily during care, document any new skin areas into the care tracker and report to a Nurse, and weekly skin checks by a licensed Nurse. Interview with the Unit Manager on 3/18/15 at 10:58 a.m., indicated she was unaware of the resident having any bruising. An observation at the time indicated the resident did have 2 bruises			

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	on the top of her right and left hand. She also indicated documentation should have been completed in the resident's record 3.1-35(g)(2)			
F 309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to assess and monitor areas of bruising for 3 of 3 residents reviewed for skin conditions (non-pressure related) of the 3 residents who met the criteria for skin conditions (non-pressure related). (Residents #38, #71, and #155) Findings include: 1. On 3/17/15 at 11:20 a.m., Resident #71 was observed with multiple areas of bruising to his left forearm. A dark purple bruise was also observed to the resident's right antecubital area. On 3/19/15 at 9:01 a.m. and on 3/20/15 at	F 309	1. Resident (71) & (38) skin was documented on bruise assessment sheet. Resident (155) has been discharged. 2. All residents were assessed for any bruising any resident noted with bruising were started on bruise assessment sheet. 3. Licensed Nurse will be re-in-serviced on weekly skin checks. Skins checks will be completed and documented on the treatment administration records. Unit Manager or designee will monitor via documented audits of 5 residents per week to ensure skin checks are completed and	04/22/2015

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	8:25 a.m., multiple areas of bruising were observed to the resident's left forearm. The record for Resident #71 was reviewed on 3/19/15 at 9:13 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease on dialysis. The March 2015 Treatment Administration Record (TAR), indicated the resident was to have a weekly skin assessment on Thursday. There was no documentation to indicate if the weekly skin assessments had been completed. Also, there were no non-pressure skin sheets available for review. The current plan of care indicated the resident was to have a weekly skin check by a Licensed Nurse and document any news areas in the care tracker and report to the Nurse. Interview with the Assistant Director of Nursing (ADON) on 3/20/15 at 8:10 a.m., indicated that she would have to check and see if the resident had a non-pressure skin sheet for his bruises. Interview with LPN #3 on 3/20/15 at 9:31 a.m., indicated the resident had areas of discoloration to his left and right hands and bilateral forearms. The		documented. Unit manager or designee will report monthly findings to QA&A for 90 days or until 100% compliance is obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F309 will be completed by 4/22/15	

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	resident indicated the areas were from wheeling himself in the wheelchair and where he received the blood thinners. The LPN indicated there were no skin sheets initiated for the areas. 2. On 3/17/15 at 10:59 a.m., Resident #155 was observed with an area of dark purple discoloration to the top of his left hand. On 3/19/15 at 10:09 a.m. and 12:50 p.m., the area of dark purple discoloration remained to the top of the resident's left hand. On 3/20/15 at 8:10 a.m., the area of reddish purple discoloration remained to the top of the resident's left hand. The record for Resident #155 was reviewed on 3/18/15 at 9:47 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and coronary artery disease. The March 2015 Treatment Administration Record (TAR), indicated the resident was to have a weekly skin assessment on Thursday. The weekly skin assessment for 3/12/15 had not been signed out as completed. There was also no non-pressure skin sheet related to the discoloration on the resident's left hand.			

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	The current plan of care indicated the resident was to have a weekly skin check by a Licensed Nurse and document any new areas in the care tracker and report to the Nurse. Interview with the Assistant Director of Nursing (ADON) on 3/20/15 at 8:10 a.m., indicated that she would have to check and see if the resident had a non-pressure skin sheet completed. 3. On 3/16/2015 at 12:24 p.m., Resident #38 was observed with an approximate nickel sized area of purple discoloration to the top of her right hand. On 3/17/2015 at 1:02 p.m., the area of purple discoloration remained to the top of the resident's right hand. On 3/18/2015 at 8:06 a.m., the area of purple discoloration was again observed on the top of the resident's right hand. On 3/18/2015 at 10:58 a.m., an approximate nickel sized area of purple discoloration was observed on the top of the resident's left hand. The nickel sized purple discoloration remained on the top of the resident's right hand. The record for Resident #38 was observed on 3/18/2015 at 10:33 a.m. The			

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	resident's diagnoses included, but were not limited to, anemia, dementia, and hypertension. Review of the Annual Minimum Data Set (MDS) assessment dated 3/10/14, indicated the resident was not cognitively intact and had no skin issues during the assessment reference period. Review of the Multiple Bruise Monitoring Sheets for March 2015 indicated no forms had been completed related to the resident's bruising to the top of her right hand. Review of the Nursing progress notes dated 3/1/2015 through 3/18/2015, indicated there was no evidence of documentation related to the resident's bruising to the top of her right hand. Review of the March 2015 shower sheets, indicated the resident's skin was listed as being intact on shower days. No bruising was documented. The resident was documented as receiving a shower on 3/14/2015 and her skin was listed as having no new areas of bruising. Review of the individual plan report indicated the resident had fragile skin and would occasionally get skin tears and bruising as she propelled herself in her			

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	wheelchair and bumped into things. The interventions included, but were not limited to, observe skin daily during care, document any new skin areas into the care tracker and report to a Nurse, and weekly skin checks by a licensed Nurse. Interview with the Unit Manager on 3/18/15 at 10:58 a.m., indicated she was unaware of the resident having any bruising. An observation at the time indicated the resident did have 2 bruises on the top of her right and left hand. She also indicated documentation should have been completed in the resident's record. The Weekly Skin Assessment Guideline policy dated 4/08 indicated, "6. In addition to the Weekly Assessment by the licensed nurse the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified." 3.1-37(a)			
F 329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive			

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SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

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	dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure insulin was administered as ordered and signs and symptoms of constipation were monitored for 2 of 3 residents reviewed for unnecessary medications. (Residents #3 and #95) Findings include: 1. The record for Resident #95 was reviewed on 3/18/15 at 10:48 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus. A Physician's order dated 1/31/15, indicated the resident was to receive Novolog (a type of insulin) based on the	F 329	1. Resident (95) was assessed on 4/3/15 no adverse side effects noted related to sliding scale. Resident (3) had no adverse side effect related to bowels. 2. All other residents receiving sliding scale in the last 30 days were reviewed no adverse side effects noted. All residents were assessed the next day to ensure no other deficiencies. 3. Licensed Nurses will be re-in-serviced on following MD orders for sliding scales. Unit Manager of designee will monitor via document audits of 5 residents per week to ensure sliding scales is being followed per MD order. Unit	04/22/2015

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	following sliding scale three times a day: 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units over 400=12 units and call MD The February 2015 Medication Administration Record (MAR), indicated the resident's blood sugar upon rising on 2/13/15 was 140, the resident received two units of Novolog insulin. The resident's blood sugar upon rising on 2/25/15 was 191, the resident received four units of insulin rather than two units. The resident's blood sugar upon rising on 2/26/15 was 207. There was no documentation of insulin being given. The current plan of care indicated the resident had the potential for hypo/hyperglycemia (low or high blood sugar) related to diabetes. The interventions included, but were not limited to, administer insulin as ordered. Interview with the Assistant Director of Nursing (ADON) on 3/23/15 at 9:15 a.m., indicated the resident did not receive his insulin as ordered. 2. The record for Resident #3 was reviewed on 3/18/15 at 10:00 a.m. The		Manager or designee will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. Licensed Nurses will be re-in-serviced on the facility's policy regarding bowel movements. Unit Manager or designee will monitor via documented audits of 5 residents per week to ensure a bowel protocol is being followed per facility policy. Unit Manager or designee will report findings to QA&A monthly for 90 days or until 100% compliance is obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F329 will be completed by 4/22/15.	

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	resident's latest readmission back to the facility from the hospital was on 1/31/15. The resident's diagnoses included, but were not limited to, Multiple Sclerosis, paraplegia, chronic pain, chronic indwelling catheter, depression, anxiety, hypotension, neurogenic bladder, and Alzheimer's disease. Review of the Significant Change Minimum Data Set (MDS) assessment dated 2/23/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was an 11, indicating she was alert and oriented. The resident had no behaviors. The resident was totally dependent on staff for transfers. She was always incontinent of bowel and was not on any toileting program to manage the resident's bowel continence. Constipation was not present. The current and updated plan of care dated 2/23/15 indicated the resident was at risk for pain. The interventions did not include anything regarding being at risk for constipation. Another current and updated plan of care dated 2/23/15 indicated the resident was incontinent of bowel. The interventions did not include anything regarding being at risk for constipation.			

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	Physician Orders dated 2/17/15 indicated the resident was admitted to Hospice care. Physician Orders dated 1/31/15 and on the current 3/2015 recap indicated Docusate Sodium (a stool softener) 100 milligrams (mg) 1 twice a day (bid) for constipation. The resident also had an order dated 1/31/15 for Hydrocodone (a narcotic pain medication) 5-325 mg 1 every 6 hours as needed (prn) for chronic pain. Another order dated 1/31/15 indicated Morphine Sulfate (a narcotic pain medication) 30 mg 1 tablet twice a day for chronic pain. The Medication Administration Record (MAR) for 2/2015 indicated the Morphine Sulfate was signed out as given 2/1-2/28/15. The 3/2015 MAR indicated the resident had received the Morphine Sulfate from 3/1-3/20/15. The 2/2015 and 3/2015 MAR indicated the resident received the prn Hydrocodone on 2/1, 2/3, 2/4, 2/24, 2/28, 3/5, 3/10, and 3/16/15 for chronic pain. Physician Orders dated 2/17/15 indicated Roxanol (a narcotic pain medication) 20 mg/milliliters (ml) give .25 ml every 2 hours prn restlessness and agitation.			

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	The 2/2015 and 3/2015 MAR indicated the resident received the prn Roxanol on 2/17, 3/8, and 3/16/15. The resident's Bowel Movements (BM) were reviewed for the last 30 days. The resident had a BM on 2/4 during the evening shift and then not again until 2/7 day shift. The resident had a BM on 2/17 during the midnight shift and then not again until 2/20 day shift. The resident had a BM on 2/20 during the day shift and then not again until 2/23 day shift. The resident had a BM on 2/27 during the evening shift and then not again until 3/4 day shift. Nursing Progress Notes 2/1-2/28/15 and from 3/1-3/20/15 and the 2/2015 and 3/2015 MARs lacked documentation regarding any interventions done for the resident's constipation. The current 2/17/15 Bowel Protocol provided by the Director of Nursing indicated the purpose was to provide guidance for the use of bowel stimulants for residents with constipation. The			

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	Bowel and Bladder Circumstance form or Ineffective Bowel Pattern form shall be initiated for any resident not having a BM within 72 hours (unless this has been determined to be a usual bowel pattern for the individual). The 72 Hour follow up on the Bowel and Bladder Circumstance form should be completed until the resident has a BM or the bowel pattern returns to normal for the resident. The Ineffective Bowel Pattern form should be completed each shift until the resident has a BM or bowel pattern has returned to "normal" for the resident. The Bowel Protocol may be implemented: 2 Tablespoons (30 cc) of Natural Laxative (mixture of bran, applesauce and prune juice) bid. This mixture may also be given daily in place of a stool softener. If no results within 24 hours of above give 30 cc of Milk of Magnesia and continue Natural Laxative as above. If no results within approximately 12 hours of above MOM administration give Dulcolax suppository. Interview with the Director of Nursing on 3/20/15 at 2:30 p.m., indicated Nurses should follow a 72 hour bowel program and after 72 hours they should have administered a natural laxative like applesauce to the resident. She further indicated there was no evidence of any			

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	documentation the resident received the applesauce or other type of natural laxative after 72 hours of no bowel movement. 3.1-48(a)(3)			
F 371 SS=F Bldg. 00	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 observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to touching food, lack of beard guards in use, and the accumulation of dust and debris on food preparation equipment in 1 of 1 kitchen areas and on 1 of 2 units throughout the facility. (The Main kitchen and the Transitional Care Unit) Findings include: 1. On 3/16/15 at 12:27 p.m., in the Transitional Care Unit (TCU) dining room, Dietary Cook #3 was setting up for the lunch meal. At 12:28 p.m., the dietary employee put on a pair of gloves. At this time he touched a plate, tray card	F 371	1. The box of oranges & lemons was removed; grease and food crumbs were cleaned. Grates on top of the frill were cleaned, floor against the base board behind the stove, deep fryer and grill. All food spillage was cleaned. Beard guard was initiated on 3/20/15. 2. All areas of the dietary department have the ability to be effective. 3. The dietary staff was re-in-serviced on sanitation, beard guards and handling of food on the tray line in the dietary department. The Dietary food service manager will monitor via documented audits 3 times per week (to include all meal times) of sanitation being	04/22/2015

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	and other items on the steam table. He placed a sandwich on a plate and touched the sandwich with his gloved hand while he cut the sandwich in half. He touched all of the sandwiches he cut in half with his gloved hand that he had touched other things with. Interview with the Dietary Food Manager on 3/23/15 at 11:30 a.m., indicated the employee should not have been touching food with his gloved hand. 2. The Brief Kitchen Sanitation tour was completed on 3/16/15 at 9:30 a.m. with the Dietary Food Manager (DFM). The following was observed: A. The DFM, Dietary Cook #1 and Dietary Cook #2 were observed with facial hair to the sides of their face and chin areas. All three men were not observed to be wearing beard guards to their face. B. There was a box of oranges in the walk in cooler with a large amount of some kind of beverage spillage noted in the box and on the oranges. There was a box of lemons also noted in the cooler. Approximately 6 lemons were rotten. C. There was a large accumulation of grease and food crumbs around the deep fryer. The sides of the fryer were dirty		completed, observation of staff handling food on the tray line and observation of the use of beard guards. DFS or designee will report findings to QA&A monthly for 3 months or until 100% compliance will be obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for 90 days or until 100% compliance is obtained. Correction of F371 will be completed by 4/22/15	

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	and greasy. Both Dietary Cook #2 and the DFM indicated the deep fryer had not been used that morning to prepare the breakfast. D. The grates on top of the grill were dirty with black burned food substance noted. There was also a large accumulation of black grease noted on top of the grill. E. There was a large accumulation of food crumbs and dirt on the floor against the base board behind the stove, deep fryer and grill. The yellow pipes behind the stove had a large accumulation of grease and food spillage. The wall behind that equipment was also dirty. The pipes behind the stove, fryer and grill were dirty and greasy with a large accumulation of grease noted. The floor tile and the grout were also dirty with an accumulation of dried and adhered dirt and grease. Interview with the Dietary Food Manager on 3/20/15 at 2:00 p.m., indicated all of the above was in need of cleaning. 3. On 3/17/15 at 9:00 a.m. until 9:30 a.m., Dietary Cook #1 was observed preparing the resident's breakfast behind the steam table on Healthcare Center 2. The Dietary Cook was placing the food			

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	on the resident's plates. At that time, his beard guard was observed under his chin and around his neck. His facial hair was exposed to the food while he was serving the breakfast. Interview with Dietary Cook #1 on 3/17/15 at 9:30 a.m., indicated he was aware he was supposed to be wearing the beard the guard while serving behind the steam table. 3.1-21(i)(1)(2)			
F 431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only			

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	authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications were properly labeled with the date opened related to multi dose vials and tubes of medications. The facility also failed to ensure the EDK (Emergency Drug Kit) box was locked. The facility also failed to ensure medications were not administered post the expiration date on multi dose vials of Insulin for 2 of 3 units. (The TCU (Transitional Care Unit) and Healthcare Center 2) Findings include: 1. On 3/23/15 at 10:55 a.m., the following was observed on the TCU unit in the medication cart: A. There was a multi dose vial of Novolog Insulin with a date opened of 2/21/15. The vial was in a clear plastic	F 431	1. All medication carts were audited and any open medication which was expired per the facility policy was destroyed. All medications were reviewed for opening dates. EDK box was stored securely in the Locked Medication room. 2. All medication carts and med rooms were audited and any expired medications were removed. All EDK boxes are secured. 3. Licensed Nurses were re-in-serviced on dating medications once opened, using medication past expiration date, ensure labeling of medications correctly, and ensuring EDK box are secured. Unit Manager or Designee will do documented audits of the medications carts and medication rooms 3 times per week for any expired medications, EDK box sealed and to assure they labeled when opened. Unit Manager or designee will report	04/22/2015

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	bag with no label on it. The resident's name and the date opened was hand written in black marker on the vial. There was no other information on the plastic bag or vial indicating the Physician's name and directions for use. Interview with LPN #1 at the time, indicated the vial of Insulin was taken from the EDK box. B. There was a tube of Bacitracin ointment opened. Further observation indicated there was no date noted on the tube when it was opened. The label indicated it had been delivered to the facility on 3/10/15. Interview with the Assistant Director of Nursing at that time, indicated the vial of Insulin and the tube of Bacitracin should have had a date opened on them. She further indicated there should have been a better label on the vial of Novolog Insulin that came from the EDK box. 2. On 3/23/15 at 11:03 a.m., the following was observed on the Healthcare center 2 unit: A. There was multi dose vial of Novolog Insulin 70/30 opened with no date when it was opened.		findings monthly to QA&A for 90 days or until 100% compliance is obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F431 will be completed by 4/22/15.	

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	B. The injectable EDK box was opened and not locked in the medication room. Interview with the Unit Manager indicated it must have been opened over the weekend and not locked back. The other EDK box with had p.o. (by mouth) medication was also open and not locked. Interview with LPN #2 at that time, indicated she used the p.o. EDK box earlier but could not find a black twist tie to close it back again. The current 9/1/13 Storage of Medication policy provided by the Director of Nursing indicated medications and biologicals were stored safely and securely, and properly, following manufactures recommendations. 3. On 3/25/15 at 10:55 a.m., the following was observed on the TCU Unit: A. There was a Multi does vial of Novolog Insulin with the date opened on 2/21/15. B. There was a multi dose vial of Lantus Insulin with the date opened of 2/18/15. Interview with the Assistant Director of Nursing at that time, indicated the insulins should have been discarded 28			

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	days after opening. 4. On 3/23/15 at 11:03 a.m., the following was observed on the Health Center Unit. There was an Advair Diskus (type of inhaler medicine) opened and in its box. The Diskus was delivered to the facility on 2/15/15 and it was opened on that day also. Interview with the Unit Manager at that time indicated the Diskus was still being used by the resident and should have been discarded 30 days after opening. The current 9/2010 Recommended Expiration dates provided by the Assistant Director of Nursing indicated vials of Novolog and Lantus Insulins were to be discarded 28 days after they had been opened. Inhalation products such as Advair Inhaler was to be discarded after 30 days from removal of foil pouch. 3.1-25(a) 3.1-25(k)(2) 3.1-25(k)(5)			

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	155764		03/23/2015

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SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(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
F 441 SS=D Bldg. 00	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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview the	F 441	1. Residents 151, 67, 73.	04/22/2015

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	facility failed to maintain infection control related to the storage of residents' toothbrushes and wash basins being stored uncovered on the edge of sinks and shower floors, for 3 residents in a sample of 30. (Resident #67, #73, and #151) Findings include: 1. On 3/17/2015 at 8:43 a.m., Resident #151's restroom was observed. A toothbrush was observed stored uncovered on the edge of the sink pointing down. On 3/20/2015 at 9:55 a.m., Resident #151's restroom was observed. A toothbrush was observed stored uncovered on the back of the sink pointing up. 2. On 3/17/2015 at 9:24 a.m., Resident #67's restroom was observed. Two wash basins were observed stacked on each other stored on the edge of the sink uncovered. On 3/20/2015 at 9:45 a.m., Resident #67's restroom was observed. Two wash basins were observed stacked on each other uncovered stored on the back of the commode.		Personal care products were placed in the resident's bed side stands. 2. All residents were rooms were audited on 3/23/15 and all personal care products were put into resident's bedside stands. 3. Nursing staff will be re-in-serviced on storage of personal care products to prevent potential infection spreads. Unit Manager or designee will do documented audits of 5 rooms per week to ensure personal care items are stored to prevent infection control. Unit Manager or designee will report findings to QA&A. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for monthly for 90 days or until 100% compliance is obtained. 5. Correction of F441 will be completed by 4/22/15.	

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	3. 3/17/2015 at 9:39 a.m., Resident #73's restroom was observed. A wash basin was observed stored uncovered on the shower floor. On 3/20/2015 at 9:50 a.m., Resident #73's restroom was observed. A wash basin was observed uncovered on the shower floor. Interview with the Director of Environmental Services and the Director of Plant Services on 3/20/2015 at 10:00 a.m., indicated the above items should not have been stored uncovered. 3.1-18(j)			
F 465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment was in good repair related to marred doors, cabinets and walls for 3 of 3 units. The facility also failed to ensure the kitchen was clean related to dirty floor drains, walls, and pipes in the dish room for 1 of 1 kitchens. (TCU, Healthcare 1, Healthcare 2 and the Main Kitchen)	F 465	1. Back splash was cleaned. The floor drain was cleaned. The caulking in BR sink was fixed. Room 2202 door was fixed. Room 2217 was fixed. Room 1101 cabinet was fixed. 1104 cabinet was fixed. Room 1105 cabinet was fixed. 2. All area of the environmental has the potential to be effective. 3. Director of Plant operations and housekeeping were re-educated on ensuring areas were cleaned	04/22/2015

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	Findings include: 1. The following was observed during the Brief Kitchen Sanitation tour on 3/16/15 at 9:30 a.m., with the Dietary Food Manager: A. The white back splash behind the dish machine was dirty with a large accumulation of food spillage noted. There was a large accumulation of food crumbs and dirt noted behind the dish machine and in the grout on the floor tile. The white PVC drain pipes under the dish machine were dirty with food spillage. B. The floor drain under the steam table and the white PVC drain pipes were dirty. Interview with the Dietary Food Manager on 3/20/15 at 2:00 p.m., indicated all of the above was in need of cleaning. 2. During the Environmental Tour on 3/20/2015 at 9:45 a.m., with the Director of Housekeeping and the Director of Plant Services, the following was observed on Transitional Care Unit: A. The caulking around the bathroom sink was cracked and peeling in Room		and on environmental issues. ED or designee will do documented audits of 5 rooms per week to ensure the room has no chipped or marred areas in the room. ED or designee will report findings to QA&A monthly. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor for monthly for 90 days or until 100% compliances obtained. 5. Correction of F465 will be completed by 4/22/15	

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	3105. One resident resided in this room. 3. During the Environmental Tour on 3/20/2015 at 9:50 a.m., with the Director of Housekeeping and the Director of Plant Services, the following was observed on Healthcare 2: A. The door to the bathroom was gouged and splintered in Room 2202. Two residents resided in this room B. The entrance and bathroom doors were marred in Room 2217. The wall near the bathroom entrance was marred. The paint was chipped on the wall underneath the picture frame near the bathroom and the paint was chipped behind the bed. Two residents resided in this room. 4. During the Environmental Tour on 3/20/2015 at 9:55 a.m., with the Director of Housekeeping and the Director of Plant Services, the following was observed on Healthcare 1: A. The cabinet was marred and chipped in the bathroom of Room 1101. The caulking around the toilet was discolored and peeling. Two residents resided in			

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	this room. B. The cabinet was marred and missing a handle in the bathroom of Room 1104. The shower floor tile was chipped and peeling. One resident resided in this room. C. The cabinet was scratched and marred in the bathroom of room 1105. One resident resided in this room. Interview with the Director of Housekeeping and the Director of Plant Services on 3/20/2015 at 10:00 a.m., indicated the above items were in need of repair. 3.1-19(f)			
F 999 Bldg. 00	PERSONNEL 3.1-14 (p)(4) Initial orientation of all staff must be conducted and documented and shall include the following: A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned.	F 999	1. Social Service and Dietary employee job specific checklist have been completed. 2. Employee files have been reviewed and job specific checklist has been completed. 3. Human Resources were re-in-service on completion of Jon specific checklist. All new associates	04/22/2015

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	THIS STATE FINDING WAS NOT MET: Based on record review and interview, the facility failed to ensure job specific orientation was completed for 2 of 5 employees who were hired within the last 120 days. (The Social Service Director and Dietary Employee #4) Findings include: 1. The employee file for the Social Service Director was reviewed on 3/23/15 at 11:00 a.m. The Social Service Director was hired on 1/6/15. There was no documentation of job specific orientation in the employee file. Interview with the Human Resources Director on 3/23/15 at 1:30 p.m., indicated there was no documentation to indicate if job specific orientation had been completed. 2. The employee file for Dietary Employee #4 was reviewed on 3/23/15 at 11:10 a.m. The dietary employee was hired on 2/10/15. There was no documentation of job specific orientation in the employee file Interview with the Human Resources		will have job specific orientation checklist completed with 90 days of orientation. ED or designee will review 5 new associates per week to ensure compliance with completion of the job specific checklist. ED or designee will report findings to QA&A monthly. 4. QA&A will monitor monthly for any trends and make recommendations to the plan of correction as needed. QA&A will monitor monthly for 90 days or until 100% compliance is obtained. 5. Correction of F-9999 will be completed by 4/22/15.	

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	Director on 3/23/15 at 1:30 p.m., indicated there was no documentation to indicate if job specific orientation had been completed. 3.1-14 (p)(4)			
R 000 Bldg. 00	These deficiencies reflect state findings cited in accordance with 401 IAC 16.2-5.	R 000	This plan of correction is submitted by Spring Mill Health Campus in order to respond to the alleged deficiencies sited during the Complaint survey which was conducted on March 16, 2015 . Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective April 22, 2015. The	

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			Facility is requesting a desk review.	
R 120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			

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	Based on record review and interview the facility failed to provide annual employee training related to the prevention and control of infection, fire prevention, residents rights and/or medications administration for 10 of 10 employee records reviewed. (CRCA (Certified Resident Care Associate) #2, LPN #7, LPN #6, LPN #10, CRCA #3, CRCA #6, CRCA #4, LPN #8, CRCA #7 and CRCA #5). Findings include: 1. The record for CRCA (Certified Resident Care Associate) #2 was reviewed on 3/23/15 at 3:00 p.m. The record indicated the employee was hired on 10/18/12. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no prevention and control of infections and fire prevention in-servicing for 2014. 2. The record for LPN #10 was reviewed on 3/23/15 at 3:05 p.m. The record indicated the employee was hired on 11/15/12. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no prevention and control of infections, fire prevention, or accident prevention in-servicing for 2014.	R 120	1. Associate CRCA 2, LPN 7, LPN 6, LPN 10, CRCA 3, CRCA 6, CRCA 4, LPN 8, CRCA 7, CRCA 5, in-services were completed. 2. Employees files were reviewed for required in-services. 3. An in-service calendar was developed by Director of Health services, (DHS), to include the required 8 hours per year. In-service calendar also includes Dementia specific training as required. DHS or designee will review in-service records to ensure completion of required in-service. DHS or designee will report findings to QA&A monthly. 4. QA&A will monitor monthly for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for 90 days or until 100% compliance is obtained. 5. Correction of R120 will be completed by 4/22/15.	04/22/2015

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	3. The record for LPN #6 was reviewed on 3/23/15 at 3:10 p.m. The record indicated the employee was hired on 11/1/12. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no fire prevention inservicing for 2014. 4. The record for LPN #7 was reviewed on 3/23/15 at 3:15 p.m. The record indicated the employee was hired on 7/2/13. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no prevention and control of infections, fire prevention, or accident prevention in-servicing for 2014. 5. The record for CRCA #3 was reviewed on 3/23/15 at 3:20 p.m. The record indicated the employee was hired on 8/5/09. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no prevention and control of infections, fire prevention, or accident prevention in-servicing for 2014. 6. The record for CRCA #6 was reviewed on 3/23/15 3:25 p.m. The record indicated the employee was hired on 2/28/08. Review of the in-service sheets provided by the Administrator via			

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	email on 3/24/15 indicated the employee had no resident rights prevention and control of infection, fire prevention, and accident prevention in-servicing for 2014. 7. The record for CRCA #4 was reviewed on 3/23/15 3:30 p.m. The record indicated the employee was hired 5/27/09. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no resident rights, prevention and control of infection, fire prevention, and accident prevention in-servicing for 2014. 8. The record for LPN #8 was reviewed on 3/23/15 at 2:55 p.m. The record indicated the employee was hired 5/18/07. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no medication administration, fire prevention, accident prevention, and prevention and control of infection in-servicing for 2014. 9. The record for CRCA #5 was reviewed on 3/23/15 at 2:50 p.m. The record indicated the employee was hired 12/08/11. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had no prevention and control of			

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	infections, fire prevention, or accident prevention in-servicing for 2014. 10. The record for CRCA #7 was reviewed on 3/23/15 at 2:45 p.m. The record indicated the employee was hired on 8/8/97. Review of the in-service sheets provided by the Administrator via email on 3/24/15 indicated the employee had resident rights and fire prevention in-servicing for 2014. Interview with the Executive Director on 3/23/15 at 4:00 p.m., indicated staff had in-servicing and he was working with the corporate office to provide the information. He would email the information as soon as he received the forms from the corporate office.			
R 123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the			

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	facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure job specific orientation was completed for 3 of 5 employee files reviewed. (LPN #4, LPN #5, and CNA #1) Findings include: 1. The employee file for LPN #4 was reviewed on 3/23/15 at 1:00 p.m. The LPN was hired on 10/7/14. There was no job specific orientation documentation in the employee file. Interview with the Human Resources Director on 3/23/15 at 1:30 p.m., indicated there was no documentation to indicate if job specific orientation had been completed. 2. The employee file for LPN #5 was reviewed on 3/23/15 at 1:00 p.m. The LPN was hired on 9/23/14. There was no job specific orientation documentation in the employee file. Interview with the Human Resources Director on 3/23/15 at 1:30 p.m.,	R 123	1. Employee files LPN4, LPN 5, & C.N.A 1 files were completed. 2. Employee files were audit for job specific orientation checklist. 3. Human Resources were re-in-serviced on completion of job specific checklist. All new associates will have job specific orientation checklist completed with 90 days of orientation. ED or designee will review 5 new associates per week to ensure compliance with completion of the job specific checklist. ED or designee will report findings to QA&A monthly. 4. QA&A will monitor monthly for any trends and make recommendations to the plan of correction as needed. QA&A will monitor monthly for 90 days or until 100% compliance is obtained. 5. Correction of R123 will be completed by 4/22/15.	04/22/2015

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	indicated there was no documentation to indicate if job specific orientation had been completed. 3. The employee file for CNA #1 was reviewed on 3/23/15 at 1:10 p.m. The CNA was hired on 7/22/14. There was no job specific orientation documentation in the employee file. Interview with the Human Resources Director on 3/23/15 at 1:30 p.m., indicated there was no documentation to indicate if job specific orientation had been completed.			
R 144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred and chipped chair rails, cracks in the ceiling drywall, marred doors at the bases, loose door frames, brown moisture	R 144	1. Chair rails were fixed, rooms 120, 211,223,230,232, were all fixed. Wellness Center entrance door was fixed and the ceiling vent was dusted. Crown molding in Assisted Living was fixed. Room 223, 225,235 was fixed. Ceiling vents were	04/22/2015

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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410	

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	stains around ceiling vents, and cracked crown molding for 1 of 2 units throughout the facility. (The Assisted Living) Findings include: During the Environmental Tour on 3/20/2015 at 11:21 a.m., with the Director of Housekeeping and the Director of Plant Services, the following was observed: a. The chair rails were chipped throughout the entire unit. b. The entrance door was marred in Room 120. One resident resided in this room. c. The door frame was loose and separating from the wall at the bottom of door on both sides in Room 211. This room was not occupied. d. The entrance door was marred in Room 223. One resident resided in this room. f. The entrance door was marred in Room 230. One resident resided in this room. g. The entrance door was marred in Room 232. One resident resided in this room.		replaced. 2. All areas have the potential to be effective. 3. Director of Plant operations and housekeeping were re-in-serviced on ensuring areas were cleaned and on environmental issues. ED or designee will do documented audits of 5 rooms per week to ensure the room has no chipped or marred areas in the room. ED or designee will report findings to QA&A monthly.t 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor for monthly for 90 days or until 100% compliances obtained. 5. Correction of F144 will be completed by 4/22/15.	

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	i. The entrance door of the Wellness Center was marred and chipped. j. The ceiling vent by the Wellness Center was dusty. k. The crown molding was separating from the walls throughout the entire unit. l. The ceiling dry wall near Room 224 was cracked. m. The ceiling drywall between Room 223 and 225 was cracked. n. The dry wall above the door of Room 235 was cracked. o. There was brown moisture spots around the ceiling vent near the north elevator. Interview with the Director of Housekeeping and the Director of Plant Services at the time, indicated the above items were in need of cleaning and/or repair.			
R 154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was clean related to dirty floor drains, walls, and pipes in the dish room for 1 of 1	R 154	1. The white back splash was cleaned. The PVC drain pipes were cleaned.	04/22/2015

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	kitchens. (The Main Kitchen) Findings include: The following was observed during the Brief Kitchen Sanitation tour on 3/16/15 at 9:30 a.m., with the Dietary Food Manager: A. The white back splash behind the dish machine was dirty with a large accumulation of food spillage noted. There was a large accumulation of food crumbs and dirt noted behind the dish machine and in the grout on the floor tile. The white PVC drain pipes under the dish machine were dirty with food spillage. B. The floor drain under the steam table and the white PVC drain pipes were dirty. Interview with the Dietary Food Manager on 3/20/15 at 2:00 p.m., indicated all of the above was in need of cleaning.		2. All areas of the dietary department have the ability to be effective. 3. The dietary staff was re-in-serviced on sanitation in the dietary department. The Dietary food service manager will monitor via documented audits 3 times per week (to include all shifts) of sanitation being completed. DFS or designee will report findings to QA&A monthly for 3 months or until 100% compliance will be obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for monthly for 90 days or until 100% compliance is obtained. 5. Correction of R154 will be completed by 4/22/15.	
R 217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff			

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	members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview the facility failed to ensure the resident's service plans were signed by the resident or the POA (Power of Attorney) for 3 of 7 residents records reviewed in a sample of 9. (Residents #2, #3, and #4) Findings include: 1. The record for Resident #2 was reviewed on March 20, 2015 at 10:30	R 217	1. Resident #2, 3, and 4 service plans were completed. 2. All residents have the potential to be affected. 3. Service plans will be completed and signed every 6 months per the regulation. The DHS or designee will audit 2 residents per week to ensure services plans have been updated and signed. DHS or designee will report monthly	04/22/2015

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	a.m. The residents diagnoses included, but were not limited to, hypothyroidism, dementia, COPD (Chronic Obstructive Pulmonary Disease-Lung Disease), MI (myocardial infarction-heart attack) CAD (coronary artery disease). Review of a Service Plan (evaluation of the resident) dated 1/24/13 and updated 2/10/14 indicated the resident required physical assist with mobility, supervision with transfers, set up, cues and or encouragement with eating, physical assist with hygiene/dressing, incontinent, required cues and assist 1-3 times a day. She required her medications and treatments to be given with assistance, had no mood or behaviors, and was in a stable health condition. She also requires staff assistance to manage time daily for activities. The Service Plan was signed by the POA on 1/31/14. A Service Plan, dated 6/4/14 with updates on 7/10/14 and 8/15/14, indicated the resident required physical assistance with mobility, supervision to transfer to/from bed or chair, required set up, cues and/or encouragement with eating, and physical assist with hygiene/dressing. She was incontinent with the assist of one, the mood and behavior section was not completed, medications and treatments she required		findings to QA&A. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for monthly for 90 days or until 100% compliance is obtained. 5. Correction of R217 will be completed by 4/22/15.	

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	assist to administer, organize or store medication s and required vital signs (blood pressure, pulse and respirations) prior to the administration of medications. She required staff assistance to manage time throughout 2-3 shifts daily. The Service plan was not signed by the resident or the POA. Interview with the Administrator on 3/23/15 at 2:45 p.m., indicated the Service Plans were being updated monthly. He was in the process of getting the a family member in the facility to sign the Service Plans. He thought the Service Plans only had to be signed quarterly. 2. The record for Resident #3 was reviewed on 3/20/15 at 1:45 p.m. The resident's diagnoses included, but was not limited to, Alzheimer's Disease (dementia), hypertension (high blood pressure), altered mental status, and dementia with delusions. Review of a Service Plan dated 12/19/13, updated on 1/23/14, and 2/10/14 indicated the resident was totally dependent for mobility, total assist for transfers to/from bed or chair, dependent on staffing for feeding, totally dependent on staff for hygiene and dressing and incontinent requiring reminders and assist			

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	4 or more times a day. He required assist to administer, organize or store medications and required vital or lab monitoring, he had no mood or behavior issues, and his health status was stable. He required staff assistance to manage time daily for activities. The Service Plan was given to his POA via phone on 1/23/14. A Service Plan completed on 6/15/14 and updated on 7/10/14 and 8/15/14, indicated the resident was a totally dependent on for mobility and transfer to/from bed to chair, eating, hygiene/dressing. He was incontinent with the assist of one, his mood and behaviors were showing little interest or pleasure in doing things and anxious and or agitated more than daily. He required assist to administer, organize or store medications and his health status was stable. He required one on one staff involvement for social involvement or individualized activities daily. The Service plan was not signed by the resident or the POA. Interview with the Administrator on 3/23/15 at 2:45 p.m., indicated the Service Plans were being updated monthly. He was in the process of getting the a family member in the facility to sign the Service Plans. This			

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	resident's family was schedule to come in today but had canceled due to the weather. 3. The record for Resident #4 was reviewed on 3/20/15 at 11:04 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, hypertension (high blood pressure) osteoarthritis, anxiety and depression. Review of a Service Plan dated 8/25/13 and updated on 9/10/13 and 10/21/13 indicated the resident required supervision or escort for mobility, supervision to/from bed or chair for transfers, required supervision, cues, and encouragement for hygiene/dressing, and was incontinent requiring reminders, assist 4 or more times a day. She required assist to administer, organize or store her medications, required 9 or more medications, required blood glucose monitoring and/or injections and required vital signs (blood pressure, pulse, and respirations) or lab monitoring. She required supervision or interventions to manage mood or behaviors 1-2 times per week. His health status was stable. She required staff assistance to manage time daily for activities. The Service Plan was given to her POA via phone on 10/21/13.			

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	A Service Plan dated 11/1/14 indicated the resident required physical assistance with mobility and transfers, she required set up, cues and/or encouragement to eat. She required physical assistance with hygiene and dressing. She was incontinent with assist of one, she had little interest or pleasure in doing things for her mood and behaviors. She required assistance to administer, organize or store medications, required 9 or more medications, required blood glucose monitoring and/or injections, and medications required vitals prior to administration of medications. Her health status was stable. In regard to activities she required one on one staff involvement for social involvement or individualized activities daily. The Service plan was not signed by the resident or the POA. Interview with the Administrator on 3/23/15 at 2:45 p.m., indicated the Service Plans were being updated monthly. He was in the process of getting the a family member in the facility to sign the Service Plans. He thought the Service Plans only had to be signed quarterly.			
R 273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas			

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	(excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was clean related to the wearing of beard guards and greasy and dirty food equipment for 1 of 1 kitchens. (The Main Kitchen) Findings include: 1. The Brief Kitchen Sanitation tour was completed on 3/16/15 at 9:30 a.m. with the Dietary Food Manager (DFM). The following was observed: A. The DFM, Dietary Cook #1 and Dietary Cook #2 were observed with facial hair to the sides of their face and chin areas. All three men were not observed to be wearing beard guards to their face. B. There was a box of oranges in the walk in cooler with a large amount of some kind of beverage spillage noted in the box and on the oranges. There was a box of lemons also noted in the cooler. Approximately 6 lemons were rotten. C. There was a large accumulation of grease and food crumbs around the deep fryer. The sides of the fryer were dirty	R 273	1. The box of oranges & lemons was removed; grease and food crumbs were cleaned. Grates on top of the frill were cleaned, floor against the base board behind the stove, deep fryer and grill. All food spillage was cleaned. Beard guard was initiated on 3/20/15. 2. All areas of the dietary department have the ability to be effective. 3. The dietary staff was re-in-serviced on sanitation, beard guards and handling of food on the tray line in the dietary department. The Dietary food service manager will monitor via documented audits 3 times per week (to include all meal times) of sanitation being completed, observation of staff handling food on the tray line and observation of the use of beard guards. DFS or designee will report findings to QA&A monthly for 3 months or until 100% compliance will be obtained. 4. QA&A will monitor for any trends and make recommendations to the Plan of Correction as needed. QA&A will monitor monthly for 90 days or until 100% compliance is obtained. 5. Correction of R273 will be completed by 4/22/15	04/22/2015

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	and greasy. Both Dietary Cook #2 and the DFM indicated the deep fryer had not been used that morning to prepare the breakfast. D. The grates on top of the grill were dirty with black burned food substance noted. There was also a large accumulation of black grease noted on top of the grill. E. There was a large accumulation of food crumbs and dirt on the floor against the base board behind the stove, deep fryer and grill. The yellow pipes behind the stove had a large accumulation of grease and food spillage. The wall behind that equipment was also dirty. The pipes behind the stove, fryer and grill were dirty and greasy with a large accumulation of grease noted. The floor tile and the grout were also dirty with an accumulation of dried and adhered dirt and grease. Interview with the Dietary Food Manager on 3/20/15 at 2:00 p.m., indicated all of the above was in need of cleaning.			