STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING				(X3) DATE SURVEY COMPLETED 08/11/2023			
	ROVIDER OR SUPPLIER		1	01 W 8	ddress, city, state, zip cod 7TH AVE LVILLE, IN 46410		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LIGHT DEPOT OF THE PROPERTY OF THE PROP	PRE	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION	
TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	1.	AG	BEIGHAUT		DATE
F 0000 Bldg. 00	This visit was for a Licensure Survey ar Nursing Home Com IN00413771. This Residential Licensu Investigation of Res IN00414473. Complaint IN00413 the allegations are c Complaint IN00414 to the allegations are	Recertification and State and the Investigation of aplaints IN00413735 and visit included a State are Survey and the idential Complaint 735 - No deficiencies related to ited. 771 - No deficiencies related to ited. 473 - State deficiencies related e cited at R0036 and R0349. st 7, 8, 9, 10, and 11, 2023 0739 55764 56890	F 0000				
	These deficiencies r accordance with 410	eflect State Findings cited in IAC 16.2-3.1.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Lakeithia Webb Executive Director 08/28/2023

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD (X3) DATE SURVEY COMPLETED 08/11/2023					
	PROVIDER OR SUPPLIER MILL HEALTH CAN				87TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0554 SS=D Bldg. 00	Quality review com 483.10(c)(7) Resident Self-Adn §483.10(c)(7) The medications if the defined by §483.2 that this practice is Based on observation interview, the facilithad Physician's Ord assessment to self-amedications for 1 of self-administration. Finding includes: On 8/7/23 at 10:45 amicrograms inhaler Legs supplement watable in Resident 41 indicated she had be home. On 8/8/23 at 1:13 pund Hylands Natura were noted to be sitted the table in Resident Resident 41's record 11:35 a.m. Diagnos limited to, acute res failure, and restless The Admission Min assessment, dated 8	pleted on 8/15/23. nin Meds-Clinically Appropright to self-administer interdisciplinary team, as 1(b)(2)(ii), has determined solinically appropriate. on, record review, and ty failed to ensure residents ers for medications and an administer their own for 1 residents reviewed for of medication. (Resident 41) a.m., an Arnuity Ellipta 100 and a Hylands Natural Restful as noted to be on the bedside 's room. The resident rought the supplement in from the supplement in from the supplement ting next to the television on to 41's room. If was reviewed on 8/10/23 at the sincluded, but were not piratory failure, end stage renal	F 05		Spring Mill Health Campus Annual Survey: 8-7-23 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requipaper compliance for this survey paper compliance for this survey paper compliance for this survey paper compliance for the survey pape	08/28/2023 s the an y the n lests vey. II n nent 41 If- n I for	
	A Physician's Order	dated 8/1/23, indicated			same deficient practice and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155764	B. W	ING		08/11/2	2023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ODDINO	NAUL LIEALTILOA	ADUG			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	fluticasone furoate	inhalation aerosol powder			what corrective action will be	е	
	breath activated 100	0 micrograms/act, 1 puff inhale			taken.		
	orally one time a da	ny.			All facility residents with		
					medication orders have the		
	There was no self-a	dministration assessment			potential to be affected by the		
	completed for the resident to self-administer				same alleged deficient practic	e.	
	medications.				What measures will be put in	nto	
					place or what systemic		
	There were no orde	ers for self-administration of			changes will be made to		
	medications and the	ere was no order for the restful			ensure that the deficient		
	legs supplement.				practice does not reoccur.		
					Staff were educated on not lea	aving	
Interview with the Director of Nursing on 8/10/23				medications at resident bedsic	de		
	at 10:44 a.m., indic	ated the resident had brought			unless there is an order for		
	the medications in	from home, however, she had			self-administration in place.		
	not had updated ord	lers for the medications and			Licensed Nurses were also		
	the self-administrat	ion of medications assessment			educated on the need for a		
	was not completed.				physician order and a medica	tion	
					self-administration assessmer	nt	
	A Policy titled, "Se	lf-Administration of			when a resident self-administe	ers	
	Medications-Clinic	ally Appropriate," and noted			medication.		
	as current, indicated	d "1. The resident has right to			MDS Nurses are educated on	the	
	self-administer med	lications if the interdisciplinary			need for care plans for any		
	team has determine	d that this practice is clinically			resident who has a self-		
	appropriate3. A re	esident may only			administration order.		
	self-administer med	lications after the IDT has			How the corrective action(s)		
	determined which r				will be monitored to ensure	the	
	self-administered."				deficient practice will not		
					recur, i.e., what quality		
	3.1-11(a)				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 bedsi		
					The Director of Nursing/design	nee	
					will present a summary of the		
					audits to the Quality Assurance	e	
					committee monthly for 6 mont	hs.	
					Thereafter, if determined by the	ne	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2023		
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Quality Assurance committee auditing and monitoring will be done quarterly and present at QA meeting. Monitoring will be going. Date by which systemic corrections will be complete 8/28/23.	e the pe on
F 0677 SS=D Bldg. 00	§483.24(a)(2) A recarry out activities necessary service	d for Dependent Residents esident who is unable to of daily living receives the s to maintain good g, and personal and oral			
	interview, the facili residents received a (activities of daily l care, shaving, and cof 4 residents review and 37) Findings include: 1. Interview with R a.m., indicated she since being admitted. The record for Resi 8/8/23 at 1:21 p.m. not limited to, strok spinal stenosis. The facility on 7/20/23. The Admission Mir	dent 110 was reviewed on Diagnoses included, but were e, lack of coordination, and e resident was admitted to the	F 0677	Spring Mill Health campus Annual Survey: 8-7-23 Please accept the following at facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only it response to the regulatory requirement. The Facility respectfully request paper compliance for this survey. F677 ADL Care Provided for Dependent Residents What corrective action(s) will accomplished for these resides.	an y the n ests vey.
	was cognitively inta	/26/23, indicated the resident and she required extensive mobility and transfers. The		accomplished for those reside found to have been af fected the deficient practice;	ents

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155764	B. W	ING		08/11/2023
NAME OF T	DROLUDED OF CURRY TO		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER				87TH AVE	
SPRING	MILL HEALTH CAN	/IPUS		MERRI	LLVILLE, IN 46410	-
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		dependent on staff for			B	.,
	bathing.				Resident 37 had their fingerna	
	A C Dl d-4-d	7/24/22 : 4:4- 4 4 : 4			cleaned, shaven and gown an	id
		7/24/23, indicated the resident			linens changed.	
	_	with ADLs (activities of daily			Resident 110 had a shower	
	living) including bed mobility, eating, transfers, toileting, and bathing. Interventions included, but				provided and shower schedule	
	were not limited to, assist with bathing as needed,				adjusted to reflect preferences	5.
	offer a shower at least 2 times weekly, and offer				How the facility will identify oth	ner
	full/partial bed bath on non-shower days or with				residents having the potential	
	shower refusals.				be affected by the same	10
shower retusals.				deficient practice and what		
	The resident's shower days were Monday and				corrective action will be taken;	
Thursday evenings. The August 2023 Bath and				Corrective action will be taken;	,	
	1	id not indicate the resident's			All dependent residents, who	
	preference for a bat				require assistance with nail ca	ire.
	1				shaving, changing gowns and	
	The Task section re	lated to bathing was reviewed			linens and showers, have the	
		-8/8/23. The resident received			potential to be affected by the	
	1	n 7/21, 7/24, 7/28, and 8/1/23.			same alleged deficient practic	
	A complete bed bat	h was given on 7/23, 7/24,				
	7/25, and 8/7/23. T	he resident received a shower			What measures will be put into	0
	on 7/31/23.				place or what systemic change	es
					will be made to ensure that	
	_	ath and Skin Report sheet,			the deficient practice does not	t
	indicated the reside	nt's skin was intact on 8/3 and			recur;	
		e sheet did not list what type			Staff were re-educated on	
	of bathing the resid	ent received, if any.			providing dependent residents	s with
					assistance with ADL's per	
		Director of Nursing on 8/11/23			resident's plan of	
	_	ted she thought the resident's			care/preferences, including Na	
	1 ~	mplete bed bath. She would			Care, shaving, changing gowr	าร
		lent and update her bathing			and linens and showers.	
	preference. 2. On 8/7/23 at 11:09 a.m., Resident 37					
		facial hair, long dirty			How the corrective action(s) w	
		re was food and stains all over			monitored to ensure the defici	
		sident's gown. The resident			practice will not recur, i.e., who	
	indicated he liked to	be clean shaven.			quality assurance programs w	ill be
					put into place;	
	On 8/8/23 at 1:25 p	.m., Resident 37's blanket and			1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/11/2023		
	ROVIDER OR SUPPLIER MILL HEALTH CAN			101 W 8	ADDRESS, CITY, STATE, ZIP COD B7TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	(X5) COMPLETION
TAG	REGULATORY OR gown had food and	LSC IDENTIFYING INFORMATION stains on them		TAG	DON/Designee will Audit 10		DATE
	Resident 37's record 9:44 a.m. Diagnoses to, dementia and end	I was reviewed on 8/10/23 at sincluded, but were not limited d stage renal disease.			random residents weekly for 3 months, with a focus on dependent residents, requiring ADL assistance, to ensure the are being assisted with Nail Ca	y are,	
	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.				shaving, changing gowns and linen and Showers per the		
					residents' plan of care/prefere	nce.	
					Director of Nursing/designee w	/ill	
					present a summary of the audito the Quality Assurance		
	required assistance mobility, eating, tra Interventions includ assist with person h dressing/grooming a				committee monthly for 3 month. Thereafter, if determined by th 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:	е	
	information to prove 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2) 3.1-38(b)(4)				8/28/23		
F 0684 SS=D Bldg. 00	applies to all treatifacility residents. Ecomprehensive as facility must ensur treatment and care professional stand	a fundamental principle that ment and care provided to					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		155764	B. W	ING		08/11/	/2023	
	PROVIDER OR SUPPLIE		•	101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410			
	1				1			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
	and the residents		FO	CO 4			00/20/2022	
		eview and interview, the facility I follow-ups and neurological	F 00	584	Coming Mill Health Commun		08/28/2023	
		ted and/or completed following			Spring Mill Health Campus			
		idents reviewed for falls.			Annual Survey: 8/7/2023			
	(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				Allilual Survey. 6/1/2023			
					Please accept the following as	the		
					facility's credible allegation of	, uic		
					compliance . This plan of			
					correction does not constitute	an		
					admission of guilt or liability by			
both sides of the bed.				facility and is submitted only in				
	Resident 213's record was reviewed on 8/8/23 at 12:58 p.m. Diagnoses included, but were not				response to the regulatory			
					requirement.			
	limited to, fracture	of the left femur, dementia			The Facility Respectfully requ	ests		
	without behavioral	disturbance, and cognitive			paper compliance for this surv	ey.		
	communication de	ficit.						
					F684 Quality of Care			
		Day Minimum Data Set (MDS)						
		7/3/23, indicated the resident			What corrective action(s) will I			
		itively impaired. She required			accomplished for those reside			
		th bed mobility, toilet use, and			found to have been affected by			
		and limited assist for transfers.			the deficient practice;			
	on one side of the	nt in functional range of motion			Desident 242 was assessed	al		
	on one side of the	lower extremities.			Resident 213 was assessed, a			
	A Care Plan dated	1 6/29/23, indicated the resident			no adverse effects were noted How the facility will identify oth			
	· ·	e with Activities of Daily Living			residents having the potential			
	_	bed mobility, transfers, eating,			be affected by the same	10		
	toileting, and bath	-			deficient practice and what			
	8,	6			corrective action will be taken			
	A Care Plan, dated	1 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				All residents with falls can be			
					affected by the same alleged			
					deficient practice.			
	non-skid footwear	•						
					What measures will be put into)		
	A Nurses' Note, da	ated 6/29/23 at 5:08 p.m.,			place or what systemic chang	es		
	indicated the resid	ent was observed laying on the			will be made to ensure that			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/11/2023	
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION I. The Physician and family	TAG	DEFICIENCY)	DATE
	were notified of the	3		thedeficient practice does not recur;	
	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			Nurses were educated on completing post fall follow up documentation which include: Daily follow up fall assessmentation per facility pol	ent
	were notified and no was ordered.	ew orders for a left hip x-ray		for 72 hours • Neurological checks per fac policy • Vital signs per facility policy	ility
	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.			How the corrective action(s) we monitored to ensure the defice practice will not recur, i.e., whe quality assurance programs we put into place;	ient at
	A Post Fall Evaluat indicated the reside	bleted Neurochecks that he fall on 7/9/23 in the record. ion on 7/15/23 at 12:43 p.m., ht had an unwitnessed fall at hian and family were notified.		Nurse managers will audit clir documentation 2 times per we for 3months to ensure follow up assessments and neuro checks are completed.	
	There were no completed Neurochecks that corresponded with the fall on 7/15/23 in the record.			The Director of Nursing/desig will present a summary of the audits to the Quality Assurance committee monthly	
		ed 8/4/23 at 6:10 a.m., nt was noted on the floor on		6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done	
		ed 8/4/2023 at 3:24 p.m., at had a fall in the dining area.		quarterly at the QA meeting. Monitoring will be on going.	
	The Neuro Check A 6:10 a.m., was inco	assessment, dated 8/4/23 at mplete.		Date by which systemic corrections will be completed:8/28/23	
	Interview with the I	Director of Nursing on 8/11/23		σοπριστου.σ/20/23	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/11/2023	
	ROVIDER OR SUPPLIER MILL HEALTH CAN			101 W 8	DDRESS, CITY, STATE, ZIP COD 37TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ated she had no other fall follow	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	ups or neurochecks 3.1-37(a)						
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre-Based on the coma resident, the face (i) A resident receiprofessional stand pressure ulcers are pressure ulcers are pressure ulcers unavoidable; and (ii) A resident with necessary treatmed with professional sepromote healing, pressure ulcers from desided to ensure a received the necessary promote healing, recompleted as ordered updated timely for 20 pressure ulcers. (Refindings include: 1. Resident 49's received to, acute ost pressure ulcer of sace left lower limb, several entered as promoted to acute ost pressure ulcer of sace left lower limb, several entered as promoted to acute ost pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcer of sace left lower limb, several entered as pressure ulcers.	ssure ulcers. prehensive assessment of ility must ensure thatives care, consistent with lards of practice, to prevent and does not develop aless the individual's clinical trates that they were pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent	F 06	86	Spring Mill Health Campus Annual Survey: 8-7-23 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. The Facility respectfully requespaper compliance for this surv F686- Treatments/Svcs to Prevent/Heal Pressure Ulcers What corrective action(s) will be accomplished for those	an the sts ey.	08/28/2023

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155764	B. W	ING		08/11/2023
		ı		STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF F	PROVIDER OR SUPPLIER	L.			87TH AVE	
SPRING	MILL HEALTH CAN	MPUS			LLVILLE, IN 46410	
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE		ID	1	(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
inu		mum Data Set (MDS)		1710	residents found to have been	
	` `	/22/23, indicated the resident			affected by the deficient	'
	· ·	act for daily decision making.			practice.	
		ve assistance with one person			Resident 212 was assessed,	and
	_	ed mobility, transfers,			no adverse effects were noted	
	dressing, and personal hygiene. He had a				related to not having wound	1
	functional limitation in range of motion to both				treatment updated timely.	
	lower extremities. He had 4 stage 4 pressure ulcers				Resident 49 was assessed, a	nd
	and 3 unstageable deep tissue injuries present				no adverse effects were noted	
	upon admission/ent				related to not having wound	^
	apon admission en	.,.			treatment completed as order	ed
A Physician's Order, dated 6/5/23, indicated				How the facility will identify	cu.	
	cleanse left lateral hip with normal saline, pat dry,				other residents having the	
	and apply anasept antimicrobial gel, fill cavity				potential to be affected by th	10
		auze, and cover with dry			same deficient practice and	
	dressing every day				what corrective action will be	_
	aressing every day i				taken.	
	A Physician's Order	r, dated 6/5/23, indicated			All residents with wounds can	he
		ack with normal saline, pat dry,			affected by the same alleged	
		ntimicrobial gel, fill cavity			deficient practice.	
		auze, and cover with dry			What measures will be put in	nto
	dressing every day				place or what systemic	
					changes will be made to	
	A Physician's Order	r, dated 6/5/23, indicated			ensure that the deficient	
		n normal saline, pat dry, and			practice does not recur.	
		nicrobial gel, fill cavity with			Nursing staff were re-educate	d to
		and cover with dry dressing			ensure all wound treatments a	
	every day shift.	-			updated in a timely manner ar	
					completed as ordered.	
	A Physician's Order	r, dated 6/5/23, indicated apply			How the corrective action(s)	
		al gel to the right hip topically			will be monitored to ensure	
	every day shift.	- -			deficient practice will not	
					recur, i.e., what quality	
	A Physician's Order	r, dated 6/23/23, indicated			assurance programs will be	put
	cleanse the left dista	al foot with normal saline, pat			into place.	
	dry, apply betadine	and wrap with roll gauze daily.			DON/Designee to review all n	ew
					wound orders 5 times per wee	ek,
	A Physician's Order	r, dated 6/23/23, indicated			for 3 months to ensure all wou	
		with normal saline, pat dry,			treatments are updated in a til	mely
		wrap with roll gauze daily.			manner and completed as	-

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/11/2023	
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	cleanse the right me pat dry, apply betaddaily. The July 2023 Treat (TAR) indicated the hip, left lower back, foot, and right mediordered on 7/2/23, 7 A Physician's Order cleanse the left med pat dry, apply anase cavity with fluff dry dressing daily. A Physician's Order cleanse the right late pat dry, apply anase cavity with fluff dry dressing daily. A Physician's Order cleanse the right me pat dry, apply anase cover with dry dress. A Physician's Order cleanse left lateral a dry, apply betadine A Physician's Order cleanse the left shin apply skin prep and The July 2023 TAR left medial ankle, right medial ankle,	c, dated 6/5/23, indicated lial ankle with normal saline, ept gel to wound bed, fill v roll gauze, and cover with dry c, dated 6/5/23, indicated eral foot with normal saline, ept gel to wound bed, fill v roll gauze, and cover with dry c, dated 7/1/23, indicated edial shin with normal saline, ept gel to wound bed, and		ordered. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Therea if determined by the Quality Assurance committee, auditir and monitoring will be done quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 8/28/23	ifter,
			1		ı

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155764		 UILDING	NSTRUCTION 00	(X3) DATE COMPI 08/11	LETED	
	PROVIDER OR SUPPLIE		101 W 8	DDRESS, CITY, STATE, ZIP COD 17TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 2 of on 7/2/23, 7/4/23, and 7/7/23.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE.	(X5) COMPLETION DATE
	cleanse the left dist pat dry, apply anast cavity with fluff dr dressing daily. A Physician's Orde	r, dated 6/16/23, indicated al first toe with normal saline, ept gel to wound bed, fill y roll gauze, and cover with dry r, dated 5/20/23, indicated eral 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					
	A Wound Care Not following new order left distal first toe xeroform and cover left lateral: cleans of silvasorb gel, xe MAX silver, ABD	e cleanse, silvasorb gel, with a dry dressing e, fill with iodoform, application reform dressing, PolyMem				
	bordered gauze - left shin: cleanse, bordered gauze - right hip trochante film, silvasorb gel, silver, mepilex - right lateral ankle bordered gauze - right lateral foot: silvasorb gel, xerof	silvasorb gel, xeroform, er: cleanse, no-sting barrier xeroform, PolyMem MAX e cleanse, silvasorb gel, cleanse, no-sting barrier film, form, PolyMem MAX silver,				
	iodoform, silvasorb silver, bordered gau	cleanse, no-sting barrier film, gel, xeroform, PolyMem MAX nze no-sting barrier film, iodoform,				

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CENTERS FOR MEDICARE & MEDICAID SERVICES					0	MB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G 00	COM	PLETED	
		155764	B. WING			1/2023	
		100701	Di Willio		_ 00/1	172020	
NAME OF	PROVIDER OR SUPPLIEF	D.	STRI	EET ADDRESS, CITY, STATE, ZIP C	COD		
NAME OF	FROVIDER OR SUFFLIER	A.	101	W 87TH AVE			
SPRING	MILL HEALTH CAN	MPUS	ME	RRILLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI		COMPLETION	
	`			CROSS-REFERENCED TO THE A	APPROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION	TAG	J. BEHELINETT		DATE	
	1	form, PolyMem MAX silver,					
	bordered gauze						
	-	er 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 star	rted until 7/21/23 per the July					
	2023 Physician Ord	der Summary (POS).					
	The Physician Orde	er for the left lateral hip and left					
	shin was never star	ted per the July 2023 POS.					
	There were no orders for the PolyMem MAX Silver for any wound care treatments including for						
	1	right hip trochanter, right					
		edial shin, and sacrum.					
	lateral root, right in	section string, and sections.					
	Interview with the	Director of Nursing on 8/11/23					
		ted she had no further					
	information to prov						
	information to prov	rue.					
	2. Resident 212's re	ecord was reviewed on 8/9/23 at					
		es included, but were not limited					
		e sided weakness) affecting					
		e, adult failure to thrive,					
	_						
	-	sure-induced deep tissue					
	damage of left heel						
	TI 0' 'C' (O)	' G(/ M' ' D /					
	_	ange in Status Minimum Data					
	` ′	nent, dated 7/6/23, indicated the					
		ely cognitively impaired for					
		ing. He required extensive					
		p+ persons physical assist for					
	bed mobility, transf	fers, toilet use, and personal					
	hygiene. He had 1 s	stage 2 pressure ulcer and 1					
	stage 4 pressure ulc						
	A Physician's Orde	r, dated 5/20/23, indicated					
		h normal saline, pat dry, apply					
	-	ith silver to wound bed and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIER		•	101 W 8	.ddress, city, state, zip cod 87TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IVE ACTION SHOULD BE CO	
		sing every Monday,					DATE
		atment Administration Record nent to the coccyx was not ed on 6/9/23.					
	cleanse the right he	r, dated 6/16/23, indicated el with normal saline, pat and leave open to air daily.					
	indicated the treatm	atment Administration Record nent to the right heel was not ed on 6/24/23 and 6/26/23.					
	cleanse the right he	r, dated 5/20/23, indicated el with normal saline, pat , and wrap with roll gauze daily r soiled.					
	indicated the treatm	atment Administration Record nent to the right heel was not ed on 6/1/23, 6/6/23, 6/8/23, and					
	cleanse the distal sa	r, dated 6/9/23, indicated acrum with normal saline, pat se barrier cream twice daily for					
	indicated the treatm not completed as or	atment Administration Record nent to the distal sacrum was dered on 6/16/23 at 5 p.m., , 6/25/23 at 5:00 p.m., 6/26/23 at //23 at 8:00 a.m.					
		Director of Nursing on 8/11/23 ted she had no further ride.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155764	B. Wl	NG		08/11/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
	3.1-40(a)(2)						
F 0688	483.25(c)(1)-(3)						
SS=D		Decrease in ROM/Mobility					
Bldg. 00	§483.25(c) Mobilit						
J	- ' '	facility must ensure that a					
	- ' ' ' '	rs the facility without limited					
		oes not experience					
	_	of motion unless the					
	resident's clinical	condition demonstrates					
	that a reduction in	range of motion is					
	unavoidable; and						
	` ` ` ` ` `	esident with limited range of					
		ppropriate treatment and					
		se range of motion and/or to					
	prevent further de	crease in range of motion.					
	\$400.05(a)(0) A ma	anistant viita linaitant naalailitus					
		esident with limited mobility ate services, equipment, and					
		ntain or improve mobility					
		practicable independence					
	unless a reduction						
	demonstrably una						
		on, interview, and record	F 06	588	Spring Mil Health Campus		08/28/2023
		failed to ensure a contracture	1 00	,00	Annual Survey: 8-7-23		00/20/2023
		ted, and monitored, and splints					
	were applied as ord	ered for 2 of 4 residents					
	reviewed for range	of motion (ROM). (Residents					
	37 and 212).				Please accept the following as	s the	
					facility's credible allegation of		
	Findings include:				compliance. This plan of		
					correction does not constitute	an	
		98 a.m., Resident 37 was			admission of guilt or liability by	the	
		bed. He indicated he thought			facility and is submitted only ir	า	
		om therapy and had no range			response to the regulatory		
	of motion in his last two fingers on both hands.				requirement.		
	The resident was ur	nable to extend those fingers.					
	On 8/8/23 at 1:24 p	.m. Resident 37 was noted to be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE			(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	COMPLETED	
		155764	B. W	ING		08/11/	2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			87TH AVE			
CDDING	NAUL UEALTU CAN	ADUE						
SPRING	MILL HEALTH CAN	WPUS		MEKKII	LLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	in bed. He still had	no range of motion in the last			The Facility Respectfully reque	ests		
	two fingers on his b	oilateral hands.			paper compliance for this surv	ey.		
						-		
	Interview with RN	1 on 8/10/23 at 10:01 a.m.,						
	indicated she worke	ed with the resident often and						
	had not noticed any	contractures. Upon			F688 Increase/Prevent Decrea	ase		
	observation of the r	resident at 10:06 a.m., she			in ROM/Mobility			
	indicated she would reach out to therapy to get an							
	assessment complet	ted as the fingers were			What corrective action(s) will b	e		
	contracted.				accomplished for those reside	nts		
					found to have been affected by	y the		
	Resident 37's record was reviewed on 8/10/23 at				deficient practice:			
	9:44 a.m. Diagnoses included, but were not limited							
	to end stage renal disease, dementia, and							
	depressive disorder	S.						
					Resident 212 was assessed for	or		
		mum Data Set (MDS)	any adverse effects related to not					
		5/29/23, indicated the resident		having ordered splint in place and				
	1	gnitively impaired for daily			also not having a monitoring o	rder		
	decision making.				in place. No adverse effects			
					noted.			
		locumentation, assessments,						
	or monitoring regar	ding any contractures.						
		Administrator and Director of			Resident 37 was assessed, ar	nd		
	1	at 10:44 a.m., indicated the			OT performed evaluation for			
		erapy to get an evaluation			contractures. OT evaluation			
	completed for the c	ontractures.			indicated no further OT treatm	ent		
					required.			
	2 0 9/7/22 4 2 22	2 D:J4 212						
		3 p.m., Resident 212 was						
		eelchair in the dining area There was no splinting			How the feelite will be settle of			
	device noted on eith				How the facility will identify oth			
	device noted on ett	nei nanu.			residents having the potential			
	On 8/8/22 at 1.29 a	m Pacidant 212 was absorved			be affected by the same defici			
	On 8/8/23 at 1:28 p.m., Resident 212 was observed in bed sitting upright with a bolster on his left				practice and what corrective a will be taken;	CIIOH		
		splinting device noted on			wiii be takeri,			
	either hand.	spinning device noted on						
	omer nanu.							
			1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155764	B. W	ING		08/11/	2023
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS	_		LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rd was reviewed on 8/9/23 at			All residents with adaptive		
		s included, but were not limited			equipment or contractures have		
		sided weakness) following ease affecting right dominant		the potential to be affected by the alleged deficient practice.			
		munication deficit, adult failure			alleged delicient practice.		
	to thrive, contractur						
	The Significant Cha	ange in Status Minimum Data			What measures will be put into	0	
	Set (MDS) assessment, dated 7/6/23, indicated the				place or what systemic change		
	resident was severe	ly cognitively impaired for			will be made to ensure that the		
	daily decision maki	ng. He required extensive			deficient practice does not rec	ur:	
	assistance with two	+ persons physical assist for					
	bed mobility, transfers, toilet use, and personal hygiene.						
					Nurses were in- on ensuring		
		r, dated 6/6/23, indicated right			adaptive equipment/devices a		
		with device on in AM and off			place as per orders as well as		
	in PM.				ensuring that there is a monito	_	
	THE COLLETE IS TO	N1			order in place for all residents		
		Bilateral hand splint had no			have an order for a splint. Nur		
		ented for application and			were also re-educated related		
	removal of the nanc	d splint for the last 30 days.			whenever a change is noted to		
	Interview with CN	A 2 on 8/9/23 at 4:36 p.m.,			resident, they must call the MI and obtain an order for OT to	,	
		nt never wore a splinting			evaluate the resident.		
	device that she was				evaluate the resident.		
	active mar sile was						
	Interview with the I	Director of Nursing on 8/10/23					
		ated the splinting device was			How the corrective action(s) w	ill be	
	discontinued the da	y before (8/9/23) and new			monitored to ensure the defici		
	orders for a smaller	carrot were put into place			practice will not recur, i.e., who	at	
	because it was pain	ful for him to wear the			quality assurance programs w	ill be	
		owever, there was no			put into place;		
		ne splinting device being put					
		or removed in the evening as					
	per the Physician's	Orders.					
					DON/Designee will audit 2		
	3.1-42(a)(2)				residents with adaptive		
					equipment/devices, 2 times a		
					week, for 3 months to ensure	they	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2023
	PROVIDER OR SUPPLIE		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DISE COMPLETION PRIATE DATE
				are in place as ordered as a monitoring order to monit splint placement.	
				DON/Designee will observe residents, 2 times weekly, identify the need for OT se	to
				The Director of Nursing/de will present a summary of taudits to the Quality Assuracemmittee monthly for 6 m. Thereafter, if determined b Quality Assurance committauditing and monitoring will done quarterly and present quarterly at the QA meeting Monitoring will be on going.	the ance onths. y the tee, I be t
				corrections will be complet 8/28/23	ed:
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respi tracheostomy car The facility must needs respiratory tracheostomy car is provided such professional stan	ratory care, including re and tracheal suctioning. rensure that a resident who reare, including re and tracheal suctioning, re and tracheal suctioning, care, consistent with dards of practice, the reson-centered care plan.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
mo		s and preferences, and	mo		DATE
		on, record review, and ty failed to ensure oxygen was	F 0695	Spring Mill Health Campus Annual Survey: 8-7-23	08/28/2023
	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.			Please accept the following as facility's credible allegation of	s the
				compliance. This plan of correction does not constitute admission of guilt or liability by	
				facility and is submitted only in response to the regulatory requirement.	1
				The Facility Respectfully requipaper compliance for this surv	
	sitting in her wheeld	m., Resident 24 was observed chair with the oxygen tubing in not was wearing oxygen via a		F695 Respiratory/Tracheosto	оту
	nasal cannula with a oxygen tubing was	a flow rate set at 2.5 liters. The not connected to the		What corrective action(s) wil	I
		sing aide was notified and dent's oxygen at 2.5 liters.		be accomplished for those residents found to have beer affected by the deficient	n
	in the dining hall we	.m., Resident 24 was observed earing oxygen via nasal		practice; Resident 24 was assessed, ar	
		rate set at 2.5 liters. I was reviewed on 8/8/23 at		no adverse effects were noted related to not having oxygen of the correct setting.	
	12:06 p.m. Diagnos limited to, hyperlipi	ses included, but were not demia (high cholesterol),		How the facility will identify other residents having the	
	hypertension (high blood pressure), non- Alzheimer's dementia, Parkinson's disease, Wernicke's encephalopathy (brain disorder), and			potential to be affected by the same deficient practice and what corrective action will be	
	chronic obstructive	pulmonary disease (COPD).		taken. All residents with an order for	
		mum Data Set (MDS) /4/23, indicated the resident intact.		oxygen can potentially be affe by the same alleged deficient practice.	cted
	A Care Plan, dated	7/24/23, indicated the resident		What measures will be put in place or what systemic	nto

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155764 B. WING 08/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE had a potential for complications and shortness of changes will be made to breath while lying flat related to: COPD, and ensure that the deficient bronchitis. Interventions included, but were not practice does not recur. limited to, administer oxygen per the physician's Staff were re-educated to ensure order. all oxygen concentrators are set on the correct setting for all A Physician's Order, dated 12/26/22, indicated residents who have an order for oxygen at 3 liters per nasal cannula continuous oxygen. every shift for COPD. How the corrective action(s) will be monitored to ensure the The July and August 2023 Medication deficient practice will not Administration Records (MAR) indicated oxygen recur, i.e., what quality via nasal cannula at 3 liters was signed out every assurance programs will be put shift. in place. DON/designee will perform Interview with the Director of Nursing (DON) on observations on 5 residents, twice 8/9/23 at 10:17 a.m., indicated the resident's weekly for 3 months to ensure oxygen should have been set at 3 liters. oxygen is on the correct setting. Director of Nursing/designee will 3.1-47(a)(6) 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 483.45(f)(2) SS=D Residents are Free of Significant Med Errors Bldg. 00 The facility must ensure that its-§483.45(f)(2) Residents are free of any

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significant medication errors.

Based on record review and interview, the facility

failed to ensure residents were free of significant

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M3HU11

F 0760

Facility ID: 010739

Spring Mill Health Campus

Annual Survey: 8-7-23

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08/28/2023

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155764	B. W	NG		08/11/	/2023
		<u>I</u>	I	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			87TH AVE		
SDDING	MILL HEALTH CAN	MPHS			LLVILLE, IN 46410		
SERING	WILL HEALTH CAN	vii 00		MEKKI	LL VILLL, IIN 404 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		elated to timing of insulin					
		of 1 residents reviewed for			Please accept the following as	s the	
	insulin. (Resident	18)			facility's credible allegation of		
					compliance. This plan of		
	Finding includes:				correction does not constitute	an	
					admission of guilt or liability by		
	Interview with Resident 18 on 8/7/23 at 2:19 p.m.,				facility and is submitted only ir	า	
	indicated she did not always receive her insulin				response to the regulatory		
	on time.				requirement.		
					The Facility Respectfully requ		
	The record for Resident 18 was reviewed on 8/8/23				paper compliance for this surv	ey ey	
	at 1:54 p.m. Diagnoses included, but were not						
	limited to, type 2 diabetes mellitus.				F760 Residents are free of		
					Significant Med Errors		
		nimum Data Set (MDS)			What corrective action(s) wil	I	
		7/13/23, indicated the resident			be accomplished for those		
	1	act and she received insulin			residents found to have beer	า	
	injections.				affected by the deficient		
					practice;		
		7/20/23, indicated the resident			Resident 18 was assessed, ar		
		plications related to the			no adverse effects were noted	l	
	_	es mellitus. Interventions			related to timing of insulin		
		not limited to, administer			administration.		
		n as ordered by the doctor.			How the facility will identify		
	Monitor/document	side effects and effectiveness.			other residents having the		
	DI	1 . 17/0/02 . 1:			potential to be affected by th	е	
		dated 7/9/23, indicated the			same deficient practice and		
		eive Glargine insulin 30 units			what corrective action will be	9	
	1	time daily at 8:00 a.m. The			taken;		
		receive Lispro insulin, inject			All residents with insulin order		
		th meals: if blood sugar 151 -			have the potential to be affect	ed	
		250=4 units, 251-300=6 units,			by the same alleged deficient		
		nd call with blood sugar greater			practice.	.4	
	than 351.				What measures will be put in	ito	
	Th - 1 2022 3.5	lination Administration D 1			place or what systemic		
	I	lication Administration Record			changes will be made to		
	, ,	he resident received her insulin			ensure that the deficient		
	late on the followin	_			practice does not recur;		
		ine and Lispro insulin was			· RN's, LPN's, and QMA'	S	
	signed out at 11:40	a.m. Both insulins were	1		were educated on medication		I

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SUR COMPLETE 08/11/202	D
	PROVIDER OR SUPPLIEF		101 W	ADDRESS, CITY, STATE, ZIP CO 187TH AVE RILLVILLE, IN 46410	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF scheduled for 8:00	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION a.m. ine insulin was signed out at	ID PREFIX TAG	PROVIDER'S PLAN OF CORRIGINATION SHOWS A CROSS-REFERENCED TO THE APPLICATION SHOWS A CROSS-REFERENCED TO THE APPLICATION OF T	the 5	(X5) OMPLETION DATE
	- 7/12/23 the Lisprop.m. The insulin ware - 7/14/23 the Glargi signed out at 9:51 a scheduled for 8:00 and - 7/15/23 the Glargi signed out at 9:38 a scheduled for 8:00 and - 7/16/23 the Glargi signed out at 10:22 scheduled for 8:00 and - 7/20/23 the Glargi signed out at 10:22 scheduled for 8:00 and - 7/20/23 the Glargi signed out at 10:22 scheduled for 8:00 and - 7/20/23 the Glargi	ine and Lispro insulins were a.m. Both insulins were a.m. ine and Lispro insulins were a.m. Both insulins were a.m. ine and Lispro insulins were a.m. ine and Lispro insulins were a.m. Both insulins were		emphasis on the correct How the corrective act will be monitored to en deficient practice will r recur, i.e., what quality assurance programs w into place; Nurse manager/designe randomly audit/observe administer insulin 3 time week, for 3 months to e proper insulin administratimes. DON/designee will pres	ion(s) esure the not vill be put ee will 2 Nurses es per ensure ation	
	signed out at 10:07 scheduled for 8:00 scheduled fo	Director of Nursing on 8/11/23 ated the resident's insulin gned out when given. The ir before or after the scheduled		summary of the audits to Quality Assurance commonthly for 3 months. The determined by the Quality Assurance committee, and monitoring will be departed at the QA meet the Date by which systemic corrections will be considered.	o the mittee Thereafter, ality auditing one ting.	
F 0773 SS=D Bldg. 00	§483.50(a)(2) The (i) Provide or obta when ordered by assistant; nurse p specialist in accor including scope of	in laboratory services only a physician; physician ractitioner or clinical nurse dance with State law,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155764	B. W	ING		08/11/	/2023	
NAME OF F	PROVIDER OR SUPPLIER			101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE			
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		nt, nurse practitioner, or cialist of laboratory results						
		clinical reference ranges in						
	accordance with fa	_						
	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		F 0'	773	Spring Mill Health Campus		08/28/2023	
					Annual Survey: 8-7-23			
					Please accept the following as			
	(Resident 49).				facility's credible allegation of			
	Finding includes:				compliance. This plan of			
					correction does not constitute			
	Pasidant 10's racor	d was reviewed on 8/9/23 at			admission of guilt or liability by	-		
		es included, but were not			facility and is submitted only in response to the regulatory	11		
	1	teomyelitis of the left femur,			requirement.			
		cral region stage 4, cellulitis of			The Facility Respectfully requ	ests		
	1 ~	ssure ulcer of right hip, and			paper compliance for this surv			
	heart failure.				F773 Lab Svs Physician	•		
					Orders/Notify of Results			
		mum Data Set (MDS)			What corrective action(s) will	II		
		/22/23, indicated the resident			be accomplished for those			
		act for daily decision making.			residents found to have bee	n		
		essure ulcers that were present			affected by the deficient			
	_	ry and 3 unstageable deep ent upon admission/entry.			practice;	lo.		
	ussuc injuries prese	an apon admission/entry.			Resident 49 had lab drawn. Nature adverse effects were noted du			
	A Physician's Order	r, dated 7/27/23, indicated			not having lab drawn prior to t			
		(BUN), creatinine, and			administration of an antibiotic			
	_	n rate (eGFR) draw prior to			How the facility will identify			
	initiation of antibio	tic courses.			other residents having the			
					potential to be affected by the	ne		
		port, dated 7/28/23, indicated			same deficient practice and			
		GFR were collected on 7/28/23			what corrective action will b	е		
	at 2:35 a.m. and rep	ported on 7/28/23 at 1:02 p.m.			taken;			
	A DI COLO	1 4 17/27/22 11 11			All residents have the potentia			
	1	r, dated 7/27/23, indicated			be affected by the alleged def	ricient		
	_	vulanate (an oral antibiotic) igrams 1 tablet by mouth twice			practice.	at a		
	lance 0/3-123 milli	igrams i tabiet by mouni twice	- 1		What measures will be put in	ιιO	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLI	
		155764	B. W	ING		08/11/2	2023
	PROVIDER OR SUPPLIER			101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	daily.				place or what systemic		
					changes will be made to		
		ication Administration Record			ensure that the deficient		
	, ,	ne amoxicillin tablet was			practice does not recur;		
	administered on 7/27/23 at 8:00 a.m.				Nurses were educated on ens	uring	
					that all lab orders are carried		
	A Physician's Order, dated 7/27/23, indicated				and results are received prior		
		otic) oral tablet 750 milligrams 1			the administration of an antibion		
	tablet by mouth onc	ee daily.			How the corrective action(s)		
					will be monitored to ensure t	the	
	-	R indicated the levaquin was			deficient practice will not		
	administered on 7/2	7/23 at 8:00 a.m.			recur, i.e., what quality		
		21			assurance programs will be	put	
		Director of Nursing on 8/11/23			into place;		
	-	ted the laboratory draw should			DON/Designee will audit 2		
	_	ed prior to administering the			residents with lab and antibiot		
	antibiotics per the P	'hysician's Orders.			orders weekly for 3 months to		
	2.1.40()				ensure all ordered labs are be	ing	
	3.1-49(a)				drawn, if needed, prior to the		
					administration of an antibiotic.		
					Nurse manager/designee will		
					present a summary of the aud	IIIS	
					to the Quality Assurance	ha	
					committee monthly for 3 mont		
					Thereafter, if determined by the Quality Assurance committee,		
					auditing and monitoring will be		
					done quarterly at the QA mee		
					done quarterly at the QA mee	urig.	
					Date by which systemic		
					corrections will be complete	d:	
					8/28/23		
						į	
F 0880	483.80(a)(1)(2)(4)	(e)(f)					
SS=D	Infection Prevention	on & Control					
Bldg. 00	§483.80 Infection	Control					
	The facility must e	stablish and maintain an					
	•	on and control program					
	designed to provid	le a safe, sanitary and					
	comfortable enviro	onment and to help prevent					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155764	B. W	ING		08/11	/2023
		1		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			87TH AVE		
SDDING	MILL HEALTH CAN	MDUS			LLVILLE, IN 46410		
OI INING	WILL FILALITY CAI	WII 03		IVILIXIXII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the development	and transmission of					
	communicable dis	seases and infections.					
	§483.80(a) Infecti	on prevention and control					
	program.						
	The facility must establish an infection						
	prevention and control program (IPCP) that						
	must include, at a minimum, the following						
	elements:						
	\$402.00/=\/4\ A =	t					
	- , , , ,	ystem for preventing,					
		ing, investigating, and ons and communicable					
		sidents, staff, volunteers,					
		individuals providing					
		contractual arrangement					
	based upon the fa	<u> </u>					
		ling to §483.70(e) and					
		d national standards;					
	l lonewing decopies	a national standards,					
	\$483.80(a)(2) Wri	tten standards, policies,					
	- , , , ,	or the program, which must					
	include, but are no	. •					
		rveillance designed to					
		communicable diseases or					
		they can spread to other					
	persons in the fac	-					
	(ii) When and to w	whom possible incidents of					
	communicable dis	sease or infections should					
	be reported;						
	(iii) Standard and	transmission-based					
	precautions to be	followed to prevent spread					
	of infections;						
	, ,	visolation should be used					
		luding but not limited to:					
		duration of the isolation,					
		he infectious agent or					
	organism involved						
	(B) A requirement	that the isolation should be					
	the least restrictiv	e possible for the resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	A. BUILDING 00 COMPLETED			ETED
		155764	B. WING			08/11/	2023
	PROVIDER OR SUPPLIER		10)1 W 8	DDRESS, CITY, STATE, ZIP COD 17TH AVE LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)		DATE
	under the circums (v) The circumstar must prohibit emp communicable dis lesions from direct their food, if direct disease; and (vi)The hand hygie followed by staff in contact. §483.80(a)(4) A sy incidents identified and the corrective facility. §483.80(e) Linens Personnel must ha transport linens so of infection. §483.80(f) Annual The facility will con its IPCP and upda necessary. Based on observation interview, the facility control guidelines w including those to p COVID-19, related reusable equipment between glove use,	tances. Inces under which the facility loyees with a sease or infected skin at contact with residents or a contact will transmit the sene procedures to be involved in direct resident system for recording district under the facility's IPCP actions taken by the sease of prevent the spread of as to prevent the spread of as to prevent the spread of the their program, as son, record review, and the facility and ty failed to ensure infection over in place and implemented, prevent and/or contain to improper cleaning of the improper disposal of a idents observed during	F 0880		Spring Mill Health Campus Annual Survey: 8-7-23 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory	an / the	08/28/2023
	rmaing includes:				requirement. The Facility Respectfully reque	ests	
	_	.m., LPN 1 was observed			paper compliance for this surv		
	1 -	cose levels of Resident 45.			POC F-880 Infectio	n	
LPN 1 washed her hands and donned clean							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED				
		155764	B. W	ING		08/11/	/2023
		!		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF	PROVIDER OR SUPPLIEF	₹			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS	_	MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	the glucometer down with an laced the glucometer into a			Prevention & Cont	rol	
	_	emoved her gloves and donned			Corrective actions which wi	II	
	_	t performing hand hygiene in			be accomplished for those		
		She performed the finger stick			residents found to have beer	า	
		sident's blood glucose			affected by the deficient		
		the room and placed the used			practice:		
		lar garbage can. LPN 1 then					
		f Novolog (an insulin). She			Employees were immediately		
	retrieved the medic	ation from the cart, donned			educated related to performing	•	
	new gloves without	performing hand hygiene			hand hygiene in between char		
	first. She wiped the	vial with an alcohol swab,			gloves, the proper method in v	wnicn	
	_	ringe, and withdrew 30 units of			to dispose of lancets and the	otor	
		donned new gloves without			correct way to clean a glucom	eter.	
		giene first and entered the			How the facility will identify		
	resident's room and	administered the medication.			other residents having the		
					potential to be affected by th	e	
		the time, that she should have		same deficient practice:			
		giene between glove use, the					
		been disposed of in the sharps was unaware that an alcohol			All residents have the potentia	al to	
	· ·	riate to clean the glucometer		be affected by the alleged of			
		ong residents in the facility.			practice.		
	and was shared ann	ong residents in the facility.					
	Interview with the	Nurse Consultant on 8/9/23 at			The measures the facility wil		
		I she had no further information			take or systems the facility v	vill	
	to provide.				alter to ensure that the		
					problem will be corrected an	d	
	A Policy titled, "Gl	ucometer Cleaning" and noted			will not recur:		
	as current, indicated	d"3. To clean and disinfect			DON/Designee re-educated the		
	_	noistened germicidal or			staff related to performing han	iu	
	Antimicrobial wipe/towel. 4. Wipe meter with				hygiene in between changing gloves, the proper method in v	which	
	_	surfaces of the glucometer are			to dispose of lancets and the	WITICIT	
		ce glucometer on a clean surface			correct way to clean a glucom	eter	
		and allow to air dry for no			grade may to dicarr a gradem		
		, or according to manufacturer			Quality Assurance Plans to		
	instructions."				monitor facility performance	to	
	A Dollor-441-4 UTT	and Washing/Hand H:			make sure that corrections a		
		and Washing/Hand Hygiene" t, indicated "4. When hands			achieved and are permanent		
	and noted as curren	ii, maicated4. when hands			The D.O.N. or designed		

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	of correction identification number 155764	A. BUILDING B. WING	00	COMPLETED 08/11/2023
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W 8	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	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 were for 3 months to monitor staff for handwashing, lancet disposal glucometer cleaning practices. Administrator/designee was present a summary of the audit to the Quality Assurance committee monthly for 6 month 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	or and vill its ns. e
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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Event ID:

 $M3HU11 \quad \text{Facility ID:} \quad 010739$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764			UILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/11 ,	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD 87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
1710		resistance related to a		mo	Please accept the following as	the	DATE
		bing antibiotics for wounds			facility's credible allegation of		
	_	red for 1 of 2 residents			compliance. This plan of		
	reviewed for pressu	re ulcers. (Resident 49).			correction does not constitute		
	Finding includes:				admission of guilt or liability by		
	rinding includes.				facility and is submitted only in response to the regulatory	1	
	Resident 49's record	d was reviewed on 08/09/23 at			requirement.		
	11:18 a.m. Diagnos	es included, but were not			'		
		teomyelitis of the left femur,			The Facility respectfully reque		
	pressure ulcer of sacral region stage 4, cellulitis of left lower limb, pressure ulcer of right hip, and heart failure.				Paper Compliance for this sur	vey.	
					DOC E 804 Austibiatia Stavena	الماماء	
	neart failure.				POC F-881 Antibiotic Steward	isnip	
	The Quarterly Minimum Data Set (MDS)				Corrective actions which will b	e	
		5/22/23, indicated the resident			accomplished for those reside	nts	
		act for daily decision making.			found to		
		essure ulcers that were present			have been affected by the def	icient	
	_	ry and 3 unstageable deep ent upon admission/entry.			practice:		
	ussue injuries prese	in upon admission/entry.			Resident 49 was assessed, a	nd	
	Wound Care Notes	, dated 7/26/23, indicated a			no adverse effects were noted		
	wound culture was	completed on 7/19/23, which			related to		
		s were detected in the right			antibiotics not meeting criteria		
		edial foot, and left lateral foot.			antibiotic stewardship program		
	_	an, and visit details indicated ven for gentamicin sulfate			How the facility will identify oth		
	_	o all wound beds with every			residents having the potential be	i.	
	dressing change.	s air weard seas with every			affected by the same deficient		
					practice:		
	_	hysician Order Summary (POS)					
		n normal saline, pat dry, apply			All residents, on antibiotics, ha		
		external ointment 0.1% and bed cover with dry dressing			the potential to be affected by	the	
		Wednesday to the left distal			alleged deficient practice.		
		eral hip, left distal first toe, left			donoioni praodioo.		
	· ·	al medial foot, left lateral foot,			The measures the facility will	take	
		medial first toe, left medial			or systems the facility will alte		
		oot, left shin, right hip, right			ensure		
	lateral ankle, right l	ateral foot, right medial heel,			that the problem will be correct	ted	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $M3HU11 \quad \text{ Facility ID:} \quad 010739$

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	distal first toe, left of medial first toe, left lateral ankle, right lateral shin, and Interview with the I at 3:58 p.m., indicat the Wound Nurse P	res completed for the left listal foot, left lower back, left medial ankle, left shin, right ateral foot, right medial heel,		and will not recur: Infection Preventionist re-edu on McGreer's criteria for bein prescribed antibiotics. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and permanent: • The DON/ designee will revent the culture 2x per week for 3 months, for all residents prescribed an antibeto ensure the resident meets McGreer's criteria for infections. • Administrator/designee will present a summary of the auto to the Quality Assurance committee monthles of months. Thereafter, if determined by the Quality Assurance commanditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going.	o are iew iotic, dits y for ittee, e
F 0921 SS=D Bldg. 00	§483.90(i) Other E	anitary/Comfortable Environ Environmental Conditions provide a safe, functional,		be completed Completion date: 8/28/23	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $M3HU11 \quad \text{ Facility ID:} \quad 010739$

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PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER A. BUILDING B. WING		JILDING	ONSTRUCTION 00	(X3) DATE COMPL 08/11/	ETED	
	PROVIDER OR SUPPLIER		•	101 W 8	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	residents, staff an Based on observation failed to ensure the clean and in good re	fortable environment for d the public. on and interview, the facility residents' environment was epair related to urine odor and of 3 units. (Healthcare 2 Unit	F 09	921	Spring Mill Health Campus Annual Survey: 8/7/23		08/28/2023
	Findings include: During the Environ of Maintenance and	mental Tour with the Director the Housekeeping Supervisor i.m., the following was			Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement.	an / the	
		e was a rip in the carpet upon n. One resident resided in the t:			The Facility Respectfully requipaper compliance for this surv		
	Two residents resid Interview with the Management of the Manageme	room had a strong urine odor. ed in the room. Maintenance Director and ervisor at the time, indicated ed of cleaning and/or repair.			F921 Safe/Functional/Sanitary/Comble Environment What corrective action(s) will taccomplished for those reside found to have been affected bedeficient practice;	oe nts	
					The foul odor was resolved. The ripped carpet was repaire	d.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $M3HU11 \quad \text{ Facility ID:} \quad 010739$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155764	A. BU B. WI	JILDING NG	00	COMPLETED 08/11/2023	
		155704	D. WI	_		00/11/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
SPRING	MILL HEALTH CAN	MPUS .			LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	How the facility will identify oth	ner	DATE
					residents having the potential		
					be affected by the same defici		
					practice and what corrective a	ction	
					will be taken;		
					All residents have the potentia	l to	
					be affected by the same allege		
					deficient practice.		
					What measures will be put into		
					place or what systemic change		
					will be made to ensure that the deficient practice does not rec		
					denoient practice does not rec	ui,	
					0. "		
					Staff were re-educated on the procedure of notifying		
					maintenance/environmental		
					services of any necessary		
					repairs/cleaning needed.		
					How the corrective action(s) w	rill be	
					monitored to ensure the defici		
					practice will not recur, i.e., who quality assurance programs w		
					put into place;	III DE	
					, ,		
					Maintenance supervisor/desig		
					will audit the facility 3x per we		
					for 4 weeks, on alternating uni for Maintenance issues/smells		
					Any identified issues will be	•	
					corrected.		
			1				

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Event ID:

M3HU11 Facility ID: 010739

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BUILDING B. WING	00 00	COMPLETED 08/11/2023	
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	Survey. This visit in Residential Complaint Included a Recertific Survey and the Inve Complaints IN00412 to the allegations are Complaint IN00413 the allegations are complaint IN00413	771 - No deficiencies related to	R 0000	/designee will present a summ of the audits to the Quality Assurance committee monthly 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/23	y for g y at

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PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BUILDING B. WING	00	COMPLETED 08/11/2023	
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0036 Bldg. 00	Quality review come. 410 IAC 16.2-5-1.2 Residents' Rights-(k) The facility must resident 's physical legal representation noticed: (1) a significant dephysical, mental, of (2) a need to alter is, a need to discontreatment due to a commence a new Based on record revisaled to ensure the an interested family of a fall for 1 of 4 resident C) Finding includes: The record for Resident 12:00 p.m. Diagnolimited to, unsteadir dementia with behavarthritis. An Assisted Living	Deficiency st immediately consult the an and the resident 's when the facility has cline in the resident 's or psychosocial status; or treatment significantly, that ntinue an existing form of dverse consequences or to form of treatment. iew and interview, the facility resident's responsible party or member was promptly notified exidents reviewed for falls. Ident C was reviewed on 8/8/23 oses included, but were not ness on feet, repeated falls, vioral disturbance, and Level of Care Assessment, ted the resident was severely	R 0036	Spring Mill Health Campus Annual Survey: 8-7-23 R 036- Notification of Change What corrective action(s) will accomplished for those reside found to have been affected by the deficient pract Resident C family was notified the fall. How will facility identify other	be ents ice?

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		UILDING	onstruction 00	(X3) DATE : COMPL 08/11 /	ETED	
	ROVIDER OR SUPPLIER		 101 W 8	ADDRESS, CITY, STATE, ZIP COD B7TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	indicated the reside his room without as			residents who have the potent be affected by the same alleged deficient practice		
	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.			The deficient practice has the potential to affect all facility residents.		
				What corrective measures will facility take or will alter to ensuthat the problem will not reoccur?		
	was notified of the			Licensed nursing staff educate on ensuring that family is notifi		
		Director of Nursing on 8/9/23 at I there was no additional iew.		any time a resident has a fall. What quality assurance plans	will	
	This State Resident IN00414473.	ial tag relates to Complaint		be implemented to monitor factories performance to ensure corrections are achieve and permanent?	ility	
				DON/Designee will audit all fall documentation 3 x per week for months, to ensure family is notified of the fall. A summary will be presented to Quality Assurance committee monthly x 3 months.	or 3	
				By what date the systemic changes will be completed: 8-28-23		
R 0092 Bldg. 00	410 IAC 16.2-5-1. Administration and Noncompliance (i) The facility mus					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155764		A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIEF		101 V	T ADDRESS, CITY, STATE, ZIP COD V 87TH AVE RILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	continuity of care emergency as foll (1) Fire exit drills i transmission of a simulation of eme except that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency acconditions. At least held every year. V between 9 p.m. ar announcement manudible alarms. (2) At least every shall attempt to he in conjunction with A record of all trait documented with of the personnel passed on record revisited to ensure at least empt was made to in conjunction with had the potential to resided in the facility. Finding includes: The Fire and Disast 9:53 a.m. There was no document of the drill every 6 more drill every 6 m	in facilities shall include the fire alarm signal and regency fire conditions, ovement of nonambulatory areas or to the exterior of required. Drills shall be the only on each shift to the personnel with signals cition required under varied at twelve (12) drills shall be when drills are conducted and 6 a.m., a coded and be used instead of the local fire department. In the local fire department and interview, the facility east every 6 months, an or hold a fire and disaster drill the local fire department. This affect 34 residents who by. The Drills reviewed on 8/9/23 at the name of the local fire department affect 34 residents who by.	R 0092	Spring Mill Health Campus Annual Survey: 8/7/23 R 092- Administration Correct action(s) will be accomplished those residents found to have been affected by the deficient practice; Fire Department invin fire drill on 8-11-23. How the facility will identify other resident having the potential to be affected by the same deficient practice 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	d for colved colved che ents coted cond cond cond cond cond cond cond con

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/11/2023
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Direct did not know if the any of the fire drills find out. Interview with the A Director on 8/9/23 a spoken to the Maintindicated he had embut never heard bac He also indicated he	at 10:07 a.m., indicated the or was on sick leave and he fire department participated in , but would give him a call and assistant Maintenance at 10:20 a.m., indicated he had enance Director, who ailed the local fire department, k, and did not have that email. As a did remember calling them as ord of the phone call.		what systemic changes will be made to ensure that the defic practice does not recur; Administrator and Maintenance Department educated about the need to in the fire department in fire drill the facility every 6 months. He the corrective action(s) will be monitored to ensure the deficient practice will not recuive, what quality assurance programs will be put into place; Maintenance/Designeensure that the fire department involved in fire drills every 6 months at the facility. The nusupervisor/designee will presessummary of the audits to the Quality Assurance committee monthly for 3 months. There if determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring who en going. Date by which systemic corrections will be completed: 8/28/23	ivolve s at ow r, e will int is rse ent a after, g
R 0144 Bldg. 00	(a) The facility sha a state of good re and shall provide	5(a) fety Standards - Deficiency fill be clean, orderly, and in pair, both inside and out, reasonable comfort for all			
	failed to ensure the clean and in good re	on and interview, the facility residents' environment was epair related to marred walls	R 0144	Spring Mill Health Campus Annual Survey: 8/7/23	08/28/2023
	and moors, stained o	arpets, sewage odors, rusted		R 144- Sanitation and Safety	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE C A. BUILDING B. WING	OO OOSTRUCTION	(X3) DATE SURVEY COMPLETED 08/11/2023
	PROVIDER OR SUPPLIEF		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE IILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ON (X5) BE COMPLETION DATE
	2 of 2 units. (The L units) Findings include:	ast particles in ceiling lights for egacy and Assisted Living .m. the Environmental Tour was		What corrective action(s) be accomplished for those residents found to have be affected by the deficient practice;	e
	completed and the f	following was observed:		Room 116, 126, 127 ceiling the bathroom was cleaned. Room 116, 126, 127-bathrodoor was repainted and cle	oom aned.
	observed in the ceil bathroom door fran	re was debris and particles ing light in the bathroom. The ne and door was rusted. There no shared the room and		Room 127 toilet seat was c Hallways free of foul odor. Wallpaper was cleaned and longer bubbled. Walls repainted and no long	d no
	observed in the ceil bathroom door was	ere was debris and particles ing light in the bathroom. The rusted brown in color and 1 resident who resided in the		marred. Carpet in the dining room c Floors in the parlor were cle and repainted.	
	with dried bowel m particles in the ceili	toilet high rise seat was dirty overnent. There was debris and ing light in the bathroom. The marred and had a rusted door		How the facility will identify other residents having the potential to be affected by same deficient practice and what corrective action will taken;	the
	bathroom. d. There was a stroi	2 residents who shared the ng smell of sewage in the the residents' rooms.		All Residents have the pote be affected by the same de practice.	ficient
	was marred and bul	the chair rail were marred in the		What measures will be purplace or what systemic changes will be made to ensure that the deficient practice does not recur;	t into
	throughout.	arpet had many large stains		Staff were re-educated to complete work orders.	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	X3) DATE SURVEY COMPLETED 08/11/2023	
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	_	parlor next to the dining room ed with scuff marks. The walls rty.		Housekeeping supervisor and maintenance will complete war rounds daily.		
	outside of the reside	Administrator on 8/10/23 at 1:05 f the above was in need of		How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; Maintenance/Housekeeping wensure that the facility is free foul odors, and facility remain clean and good living condition. The Housekeeping supervisor/designee will pressummary of the audits to the Quality Assurance committee monthly for 3 months. There if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarter the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 8/28/23	put vill of s in ons. ent a after, ag ly at vill	
R 0217 Bldg. 00	facility, using appr members, shall ide	, , ,				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2023
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LOCK DEPARTMENT OF DEFINITION OF THE PROPERTY OF T	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
PREFIX TAG	(1) The services of resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as appropresident and facility change. Either the request a service (3) The agreed up signed and dated of the service plan resident upon request a service (4) No identification services provided subsequent to the no need for a chain (5) If administration provision of resident services of the services provided subsequent to the no need for a chain (5) If administration provision of resident services of the services of the services of the services provided subsequent to the no need for a chain (5) If administration of resident services of the services of t	a LSC IDENTIFYING INFORMATION offered to the individual appropriate to the: offered shall be reviewed and riate and discussed by the ty as needs or desires a facility or the resident may plan review. on service plan shall be by the resident, and a copy in shall be given to the uest. on and documentation of its needed if evaluations initial evaluation indicate	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	the services to be Based on record rev failed to ensure the the resident and the according to the res 6 of 6 residents rev (Residents 2, B, C, Findings include: 1. The record for Re 8/8/23 at 2:25 p.m. not limited to, type	view and interview, the facility service plan was signed by y were revised and updated ident's change in condition for lewed for service plans.	R 0217	Spring Mill Health Campus Annual Survey: 8-7-2023 Please accept the following as facility's credible allegation of compliance. This plan of correction does no constitute an admission of guiliability by the facility and is	ot
	The Service Plan, d	ated 8/6/23, was not signed by		submitted only in response to	the

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		NSTRUCTION (X3) DATE SURV 00 COMPLETEI 08/11/202		ETED		
	PROVIDER OR SUPPLIER		101 W 8	ADDRESS, CITY, STATE, ZIP COD 37TH AVE LLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the resident, only by	y facility staff.		regulatory requirement.		
		Administrator on 8/9/23 at 1:15 was unaware the service plans the resident.		R 217 Evaluation		
	8/8/23 at 10:24 a.m not limited to, meta	esident B was reviewed on Diagnoses included, but were bolic encephalopathy, anxiety, major depressive blood pressure.		What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice;	nts	
	hospice to evaluate	r, dated 5/6/23, indicated and treat. ated 8/6/23, was not signed by		Service Plans signed by family members.	<i>y</i>	
	the resident, only by plan did not address	y facility staff. The service s hospice care.		Service plans updated as nee	ded.	
	p.m., indicated she had to be signed by Interview with the I	Director of Nursing on 8/9/23 at there was no additional		How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken;	to ent	
	3. The record for Ro 8/8/23 at 12:00 p.m not limited to, unste	esident C was reviewed on Diagnoses included, but were eadiness on feet, repeated falls, vioral disturbance, and		All facility residents have the potential to be affected by the same alleged deficient practic		
	hospice to evaluate A Physician's Order	r, dated 12/31/21 and on the		What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not reconstruction.	es e	
	current 8/2023 Orde 50 milligrams at be	er Summary , indicated Seroquel d time.				
	- 5 mmgramo at 00			Director was educated on the		

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155764	B. WI	NG	_	08/11/2023	
NAME OF T	DROWNER OF CURPY TEX		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		ated 8/6/23, was not signed by	+	TAG	need to ensure that all service		DATE
		y facility staff. The Service			plans are signed by residents		
	Plan did not address hospice care or the use of				unable to sign their family	OI II	
	antipsychotic medic	-			members.		
		Administrator on 8/9/23 at 1:15					
	•	was unaware the service plans					
	had to be signed by	the resident.			Staff were educated to ensure		
	Interview with the	Director of Nursing on 8/9/23 at			service plans are updated with changes of condition.	1	
		I there was no additional			Granges of Condition.		
	information to revie						
		esident D was reviewed on			How the corrective action(s) w	ill be	
	_	Diagnoses included, but were			monitored to ensure the defici-		
		ntia without behavioral,		practice will not recur, i.e., what			
		anxiety disturbances, and high			quality assurance programs w	ill be	
	blood pressure.				put into place;		
	The Service Plan, d	ated 8/6/23, was not signed by			Nurse Supervisor/Designee w	ill	
	the resident, only by				audit 5 residents service plans		
					week x 3 months to ensure that	at	
		Administrator on 8/9/23 at 1:15			the service plans are being sig	gned	
	_	was unaware the service plans			and updated.		
	had to be signed by	the resident.					
	5. The closed recor	rd for Resident E was reviewed					
		m. Diagnoses included, but			The Nurse Supervisor/designe	ее	
	·	anxiety, chronic kidney			will present a summary of the		
		piratory failure, high blood			audits to the Quality Assurance		
	-	dness, hearing loss, COPD,			committee monthly for 3 mont		
	heart failure, repeat disorders.	ed falls, and depressive			Thereafter, if determined by the		
	uisorucis.				Quality Assurance committee, auditing and monitoring will be		
	The Service Plan. d	ated 6/26/23, was not signed			done quarterly and present	•	
	by the resident, only				quarterly at the QA meeting.		
					Monitoring will be on going.		
		Administrator on 8/9/23 at 1:15					
		was unaware the service plans					
	had to be signed by	the resident.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 08/11/2023			
		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
8/8/23 at 4:40 p.m. not limited to, Parki disorder, arthritis, a	Diagnoses included, but were nson's disease, anxiety, bipolar nd major depressive disorder.			Date by which systemic corrections will be completed:8/28/23		
Interview with the A	Administrator on 8/9/23 at 1:15 was unaware the service plans					
Clinical Records - (a) The facility mu on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that records must be as umented. sible.					
Based on record reversal failed to ensure climaccurate related to form documentation after checks completed, and administered only a interventions were assigned out as being residents reviewed for B, C, D, and F) Findings include: 1. The record for F	riew and interview, the facility ical records were complete and follow up assessment and a fall with injury, neurological as needed (PRN) medication fter non-pharmacological attempted, and medications administered for 4 of 6 for clinical records. (Residents	R 0349		facility's credible allegation of compliance. This plan of correction does no constitute an admission of guil liability by the facility and is submitted only in response to regulatory requirement.	ot t or the	08/28/2023
	PROVIDER OR SUPPLIER MILL HEALTH CAN SUMMARY S (EACH DEFICIEN REGULATORY OR 6. The record for Re 8/8/23 at 4:40 p.m. not limited to, Parki disorder, arthritis, at The Service Plan, de the resident, only by Interview with the A p.m., indicated she shad to be signed by 410 IAC 16.2-5-8. Clinical Records - (a) The facility muston each resident. maintained under employee of the faresponsibility. The follows: (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on record rev failed to ensure clin accurate related to f documentation after checks completed, a administered only a interventions were a signed out as being residents reviewed f B, C, D, and F) Findings include: 1. The record for F	DEROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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. 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)	A BUILD B WING PROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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. 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	STREET A 101 W 8 MERRIL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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. 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	OF CORRECTION IDENTIFICATION NUMBER 155764 ROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ILSC IDENTIFYING INFORMATION 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. 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 interventions were attempted, and medications 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) This plan of correction does not constitute an admission of guil liability by the facility and is submitted only in response to regulatory requirement.	FROVIDER OR SUPPLIER MILL HEALTH CAMPUS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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. 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 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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155764	B. W	NG		08/11/	2023
				CTD FET	ADDRESS CITY STATE ZID COD		
NAME OF PI	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
CDDING N	MILL HEALTH CAN	ADULE			B7TH AVE		
SPRING	WILL HEALTH CAN	WPU5		MEKKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	not limited to, meta	bolic encephalopathy,			paper compliance for this surv	еу	
	dementia with mild	anxiety, major depressive					
	disorder, and high b	plood pressure.					
		ed 7/10/23 at 10:26 p.m.,			R349 Clinical Records – Non		
	indicated around 3:45 p.m., the resident was observed on the floor in front of the bathroom.						
		ted she had pain all over, but					
		ead. There was small bruise			What corrective action(s) will b		
		n that measured 0.5 centimeters			accomplished for those reside		
	(cm) by 0.3 cm.				found to have been affected by	y the	
					deficient practice;		
		ation, dated 7/10/23, indicated					
		unwitnessed fall with injury to					
	her left arm.						
					Resident ,D, F were assessed	,	
	_	Assessment was completed on			and no adverse effects were		
	-	/11 at 12:03 a.m., 7/13 at 9:57			noted.		
	p.m., and 7/15/23 at	1 12:00 p.m.					
	There were no neur	ological checks initiated after					
	the unwitnessed fall	_			How the facility will identify oth	or	
	the unwithessed fan				residents having the potential		
	Δ Nurses' Note dat	red 7/21/23 at 1:58 p.m.,			be affected by the same defici		
		nt was observed by staff on			practice and what corrective a		
		the wheelchair. The fall was			will be taken;	CHOIT	
		e was unable to verbalize			wiii bo takon,		
		ere were no apparent injuries					
		The resident had an old					
		to the left side of the			All residents with falls can be		
	forehead.				affected by the same alleged		
					deficient practice.		
	A Post Fall Observa	ation, dated 7/21/23 at 1:47					
		resident had an unwitnessed					
	-	e to verbalize what had					
	happened. A neurol	ogical check was completed			What measures will be put into)	
		e noted except she had an old			place or what systemic change		
	faded green bruise t				will be made to ensure that the		
	-				deficient practice does not rec	ur;	
	There was no docur	mentation or an assessment in			•		

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155764)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 08/11/	ETED
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	STREET 101 W MERRI			
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
	the clinical record of any left forehead bruise after the fall on 7/10/23. There was no documentation continued		p paraid="286295553" paraeid="{a133d012-9642	-4302-85	
	neurological checks had been initiated. A Fall Follow Up Assessment, dated 7/24/23 at		bd-d1cd98b19886}{7}" >N were educated on comple fall follow up documentation	urses ting post	
	8:28 p.m., was the only one completed after the fall on 7/21/23.		when to use non- pharmac interventions which include		
	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		Daily follow up fall assessment documentation per facility policy for		
	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.		·Neurological checks pe policy	r facility	
	Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated neurological checks were to be		·Vital signs per facility po	blicy	
	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.		·Utilize non-pharmacological interventions prior to using PRN Medication.		
	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.		How the corrective action(•	
	An Assisted Living Level of Care assessment, dated 8/6/23, indicated the resident was severely impaired for decision making.		monitored to ensure the do practice will not recur, i.e., quality assurance program put into place;	what	
	Physician's Orders, dated 5/10/23, indicated Lorazepam (an anti-anxiety medication) 2 milligrams (mg) per milliliters (ml), give 0.25 ml		Nurse managers will audit	clinical	

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	OF CORRECTION	IDENTIFICATION NUMBER 155764	A. BUILD B. WING		00	COMPL 08/11/	ETED
NAME OF F	PROVIDER OR SUPPLIEF	1			DDRESS, CITY, STATE, ZIP COD		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	anxiety and restless				documentation 2 times per week, for 3months to ensure follow up assessments and neuro checks		
	the months of 6/202 PRN medication wa on 6/6 at 11:28 a.m	ministration Record (MAR) for 23 and 7/2023, indicated the as signed out as administered ., 6/11 at 7:20 p.m., 6/24 at 7:09 .m., 7/1 at 10:44 p.m., 7/4 at 3:22 3 p.m.			are complete. The use of PRN medication will be audited twice week.		
	the above mentione non-pharmacologic	mentation in Nurses' Notes on d dates to indicate al interventions were re administering the PRN			The Director of Nursing/design will present a summary of the audits to the Quality Assurance committee monthly for 6 monthsThereafter, if determine the Quality Assurance commit auditing and monitoring will be	ed by	
	indicated the reside ambulating in the h his arms. The reside room and leaned or	d 6/17/23 at 3:39 p.m., nt was observed by staff to be allway and carrying briefs in ent stepped inside a resident wer towards a shelf, and tusing him to lose his balance			done quarterly at the QA meetingMonitoring will be on going.	•	
	by 0.2 cm open area	a was observed to the left al assessment was initiated.			Date by which systemic corrections will be completed:8/28/23		
	the resident was ob	d 6/18/23 at 9:22 a.m., indicated served with swelling to the d and his fingers had					
	Physician's Order, of hand X-ray.	lated 6/19/23, indicated left					
	resident had an acut	r, dated 6/19/23, indicated the te fourth proximal phalanx I bone in the finger)					
		dated 6/19/23, indicated d swelling to left hand and					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023		
	ROVIDER OR SUPPLIER		10)1 W 8	DDRESS, CITY, STATE, ZIP COD 7TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLEMENT) TAG DEFICIENCY)		TE	(X5) COMPLETION DATE
MG		related to acute fourth proximal	11				DATE
	the month of 6/202, not signed as being shift on 6/28 and or 6/24, 6/25, 6/27 and The TAR for the monitoring was not	onth of 7/2023 indicated the signed as being completed					
		on 7/17, the evening shift on the shift on 7/3, 7/8, 7/9, 7/13, 23, and 7/25/23.					
	1:15 p.m., indicated	Director of Nursing on 8/9/23 at I fall follow up was to be ift for 72 hours. She had no ion to review.					
	8/8/23 at 3:30 p.m. not limited to deme	esident D was reviewed on Diagnoses included, but were entia without behavioral, anxiety disturbances, and high					
	dated 8/6/23, indica	Level of Care assessment, ated the resident was d for decision making.					
	the resident had an sustained a hemator	ation, dated 6/4/23, indicated unwitnessed fall and ma (blood-filled localized of her scalp that measured by by 6 cm.					
	completed through	s were initiated on 6/4/23 and 6/5/23 at 5:10 a.m. They were levery shift for 48 hours.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIER			101 W 8	DDRESS, CITY, STATE, ZIP COD 7TH AVE LVILLE, IN 46410		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TC	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
		ation, dated 7/27/23 at 4:40					
	-	resident had a fall and hit her a bruise to the right cheek that					
	measured 3.1 cm by	-					
	completed on 7/28	Assessment, was only at 10:29 a.m., 7/29 at 11:01 a.m. (30 at 6:53 a.m., 1:26 p.m., and					
	There was no follow	w up assessment for the bruise					
		t weekly skin assessment was					
		23. There was no weekly skin					
	1:15 p.m., indicated completed for every up was to be compl	Director of Nursing on 8/9/23 at d neurological checks were to be y unwitnessed fall. Fall follow leted every shift for 72 hours. hal information to review.					
	4. The record for R	Resident F was reviewed on					
		Diagnoses included, but were					
	· ·	inson's disease, anxiety, bipolar					
	disorder, arthritis, a	and major depressive disorder.					
	A Basic Level of C	are Assessment, dated 8/6/23,					
		ent had mild impairment for					
		nfusion, and difficulty in					
	remembering conve	ersations and forgetfulness.					
	Physician's Orders,	dated 3/23/23, indicated					
		-anxiety medication) 0.5					
	milligrams, give 1 of for anxiety.	every 12 hours as needed (PRN)					
	for the month of 6/2 Lorazepam was sig	Iministration Record, (MAR) 2023, indicated the PRN ned out as being administered a. and 6/26 at 12:12 p.m.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/11/2023				ETED	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	signed out as being p.m. and 7/24/23 at The 8/2023 MAR, i signed out as being 11:40 p.m.	indicated the medication was administered on 8/3/23 at					
	There were no non-pharmacological interventions attempted first before the administration of the PRN Lorazepam.						
	a.m., indicated the fall and was not abl happened. The resid	resident had an unwitnessed e to tell anyone how it dent sustained an abrasion e the right brow that measured					
	assessment was cor and 7:01 p.m., 4/12 and 4/14/23 at 2:20	Assessment, indicated an impleted on 4/11 at 11:01 a.m., at 8:33 p.m., 4/13 at 10:56 a.m., p.m. The Fall Follow Up not completed every shift for					
	_	s were initiated on 4/11/23 at e not fully completed.					
	1:15 p.m., indicated completed for every up was to be compl She had no addition	Director of Nursing on 8/9/23 at a neurological checks were to be y unwitnessed fall. Fall follow eted every shift for 72 hours. all information to review.					
	This State Resident IN00414473.	ial finding relates to Complaint					

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155764	B. WI			/2023	
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ODDING MILL LIENT THE GAMBLIG				B7TH AVE			
SPRING MILL HEALTH CAMPUS			MERRII	LLVILLE, IN 46410			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0407	410 IAC 16.2-5-12	2(b)(1-4)					
	Infection Control -						
Bldg. 00		st establish an infection					
J		at includes the following:					
		enables the facility to					
		of known infectious					
	symptoms.						
	• •	tation and in-service					
	` '	ction prevention and control,					
	including universa	·					
	-	information to residents,					
	including, but not l						
	transmission and i	•					
		municable disease to					
	public health author						
	•	on, record review, and	R 04	107	Spring Mill Health Campus		08/28/2023
		ty failed to ensure proper		,	Annual Survey: 8-7-23		00,20,202
		ormed before reusing a lancet			, , , , , , , , , , , , , , , , , , , ,		
	-	gar level, gloves were used for			R 407 Antibiotic Stewardship	,	
	_	of insulin, residents who			and Infection Control		
	received antibiotics	had true infections, and					
	influenza and pneur	nococcal vaccines were			Please accept the following as	the	
	offered to residents	for 1 of 1 residents observed			facility's credible allegation of		
	for insulin, 2 of 6 re	esidents reviewed for			compliance. This plan of		
	medications, and for	r 6 of 6 residents reviewed for			correction does not constitute	an	
	vaccines. (Residents	s 5, 2, B, C, D, E, and F)			admission of guilt or liability by	/ the	
					facility and is submitted only in		
	Findings include:				response to the regulatory		
					requirement.		
	1. At 11:03 a.m. on	8/8/23, LPN 2 donned clean			·		
	gloves to both hand	s and walked into Resident 5's			What corrective action(s) will	1	
	room. She wiped he	er finger with an alcohol wipe,			be accomplished for those		
	pricked the resident	's finger and no blood was			residents found to have beer	,	
		pricked her finger again with			affected by the deficient		
	the same lancet with	nout cleaning the area again			practice;		
		e. She obtained the blood and			Infection Preventionist educate	∍d	
	put the strip into the	glucometer. After completing			on the Antibiotic Stewardship		
	the glucometer test,	she removed her gloves and			program and the need to have	a	
	went out to the med	cart in the hallway. The LPN			true infection to prescribe an		
	drew up 12 units of	insulin from a multi-dose vial			antibiotic.		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED		
155764		B. W	ING		08/11/2023		
		l .	<u> </u>	STREET A	STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER				87TH AVE		
SDDING	MILL HEALTH CAN	APLIS			LLVILLE, IN 46410		
SEKING	WILL HEALTH CAN	vii OO		MEKKII	LLVILLE, IIN 404 IU		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)	DATE	
		r verifying the insulin, she did			AL Nurse Manager educated	on	
	-	needle and she walked into the			the need to offer influenza,		
		e did not perform hand			pneumonia and COVID		
		ves. LPN 2 informed the			immunizations annually and		
		ing to administer the injection			document it in the EMR.		
		arm. The needle was still			AL Nurse educated on the pro		
		had pulled down the resident's			sanitation process to use whe		
	long sleeve shirt wi	th the needle still exposed.			checking blood sugar and the	use	
					of gloves when administering		
		Director of Nursing on 8/9/23 at			insulin.		
	_	I the nurse should have					
		r finger again before reusing			How the facility will identify		
		worn gloves to administer the			other residents having the		
	insulin injection.				potential to be affected by th	е	
	2 Th 10 P	:-I			same deficient practice and		
		esident B was reviewed on			what corrective action will be	9	
		. Diagnoses included, but were			taken;		
		bolic encephalopathy, anxiety, major depressive			All facility residents can be		
	disorder, and high b				affected by the same alleged deficient practice.		
	alsorder, and high t	nood pressure.			г ченовні ріасцов.		
	A Physician's Order	r, dated 3/21/23, indicated may			What measures will be put in	nto	
		nalysis, culture and sensitivity)			place or what systemic		
		complains of burning or had			changes will be made to		
	increased confusion	-			ensure that the deficient		
					practice does not recur;		
	Nurses' Notes, dated	d 4/6/23 at 9:27 a.m., indicated			IP to monitor every resident p	out	
		en yelling and looking for			on an antibiotic and ensure th		
	family. The residen	t's daughter indicated when			the resident meets McGreer's		
		onfusion, it could mean she			criteria to be on the antibiotic.		
	had a urinary tract i	nfection, so she requested a			DON/Designee to audit all ne	w	
	urinalysis.				admissions and re-admissions	s to	
					ensure that they were offered		
	A urinalysis, dated	4/8/23 (a partial report),			influenza, pneumonia and CO	VID	
		nt's urine was less than 10,000			immunizations and that the		
	gram negative bacil	li organisms.			information is documented in t	the	
					medical record.		
	A Nurses' Note, dat	ed 4/10/23 at 9:00 p.m.,					
		was called and informed of			How the corrective action(s)		
	the results of the uri	inalysis. A new order for Cipro			will be monitored to ensure t	:he	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	A. BUILDING <u>00</u> COMPLE				
155764		B. WING 08/11/2023					
		<u> </u>		CTREET 4	ADDRESS CITY STATE ZIR COR		
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD 87TH AVE		
CDDING	NAUL LIEALTILOAN	ADUC					
SPRING	MILL HEALTH CAN	MPUS		MERKII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(.	X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMP	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DA	TE.
	(an antibiotic) 250 ı	ng twice a day times 10 days			deficient practice will not		
	was noted and carri	ed out.			recur, i.e., what quality		
					assurance programs will be	out	
	Nurses' Notes, dated	d 5/27/23 at 8:05 p.m.,			into place;		
	indicated the reside	nt had complaints of			DON/Designee will audit 100%	of	
	frequency and urger	ncy with pain while passing			residents with a new order for		
	urine. A new order	from the medical doctor was			antibiotics to ensure that they		
	obtained.				meet McGreer's Criteria to be		
					taking the antibiotic.		
	Physician's Order, o	lated 5/27/23, indicated			DON/Designee will audit 100%	of	
	Macrobid (an antibi	iotic) 100 milligrams (mg) by			new admissions and readmiss	ions	
		and at bedtime for burning			to ensure that residents are be	eing	
	upon urination and increased confusion until				offered Influenza, Pneumonia	and	
	6/6/23.				COVID immunizations and tha	t	
					the documentation is in the EN	1R.	
	There was no urinal	lysis results available for					
	review.				Administrator/designee will		
					present a summary of the aud	its	
		Director of Nursing on 8/9/23 at			to the Quality Assurance		
	_	I there was no additional			committee monthly for 6 mont	l I	
	information for revi	ew.			Thereafter, if determined by th	e	
	l				Quality Assurance committee,		
		d for Resident E was reviewed			auditing and monitoring will be		
		m. Diagnoses included, but			done quarterly and presented	l I	
		anxiety, chronic kidney			the QA meeting. Monitoring w	1111	
		piratory failure, high blood			be on going.		
		lness, hearing loss, COPD,			Date by which systemic	.	
	_	ed falls, and depressive			corrections will be complete	a:	
	disorders.				8/28/23		
	Numacal Ni-4 3 4	4 4/10/22 at 2:22 m					
		d 4/10/23 at 2:32 p.m., nt was much more confused					
		order to obtain an urine					
	specimen for UA C						
	specificil for UA C	cas was received.					
	A IIA cample was a	collected on 4/12/23 with the					
		/14/23. The report indicated					
	_	leukocytes, negative for					
		pacteria. A hand written order					
		lab report indicated Keflex (an					
	at the bottom of the	iao report muicated Kenex (an					

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	OF CORRECTION	IDENTIFICATION NUMBER 155764	A. BUILDI B. WING		00	COMPL 08/11/	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
SPRING MILL HEALTH CAMPUS				LVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	III PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
1710		three times a day for 7 days to					DATE
	-	r, dated 4/15/23, indicated apsule by mouth three times a 3.					
	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.						
	noted as current, ind microbiology cultur when possible so ar stopped when appro- antibiotics is only a practitioner determi- evaluation, that the patient's symptoms Resident C's record 12:00 p.m. Diagnos	atimicrobial Stewardship," and dicated "4iii Obtain res prior to starting antibiotics attibiotics can be adjusted or opriate. Treatment with ppropriate when the tines, on the basis of an most likely cause of the is a bacterial infection." 4. was reviewed on 8/8/23 at the included, but were not mess on feet, repeated falls,					
		mentation related to the ed the pneumococcal					
		Director of Nursing on 8/11/23 ated she had no further ide.					
	10:24 a.m. Diagnos	ord was reviewed on 8/8/23 at es included, but were not , major depressive disorder, ation.					

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PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 A. BUILDING 00 B. WING		COMP	COMPLETED 08/11/2023		
	PROVIDER OR SUPPLIER		101	EET ADDRESS, CITY, STATE, ZIP COD W 87TH AVE RRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION DATE
		nentation related to the ed the pneumococcal				
	Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.					
	2:25 p.m. Diagnose	rd was reviewed on 8/8/23 at s included, but were not limited s, high blood pressure, and				
		mentation related to the ed the pneumococcal				
		Director of Nursing on 8/11/23 ated she had no further ide.				
		ord was reviewed on 8/8/23 at s included, but were not limited sure and dementia.				
		mentation related to the ed the pneumococcal or on.				
		Director of Nursing on 8/11/23 ated she had no further ide.				
	8:25 a.m. Diagnose	ord was reviewed on 8/9/23 at s included, but were not limited disease, chronic respiratory pood pressure.				
		nentation related to the ed the pneumococcal or				

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		IDENTIFICATION NUMBER 155764	A. BUILDING B. WING	00	COMPLETED 08/11/2023
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0414	at 10:44 a.m., indical information to provide 10:40 p.m. Diagnoses to, breast cancer, Paradisorder. There was no documeresident being offer influenza vaccination. Interview with the I at 10:44 a.m., indical information to provide 10 IAC 16.2-5-12	Director of Nursing on 8/11/23 ated she had no further ide. Ind was reviewed on 8/8/23 at as included, but were not limited rkinson's disease, and bipolar mentation related to the ed the pneumococcal or in. Director of Nursing on 8/11/23 ated she had no further ide.			
Bldg. 00	hands after each o	st require staff to wash their direct resident contact for ng is indicated by accepted			
	Based on observation failed to ensure hand before donning and medication pass for	on and interview, the facility d hygiene was performed after doffing gloves during 2 of 5 residents observed cass. (Residents 4 and 5)	R 0414	Spring Mill Health Campus Annual Survey: 8-7-23	08/28/2023
	Findings include: 1. During medication pass on 8/8/23 at 10:59 a.m. LPN 2 was observed preparing medications for			R 414 Handwashing	
	resident's room and She did not perform the medication pass	ime, she walked into the administered his medications. hand hygiene before or after. The LPN then pushed the on the hallway to Resident 5's		Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute	

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155764)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2023
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	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		admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. What corrective action(s) will I	
	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		accomplished for those reside found to have been affected b deficient practice; related to the hand washing	nts
	removing her gloves. She administered the resident's insulin, threw the syringe into the sharps container and did not perform hand hygiene.		policy and the need to wash ir between changing gloves.	
	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		How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken;	to ent
	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.		All facility residents have the potential to be affected by the same alleged deficient practic	e
	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		What measures will be put into place or what systemic chang will be made to ensure that the deficient practice does not reconstructed.	es e ur;
	handling medications; h. before and after putting		Staff re-in serviced related to	ine

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	OF CORRECTION	IDENTIFICATION NUMBER 155764	A. BUILDING B. WING	00	COMPLETED 08/11/2023
	ROVIDER OR SUPPLIER		101 W 8	ADDRESS, CITY, STATE, ZIP COD 87TH AVE	
SPRING	MILL HEALTH CAM	IPUS	MERRI	LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on and upon remova	al of PPE, including gloves"		handwashing policy and the note to wash hands in between changing gloves.	eed
				How the corrective action(s) we monitored to ensure the deficiency practice will not recur, i.e., who quality assurance programs we put into place;	ent at
				DON/Designee will perform handwashing observations on employees, 3 x weekly for 4 months to ensure that they are following the handwashing pol and washing hands in between changing gloves.	e icy
				/designee will present a summ of the audits to the Quality Assurance committee monthly 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going.	o for
				Date by which systemic corrections will be completed: 8/28/23	

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	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/11/2023	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				101 W 8	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 58 of 58