STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	11/15/2021

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00362265, IN00366351, and IN00366447. This visit resulted in a Partially Extended Survey-Substandard Quality of Care- Immediate Jeopardy. Complaint IN00362265 - Substantiated. Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00366351 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00366447 - Substantiated. Federal/state deficiencies related to the allegations are cited at F921. Survey dates: 11/12, 11/13, 11/14, and 11/15/21. Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 8 SNF: 39 Residential: 49 Total: 96 Census Payor Type: Medicare: 26 Medicaid: 8 Other: 7 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration,Respectfully, Kevin Mehay Executive Director Spring Mill Health Campus 317-525-3537	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Quality review completed on 11/22/21.			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to implement adequate supervision measures to prevent a cognitively impaired resident deemed at risk for elopement from exiting the building. The resident left the building unattended around 3:30 a.m. on 11/2/21 and was found by security on rounds at a nearby office park and taken to the local hospital for evaluation. The facility is located within 1 mile of a major interstate and adjacent to a busy 4 lane road. (Resident D) The immediate jeopardy began on 11/2/21 when the resident had exited the facility without supervision. The alarm to the second floor door he exited was activated. The door to the outside was on the same alarm, so no secondary alarm went off as the resident left the facility. The resident was located at a nearby office park by a security company on rounds and was taken to the local hospital for evaluation by EMS, who had been called by the local police department. The Administrator, Assistant Director of Nursing (DON) and Regional Nurse Consultant were notified of the immediate jeopardy at 3:00 p.m. on	F 0689	Past noncompliance: No POC required.	11/24/2021

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	11/12/21. The immediate jeopardy was removed, and the deficient practice corrected on 11/5/21 prior to the start of the survey and was therefore Past Noncompliance. Finding includes: The record for Resident D was reviewed on 11/13/21 at 11:45 AM. Diagnoses included, but were not limited to unspecified psychosis, traumatic subdural hematoma, dementia with behaviors, and repeated falls. An Admission Minimum Data Set (MDS) assessment, dated 9/30/21, indicated the resident was cognitively impaired. The resident was initially admitted on 5/1/21 to the Assisted Living Legacy locked unit and sent to the hospital on 9/24/21 after a fall. He was readmitted from the hospital on 9/30/21 to the skilled nursing unit. An Indiana Department of Health (IDOH) reportable incident, dated 11/2/21 at 6:30 p.m., indicated, "Resident exited from the facility at 3:36 a.m. Staff initiated protocol. Police were called to assist. Resident was located with police assistance at 4:27 am. Abrasion to left knee. MD and family contacted. Resident sent to ER for eval [evaluation]. Resident returned to facility. MD orders will be followed. Social Services will assess for S/S [signs/ symptoms] of distress. Head to toe assessment completed. Care plans will be reviewed and changes made as needed." A Follow up, dated 11/5/21, indicated, "MD and family contacted. [Resident's name] BIMS [cognitive evaluation] is a 5 [cognitively impaired]. Resident exited facility at 3:36 a.m.. He			

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	was located and taken to the ER for eval [evaluation] at 4:27 a.m. Resident returned to the facility at 7:30 a.m. from the hospital. Head to toe assessment completed with abrasion noted to left knee. No other injuries noted. [Resident's name] held the egress alarmed door for 15 seconds which allowed the door to open. He walked down the stairwell and exited the building. Maintenance verified that the doors were functioning properly. Door company called to verify the doors were functioning properly. Door company installed an individual mag lock to the exit door. MD orders followed. Safety checks initiated, no further incidents. With family consent, resident transferred back to secured dementia care unit. Social Services assessed for s/s of distress, none noted. Care plan reviewed and updated." An elopement assessment, dated 9/30/21, indicated high risk for elopement. No wanderguard was placed. An Elopement Care Plan was initiated on 5/4/21. Resident D was at risk for Elopement due to diagnoses of Dementia, ability to ambulate independently, history of attempting to exit the facility approaching the facility door and closely following behind visitors exiting. Approaches included, but were not limited to, redirect the resident away from doors as needed, encourage resident to participate in facilities and structured programming, add mural to outside door, resident's information placed in an Elopement Binder at the Nursing Station. A Fall Care Plan was initiated on 11/4/2021. The Care Plan indicated the resident had a history of falls as evidenced by admitting with stitches from a fall. Approaches included to help the resident to his destination if seen walking unsteadily,			

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	approach resident to slow down when walking, review new medications ordered. Resident was started on Aricept (medication to treat dementia) by the Neurologist. Physical and Occupational therapy to evaluate. The local Police Department report, dated 11/2/21, indicated they were dispatched at 3:59 a.m. to investigate a "suspicious person" report. The police arrived to the area and saw the resident in a nearby business complex. "Upon arrival, I located an elderly male in the vestibule of this building. He was very cold and confused, although he could identify himself as [name] but could provide no further information." Medics were called to take the resident to the hospital to be evaluated. It was determined the male party was missing from as adjacent nursing home, who was notified of his location. Nurses' Note, dated 11/2/2021 at 3:50 a.m., indicated, "Writer was notified that res [resident] was missing off unit by staff personnel. Writer initiated code pink alert and began looking room to room and though-out unit/s. writer notified 9-1-1 an reported findings and informed family member of information. 9-1-1 personnel called writer to inform writer that res was located and transferred to hospital SLM for eval and treatment. ER given reported by writer." Per The Weather Channel, the local high temperature on 11/2/21 was 47 degrees Fahrenheit; the low (at night) was 28 F. (https://weather.com) Interview with the Administrator on 11/12/21 at 10:00 a.m., indicated CNA 1 heard an alarm during resident care and noticed Resident D was not on the unit. She checked the unit door and saw			

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	nothing. The unit nurse returned from break at that time and called the police. The police called the facility at 4:27 a.m. to notify of Resident D being evaluated in the local emergency room. Telephone interview with CNA 1 on 11/13/21 at 11:00 a.m. indicated the nurse had left the floor on break at the time of the incident. The census on the floor was 25 residents. CNA 1 was in another resident's room at the time. Resident D had been seated in the common area. CNA 1 heard an alarm while providing care to another resident. After completing care, CNA 1 exited the room. Resident D was no longer in the common area. The CNA checked the door at the end of the hall and did not see anything. The CNA then checked the area on the other end of the hall and did not see the resident. CNA 1 then notified other facility staff and a facility wide search was initiated. Follow up interview with the administrator on 11/15 21 at 2:30 p.m. indicated the facility had targeted educational inservicing for staff to address resident-specific supervision needs based on root cause analysis, especially when covering break times. The facility Elopement Policy, created on 2/12/21 was reviewed on 11/13/21 at 2:00 p.m.. The Policy was dated 02/12/21. The policy indicated it was the intent of the facility to be aware of it's residents' usual habits and locations as reasonably. Per IDOH elopement is recognized as "a resident with cognitive deficits who was found outside the facility and whose whereabouts were unknown or whose return involves law enforcement." This past noncompliance Immediate Jeopardy began on 11/2/2021. The Immediate Jeopardy was			

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	removed and the the deficient practice corrected by 11/5/21 after the facility implemented a systemic plan that included the following actions: House wide assessment of all residents identified as wanderers or at risk for elopement, including resident-specific supervision needs. The assessments were all place in the Elopement binder at the Nursing Station. Staff inservicing had occurred prior to all staff returning to work and elopement drills were conducted. Random staff from various departments were interviewed and able to correctly answer questions related to the Elopement protocols, including resident-specific supervision needs. As as additional measure, the upper stairway door & downstairs exit door were placed on different alarm circuits. This Federal tag relates to Complaint IN00366351. 3.1-45(a)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions 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 maintain a functional, sanitary, and homelike environment related to a black substance in resident's room and underneath the common area sink for 1 of 1 units observed. (Transitional Care Unit) Findings include: In the TCU (Transitional Care Unit), the following was observed:	F 0921	**F921 Safe/Functional/Sanitary/ Comfortable Environment** **1) Immediate actions taken for those residents identified:** ·Black substance covering the bottom cabinet under the kitchen sink was cleaned with approved EPA registered disinfectant. ·Black Substance under AC unit in rooms 3112, 3102 and 3109	11/16/2021

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	1. On 11/15/21 at 9:46 a.m. in the kitchen in the common area under the sink, there was a black substance covering the bottom of the cabinet. 2. On 11/15/21 at 9:50 a.m. in Room 3112, under the air conditioning unit (acu) on the wall, a large amount of black substance was observed. One resident resided in the room. 3. On 11/15/21 at 9:56 a.m. in Room 3108, under the acu on the wall, a large amount of black substance was observed. One resident resided in the room. 4. On 11/15/21 at 10:00 a.m. in Room 3102, under the acu on the wall, a small amount of black substance was observed. One resident resided in the room. 5. On 11/15/21 at 10:10 a.m. in Room 3104, under the acu on the wall, a small amount of black substance was observed. One resident resided in the room. Interview with the Maintenance Director on 11/15/21 at 10:24 a.m., indicated that she had not looked under that sink in years. She observed the black substance under the acu on the wall and indicated that she did not know what it was. Housekeeping should have been cleaning under the acus with their deep cleanings that had occurred within 30 days. She believed the black substance came from the repairs two months ago from water leaking from the windows. Interview with Housekeeping 1 on 11/15/21 at 10:44 a.m., indicated that deep cleaning included, but was not limited to, cleaning underneath the acu units. He indicated a deep cleaning consisted of rotating 1 room per unit per day and he had 30 days to complete the deep cleaning of that unit.		was cleaned with approved EPA registered disinfectant. **2) How the facility identified other residents:** . **3) Measures put into place/ System changes:** ·The environmental staff was re-educated on facility daily cleaning and monthly deep clean task list to include cleaning underneath sinks and AC units on 11/16/21. ·The Maintenance Director or designee will inspect 10 rooms weekly x 8 weeks then monthly to ensure proper cleaning procedures are followed. The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** ·An Environmental QAPI tool will be utilized to monitor compliance. ·The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance id achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** **11/16/2021**	

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	Interview with the Executive Director on 11/15/21 11:40 a.m. indicated it was the responsibility of the Maintenance Director to monitor these tasks. A policy titled, "Deep Clean Task List," was provided by the Maintenance Director on 11/15/21 at 11:54 a.m. This current policy indicated, "...Room:...Wipe down baseboards...." This Federal tag relates to Complaints IN00362265 and IN00366447. 3.1-19(f)(5)			