STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155154		12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00185687, IN00187981, IN00188032 and IN00188413. Complaint IN00185687 Substantiated. No deficiencies related to the allegations are cited. Complaint IN00187981 Substantiated. Federal/State deficiency related to the allegation is cited at F441. Complaint IN00188032 Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309 and F333. Complaint IN00188413 Substantiated. Federal/State deficiency related to the allegation is cited at F309. Unrelated deficiency cited. Survey dates: December 9, 10 and 11, 2015 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 Census Bed Type:	F 0000	The following Plan of Correction constitutes our written allegation of compliance for the deficiency cited Submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly This plan of Correction is submitted to meet the requirements established by State and Federal law This facility requests paper compliance for the deficiency cited	

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

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

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	SNF: 13 SNF/NF: 87 Total: 100 Census Payor Type: Medicare: 20 Medicaid: 60 Other: 20 Total: 100 Sample: 9 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1 in regard to the Investigations of Complaint IN00187981, IN00188032, and IN00188413. QR completed by 11474 on December 17, 2015.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the			

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	facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure resident plans of care and physician orders were followed for 2 of 9 sampled residents. (Residents "I" and "J"). Findings include: 1. The record for Resident "I" was reviewed on 12-11-15 at 9:07 a.m. Diagnoses included, but were not limited to, venous thrombosis, diabetes and hypertension. These diagnoses remained current at the time of the record review. A review of the current Resident's Plan of Care, originally dated 05-26-15, indicated the following: "Resident is at risk for abnormal excessive bleeding due to use of anticoagulant medication." An intervention to this Plan of Care, included "Medications as ordered." A review of the Physician orders, dated 07-08-15, instructed the nursing staff to administer Coumadin (an anticoagulant) 3.5 mg (milligrams) by mouth daily. A review of the medication administration record for 07-2015 indicated the resident	F 0282	1.Resident I no longer resides in the facility, however, at the time of finding, nurse was given a teachable moment in regards to transcribing Coumadin orders. Resident J's plan of care has been updated. 2.All residents who are receiving Coumadin have the potential to be affected by the same deficient practice. All residents with Coumadin will be audited to verify new physician orders transcribed timely. All residents who have catheters will be audited to ensure plans of care are being followed. 3.Licensed nursing staff will be educated on timely transcription of new Coumadin orders and following plans of care. 4.DNS/Designee will audit new Coumadin physician orders daily Monday-Friday times four weeks, then monthly times two months. DNS/Designee will audit catheter plan of care. Documentation Audit form daily Monday-Friday times four weeks, then monthly times two months.	01/04/2016

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	did not receive the medication as ordered but received the previous physician ordered dosage of 3 mg on 07-08-15. The resident did not receive the correct dosage until 07-09-15. During an interview on 12-10-15 at 10:00 a.m., the Director of Nurses indicated the error was not discovered until the following day, when the Unit Manager reviewed the physician orders. A review of the "Employee Communication Form," dated 07-09-15, indicated the following: "[Name of Employee Licensed Nurse #14] made a medication error with Coumadin for a resident, noted p/o [by mouth], charted the med. [medication] change in progress note but transcribed p/o wrong and administered wrong dose." The "Medication/Treatment Error" report indicated the "wrong dose" had been given. "Description of error: Coumadin change was not noted in MAR [medication administration record] correctly per order, wrong dose given." 2. The record for Resident "J" was reviewed on 12-10-15 at 11:00 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, obstructive reflux uropathy, and enlarged prostate			

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	with lower urinary tract symptoms. These diagnoses remained current at the time of the record review. A review of the resident's current plan of care, originally dated 05-21-15, indicated the following: "Resident requires a supra-pubic urinary catheter r/t [related to] dx. [diagnosis] of BPH [benign prostatic hyperplasia] with obstruction." Interventions to this plan of care included "do not allow tubing or any part of the drainage system to touch the floor, position bag below level of bladder, when observed, ask resident to pick Foley up off floor/remove from table during meal service." A review of the progress note, dated 10-22-15 at 8:42 a.m., indicated, "Resident alert to tactile and verbal stimuli, cath. [catheter] bag changed early in shift d/t [due to] resident dragging cath bag across floor...." During an observation on 12-09-15, at 12:30 p.m., during the lunch meal service, the resident ambulated into the second floor dining room, carrying his urinary catheter bag, at waist level, sat down on the dining room chair and threw the catheter bag onto the floor. Upon completion of the meal service the			

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	resident stood up, grabbed the tubing, pulling up on it until he reach the top of the drainage bag, held onto the top of the drainage bag, turned around and exited the dining room. During an observation on 12-10-15 at 8:15 a.m., the resident was observed lying in bed. The urinary drainage bag was laying on the floor, and filled to the capacity of possibly bursting. During an observation on 12-10-15 at 8:45 a.m., the resident ambulated into the dining room, carrying the urinary drainage bag, sat down in the chair and threw the bag onto the floor. During observations on 12-09-15 and 12-10-15, there was no staff intervention related to the positioning of the bag, or allowing the tubing or any part of the drainage system to touch the floor. This Federal tag relates to Complaint IN00188032. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and			

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	services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure the highest practicable standards of care when two resident's were found non responsive for 2 of 4 records reviewed in a sample of 9. (Residents "E" and "D"). Findings include: 1. The record for Resident "E" was reviewed on 12-09-15 at 2:15 p.m. Diagnoses included, but were not limited to, chronic embolism and thrombosis deep vein lower extremity, cerebral vascular accident, prostate cancer respiratory failure, tracheostomy, and a history of sepsis. These diagnoses remained current at the time of the record review. A review of the Progress Notes, dated 11-22-15 at 6:10 a.m., indicated the following: "Called to room per day shift CNA [certified nurses aide]. Res. [resident] sitting on side of bed leaning on his left side face down in mattress. Pulse faint, pallor gray, skin warm to touch, no respiration's noted. 911 called, CPR	F 0309	1.Residents no longer reside in the facility. 2.All residents who are a Full Code have the potential to be affected by the same deficient practice. Clinical EducationCoordinator/Designee will perform mock Code Blue drills. 3.Nursing staff will be educated on the CPR Policy and Procedure. 4.Clinical Education Coordinator/Designee will perform Code Blue drills quarterly.	01/04/2016

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	[cardiopulmonary resuscitation] initiated." During an interview on 12-10-15 at 2:00 p.m., Licensed Nurse #6 indicated she was at the nurses station which was directly across from the resident's room when the aide asked her to come in and assess the resident. "He was slumped over and I raised him up. His pulse was faint and I couldn't see any respirations but he did have a faint pulse. I instructed the CNA to go up stairs and get a nurse and told another CNA to call 911. I went to get the crash cart. When I got back to the room, the other nurse was there and we attempted to get the back board under the resident. I started the oxygen because he had a trach. [tracheostomy.] He remained non responsive and then the EMT's [Emergency Medical Technicians] arrived." When interviewed if the resident had oxygen and the Ambu bag at the bedside in his room, the nurse responded "He had an Ambu bag and a concentrator in his room." 2. The record for Resident "D was reviewed on 12-09-15 at 2:50 p.m. Diagnoses included, but were not limited to respiratory failure, pulmonary hypertension, dependent on oxygen,			

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	congestive heart failure and chronic obstructive pulmonary disease. These diagnoses remained current at the time of the record review. A review of the progress notes, dated 12-01-15 R 12:10 a.m., indicated the following: "Writer arrived to room to administer meds. [medications] and perform assessment; found resident unresponsive to tactile and verbal stimuli; no pulse or breath sounds noted; writer immediately went to nursing station; notified 2nd nurse for immediate assistance and to contact 911; code initiated; writer returned to room with crash cart, 2nd nurse and CNA immediately followed; CPR started. During process additional staff arrived for assistance; CPR continued with multiple changes to nurses during CPR cycles; AED [automated external defibrillator] not administer <sic> d/t [due to] EMS proceeded with all emergency care.... " The documentation indicated the resident was left unattended after initially found unresponsive. A review of the facility policy, dated as revised "1/2015," indicated the following:			

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	"POLICY: It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention takes place. PROCEDURE: 1. Life Threatening Change - a. The licensed nurse will initiate appropriate first aide measures until emergency response personnel arrive on the scene." During an interview on 12-10-15 at 2:45 p.m., the Director of Nurses indicated the facility policy instructed the nurses to make sure the resident was "safe" before leaving the resident unattended in order to get the Crash Cart. In addition, the Director of Nurses indicated Licensed Nurse #6 could have used the Ambu bag in resident "E" room in order to administer oxygen through his tracheostomy immediately and then obtain the Crash Cart. During an interview on 12-11-15 at 2:15 p.m., the Assistant Director of Nurses provided the current American Heart Association guidelines which indicated, if a person is "unresponsive - no breathing or no normal breathing (only gasping) activate the emergency response, check the pulse and then start CPR."			

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	This Federal tag relates to Complaints IN00188032 and IN00188413. 3.1-37(a)			
F 0333 SS=D Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free from a significant medication error for 1 of 3 resident's reviewed. (Resident "I"). Findings include: The record for Resident "I" was reviewed on 12-11-15 at 9:07 a.m. Diagnoses included, but were not limited to, venous thrombosis, diabetes and hypertension. These diagnoses remained current at the time of the record review. A review of the Physician orders, dated 07-08-15, instructed the nursing staff to administer Coumadin (an anticoagulant) 3.5 mg (milligrams) by mouth daily. A review of the medication administration record for 07-2015 indicated the resident did not receive the medication as ordered	F 0333	1.Resident I no longer resides in the facility,however, at time of finding, nurse was given a teachable moment in regards to transcribing Coumadin orders. 2.All residents who are receiving Coumadin have the potential to be affected by the same deficient practice. All residents with Coumadin will be audited to verify new physician orders transcribed timely. 3.Licensed nursing staff will be educated on timely transcription of new Coumadin orders. 4.DNS/Designee will audit new coumadin physician orders daily Monday-Friday times four weeks, then monthly times two months.	01/04/2016

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	but received the previous physician ordered dosage of 3 mg on 07-08-15. The resident did not receive the correct dosage until 07-09-15. A review of the employee disciplinary action indicated Licensed Nurse #14 received a physician order for a change in the Coumadin dosage, but failed to document the change on Medication Administration Record for July 2015. A review of the "Employee Communication Form, dated 07-09-15, indicated the following: "[Name of Employee Licensed Nurse #14] made a medication error with Coumadin for a resident, noted p/o [by mouth], charted the med. [medication] change in progress note but transcribed p/o wrong and administered wrong dose." The "Medication/Treatment Error" report indicated the "wrong dose" had been given. "Description of error: Coumadin change was not noted in MAR [medication administration record] correctly per order, wrong dose given." During an interview on 12-10-15 at 10:00 a.m., the Director of Nurses indicated the error was not discovered until the following day, when the Unit Manager reviewed the physician orders.			

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	This Federal tag relates to Complaint IN00188032. 3.1-48(c)(2)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.			

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	(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure effective infection control measures in regard to a resident who displayed behaviors of defecation for 1 of 3 residents reviewed. (Resident "C"). Findings include: The record for Resident "C" was reviewed on 12-09-15 at 1:10 p.m. Diagnoses included, but were not limited to, Hepatitis "C", HIV+ (Human immunodeficiency virus), hypertension and renal disease. These diagnoses remained current at the time of the record review. A review of the resident's Minimum Data Set assessment, dated 09-19-15, indicated the resident was alert/oriented, no cognitive impairment and continent of bowel and bladder. During the Initial tour of the facility on 12-10-15 at 9:30 a.m., Licensed Nurse #5 indicated the resident was incontinent.	F 0441	1.Incontinence and ADL care was immediately provided to Resident J and his floor was mopped with appropriate cleaning solution. 2.All residents who are incontinent of bowel and bladder have the potential to be affected by the same deficient practice. DNS/Designee will complete an audit of all residents with an increase in bowel and bladder incontinence and plans of care will be updated as needed. 3.Nursing staff will be educated on communicating and documenting changes in ADL care and increases in bowel and bladder incontinence. 4.Infection Control Nurse/Designee will audit residents with a decrease in ADLs and an increase in bowel and bladder incontinence and confirm utilization of proper infection control practices daily Monday-Friday times four weeks, then monthly times two months.	01/04/2016

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	While standing at the entrance to the resident's room a pungent odor permeated the air. The resident was seated in a wheelchair and appeared unkept, with soiled clothes. The floor of the resident's room, appeared smeared with a dried substance. A review of the Progress notes indicated the following: "11-15-15 at 2:26 a.m. - Incont. [incontinent] of bowel and bladder. Trash noted to be scattered around the room and urine noted to be soaking the floor. Small amount of feces noted as well." "12-03-15 5:39 p.m. - Nurse answered res's [resident's] call light and found him in the bathroom with BM [bowel movement] smeared on the floor, his wheelchair, and his hands. When the nurse questioned the resident if he felt okay, he stated that he had a really loose bowel movement and had tried to clean himself up...." "12-03-15 11:45 p.m. - Increase in behaviors noted during the evening shift. Res. reminded repeatedly to call for assistance when needing help for bathroom, but when nurse would enter the room, there would be large areas of			

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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260	

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	BM on the floor." The resident had frequent visits by a contracted behavioral health care center. A review of the behaviorist notation, dated 11-25-15, indicated the resident "urinated through pants. Resident asleep in chair in need of assistance to change clothes (wet on self). Recommendations: requires increasing monitoring/assistance for hygiene." During an interview on 12-09-15 at 12:45 p.m., Housekeeper #9 indicated, (name of resident "C") is "real bad and we have to keep up on it all the time." During an observation on 12-09-15 at 1:00 p.m., a housekeeper was standing adjacent to the resident's room and stated, "Look in there, it's a mess. I done lost my appetite." During this observation, the resident was seated in the wheelchair and liquid was observed throughout the floor of the resident's room, and feces were smeared throughout the resident's bathroom. The feces were observed on the toilet seat, on the floor and walls. During an observation on 12-10-15 at 11:00 a.m., the resident was observed lying across his bed. When requested the			

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	resident gave permission to enter the room. Upon walking across the room, the floor was sticky beneath each step. The floor was smeared with a dried substance and the room had a pungent odor. The bathroom door was open and urine was observed throughout the bathroom floor. A urinal was observed on the window sill with yellow urine contained in the urinal. During an interview on 12-10-15 at 11:30 a.m., the Infection Control Nurse was alerted to the conditions in the resident's room and the defecation behaviors of the resident. The Infection Control Nurse indicated she was unaware of the resident's behaviors. During further interview on 12-10-15 at 2:00 p.m., the Infection Control Nurse indicated the facility would implement interventions for the behaviors of the resident, a toileting program and an ongoing cleaning schedule to reduce the possibility or incidence of spread of infections. This Federal tag relates to Complaint IN00187981. 3.1-18(b)(2)			

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	155154		12/11/2015

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F 0514 SS=A Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure accurate clinical records for 1 of 9 sampled residents. (Resident "G"). Findings include: The record for Resident "G" was reviewed on 12-10-15 at 10:00 a.m. Diagnoses included, but were not limited to, lymphoma, total occlusion coronary artery, shortness of breath, anxiety, and Alzheimer's dementia. These diagnoses remained current at the time of the record review. A review of the resident Minimum Data Set assessment indicated the resident had severe cognitive impairment, required extensive assistance with transfer and	F 0514	1.Resident G no longer resides at the facility, therefore, nurse's note could not be invalidated. 2.All residents have the potential to be affected by the same deficient practice. 3.Licensed nursing staff will be educated on documenting accurately in the correct chart. 4.DNS/Designee will audit ten residents' charts daily Monday – Friday times four weeks, then monthly times two months.	01/04/2016

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	eating, non ambulatory and total assistance with dressing. In addition the record indicated the resident was incontinent of bowel and bladder. A review of the "Observation Report," dated 09-03-15, and transcribed by Licensed Nurse #12, indicated the resident was "A+O x 3 [alert and oriented times three]; able to make needs and wants known, speech clear, assist times 1 with ADL's [activities of daily living]; limited assist with transfers and bed mobility; ambulates with steady gait...." During an interview on 12-10-15 at 2:14 p.m., the Director of Nurses indicated the nurses entry was incorrect and the document needed to be invalidated. 3.1-50(a)(2)			