DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	08/11/2023

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 a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00413735 and IN00413771. This visit included a State Residential Licensure Survey and the Investigation of Residential Complaint IN00414473. Complaint IN00413735 - No deficiencies related to the allegations are cited. Complaint IN00413771 - No deficiencies related to the allegations are cited. Complaint IN00414473 - State deficiencies related to the allegations are cited at R0036 and R0349. Survey dates: August 7, 8, 9, 10, and 11, 2023 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 26 SNF: 29 Residential: 34 Total: 89 Census Payor Type: Medicare: 24 Medicaid: 17 Other: 14 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lakeithia Webb	Executive Director	08/28/2023

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 8/15/23.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident 41) Finding includes: On 8/7/23 at 10:45 a.m., an Arnuity Ellipta 100 micrograms inhaler and a Hylands Natural Restful Legs supplement was noted to be on the bedside table in Resident 41's room. The resident indicated she had brought the supplement in from home. On 8/8/23 at 1:13 p.m., an Arnuity Ellipta inhaler and Hylands Natural Restful Legs supplement were noted to be sitting next to the television on the table in Resident 41's room. Resident 41's record was reviewed on 8/10/23 at 11:35 a.m. Diagnoses included, but were not limited to, acute respiratory failure, end stage renal failure, and restless leg syndrome. The Admission Minimum Data Set (MDS) assessment, dated 8/5/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 8/1/23, indicated	F 0554	**Spring Mill Health Campus Annual Survey: 8-7-23** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A self-administration assessment was completed for Residents 41 and MD order received for self-administration of medication. Medication self- administration care plan was also completed for Resident 41. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	08/28/2023

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	fluticasone furoate inhalation aerosol powder breath activated 100 micrograms/act, 1 puff inhale orally one time a day. There was no self-administration assessment completed for the resident to self-administer medications. There were no orders for self-administration of medications and there was no order for the restful legs supplement. Interview with the Director of Nursing on 8/10/23 at 10:44 a.m., indicated the resident had brought the medications in from home, however, she had not had updated orders for the medications and the self-administration of medications assessment was not completed. A Policy titled, "Self-Administration of Medications-Clinically Appropriate," and noted as current, indicated "1. The resident has right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate...3. A resident may only self-administer medications after the IDT has determined which medications may be self-administered." 3.1-11(a)		**what corrective action will be taken.** All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur.** Staff were educated on not leaving medications at resident bedside unless there is an order for self-administration in place. Licensed Nurses were also educated on the need for a physician order and a medication self-administration assessment when a resident self-administers medication. MDS Nurses are educated on the need for care plans for any resident who has a self-administration order. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** Facility Angel’s will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the	

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			Quality Assurance committee, auditing and monitoring will be done quarterly and present at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 8/28/23.**	
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 observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADLs (activities of daily living) related to bathing, nail care, shaving, and clean clothing and linens for 2 of 4 residents reviewed for ADLs. (Residents 110 and 37) Findings include: 1. Interview with Resident 110 on 8/7/23 at 10:16 a.m., indicated she had not received a shower since being admitted. The record for Resident 110 was reviewed on 8/8/23 at 1:21 p.m. Diagnoses included, but were not limited to, stroke, lack of coordination, and spinal stenosis. The resident was admitted to the facility on 7/20/23. The Admission Minimum Data Set (MDS) assessment, dated 7/26/23, indicated the resident was cognitively intact and she required extensive assistance with bed mobility and transfers. The	F 0677	Spring Mill Health campus Annual Survey: 8-7-23 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response tothe regulatory requirement. The Facility respectfully requests paper compliance for this survey. F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been af fected by the deficient practice;	08/28/2023

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	resident was totally dependent on staff for bathing. A Care Plan, dated 7/24/23, indicated the resident required assistance with ADLs (activities of daily living) including bed mobility, eating, transfers, toileting, and bathing. Interventions included, but were not limited to, assist with bathing as needed, offer a shower at least 2 times weekly, and offer full/partial bed bath on non-shower days or with shower refusals. The resident's shower days were Monday and Thursday evenings. The August 2023 Bath and Skin Report sheet did not indicate the resident's preference for a bath or shower. The Task section related to bathing was reviewed for the days of 7/21-8/8/23. The resident received a partial bed bath on 7/21, 7/24, 7/28, and 8/1/23. A complete bed bath was given on 7/23, 7/24, 7/25, and 8/7/23. The resident received a shower on 7/31/23. The August 2023 Bath and Skin Report sheet, indicated the resident's skin was intact on 8/3 and 8/7/23, however, the sheet did not list what type of bathing the resident received, if any. Interview with the Director of Nursing on 8/11/23 at 2:10 p.m., indicated she thought the resident's preference was a complete bed bath. She would check with the resident and update her bathing preference. 2. On 8/7/23 at 11:09 a.m., Resident 37 was observed with facial hair, long dirty fingernails, and there was food and stains all over the sheet and the resident's gown. The resident indicated he liked to be clean shaven. On 8/8/23 at 1:25 p.m., Resident 37's blanket and		Resident 37 had their fingernails cleaned, shaven and gown and linens changed. Resident 110 had a shower provided and shower schedule adjusted to reflect preferences. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All dependent residents, who require assistance with nail care, shaving, changing gowns and linens and showers, have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on providing dependent residents with assistance with ADL's per resident's plan of care/preferences, including Nail Care, shaving, changing gowns and linens and showers. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;	

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	gown had food and stains on them. Resident 37's record was reviewed on 8/10/23 at 9:44 a.m. Diagnoses included, but were not limited to, dementia and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 6/29/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance with bed mobility, toileting, personal hygiene, and bathing. A Care Plan, dated 5/12/22, indicated the resident required assistance with ADLs including bed mobility, eating, transfers, toileting and bathing. Interventions included, but were not limited to, assist with person hygiene including dressing/grooming as needed. Interview with the Director of Nursing on 8/10/23 at 10:44 a.m., indicated she had no further information to provide. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2) 3.1-38(b)(4)		DON/Designee will Audit 10 random residents weekly for 3 months, with a focus on dependent residents, requiring ADL assistance, to ensure they are being assisted with Nail Care, shaving, changing gowns and linen and Showers per the residents' plan of care/preference. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 8/28/23	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. Based on record review and interview, the facility failed to ensure fall follow-ups and neurological checks were initiated and/or completed following a fall for 1 of 3 residents reviewed for falls. (Resident 213) Finding includes: On 8/8/23 at 1:27 p.m., Resident 213 was observed in bed. There were fall mats noted on the floor on both sides of the bed. Resident 213's record was reviewed on 8/8/23 at 12:58 p.m. Diagnoses included, but were not limited to, fracture of the left femur, dementia without behavioral disturbance, and cognitive communication deficit. The Admission 5-Day Minimum Data Set (MDS) assessment, dated 7/3/23, indicated the resident was severely cognitively impaired. She required extensive assist with bed mobility, toilet use, and personal hygiene, and limited assist for transfers. She had impairment in functional range of motion on one side of the lower extremities. A Care Plan, dated 6/29/23, indicated the resident required assistance with Activities of Daily Living (ADLs) including bed mobility, transfers, eating, toileting, and bathing. A Care Plan, dated 6/29/23, indicated the resident was at risk for falls. Interventions included, but were not limited to, anticipate the resident's needs, assess for transfer status and encourage use of non-skid footwear. A Nurses' Note, dated 6/29/23 at 5:08 p.m., indicated the resident was observed laying on the	F 0684	Spring Mill Health Campus Annual Survey: 8/7/2023 Please accept the following as the facility's credible allegation of compliance . This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 213 was assessed, and no adverse effects were noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with falls can be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that	08/28/2023

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	floor next to the bed. The Physician and family were notified of the resident's fall. There were no corresponding Neurochecks completed with the unwitnessed fall. A Nurses' Note, dated 7/9/23 at 12:40 p.m., indicated the resident was observed laying on the floor on her right side. The Physician and family were notified and new orders for a left hip x-ray was ordered. The Post Fall Observation Assessment, dated 7/9/23 at 12:30 p.m., included vital signs checked on 7/6/23 at 8:31 a.m. and 10:35 a.m. for temperature, respirations, pulse, and blood pressure. There were no completed Neurochecks that corresponded with the fall on 7/9/23 in the record. A Post Fall Evaluation on 7/15/23 at 12:43 p.m., indicated the resident had an unwitnessed fall at bedside. The Physician and family were notified. There were no completed Neurochecks that corresponded with the fall on 7/15/23 in the record. A Nurses' Note, dated 8/4/23 at 6:10 a.m., indicated the resident was noted on the floor on the right side. A Nurses' Note, dated 8/4/2023 at 3:24 p.m., indicated the resident had a fall in the dining area. The Neuro Check Assessment, dated 8/4/23 at 6:10 a.m., was incomplete. Interview with the Director of Nursing on 8/11/23		thedeficient practice does not recur; Nurses were educated on completing post fall follow up documentation which includes: • Daily follow up fall assessment documentation per facility policy for 72 hours • Neurological checks per facility policy • Vital signs per facility policy How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse managers will audit clinical documentation 2 times per week, for 3months to ensure follow up assessments and neuro checks are completed. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed:8/28/23	

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	at 11:50 a.m., indicated she had no other fall follow ups or neurochecks to provide. 3.1-37(a)			
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 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 record review and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services to promote healing, related to treatments not completed as ordered and treatment orders not updated timely for 2 of 2 residents reviewed for pressure ulcers. (Residents 49 and 212) Findings include: 1. Resident 49's record was reviewed on 8/9/23 at 11:18 a.m. Diagnoses included, but were not limited to, acute osteomyelitis of the left femur, pressure ulcer of sacral region stage 4, cellulitis of left lower limb, severe protein-calorie malnutrition, pressure ulcer of right hip, and heart failure.	F 0686	**Spring Mill Health Campus** **Annual Survey: 8-7-23** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **F686- Treatments/Svcs to Prevent/Heal Pressure Ulcers** **What corrective action(s) will be accomplished for those**	08/28/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 5/22/23, indicated the resident was cognitively intact for daily decision making. He required extensive assistance with one person physical assist for bed mobility, transfers, dressing, and personal hygiene. He had a functional limitation in range of motion to both lower extremities. He had 4 stage 4 pressure ulcers and 3 unstageable deep tissue injuries present upon admission/entry. A Physician's Order, dated 6/5/23, indicated cleanse left lateral hip with normal saline, pat dry, and apply anasept antimicrobial gel, fill cavity with fluff dry roll gauze, and cover with dry dressing every day shift. A Physician's Order, dated 6/5/23, indicated cleanse left lower back with normal saline, pat dry, and apply anasept antimicrobial gel, fill cavity with fluff dry roll gauze, and cover with dry dressing every day shift. A Physician's Order, dated 6/5/23, indicated cleanse sacrum with normal saline, pat dry, and apply anasept antimicrobial gel, fill cavity with fluff dry roll gauze, and cover with dry dressing every day shift. A Physician's Order, dated 6/5/23, indicated apply anasept antimicrobial gel to the right hip topically every day shift. A Physician's Order, dated 6/23/23, indicated cleanse the left distal foot with normal saline, pat dry, apply betadine and wrap with roll gauze daily. A Physician's Order, dated 6/23/23, indicated cleanse the left foot with normal saline, pat dry, apply betadine and wrap with roll gauze daily.		**residents found to have been affected by the deficient practice.** Resident 212 was assessed, and no adverse effects were noted related to not having wound treatment updated timely. Resident 49 was assessed, and no adverse effects were noted related to not having wound treatment completed as ordered. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents with wounds can be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nursing staff were re-educated to ensure all wound treatments are updated in a timely manner and completed as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** DON/Designee to review all new wound orders 5 times per week, for 3 months to ensure all wound treatments are updated in a timely manner and completed as	

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	A Physician's Order, dated 5/23/23, indicated cleanse the right medial heel with normal saline, pat dry, apply betadine and wrap with roll gauze daily. The July 2023 Treatment Administration Record (TAR) indicated the treatment to the left lateral hip, left lower back, sacrum, left distal foot, left foot, and right medial heel were not completed as ordered on 7/2/23, 7/4/23, and 7/21/23. A Physician's Order, dated 6/5/23, indicated cleanse the left medial ankle with normal saline, pat dry, apply anasept gel to wound bed, fill cavity with fluff dry roll gauze, and cover with dry dressing daily. A Physician's Order, dated 6/5/23, indicated cleanse the right lateral foot with normal saline, pat dry, apply anasept gel to wound bed, fill cavity with fluff dry roll gauze, and cover with dry dressing daily. A Physician's Order, dated 7/1/23, indicated cleanse the right medial shin with normal saline, pat dry, apply anasept gel to wound bed, and cover with dry dressing daily. A Physician's Order, dated 5/20/23, indicated cleanse left lateral ankle with normal saline, pat dry, apply betadine and wrap with roll gauze daily. A Physician's Order, dated 7/1/23, indicated cleanse the left shin with normal saline, pat dry, apply skin prep and leave open to air daily. The July 2023 TAR indicated the treatment to the left medial ankle, right lateral foot, right medial shin, left lateral ankle, and left shin was not		ordered. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 8/28/23**	

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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

completed as ordered on 7/2/23, 7/4/23, and 7/7/23.

A Physician's Order, dated 6/16/23, indicated cleanse the left distal first toe with normal saline, pat dry, apply anasept gel to wound bed, fill cavity with fluff dry roll gauze, and cover with dry dressing daily.

A Physician's Order, dated 5/20/23, indicated cleanse the right lateral ankle with normal saline, pat dry, apply betadine and wrap with roll gauze daily.

The July 2023 TAR indicated the treatment to the left distal first toe and right lateral ankle was not completed as ordered on 7/2/23 and 7/4/23.

A Wound Care Note, dated 7/12/23, indicated the following new orders:
- left distal first toe: cleanse, silvasorb gel, xeroform and cover with a dry dressing
- left lateral: cleanse, fill with iodoform, application of silvasorb gel, xeroform dressing, PolyMem MAX silver, ABD pad, mepilex foam
- left medial ankle: cleanse, silvasorb gel, xeroform, bordered gauze
- left shin: cleanse, silvasorb gel, xeroform, bordered gauze
- right hip trochanter: cleanse, no-sting barrier film, silvasorb gel, xeroform, PolyMem MAX silver, mepilex
- right lateral ankle: cleanse, silvasorb gel, bordered gauze
- right lateral foot: cleanse, no-sting barrier film, silvasorb gel, xeroform, PolyMem MAX silver, bordered gauze
- right medial shin: cleanse, no-sting barrier film, iodoform, silvasorb gel, xeroform, PolyMem MAX silver, bordered gauze
- sacrum: cleanse, no-sting barrier film, iodoform,

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silvasorb gel, xeroform, PolyMem MAX silver, bordered gauze

The Physician Order for the left distal toe, left distal medial foot, left medial ankle, right lateral ankle, right lateral foot, right medial shin, and sacrum was not started until 7/21/23 per the July 2023 Physician Order Summary (POS).

The Physician Order for the left lateral hip and left shin was never started per the July 2023 POS.

There were no orders for the PolyMem MAX Silver for any wound care treatments including for the left lower back, right hip trochanter, right lateral foot, right medial shin, and sacrum.

Interview with the Director of Nursing on 8/11/23 at 9:40 a.m., indicated she had no further information to provide.

2. Resident 212's record was reviewed on 8/9/23 at 1:32 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) affecting right dominant side, adult failure to thrive, dementia, and pressure-induced deep tissue damage of left heel.

The Significant Change in Status Minimum Data Set (MDS) assessment, dated 7/6/23, indicated the resident was severely cognitively impaired for daily decision making. He required extensive assistance with two+ persons physical assist for bed mobility, transfers, toilet use, and personal hygiene. He had 1 stage 2 pressure ulcer and 1 stage 4 pressure ulcer.

A Physician's Order, dated 5/20/23, indicated cleanse coccyx with normal saline, pat dry, apply calcium alginate with silver to wound bed and

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	cover with dry dressing every Monday, Wednesday, and Friday The June 2023 Treatment Administration Record indicated the treatment to the coccyx was not completed as ordered on 6/9/23. A Physician's Order, dated 6/16/23, indicated cleanse the right heel with normal saline, pat dry, apply betadine and leave open to air daily. The June 2023 Treatment Administration Record indicated the treatment to the right heel was not completed as ordered on 6/24/23 and 6/26/23. A Physician's Order, dated 5/20/23, indicated cleanse the right heel with normal saline, pat dry, apply betadine, and wrap with roll gauze daily and PRN if loose or soiled. The June 2023 Treatment Administration Record indicated the treatment to the right heel was not completed as ordered on 6/1/23, 6/6/23, 6/8/23, and 6/15/23. A Physician's Order, dated 6/9/23, indicated cleanse the distal sacrum with normal saline, pat dry, and apply house barrier cream twice daily for wound care. The June 2023 Treatment Administration Record indicated the treatment to the distal sacrum was not completed as ordered on 6/16/23 at 5 p.m., 6/24/23 at 8:00 a.m., 6/25/23 at 5:00 p.m., 6/26/23 at 8:00 a.m., and 6/27/23 at 8:00 a.m. Interview with the Director of Nursing on 8/11/23 at 9:40 a.m., indicated she had no further information to provide.			

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	3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, interview, and record review, the facility failed to ensure a contracture was identified, treated, and monitored, and splints were applied as ordered for 2 of 4 residents reviewed for range of motion (ROM). (Residents 37 and 212). Findings include: 1. On 8/7/23 at 11:08 a.m., Resident 37 was observed in lying in bed. He indicated he thought he would benefit from therapy and had no range of motion in his last two fingers on both hands. The resident was unable to extend those fingers. On 8/8/23 at 1:24 p.m. Resident 37 was noted to be	F 0688	Spring Mil Health Campus Annual Survey: 8-7-23 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	08/28/2023

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	in bed. He still had no range of motion in the last two fingers on his bilateral hands. Interview with RN 1 on 8/10/23 at 10:01 a.m., indicated she worked with the resident often and had not noticed any contractures. Upon observation of the resident at 10:06 a.m., she indicated she would reach out to therapy to get an assessment completed as the fingers were contracted. Resident 37's record was reviewed on 8/10/23 at 9:44 a.m. Diagnoses included, but were not limited to end stage renal disease, dementia, and depressive disorders. The Quarterly Minimum Data Set (MDS) assessment, dated 6/29/23, indicated the resident was moderately cognitively impaired for daily decision making. The record lacked documentation, assessments, or monitoring regarding any contractures. Interview with the Administrator and Director of Nursing on 8/10/23 at 10:44 a.m., indicated the nurse had called therapy to get an evaluation completed for the contractures. 2. On 8/7/23 at 3:33 p.m., Resident 212 was observed in his wheelchair in the dining area watching television. There was no splinting device noted on either hand. On 8/8/23 at 1:28 p.m., Resident 212 was observed in bed sitting upright with a bolster on his left side. There was no splinting device noted on either hand.		The Facility Respectfully requests paper compliance for this survey. F688 Increase/Prevent Decrease in ROM/Mobility What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 212 was assessed for any adverse effects related to not having ordered splint in place and also not having a monitoring order in place. No adverse effects noted. Resident 37 was assessed, and OT performed evaluation for contractures. OT evaluation indicated no further OT treatment required. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

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	Resident 212's record was reviewed on 8/9/23 at 1:32 p.m. Diagnoses included, but were not limited to, hemiplegia (one sided weakness) following cerebrovascular disease affecting right dominant side, cognitive communication deficit, adult failure to thrive, contracture, and dementia. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 7/6/23, indicated the resident was severely cognitively impaired for daily decision making. He required extensive assistance with two+ persons physical assist for bed mobility, transfers, toilet use, and personal hygiene. A Physician's Order, dated 6/6/23, indicated right resting hand splint with device on in AM and off in PM. The CNA Tasks - Bilateral hand splint had no information documented for application and removal of the hand splint for the last 30 days. Interview with CNA 2 on 8/9/23 at 4:36 p.m., indicated the resident never wore a splinting device that she was aware of. Interview with the Director of Nursing on 8/10/23 at 10:44 a.m., indicated the splinting device was discontinued the day before (8/9/23) and new orders for a smaller carrot were put into place because it was painful for him to wear the splinting device. However, there was no documentation of the splinting device being put on in the morning or removed in the evening as per the Physician's Orders. 3.1-42(a)(2)		All residents with adaptive equipment or contractures have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nurses were in- on ensuring adaptive equipment/devices are in place as per orders as well as ensuring that there is a monitoring order in place for all residents who have an order for a splint. Nurses were also re-educated related to whenever a change is noted to resident, they must call the MD and obtain an order for OT to evaluate the resident. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will audit 2 residents with adaptive equipment/devices, 2 times a week, for 3 months to ensure they	

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			are in place as ordered as well as a monitoring order to monitor the splint placement. DON/Designee will observe 5 residents, 2 times weekly, to identify the need for OT services The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/23	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan,			

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	the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was being administered at the correct flow rate for 1 of 1 residents reviewed for oxygen. (Resident 24) Finding includes: On 8/7/23 at 10:03 a.m., Resident 24 was observed sitting in her wheelchair. The resident was wearing oxygen via a nasal cannula with a flow rate set at 2.5 liters. On 8/8/23 at 9:37 a.m., Resident 24 was observed sitting in her wheelchair with the oxygen tubing in her lap. The resident was wearing oxygen via a nasal cannula with a flow rate set at 2.5 liters. The oxygen tubing was not connected to the concentrator. A nursing aide was notified and reconnected the resident's oxygen at 2.5 liters. On 8/8/23 at 1:15 p.m., Resident 24 was observed in the dining hall wearing oxygen via nasal cannula with a flow rate set at 2.5 liters. Resident 24's record was reviewed on 8/8/23 at 12:06 p.m. Diagnoses included, but were not limited to, hyperlipidemia (high cholesterol), hypertension (high blood pressure), non-Alzheimer's dementia, Parkinson's disease, Wernicke's encephalopathy (brain disorder), and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 5/4/23, indicated the resident was not cognitively intact. A Care Plan, dated 7/24/23, indicated the resident	F 0695	**Spring Mill Health Campus Annual Survey: 8-7-23** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey **F695 Respiratory/Tracheostomy care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 24 was assessed, and no adverse effects were noted related to not having oxygen on the correct setting. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents with an order for oxygen can potentially be affected by the same alleged deficient practice. **What measures will be put into place or what systemic**	08/28/2023

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	had a potential for complications and shortness of breath while lying flat related to: COPD, and bronchitis. Interventions included, but were not limited to, administer oxygen per the physician's order. A Physician's Order, dated 12/26/22, indicated oxygen at 3 liters per nasal cannula continuous every shift for COPD. The July and August 2023 Medication Administration Records (MAR) indicated oxygen via nasal cannula at 3 liters was signed out every shift. Interview with the Director of Nursing (DON) on 8/9/23 at 10:17 a.m., indicated the resident's oxygen should have been set at 3 liters. 3.1-47(a)(6)		**changes will be made to ensure that the deficient practice does not recur.** Staff were re-educated to ensure all oxygen concentrators are set on the correct setting for all residents who have an order for oxygen. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place.** DON/designee will perform observations on 5 residents, twice weekly for 3 months to ensure oxygen is on the correct setting. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:8/28/23**	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free of significant	F 0760	**Spring Mill Health Campus Annual Survey: 8-7-23**	08/28/2023

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medication errors related to timing of insulin administration for 1 of 1 residents reviewed for insulin. (Resident 18)

Finding includes:

Interview with Resident 18 on 8/7/23 at 2:19 p.m., indicated she did not always receive her insulin on time.

The record for Resident 18 was reviewed on 8/8/23 at 1:54 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

The Admission Minimum Data Set (MDS) assessment, dated 7/13/23, indicated the resident was cognitively intact and she received insulin injections.

A Care Plan, dated 7/20/23, indicated the resident was at risk for complications related to the diagnosis of diabetes mellitus. Interventions included, but were not limited to, administer diabetes medication as ordered by the doctor. Monitor/document side effects and effectiveness.

Physician's Orders, dated 7/9/23, indicated the resident was to receive Glargine insulin 30 units subcutaneously one time daily at 8:00 a.m. The resident was also to receive Lispro insulin, inject per sliding scale with meals: if blood sugar 151 - 200 = 2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, and call with blood sugar greater than 351.

The July 2023 Medication Administration Record (MAR), indicated the resident received her insulin late on the following dates:
- 7/10/23 the Glargine and Lispro insulin was signed out at 11:40 a.m. Both insulins were

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F760 Residents are free of Significant Med Errors
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
Resident 18 was assessed, and no adverse effects were noted related to timing of insulin administration.
How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
All residents with insulin orders have the potential to be affected by the same alleged deficient practice.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;
· RN's, LPN's, and QMA's were educated on medication

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	scheduled for 8:00 a.m. - 7/11/23 the Glargine insulin was signed out at 9:45 a.m. The insulin was scheduled for 8:00 a.m. - 7/12/23 the Lispro insulin was signed out at 1:48 p.m. The insulin was scheduled for 12:00 p.m. - 7/14/23 the Glargine and Lispro insulin was signed out at 9:51 a.m. Both insulins were scheduled for 8:00 a.m. - 7/15/23 the Glargine and Lispro insulins were signed out at 9:38 a.m. Both insulins were scheduled for 8:00 a.m. - 7/16/23 the Glargine and Lispro insulins were signed out at 10:22 a.m. Both insulins were scheduled for 8:00 a.m. - 7/20/23 the Glargine and Lispro insulins were signed out at 10:29 a.m. Both insulins were scheduled for 8:00 a.m. - 7/23/22 the Glargine and Lispro insulins were signed out at 10:07 a.m. Both insulins were scheduled for 8:00 a.m. Interview with the Director of Nursing on 8/11/23 at 12:05 p.m., indicated the resident's insulin should have been signed out when given. The window was an hour before or after the scheduled time to administer medications. 3.1-48(c)(2)		administration following the 5 rights of medication pass, with an emphasis on the correct time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse manager/designee will randomly audit/observe 2 Nurses administer insulin 3 times per week, for 3 months to ensure proper insulin administration times. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. **Date by which systemic corrections will be completed: 8/28/23**	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician,			

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	physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.			
	Based on record review and interview, the facility failed to ensure specimens for laboratory testing were collected as ordered by the Physician for 1 of 1 residents reviewed for laboratory services (Resident 49). Finding includes: Resident 49's record was reviewed on 8/9/23 at 11:18 a.m. Diagnoses included, but were not limited to, acute osteomyelitis of the left femur, pressure ulcer of sacral region stage 4, cellulitis of left lower limb, pressure ulcer of right hip, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/22/23, indicated the resident was cognitively intact for daily decision making. He had 4 stage 4 pressure ulcers that were present upon admission/entry and 3 unstageable deep tissue injuries present upon admission/entry. A Physician's Order, dated 7/27/23, indicated blood urea nitrogen (BUN), creatinine, and glomerular filtration rate (eGFR) draw prior to initiation of antibiotic courses. The Laboratory Report, dated 7/28/23, indicated BUN, creatinine, eGFR were collected on 7/28/23 at 2:35 a.m. and reported on 7/28/23 at 1:02 p.m. A Physician's Order, dated 7/27/23, indicated amoxicillin- pot clavulanate (an oral antibiotic) tablet 875-125 milligrams 1 tablet by mouth twice	F 0773	**Spring Mill Health Campus Annual Survey: 8-7-23** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey **F773 Lab Svs Physician Orders/Notify of Results** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 49 had lab drawn. No adverse effects were noted due to not having lab drawn prior to the administration of an antibiotic. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into**	08/28/2023

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	155764	A. BUILDING 00 B. WING	08/11/2023

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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	daily. The July 2023 Medication Administration Record (MAR), indicated the amoxicillin tablet was administered on 7/27/23 at 8:00 a.m. A Physician's Order, dated 7/27/23, indicated levaquin (an antibiotic) oral tablet 750 milligrams 1 tablet by mouth once daily. The July 2023 MAR indicated the levaquin was administered on 7/27/23 at 8:00 a.m. Interview with the Director of Nursing on 8/11/23 at 3:58 p.m., indicated the laboratory draw should have been completed prior to administering the antibiotics per the Physician's Orders. 3.1-49(a)		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were educated on ensuring that all lab orders are carried out and results are received prior to the administration of an antibiotic. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 2 residents with lab and antibiotic orders weekly for 3 months to ensure all ordered labs are being drawn, if needed, prior to the administration of an antibiotic. Nurse manager/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. **Date by which systemic corrections will be completed: 8/28/23**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent			

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the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident

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	under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to improper cleaning of reusable equipment, improper hand hygiene between glove use, and improper disposal of a lancet for 1 of 6 residents observed during medication pass (Resident 45, LPN 1). Finding includes: On 8/9/23 at 4:20 p.m., LPN 1 was observed checking blood glucose levels of Resident 45. LPN 1 washed her hands and donned clean	F 0880	**Spring Mill Health Campus Annual Survey: 8-7-23** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey **POC F-880 Infection**	08/28/2023

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	gloves. She wiped the glucometer down with an alcohol swab and placed the glucometer into a clean glove. She removed her gloves and donned new gloves, without performing hand hygiene in between glove use. She performed the finger stick and obtained the resident's blood glucose reading. She exited the room and placed the used lancet into the regular garbage can. LPN 1 then prepared 30 units of Novolog (an insulin). She retrieved the medication from the cart, donned new gloves without performing hand hygiene first. She wiped the vial with an alcohol swab, inserted a sterile syringe, and withdrew 30 units of Novolog. She then donned new gloves without performing hand hygiene first and entered the resident's room and administered the medication. LPN 1 indicated at the time, that she should have performed hand hygiene between glove use, the lancet should have been disposed of in the sharps container, and she was unaware that an alcohol swab was inappropriate to clean the glucometer that was shared among residents in the facility. Interview with the Nurse Consultant on 8/9/23 at 5:05 p.m., indicated she had no further information to provide. A Policy titled, "Glucometer Cleaning" and noted as current, indicated "...3. To clean and disinfect the meter, use pre-moistened germicidal or Antimicrobial wipe/towel. 4. Wipe meter with wipe/towel until all surfaces of the glucometer are visibly wet...6. Place glucometer on a clean surface such as paper towel and allow to air dry for no less than 2 minutes, or according to manufacturer instructions." A Policy titled, "Hand Washing/Hand Hygiene" and noted as current, indicated "...4. When hands		**Prevention & Control** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** Employees were immediately educated related to performing hand hygiene in between changing gloves, the proper method in which to dispose of lancets and the correct way to clean a glucometer. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur:** DON/Designee re-educated the staff related to performing hand hygiene in between changing gloves, the proper method in which to dispose of lancets and the correct way to clean a glucometer. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** · The D.O.N. or designee,	

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	are not visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: ...c. before donning gloves;...e. before preparing or handling medications;...m. after removing gloves" 3.1-18(b)		will conduct surveillance observation audits 3 times weekly for 3 months to monitor staff for handwashing, lancet disposal and glucometer cleaning practices. · Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Dates when corrective action will be completed** Completion date: 8/28/23	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy	F 0881	Spring Mill Health Campus Complaint Survey: 8-7-23	08/28/2023

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	to reduce antibiotic resistance related to a practitioner prescribing antibiotics for wounds without being cultured for 1 of 2 residents reviewed for pressure ulcers. (Resident 49). Finding includes: Resident 49's record was reviewed on 08/09/23 at 11:18 a.m. Diagnoses included, but were not limited to, acute osteomyelitis of the left femur, pressure ulcer of sacral region stage 4, cellulitis of left lower limb, pressure ulcer of right hip, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/22/23, indicated the resident was cognitively intact for daily decision making. He had 4 stage 4 pressure ulcers that were present upon admission/entry and 3 unstageable deep tissue injuries present upon admission/entry. Wound Care Notes, dated 7/26/23, indicated a wound culture was completed on 7/19/23, which indicated pathogens were detected in the right hip, left hip, left medial foot, and left lateral foot. The assessment, plan, and visit details indicated new orders were given for gentamicin sulfate external ointment to all wound beds with every dressing change. The August 2023 Physician Order Summary (POS) indicated clean with normal saline, pat dry, apply gentamicin sulfate external ointment 0.1% and xeroform to wound bed cover with dry dressing every Monday and Wednesday to the left distal medial foot, left lateral hip, left distal first toe, left distal foot, left distal medial foot, left lateral foot, left lower back, left medial first toe, left medial ankle, left medial foot, left shin, right hip, right lateral ankle, right lateral foot, right medial heel,		Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests Paper Compliance for this survey. POC F-881 Antibiotic Stewardship Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: Resident 49 was assessed, and no adverse effects were noted related to antibiotics not meeting criteria for antibiotic stewardship program. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents, on antibiotics, have the potential to be affected by the alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected	

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	right medial shin, and sacrum. There were no cultures completed for the left distal first toe, left distal foot, left lower back, left medial first toe, left medial ankle, left shin, right lateral ankle, right lateral foot, right medial heel, right medial shin, and sacrum. Interview with the Director of Nursing on 8/11/23 at 3:58 p.m., indicated she would be in-servicing the Wound Nurse Practitioner regarding the use of antibiotics without cultures completed first.		and will not recur: Infection Preventionist re-educated on McGreer's criteria for being prescribed antibiotics. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent: • The DON/ designee will review the culture 2x per week for 3 months, for all residents prescribed an antibiotic, to ensure the resident meets McGreer's criteria for infections. • Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going. Dates when corrective action will be completed Completion date: 8/28/23	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,			

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	sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to urine odor and ripped carpet on 2 of 3 units. (Healthcare 2 Unit and TCU Unit) Findings include: During the Environmental Tour with the Director of Maintenance and the Housekeeping Supervisor on 8/11/23 at 9:45 a.m., the following was observed: 1. TCU Unit: In Room 3101, there was a rip in the carpet upon entrance to the room. One resident resided in the room. 2. Healthcare 2 Unit: In Room 2206, the room had a strong urine odor. Two residents resided in the room. Interview with the Maintenance Director and Housekeeping Supervisor at the time, indicated the above was in need of cleaning and/or repair. 3.1-19(f)	F 0921	Spring Mill Health Campus Annual Survey: 8/7/23 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. F921 Safe/Functional/Sanitary/Comfortable Environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The foul odor was resolved. The ripped carpet was repaired.	08/28/2023

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			How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were re-educated on the procedure of notifying maintenance/environmental services of any necessary repairs/cleaning needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Maintenance supervisor/designee will audit the facility 3x per week, for 4 weeks, on alternating units for Maintenance issues/smells. Any identified issues will be corrected.	

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			/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/23	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Residential Complaint IN00414473. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00413735 and IN00413771. Complaint IN00414473 - State deficiencies related to the allegations are cited at R0036 and R0349. Complaint IN00413735 - No deficiencies related to the allegations are cited. Complaint IN00413771 - No deficiencies related to the allegations are cited.	R 0000		

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	Survey dates: August 7, 8, 9, 10, and 11, 2023 Facility number: 010739 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/15/23.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.			
	Based on record review and interview, the facility failed to ensure the resident's responsible party or an interested family member was promptly notified of a fall for 1 of 4 residents reviewed for falls. (Resident C) Finding includes: The record for Resident C was reviewed on 8/8/23 at 12:00 p.m. Diagnoses included, but were not limited to, unsteadiness on feet, repeated falls, dementia with behavioral disturbance, and arthritis. An Assisted Living Level of Care Assessment, dated 8/6/23, indicated the resident was severely impaired for decision making.	R 0036	Spring Mill Health Campus Annual Survey: 8-7-23 R 036- Notification of Change What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C family was notified of the fall. How will facility identify other	08/28/2023

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	A Nurses' Note, dated 8/5/23 at 3:15 a.m., indicated the resident was witnessed walking in his room without assistance. The nurse approached him and he held onto the arm of a chair and sat on the floor. The resident was assisted back to bed with the 3 staff members. A Post Fall Observation, dated 8/5/23, indicated notification to the resident's Power of Attorney (POA) would be referred to the day shift. There was no documentation the resident's POA was notified of the fall. Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated there was no additional information for review. This State Residential tag relates to Complaint IN00414473.		residents who have the potential to be affected by the same alleged deficient practice? The deficient practice has the potential to affect all facility residents. What corrective measures will the facility take or will alter to ensure that the problem will not reoccur? Licensed nursing staff educated on ensuring that family is notified any time a resident has a fall. What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent? DON/Designee will audit all fall documentation 3 x per week for 3 months, to ensure family is notified of the fall.A summary will be presented to the Quality Assurance committee monthly x 3 months. By what date the systemic changes will be completed: 8-28-23	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and			

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	disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on record review and interview, the facility failed to ensure at least every 6 months, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. This had the potential to affect 34 residents who resided in the facility. Finding includes: The Fire and Disaster Drills reviewed on 8/9/23 at 9:53 a.m. There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months. Interview with the Assistant Maintenance	R 0092	Spring Mill Health Campus Annual Survey: 8/7/23 R 092- Administration Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fire Department involved in fire drill on 8-11-23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected by the same deficient practice. What measures will be put into place or	08/28/2023

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	Director on 8/9/23 at 10:07 a.m., indicated the Maintenance Director was on sick leave and he did not know if the fire department participated in any of the fire drills, but would give him a call and find out. Interview with the Assistant Maintenance Director on 8/9/23 at 10:20 a.m., indicated he had spoken to the Maintenance Director, who indicated he had emailed the local fire department, but never heard back, and did not have that email. He also indicated he did remember calling them as well, but had no record of the phone call.		what systemic changes will be made to ensure that the deficient practice does not recur; Administrator and Maintenance Department educated about the need to involve the fire department in fire drills at the facility every 6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Maintenance/Designee will ensure that the fire department is involved in fire drills every 6 months at the facility. The nurse supervisor/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/23	
R 0144 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 ensure the residents' environment was clean and in good repair related to marred walls and floors, stained carpets, sewage odors, rusted	R 0144	**Spring Mill Health Campus Annual Survey: 8/7/23** **R 144- Sanitation and Safety**	08/28/2023

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	door frames, and dust particles in ceiling lights for 2 of 2 units. (The Legacy and Assisted Living units) Findings include: On 8/9/23 at 2:25 p.m. the Environmental Tour was completed and the following was observed: 1. Legacy: a. Room 116 - There was debris and particles observed in the ceiling light in the bathroom. The bathroom door frame and door was rusted. There were 2 residents who shared the room and bathroom. b. Room 126 - There was debris and particles observed in the ceiling light in the bathroom. The bathroom door was rusted brown in color and marred. There was 1 resident who resided in the room and used the bathroom. c. Room 127 - The toilet high rise seat was dirty with dried bowel movement. There was debris and particles in the ceiling light in the bathroom. The bathroom door was marred and had a rusted door frame. There were 2 residents who shared the bathroom. d. There was a strong smell of sewage in the hallway outside of the residents' rooms. e. The wallpaper below the chair rail in the hallway was marred and bubbled in areas. f. The walls below the chair rail were marred in the dining room. The carpet had many large stains throughout.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Room 116, 126, 127 ceiling light in the bathroom was cleaned. Room 116, 126, 127-bathroom door was repainted and cleaned. Room 127 toilet seat was cleaned. Hallways free of foul odor. Wallpaper was cleaned and no longer bubbled. Walls repainted and no longer marred. Carpet in the dining room cleaned. Floors in the parlor were cleaned and repainted. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All Residents have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated to complete work orders.	

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	g. The floors in the parlor next to the dining room were dirty and marred with scuff marks. The walls were marred and dirty. 2. Assisted Living: There was a strong sewage smell in the hallway outside of the residents' rooms. Interview with the Administrator on 8/10/23 at 1:05 p.m., indicated all of the above was in need of cleaning and/or repair.		Housekeeping supervisor and maintenance will complete walking rounds daily. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Maintenance/Housekeeping will ensure that the facility is free of foul odors, and facility remains in clean and good living conditions. The Housekeeping supervisor/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 8/28/23**	
R 0217 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 members, shall identify and document the services to be provided by the facility, as follows:			

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	(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 service plan was signed by the resident and they were revised and updated according to the resident's change in condition for 6 of 6 residents reviewed for service plans. (Residents 2, B, C, D, E, and F) Findings include: 1. The record for Resident 2 was reviewed on 8/8/23 at 2:25 p.m. Diagnoses included, but were not limited to, type 2 diabetes, high blood pressure, depressive and bipolar disorder. The Service Plan, dated 8/6/23, was not signed by	R 0217	Spring Mill Health Campus Annual Survey: 8-7-2023 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the	08/28/2023

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	the resident, only by facility staff. Interview with the Administrator on 8/9/23 at 1:15 p.m., indicated she was unaware the service plans had to be signed by the resident. 2. The record for Resident B was reviewed on 8/8/23 at 10:24 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, dementia with mild anxiety, major depressive disorder, and high blood pressure. A Physician's Order, dated 5/6/23, indicated hospice to evaluate and treat. The Service Plan, dated 8/6/23, was not signed by the resident, only by facility staff. The service plan did not address hospice care. Interview with the Administrator on 8/9/23 at 1:15 p.m., indicated she was unaware the service plan had to be signed by the resident. Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated there was no additional information to review. 3. The record for Resident C was reviewed on 8/8/23 at 12:00 p.m. Diagnoses included, but were not limited to, unsteadiness on feet, repeated falls, dementia with behavioral disturbance, and arthritis. A Physician's Order, dated 5/1/23, indicated hospice to evaluate and treat. A Physician's Order, dated 12/31/21 and on the current 8/2023 Order Summary , indicated Seroquel 50 milligrams at bed time.		regulatory requirement. R 217 Evaluation What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Service Plans signed by family members. Service plans updated as needed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Director was educated on the	

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	The Service Plan, dated 8/6/23, was not signed by the resident, only by facility staff. The Service Plan did not address hospice care or the use of antipsychotic medication. Interview with the Administrator on 8/9/23 at 1:15 p.m., indicated she was unaware the service plans had to be signed by the resident. Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated there was no additional information to review. 4. The record for Resident D was reviewed on 8/8/23 at 3:30 p.m. Diagnoses included, but were not limited to dementia without behavioral, psychotic mood or anxiety disturbances, and high blood pressure. The Service Plan, dated 8/6/23, was not signed by the resident, only by facility staff. Interview with the Administrator on 8/9/23 at 1:15 p.m., indicated she was unaware the service plans had to be signed by the resident. 5. The closed record for Resident E was reviewed on 8/8/23 at 8:25 a.m. Diagnoses included, but were not limited to, anxiety, chronic kidney disease, chronic respiratory failure, high blood pressure, legal blindness, hearing loss, COPD, heart failure, repeated falls, and depressive disorders. The Service Plan, dated 6/26/23, was not signed by the resident, only by facility staff. Interview with the Administrator on 8/9/23 at 1:15 p.m., indicated she was unaware the service plans had to be signed by the resident.		need to ensure that all service plans are signed by residents or if unable to sign their family members. Staff were educated to ensure that service plans are updated with changes of condition. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse Supervisor/Designee will audit 5 residents service plans per week x 3 months to ensure that the service plans are being signed and updated. The Nurse Supervisor/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	6. The record for Resident F was reviewed on 8/8/23 at 4:40 p.m. Diagnoses included, but were not limited to, Parkinson's disease, anxiety, bipolar disorder, arthritis, and major depressive disorder. The Service Plan, dated 8/6/23, was not signed by the resident, only by facility staff. Interview with the Administrator on 8/9/23 at 1:15 p.m., indicated she was unaware the service plans had to be signed by the resident.		Date by which systemic corrections will be completed:8/28/23	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to follow up assessment and documentation after a fall with injury, neurological checks completed, as needed (PRN) medication administered only after non-pharmacological interventions were attempted, and medications signed out as being administered for 4 of 6 residents reviewed for clinical records. (Residents B, C, D, and F) Findings include: 1. The record for Resident B was reviewed on 8/8/23 at 10:24 a.m. Diagnoses included, but were	R 0349	Spring Mill Health Campus Annual Survey: 8/7/2023 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests	08/28/2023

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	not limited to, metabolic encephalopathy, dementia with mild anxiety, major depressive disorder, and high blood pressure. A Nurses' Note, dated 7/10/23 at 10:26 p.m., indicated around 3:45 p.m., the resident was observed on the floor in front of the bathroom. The resident indicated she had pain all over, but denied hitting her head. There was small bruise noted to her left arm that measured 0.5 centimeters (cm) by 0.3 cm. A Post Fall Observation, dated 7/10/23, indicated the resident had an unwitnessed fall with injury to her left arm. A Fall Follow Up Assessment was completed on 7/10 at 3:45 p.m., 7/11 at 12:03 a.m., 7/13 at 9:57 p.m., and 7/15/23 at 12:00 p.m. There were no neurological checks initiated after the unwitnessed fall. A Nurses' Note, dated 7/21/23 at 1:58 p.m., indicated the resident was observed by staff on the floor in front of the wheelchair. The fall was unwitnessed and she was unable to verbalize what happened. There were no apparent injuries noted at this time. The resident had an old discoloration noted to the left side of the forehead. A Post Fall Observation, dated 7/21/23 at 1:47 p.m., indicated the resident had an unwitnessed fall and was not able to verbalize what had happened. A neurological check was completed and no injuries were noted except she had an old faded green bruise to the left forehead. There was no documentation or an assessment in		paper compliance for this survey R349 Clinical Records – Non What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident ,D, F were assessed, and no adverse effects were noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with falls can be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

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	the clinical record of any left forehead bruise after the fall on 7/10/23. There was no documentation continued neurological checks had been initiated. A Fall Follow Up Assessment, dated 7/24/23 at 8:28 p.m., was the only one completed after the fall on 7/21/23. A Nurses' Note, dated 7/26/23 at 7:39 p.m., indicated discoloration to the left side of the head remained and was subsiding slowly. The weekly skin observations, dated 6/27 and 7/18/23, indicated the resident had no skin issues. There was no weekly skin observation completed for 7/4 and 7/11/23. The 7/25/23 skin observation indicated it was still in progress and not completed. Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated neurological checks were to be completed for every unwitnessed fall. A fall follow up was to be completed every shift for 72 hours. She had no additional information to review. 2. The record for Resident C was reviewed on 8/8/23 at 12:00 p.m. Diagnoses included, but were not limited to, unsteadiness on feet, repeated falls, dementia with behavioral disturbance, and arthritis. An Assisted Living Level of Care assessment, dated 8/6/23, indicated the resident was severely impaired for decision making. Physician's Orders, dated 5/10/23, indicated Lorazepam (an anti-anxiety medication) 2 milligrams (mg) per milliliters (ml), give 0.25 ml		p paraid="286295553" paraeid="{a133d012-9642-4302-85bd-d1cd98b19886}{7}" >Nurses were educated on completing post fall follow up documentation and when to use non- pharmacological interventions which includes: Daily follow up fall assessment documentation per facility policy for ·Neurological checks per facility policy ·Vital signs per facility policy ·Utilize non-pharmacological interventions prior to using PRN Medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse managers will audit clinical	

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	sublingually every 4 hours as needed (PRN) for anxiety and restlessness. The Medication Administration Record (MAR) for the months of 6/2023 and 7/2023, indicated the PRN medication was signed out as administered on 6/6 at 11:28 a.m., 6/11 at 7:20 p.m., 6/24 at 7:09 p.m., 6/25 at 2:02 p.m., 7/1 at 10:44 p.m., 7/4 at 3:22 p.m., and 7/9 at 8:03 p.m. There was no documentation in Nurses' Notes on the above mentioned dates to indicate non-pharmacological interventions were attempted first before administering the PRN Lorazepam. Nurses' Notes, dated 6/17/23 at 3:39 p.m., indicated the resident was observed by staff to be ambulating in the hallway and carrying briefs in his arms. The resident stepped inside a resident room and leaned over towards a shelf, and bumped his face, causing him to lose his balance and land on his buttocks. A 0.5 centimeters (cm) by 0.2 cm open area was observed to the left brow. A neurological assessment was initiated. Nurses' Notes, dated 6/18/23 at 9:22 a.m., indicated the resident was observed with swelling to the back of the left hand and his fingers had discoloration. Physician's Order, dated 6/19/23, indicated left hand X-ray. The left hand X-ray, dated 6/19/23, indicated the resident had an acute fourth proximal phalanx fracture (a fractured bone in the finger) Physician's Orders, dated 6/19/23, indicated monitor bruising and swelling to left hand and		documentation 2 times per week, for 3months to ensure follow up assessments and neuro checks are complete. The use of PRN medication will be audited twice a week. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 monthsThereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meetingMonitoring will be on going. Date by which systemic corrections will be completed:8/28/23	

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fingers every shift related to acute fourth proximal phalanx fracture.

The Treatment Administration Record (TAR) for the month of 6/2023, indicated the monitoring was not signed as being completed during the evening shift on 6/28 and on the midnight shift on 6/19, 6/24, 6/25, 6/27 and 6/30/23.

The TAR for the month of 7/2023 indicated the monitoring was not signed as being completed during the day shift on 7/17, the evening shift on 7/5, and the midnight shift on 7/3, 7/8, 7/9, 7/13, 7/14, 7/17, 7/22, 7/23, and 7/25/23.

Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated fall follow up was to be completed every shift for 72 hours. She had no additional information to review.

3. The record for Resident D was reviewed on 8/8/23 at 3:30 p.m. Diagnoses included, but were not limited to dementia without behavioral, psychotic mood or anxiety disturbances, and high blood pressure.

An Assisted Living Level of Care assessment, dated 8/6/23, indicated the resident was moderately impaired for decision making.

A Post Fall Observation, dated 6/4/23, indicated the resident had an unwitnessed fall and sustained a hematoma (blood-filled localized swelling) to the top of her scalp that measured by 6 centimeters (cm) by 6 cm.

Neurological checks were initiated on 6/4/23 and completed through 6/5/23 at 5:10 a.m. They were not fully completed every shift for 48 hours.

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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

A Post Fall Observation, dated 7/27/23 at 4:40 p.m., indicated the resident had a fall and hit her face. She sustained a bruise to the right cheek that measured 3.1 cm by 2.8 cm.

A Fall Follow Up Assessment, was only completed on 7/28 at 10:29 a.m., 7/29 at 11:01 a.m. and at 6:29 p.m., 7/30 at 6:53 a.m., 1:26 p.m., and 9:29 p.m.

There was no follow up assessment for the bruise to the face. The last weekly skin assessment was completed on 7/26/23. There was no weekly skin assessment completed on 8/2/23.

Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated neurological checks were to be completed for every unwitnessed fall. Fall follow up was to be completed every shift for 72 hours. She had no additional information to review.

4. The record for Resident F was reviewed on 8/8/23 at 4:40 p.m. Diagnoses included, but were not limited to, Parkinson's disease, anxiety, bipolar disorder, arthritis, and major depressive disorder.

A Basic Level of Care Assessment, dated 8/6/23, indicated the resident had mild impairment for dementia, some confusion, and difficulty in remembering conversations and forgetfulness.

Physician's Orders, dated 3/23/23, indicated Lorazepam (an anti-anxiety medication) 0.5 milligrams, give 1 every 12 hours as needed (PRN) for anxiety.

The Medication Administration Record, (MAR) for the month of 6/2023, indicated the PRN Lorazepam was signed out as being administered on 6/22 at 3:40 p.m. and 6/26 at 12:12 p.m.

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The 7/2023 MAR indicated the medication was signed out as being administered on 7/8 at 10:19 p.m. and 7/24/23 at 1:44 p.m.

The 8/2023 MAR, indicated the medication was signed out as being administered on 8/3/23 at 11:40 p.m.

There were no non-pharmacological interventions attempted first before the administration of the PRN Lorazepam.

A Post Fall Observation, dated 4/11/23 at 11:00 a.m., indicated the resident had an unwitnessed fall and was not able to tell anyone how it happened. The resident sustained an abrasion with swelling above the right brow that measured 2.5 cm by 3 cm

A Fall Follow Up Assessment, indicated an assessment was completed on 4/11 at 11:01 a.m., and 7:01 p.m., 4/12 at 8:33 p.m., 4/13 at 10:56 a.m., and 4/14/23 at 2:20 p.m. The Fall Follow Up Assessments were not completed every shift for 72 hours.

Neurological checks were initiated on 4/11/23 at 10:45 a.m., but were not fully completed.

Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated neurological checks were to be completed for every unwitnessed fall. Fall follow up was to be completed every shift for 72 hours. She had no additional information to review.

This State Residential finding relates to Complaint IN00414473.

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
	Based on observation, record review, and interview, the facility failed to ensure proper sanitation was performed before reusing a lancet to check a blood sugar level, gloves were used for the administration of insulin, residents who received antibiotics had true infections, and influenza and pneumococcal vaccines were offered to residents for 1 of 1 residents observed for insulin, 2 of 6 residents reviewed for medications, and for 6 of 6 residents reviewed for vaccines. (Residents 5, 2, B, C, D, E, and F) Findings include: 1. At 11:03 a.m. on 8/8/23, LPN 2 donned clean gloves to both hands and walked into Resident 5's room. She wiped her finger with an alcohol wipe, pricked the resident's finger and no blood was observed. The LPN pricked her finger again with the same lancet without cleaning the area again with an alcohol wipe. She obtained the blood and put the strip into the glucometer. After completing the glucometer test, she removed her gloves and went out to the med cart in the hallway. The LPN drew up 12 units of insulin from a multi-dose vial	R 0407	**Spring Mill Health Campus Annual Survey: 8-7-23** **R 407 Antibiotic Stewardship and Infection Control** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Infection Preventionist educated on the Antibiotic Stewardship program and the need to have a true infection to prescribe an antibiotic.	08/28/2023

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	into a syringe. After verifying the insulin, she did not recap the clean needle and she walked into the resident's room. She did not perform hand hygiene or don gloves. LPN 2 informed the resident she was going to administer the injection into her right upper arm. The needle was still uncovered and she had pulled down the resident's long sleeve shirt with the needle still exposed. Interview with the Director of Nursing on 8/9/23 at 1:30 p.m., indicated the nurse should have properly cleaned her finger again before reusing the same lancet and worn gloves to administer the insulin injection. 2. The record for Resident B was reviewed on 8/8/23 at 10:24 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, dementia with mild anxiety, major depressive disorder, and high blood pressure. A Physician's Order, dated 3/21/23, indicated may have UA C&S (urinalysis, culture and sensitivity) whenever resident complains of burning or had increased confusion. Nurses' Notes, dated 4/6/23 at 9:27 a.m., indicated the resident had been yelling and looking for family. The resident's daughter indicated when she had increased confusion, it could mean she had a urinary tract infection, so she requested a urinalysis. A urinalysis, dated 4/8/23 (a partial report), indicated the resident's urine was less than 10,000 gram negative bacilli organisms. A Nurses' Note, dated 4/10/23 at 9:00 p.m., indicated the doctor was called and informed of the results of the urinalysis. A new order for Cipro		AL Nurse Manager educated on the need to offer influenza, pneumonia and COVID immunizations annually and document it in the EMR. AL Nurse educated on the proper sanitation process to use when checking blood sugar and the use of gloves when administering insulin. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents can be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** IP to monitor every resident put on an antibiotic and ensure that the resident meets McGreer's criteria to be on the antibiotic. DON/Designee to audit all new admissions and re-admissions to ensure that they were offered influenza, pneumonia and COVID immunizations and that the information is documented in the medical record. **How the corrective action(s) will be monitored to ensure the**	

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	(an antibiotic) 250 mg twice a day times 10 days was noted and carried out. Nurses' Notes, dated 5/27/23 at 8:05 p.m., indicated the resident had complaints of frequency and urgency with pain while passing urine. A new order from the medical doctor was obtained. Physician's Order, dated 5/27/23, indicated Macrobid (an antibiotic) 100 milligrams (mg) by mouth before meals and at bedtime for burning upon urination and increased confusion until 6/6/23. There was no urinalysis results available for review. Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated there was no additional information for review. 3. The closed record for Resident E was reviewed on 8/8/23 at 8:25 a.m. Diagnoses included, but were not limited to, anxiety, chronic kidney disease, chronic respiratory failure, high blood pressure, legal blindness, hearing loss, COPD, heart failure, repeated falls, and depressive disorders. Nurses' Notes, dated 4/10/23 at 2:32 p.m., indicated the resident was much more confused per family. A new order to obtain an urine specimen for UA C&S was received. A UA sample was collected on 4/12/23 with the final report dated 4/14/23. The report indicated there was a trace of leukocytes, negative for nitrates, and many bacteria. A hand written order at the bottom of the lab report indicated Keflex (an		**deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 100% of residents with a new order for antibiotics to ensure that they meet McGreer's Criteria to be taking the antibiotic. DON/Designee will audit 100% of new admissions and readmissions to ensure that residents are being offered Influenza, Pneumonia and COVID immunizations and that the documentation is in the EMR. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 8/28/23**	

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antibiotic) 500 mg three times a day for 7 days to start on 4/15/23.

A Physician's Order, dated 4/15/23, indicated Keflex 500 mg, 1 capsule by mouth three times a day for until 4/23/23.

There was no urine culture available for review.

Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated she had no additional information.

A Policy titled, "Antimicrobial Stewardship," and noted as current, indicated "...4...iii... Obtain microbiology cultures prior to starting antibiotics when possible so antibiotics can be adjusted or stopped when appropriate. Treatment with antibiotics is only appropriate when the practitioner determines, on the basis of an evaluation, that the most likely cause of the patient's symptoms is a bacterial infection." 4. Resident C's record was reviewed on 8/8/23 at 12:00 p.m. Diagnoses included, but were not limited to, unsteadiness on feet, repeated falls, and dementia.

There was no documentation related to the resident being offered the pneumococcal vaccination.

Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.

5. Resident B's record was reviewed on 8/8/23 at 10:24 a.m. Diagnoses included, but were not limited to dementia, major depressive disorder, and lack of coordination.

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There was no documentation related to the resident being offered the pneumococcal vaccination.

Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.

6. Resident 2's record was reviewed on 8/8/23 at 2:25 p.m. Diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, and bipolar disorder.

There was no documentation related to the resident being offered the pneumococcal vaccination.

Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.

7. Resident D's record was reviewed on 8/8/23 at 3:30 p.m. Diagnoses included, but were not limited to, high blood pressure and dementia.

There was no documentation related to the resident being offered the pneumococcal or influenza vaccination.

Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.

8. Resident E's record was reviewed on 8/9/23 at 8:25 a.m. Diagnoses included, but were not limited to, chronic kidney disease, chronic respiratory failure, and high blood pressure.

There was no documentation related to the resident being offered the pneumococcal or

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	influenza vaccination. Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide. 9. Resident F's record was reviewed on 8/8/23 at 4:40 p.m. Diagnoses included, but were not limited to, breast cancer, Parkinson's disease, and bipolar disorder. There was no documentation related to the resident being offered the pneumococcal or influenza vaccination. Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.			
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.			
	Based on observation and interview, the facility failed to ensure hand hygiene was performed before donning and after doffing gloves during medication pass for 2 of 5 residents observed during medication pass. (Residents 4 and 5) Findings include: 1. During medication pass on 8/8/23 at 10:59 a.m. LPN 2 was observed preparing medications for Resident 4. At that time, she walked into the resident's room and administered his medications. She did not perform hand hygiene before or after the medication pass. The LPN then pushed the medication cart down the hallway to Resident 5's	R 0414	Spring Mill Health Campus Annual Survey: 8-7-23 R 414 Handwashing Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	08/28/2023

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	room. 2. At 11:03 a.m. on 8/8/23, LPN 2 donned clean gloves to both hands and walked into Resident 5's room. She did not perform hand hygiene. She wiped her finger with an alcohol wipe, pricked the resident's finger and no blood was observed. The LPN pricked her finger again with the same lancet and blood was observed. She obtained the blood and put the strip into the glucometer. She walked towards the door, removed her gloves in the room and threw them away in the resident's trash can. The LPN did not perform hand hygiene after removing her gloves. She administered the resident's insulin, threw the syringe into the sharps container and did not perform hand hygiene. 3. At 1:04 p.m., LPN 2 was observed administering eye drops to Resident 5. She removed a pair of clean gloves off of her cart and walked into the resident's room. No hand hygiene was performed before donning the gloves to both of her hands. After the administration of the eye drops, she doffed both gloves and threw them away in the trash can in her room. She did not perform hand hygiene immediately after glove removal. Interview with the Director of Nursing on 8/9/23 at 1:30 p.m., indicated the nurse should have performed hand hygiene before donning and after doffing gloves. A Policy titled, "Hand Washing/Hand Hygiene," and noted as current, indicated "...4. When hands are not visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: ...e. before preparing or handling medications; h. before and after putting		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; related to the hand washing policy and the need to wash in between changing gloves. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff re-in serviced related to the	

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	on and upon removal of PPE, including gloves..."		handwashing policy and the need to wash hands in between changing gloves. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will perform handwashing observations on 5 employees, 3 x weekly for 4 months to ensure that they are following the handwashing policy and washing hands in between changing gloves. /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/23	

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