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	03/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00374424 and IN00374432. Complaint IN00374424 - Substantiated. Federal/state deficiencies related to the allegations are cited at F661 and F677. Complaint IN00374432- Substantiated. Federal/state deficiencies related to the allegations are cited at F656, F661, F677, and F686. Survey dates: March 14 & 15, 2022 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 9 SNF: 37 Residential: 46 Total: 92 Census Payor Type: Medicare: 29 Medicaid: 9 Other: 8 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/17/22.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	the requirements set forth in paragraph (c) of this section. Based on observation, record review, and interview, the facility failed to ensure a resident's Care Plan was implemented related to a treatment to the right shin for 1 of 5 residents reviewed for Care Plan implementation. (Resident D) Finding includes: During an observation on 3/14/22 at 10 a.m., Resident D was lying in bed and eyes closed. A dressing was on the right shin area with the date of 3/12/22. On 3/15/22 at 1:21 p.m., the resident was observed awake in bed. The dressing was off the right shin area. The right shin had blister-like areas with two very small scabbed areas. The resident indicated he could not remember if the dressing had been changed daily. Resident D's record was reviewed on 3/15/22 at 12:23 p.m. The diagnoses included, but were not limited to, diabetes mellitus. An Admission Minimum Data Set assessment, dated 12/23/21, indicated an intact cognition status. A Care Plan, dated 12/29/21, indicated a skin tear was located on the right shin. The interventions included the treatment to the right shin would be provided as ordered by the Physician. A Physician's Order, dated 3/9/22, indicated the right shin was to be cleansed with normal saline and patted dry. An oil emulsion dressing	F 0656	**F656** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident D care plan was reviewed, and treatment was completed and documented per physician order. **2) How the facility identified other residents:** All residents who receive wound treatments have the potential to be affected by the alleged deficient practice.	03/21/2022

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	(absorbent dressing) was to be applied and covered with a dry dressing daily. The Treatment Administration Record, dated 3/2022, indicated the treatment to the right shin had been completed on 3/12/22 and 3/14/22. The treatment had not been marked as completed on 3/13/22. There were no Nursing Progress Notes to indicate the resident had refused the treatment to the right shin on 3/13/22. During an interview on 3/15/22 at 1:24 p.m., the Director of Nursing indicated the treatment had not been signed out as being completed on the Treatment Administration Record. This Federal tag relates to Complaint IN00374432. 3.1-35(g)(2)		**3) Measures put into place/ System changes:** Staff will be re-educated on the importance of completing treatments as ordered and documenting on the clinical records any residents' treatment refusals. Director of Nursing or Designee will audit treatment documentation 5 times weekly for 4 weeks, and 2x weekly thereafter to ensure treatment and documentation were completed to ensure compliance. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/21/22**	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary			

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	When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on record review and interview, the facility failed to ensure a Discharge Summary with the resident's activity of daily living (ADL's) status, skin condition, and pressure ulcer status was completed and given to the Responsible Party for a resident who was discharged to home, for 1 of 3 residents reviewed for discharges. (Resident B) Finding includes:	F 0661	**F661** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.*	03/21/2022

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	Resident B's record was reviewed on 3/14/22 at 12:52 p.m. The diagnoses included, but were not limited to, stroke, stage four pressure ulcer of the sacral area (full thickness skin loss with extensive destruction), and dementia. An Admission Minimum Data Set assessment, dated 12/15/21, indicated a severely impaired cognitive status, required extensive assistance of two for bed mobility and transfers, dependent for locomotion, toileting, bathing, extensive assistance with eating, dressing, and hygiene, and had one stage four pressure area on admission. A Physician's Order, dated 2/11/22, indicated an order to discharge to home with Hospice Care. The wound measurements, per the Wound Specialist on 2/1/22, indicated there was pressure wound on the sacral area which was 2.7 centimeters squared and an open area on the left lateral knee that measured 0.6 centimeters squared. A Nurse's Progress Note, dated 2/9/22 at 1:41 p.m., indicated the resident was discharged to home with ambulance personnel. Paper work and personnel belongings were given to the driver. A Discharge Planning Form, dated 2/9/22, indicated the resident received skilled services and wound care, was to receive home services, post discharge medication list was discussed with family and medication list was given to the family. The special treatments/procedures indicated blood glucose monitoring. The area for discharge information, medications sent with resident, special care instructions and precautions, and names of the Medical Providers were left blank.		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B was discharged from the facility. **2) How the facility identified other residents:** All residents who are transfer/discharged may be affected by this alleged deficient practice. **3) Measures put into place/ System changes:** Licensed nurses will be re-educated on the proper procedure of completing discharge summary and information that needs to be reviewed and provided to the resident/resident representative. An audit will be completed weekly	

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	The Discharge Planning Form lacked descriptions of the resident's ADL status including that the resident had a urinary catheter and colostomy, discharge skin assessment, and pressure sore status upon discharge. A post discharge, Wound/Skin Progress Note, dated 2/10/22 at 2:03 p.m., indicated the Responsible Party notified the facility with concerns about the resident's skin status and a full description was given to him at that time. During an interview on 3/14/22 at 2:15 p.m., the Director of Nursing indicated the Discharge Planning was the only form completed. This Federal tag relates to Complaint IN00374424 and IN00374432. 3.1-36(a)(2)		on all transfer/discharges to ensure Discharge Summary was completed and receipt was documented. Director of Nursing or designee is responsible for compliance. **4) How the corrective actions will be monitored:** **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 03/21/2022**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who required extensive to dependent assistance with ADL's (activity of daily living) received bathing at least twice a week for 3 of 3 residents reviewed for ADL's. (Residents B, C, and F)	F 0677	**F677** **The facility requests paper compliance for this citation.** *This Plan of Correction is the*	03/21/2022

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	Findings include: 1) Resident B's record was reviewed on 3/14/22 at 12:52 p.m. The diagnoses included, but were not limited to, stroke, stage four pressure ulcer of the sacral area (full thickness skin loss with extensive destruction), and dementia. An Admission Minimum Data Set (MDS) assessment, dated 12/15/21, indicated a severely impaired cognitive status, required extensive assistance of two for bed mobility and transfers, and was dependent for bathing. A Care Plan, dated 12/15/21, indicated assistance was needed for all ADL's. The interventions indicated assistance would be provided by the staff for all ADL's. The Bathing/Shower Forms, dated 01/2022, provided by the Director of Nursing (DON), indicated the bathing was scheduled for Tuesday and Fridays on the Day Shift. The forms indicated bathing had not been completed on 1/24/22. 2) Resident C's record was reviewed on 3/24/22 at 10:43 a.m. The diagnoses included, but were not limited to, dementia. An Admission MDS assessment, dated 11/21/21, indicated moderately impaired cognition status, required extensive assistance of two for hygiene and was dependent for bathing. A Care Plan, dated 11/16/21, indicated assistance was required for all ADL's. The interventions indicated assistance would be provided by the staff for all ADL's.		*center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B was discharged from the facility Reviewed and verified bathing preference, record, and schedule for Resident C **2) How the facility identified other residents:** Audit completed of all resident bathing records in the last 30 days. **3) Measures put into place/ System changes:** Nursing staff will be re-educated regarding bathing schedules, preferences, refusals, and documentation.	

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	The Bathing/Shower Forms, dated 12/2021, provided by the DON, indicated bathing was scheduled for Day Shift on Wednesdays and Saturdays. Bathing had not been completed on 12/18/21 and 12/25/21. 3) Resident F's record was reviewed on 3/14/22 at 11:05 a.m. The diagnoses included, but were not limited to, stroke. An Admission Minimum Data Set assessment, dated 1/26/22, indicated an intact cognitive status and was dependent for bathing. A Care Plan, dated 1/21/22, indicated assistance was required for all ADL's. The interventions indicated assistance would be provided by the staff for all ADL's. The Bathing/Shower forms, dated 2/2022, provided by the DON, indicated the bathing was scheduled for Monday and Thursday on Day Shift. The bathing had not been completed on 2/28/22. During an interview on 3/15/22 at 1:47 P.M., the DON indicated there were no other Bathing/Shower Forms located. This Federal tag relates to Complaints IN00374424 and IN00374432. 3.1-38(b)(2)		The Director of Nursing or designee will audit bathing documentation at least 3 times per week x30 days, 2 times per week x30 days, then weekly thereafter to ensure bathing was completed as scheduled. **4) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 3/21/2022**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of			

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	a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a treatment for a pressure ulcer wound was in place as ordered by the Physician for 1 of 3 residents reviewed for pressure ulcer wounds. (Resident F) Finding includes: During an observation of Resident F on 3/14/22 at 10:52 a.m., the Assistant Director of Nursing (ADON) indicated there was a stage two (partial thickness skin loss) pressure ulcer on the resident's right buttock. The resident was then turned to the left side, there was a superficial pressure ulcer observed, approximately 2 centimeters by 1 centimeters in size. The dressing to the pressure ulcer was not on the right buttock, nor in the incontinent brief. The ADON then left the room and asked LPN 1 if she was aware the pressure ulcer dressing was not on the right buttock. LPN 1 indicated she was not aware the dressing was off. CNA's 2 & 3 were interviewed on 3/14/22 at 11:09 a.m. and indicated they were unaware there was not dressing on the resident's right buttock. CNA 2 indicated the resident had already had care when she started her shift and care was usually	F 0686	**F686** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident F was discharged from the facility	03/21/2022

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	provided after breakfast. Resident F's record was reviewed on 3/14/22 at 11:05 a.m. The diagnoses included, but were not limited to, stroke, and stage three (full thickness skin loss) pressure ulcer of right buttock was added to the diagnosis upon return from a hospital stay on 2/14/22. An Admission Minimum Data Set assessment, dated 1/26/22, indicated an intact cognitive status, required extensive assistance of two for bed mobility, dependent on two for transfers, had a urinary catheter, was always incontinent of bowels, and had no unhealed pressure ulcers. A Care Plan, dated 1/21/22, indicated a potential for impairment to the skin. The Care Plan was revised to indicate there was an open area to the right buttock. The interventions included to follow facility protocol for treatments. A Physician's Order, dated 3/12/22, indicated to cleanse the right buttock area with normal saline, pat dry, and apply silver alginate (absorbent pressure ulcer treatment) to the wound bed and cover the area with a dry dressing every Tuesday, Thursday, and Saturday. The Medication Administration Record, dated 3/2022, indicated the treatment had been done on 3/12/22. A Wound Measurement, dated 3/8/22, indicated the area measured at 2.8 centimeters by 1.1 centimeters. This Federal tag relates to Complaint IN00374432. 3.1-40(a)(2)		**2) How the facility identified other residents:** All residents may have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Staff will be re-education on ensuring treatment for pressure ulcer wounds are in place as ordered by physician. Staff will also be in-services on weekly monitoring of resident's skin condition during routine care and skin check schedule. Any abnormalities noted will be assessed, referred to MD/NP for interventions. An audit tool will be developed to ensure that weekly skin treatments for residents is in place. At least five random residents will be selected per audit. This will be completed three times weekly for 4 weeks the 2x weekly for 6 months. Any deficiencies will be corrected immediately. **4) How the corrective actions will be monitored:** The results of these audits will be	

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			reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 3/21/2022**	