STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/27/2015

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00180516. Complaint IN00180516- Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Survey date: August 24, 25, 26 & 27, 2015 Facility number: 000074 Provider number: 155154 AIM number: 100290050 Census bed type: SNF- 14 SNF/NF- 91 Total- 105 Census payor type: Medicare- 16 Medicaid- 66 Other- 23 Total- 105 Sample- 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	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	

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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F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and 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 interviews, the facility failed to contact a specialty care physician's office for further wound treatment and/or wound care orders, after a resident had an office visit, outside the facility and failed to follow policy for wound observation and documentation for 1 of 6 residents reviewed for wound care and follow-up, in a sample of 6. (Resident B) This deficient practice resulted Resident B being admitted to the hospital for intravenous antibiotics for a diagnosis of cellulitis. Findings include: The clinical record for Resident B was reviewed on 8/24/15 at 2:20 p.m. Diagnoses for Resident B included, but were not limited to, diabetes mellitus-type 2, high blood pressure, chronic ischemic heart disease, idiopathic peripheral neuropathy, peripheral	F 0309	1) Resident no longer resides in the facility 2) Any residents requiring an outside wound care visit have the potential to be impacted All residents with outside wound care visits within the last thirty days will be audited to ensure that orders and follow up were completed All residents that have a wound requiring outside wound care visits will be audited to ensure that weekly wound documentation is in place DNS or designee will educate licensed nursing staff on completing follow up to wound care appointments outside the building by 9/16/15 DNS will educate IDT on skin management program related to weekly wound rounds by 9/16/15 3) DNS or designee will educate licensed nursing staff on completing follow up to wound care appointments outside the building by 9/16/15 DNS will educate IDT on skin management program related to weekly wound rounds by 9/16/15 A nurse manager/designee will	09/16/2015

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	vascular disease, acute cerebrovascular disease, history of acute myocardial infarction, status post penile implant, penile implant infection and gangrene of scrotum. Nursing wound care notes, dated 6/18/15 at 1:30 p.m., indicated Resident B had "...gangrene to scrotum after penile implant revision. Scrotum necrotic area measures 5.5 x 7 x 0 cm [centimeters]. No Tx [treatment] ordered and per MD [medical doctor/physician] no Tx necessary at this time. He does have a f/u [follow up] appt [appointment] with urologist." Further nursing assessments for the scrotum wound, including measurements, were not available. During an interview on 8/26/15 at 4:45 p.m., the Director of Nursing Services (DNS) indicated the facility did not have documentation of Resident B's weekly wound assessment by the wound care nurse. She expected the assessment should have been completed on 6/24/15 because wound rounds were done on Wednesdays. Nursing notes, dated 6/23/15 at 4:28 p.m., indicated Resident B had an appointment with a urologist on 6/25/15 at 10:15 a.m.		audit five times a week the previous business day's wound care appointments to ensure all appointments have been followed up on DNS or designee will complete a weekly audit to ensure IDT weekly wound rounds have been completed 4) A Wound Care Appointment and IDT Wound Audit Tool will be completed as monitoring tools These tools will be completed weekly times four, monthly times six, then on a quarterly basis until continued compliance is maintained for two consecutive quarters by the DNS or designee If a threshold of 95% is not met, the results will be reviewed by the CQI committee and an action plan will be developed The CQI tool will be overseen by the ED, DNS, Medical Director, and its members	

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	On 6/25/15 at 11:41 a.m., nursing notes indicated awareness of Resident B's morning appointment and his return to the facility. Clinical documentation did not indicate the urology office was contacted for further information related to wound care and treatment. During an interview, on 8/27/15 at 10:30 a.m., the Unit Manager of the Rehabilitation Unit indicated she did not call the urology office after Resident B returned to the facility, without paperwork, from the urology office visit. Urology notes received from the Urology office on 8/27/15, dated 6/25/15, indicated Resident B was to resume Cipro (antibiotic), as previously ordered, for the treatment of penile prosthesis infection. Physician orders and an Infection Control Individual Report for Resident B, dated 6/17/15, indicated Cipro 500 milligrams, 1 (one tablet), daily for 7 days. There were no orders located to resume the Cipro or any documentation that indicated the Cipro was resumed. Resident B discharged from the facility on 6/29/15 at 7:00 p.m., to another nursing facility as indicated in a nursing			

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	note dated 6/29/15 at 7:00 p.m. Emergency room physician examination documentation, dated 6/30/15 at 9:45 p.m., indicated Resident B presented with redness and swelling to his scrotum with a large ulcer noted. He was currently on Cipro for infection, but the infection was progressing. The left scrotal ulcer measurements were 4 x 6 cm, with surrounding scrotal edema and erythema, with concern for Fournier Gangrene (a rapidly progressive soft-tissue necrotizing process to the perineal area on patients with associated co-morbidities). Clindamycin and Vancomycin (antibiotics) were begun for the scrotal infection. Resident B was admitted to the hospital for further treatment and evaluation. The emergency room admission documentation, dated 6/30/15 at 9:56 p.m., indicated admission diagnoses were active ulcer of left groin and active cellulitis of groin. A Skin Management Program policy/procedure, with a revision date of 2/2015, was presented by the DNS on 8/26/15 at 4:30 p.m. The procedure indicated the following, "5. Wound rounds will be completed on a weekly basis to assess wounds following the wound meeting guidelines. The facility must have an assigned wound nurse that			

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	assesses the wounds on a weekly basis. The wound nurse is responsible for updating the wound composite reports on a weekly basis and reporting the results to the DNS." This Federal tag relates to complaint IN00180516. 3.1-37(a)			

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