

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00123605.</p> <p>Complaint IN00123605 - Substantiated. Federal/State deficiencies related to the allegations are cited at F166 and F328.</p> <p>Survey dates: March 12, 13, 14, 15, 18, 19, and 20th, 2013</p> <p>Facility number: 010739 Provider number: 155764 AIM number: 200856890</p> <p>Survey Team: Shannon Pietraszewski, RN TC Heather Tuttle, RN Lara Richards, RN Kathleen Vargus, RN (March 12, 13, 14, and 15th) Regina Sanders, RN (March 12, and 13th)</p> <p>Census Bed Type: SNF/NF: 10 SNF: 36 Residential: 53 Total: 99</p>	F000000	<p>The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintain it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the creditle allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p>	
---------	--	---------	---	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Census Payor Source: Medicare: 32 Medicaid: 6 Private: 61 Total: 99</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 27, 2013, by Janelyn Kulik, RN.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to document and follow up on grievances per facility policy for 1 of 1 resident reviewed for grievances. (Resident #B)</p> <p>Findings include:</p> <p>Resident's #B clinical record was reviewed on 3/18/13 at 9:15 a.m. Resident #B's diagnoses included, but were not limited to, stroke, legally blind, diabetes, narcolepsy, and sleep apnea.</p> <p>A Social Service note dated 12/10/12, indicated SSD (Social Service Director) #1 had spoken with the resident's daughter and she had expressed concerns about Resident #B's care over the weekend. The concerns were discussed in the morning Stand Up Meeting. There was no grievance form initiated or documentation indicating follow up or resolution of the concern.</p> <p>A Social Service note dated 12/19/12,</p>	F000166	<p>F166 D Right to Prompt Efforts to Resolve Grievances</p> <p>Corrective action accomplished for those residents found to have been affected by the deficient practice: This resident has been discharged from this campus. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: campus leadership team (including Executive Director, Director of Health Services and Social Workers to make sure known resident grievances have been documented using our Resident Concern Form and entered into our tracking system. Also reviewed all known resident grievances to assure timely and adequate follow up has been completed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: additional education for the leadership team is underway to better understand and utilize our new web based tracking system for resident concerns. We began using this new tracking system on 3/24/13 with no concerns identified. . How the</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>indicated SSD #1 spoke with a CNA regarding an encounter between a staff member and the resident's spouse on 12/13/13. There was no grievance form initiated or documentation indicating follow up or resolution of the concern.</p> <p>An Admission Conference Note dated 12/18/12, did not indicate who, but someone was unhappy with the CNAs on the 3-11 shift, wanted medication times changed, legally blind in both eyes, the resident wants to get up later and to have tylenol scheduled for pain. Resident #B, his spouse and daughter were in attendance as verified by signatures as well as the SSD #1. There was no grievance form initiated or documentation indicating follow up or resolution of the concern.</p> <p>A Social Service note dated 12/24/12, indicated SSD #1 had received a concern form on 12/24/13, regarding the family was not satisfied with the care given by a CNA. The note indicated "...SSD will work with family to address concerns. Wife stated on today that the concern was addressed appropriately and she will continue to work with CNA and staff to address it..." The SSD #1 was unable to locate the grievance form.</p>		<p>corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: the campus leadership (ED, DHS, SS1 and SS2) will review the Resident Concern Log 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. We will review for timely notification and resolution to resident grievances. Results of monitoring will be shared with QAA monthly. Date the systemic changes will be completed: 4/19/13.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>A Social Service note dated 1/22/13, indicated SSD#2 had spoken to Resident #B's wife regarding concerns of discharge. SSD #2 indicated she had resolved the issue by locating the discharge paperwork in the resident's chart and reviewing it with the spouse, but also indicated nursing would schedule the appointment and inform the resident's spouse of such date and time. The SSD #1 was unable to locate the grievance form and was unable to indicate if nursing followed up with the spouse regarding the appointment.</p> <p>SSD #2 and SSD #1 were interviewed on 3/18/13 at 2:30 p.m. SSD #2 indicated the discharge was in regards to the hospital paperwork with orders to make a follow up doctor's appointment to be seen in one month. The spouse had thought the appointment was to be made within a week from discharge. SSD #2 indicated the wife was upset because the nurse, who was new at the time, was not able to locate the paperwork in the chart. The Social Service note had indicated some resolution, but did not indicate follow up with nursing. SSD #1 was unable to locate the grievance form. SSD #1 and SSD #2 indicated all concerns were reported</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>to the Administrator that had occurred in December and January.</p> <p>Interview with the Vice President/Corporate Consultant on 3/20/13 at 1:00 p.m., indicated she was the Interim Administrator when Resident #B was admitted in December 2012. The Vice President/Corporate Consultant indicated she had daily conversations/meetings with the spouse. She indicated she did not write down the concerns that were voiced by the wife. A Recovery Procedure dated 10/09 was provided by the Vice President/Corporate Consultant during this time. The Recovery Procedure indicated all concerns will be documented, tracked, trended and reviewed in the QA (Quality Assurance) meetings, to follow up with good communication to insure the concern does not reoccur, and follow up during family call, resident meetings, or additional phone calls to ensure the concern was resolved to the customer's satisfaction. The Vice President/Corporate Consultant indicated the "process" may need to be revised.</p> <p>Interview with the Administrator on 3/20/13 at 1:15 p.m., indicated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>Resident #B's spouse was repetitive with her complaints and he had not documented all of her concerns.</p> <p>Interview with the SSD #1 on 3/20/13 at 1:30 p.m., indicated she does fill out a complaint form when a family member or resident has a complaint. For the 12/24/2012 grievance, SSD #1 had indicated she thought a grievance form was already filled out. SSD #1 indicated the Interim Executive Director was keeping the grievance book at the time but she keeps one now.</p> <p>Interview with the SSD #1 on 3/20/13 at 2:00 p.m., indicated only the 12/26/12 grievance form was found and she was not able to locate any other grievance forms if they were filled out. SSD #1 indicated she had gotten confused because there were so many grievances.</p> <p>This Federal tag relates to complaint #IN00123605.</p> <p>3.1-7(a)(1)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review and interview, the facility failed to ensure the least restrictive restraint device was in use for 1 of 3 residents reviewed for restraints of the 5 who met the criteria for physical restraints. (Resident #155)</p> <p>Findings include:</p> <p>On 3/12/13 at 11:50 a.m., Resident #155 was observed in her room in bed. The resident had hand mitt restraints in place to both hands.</p> <p>On 3/14/13 at 8:35 a.m., the resident was observed in her room in bed. The resident's eyes were closed. The hand mitt restraints were in place to both hands. The resident was not moving her arms at this time.</p> <p>On 3/15/13 at 10:00 a.m. and 1:16 p.m., the resident was again observed in her room in bed. The resident's hand mitts were in place and she was not observed to be moving her arms or hands.</p>	F000221	<p>F221 Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #155 has been discharged. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No other residents in our facility have this type of hand restraint. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: licensed nurses have been inserviced on timely and accurate completion of the Admission Assessment Review and Consideration form. Licensed nurses have been inserviced on our restraint/enabler guidelines. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: All new admissions and readmissions with orders for restraints will be reviewed in clinical meeting daily (M-F). DHS or designee will monitor admissions and readmissions for the following time frame - Log 3 x</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>The record for Resident #155 was reviewed on 3/15/13 at 1:18 p.m. The resident's diagnoses included, but were not limited to, brain stem stroke and status post percutaneous endoscopic gastrostomy (PEG) tube.</p> <p>The resident was admitted to the facility on 3/11/13. A Physician's order dated 3/11/13, indicated the resident was to wear bilateral mittens to hands at all times. May remove for hygiene purposes.</p> <p>An entry in the Nursing progress notes dated 3/11/13 at 2:30 p.m., indicated "resident displays spasms to bilateral upper extremities intermittently." There was no further documentation in the Nursing progress notes related to the resident having spasms to the bilateral upper extremities.</p> <p>The "Assessment Review and Considerations" form dated 3/11/13, indicated the "restraint/enabler use" section had not been completed.</p> <p>The plan of care dated 3/14/13, indicated the problem of "Use of physical restraint, mitts to hands bilaterally related to medical symptom for which restraint/enabler used to</p>		per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Results of monitoring will be shared with QAA monthly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>treat: twitching and tremors which have history of causing self inflicted injuries."</p> <p>Interview with LPN #4 on 3/19/13 at 9:15 a.m., indicated that when she took care of the resident on Friday, the resident did have the hand mitts in place and she appeared to be calm. She was not sure if the resident was readmitted with the hand mitts on 3/18/13.</p> <p>3.1-3(w) 3.1-26(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p>	F000225	F225 F Investigate/Report	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>interview, the facility failed to ensure allegations of rough treatment were immediately reported to the Administrator and thoroughly investigated for 2 of 2 allegations of staff to resident abuse reviewed. (Residents #B and #23)</p> <p>Findings include:</p> <p>1. Interview with Resident #23 on 3/13/13 at 9:15 a.m., indicated that she felt a Nurse on the midnight shift had been rude to her and was always giving her orders about how to deal with her colostomy bag.</p> <p>Review of the facility's investigation of the allegation on 3/15/13 at 10:00 a.m., indicated during a phone interview with RN #2, the RN had indicated a CRCA (Certified Resident Care Assistant) had been in the room with her on Sunday night when the resident had issues with her colostomy bag. The RN indicated that she told the resident "she needed to stop messing with the bag and causing it to come off." There was no statement obtained from the CRCA that had been in the room with the RN.</p> <p>Continued review of the investigation indicated COTA #1 (Certified</p>		<p>Allegations/Individuals Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #B and Resident #23 have been discharged. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: reviewed resident concern log, 24 hour reports, Resident Council minutes to ensure no other residents have been affected. No new information was found, therefore we do not believe any other residents have been affected. Additionally, SS1 interviewed other interviewable residents. There were no indications of abuse, did not express being mistreated by any staff. No families were interviewed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: every employee (including therapy staff) will be retrained on our policy, guidelines and expectations that any allegation of potential abuse should be reported to the Administrator immediately. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: the campus leadership (ED, DHS, SS1 and SS2) will interview interviewable residents weekly to ensure any</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Occupational Therapy Assistant) was interviewed on 3/13/13 at 12:00 p.m. The COTA indicated the resident had voiced a concern that the night nurse wasn't listening to her and if she didn't start listening to her she was going to report it. The COTA encouraged the resident to report this issue if she felt she should. The COTA also said she reported it to the day shift nurses. Documentation in the investigation indicated the Administrative Consultant explained the Abuse Policy to the COTA and the need to report any concern or allegation immediately.</p> <p>Interview with the Administrative Consultant on 3/20/13 at 11:20 a.m., indicated the resident had expressed her concern to the COTA on the Friday prior to 3/13/13. The Administrative Consultant indicated the COTA should have reported the concern immediately to the Administrator. The Consultant also indicated the CRCA, who was in the room with the RN at the time of the allegation had not been interviewed.</p> <p>2. Resident's #B clinical record was reviewed on 3/18/13 at 9:15 a.m. Resident #B was admitted to the facility on 12/3/12. Resident #B's diagnoses included, but were not limited to, stroke, legally blind,</p>		<p>allegations or report of potential abuse have been acted upon immediately. The monitoring schedule will be: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Results of monitoring will be shared with QAA monthly.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>diabetes, narcolepsy, and sleep apnea.</p> <p>A Social Service note dated 12/26/12, indicated Resident #B's wife reported the resident was being handled roughly by an aide and was treated mean. The note indicated the wife expressed the mistreatment of Resident #B had been going on since his arrival. The spouse indicated the resident was upset because he felt he was being mistreated and overlooked.</p> <p>On 12/26/12 at 7:00 p.m., a Resident Concern Form was initiated by SSD #2. The concern indicated the resident was placed in dirty clothes for bed, resident was wet and not changed, and that he was handled too rough. Family also reported that needs [sic] were not within reach due to the resident's visual impairment. The form did not indicate the mistreatment or an aide was handling the resident roughly.</p> <p>A Social Service note on 12/27/12, indicated family called and had spoken with the Nursing Consultant to apologize for the complaint from 12/26/12. Family indicated the complaint was a misunderstanding from the family.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>Interview with the Nursing consultant on 3/20/13 at 2:40 p.m., indicated she had worked the week of Christmas 2012. She indicated Resident #B's spouse had called into the facility on 12/27/13, indicating her complaint of abuse on 12/26/2012 was a misunderstanding. The Nursing Consultant indicated she was not aware of the complaint until the phone call. SSD #2 did not inform the Nursing Consultant until 12/27/2012. The Nursing Consultant indicated she had educated the SSD #1 and SSD #2 on timeliness of reporting abuse allegations.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their Abuse and Neglect policy and procedure was followed as written related to immediately reporting an allegation of abuse to the facility Executive Director for 2 of 2 staff to resident abuse allegations reviewed. (Residents #B and #23)</p> <p>Findings include:</p> <p>1. Interview with Resident #23 on 3/13/13 at 9:15 a.m., indicated that she felt a Nurse on the midnight shift had been rude to her and was always giving her orders about how to deal with her colostomy bag.</p> <p>Review of the facility's investigation of the allegation on 3/15/13 at 10:00 a.m., indicated COTA #1 (Certified Occupational Therapy Assistant) was interviewed on 3/13/13 at 12:00 p.m. The COTA indicated the resident had voiced a concern that the night nurse wasn't listening to her and if she didn't</p>	F000226	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #B and Resident #23 have been discharged. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: reviewed resident concern log, 24 hour reports, Resident Council minutes to ensure no other residents have been affected. No new information was found, therefore we do not believe any other residents have been affected. Additionally, SS1 interviewed other interviewable residents. There were no indications of abuse, did not express being mistreated by any staff. No families were interviewed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: every employee (including therapy staff and vendors) will be retrained on our policy, guidelines and expectations that any allegation of potential abuse should be reported to the Administrator immediately, and</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>start listening to her she was going to report it. The COTA encouraged the resident to report this issue if she felt she should. The COTA also said she reported it to the day shift nurses. Documentation in the investigation indicated the Administrative Consultant explained the Abuse Policy to the COTA and the need to report any concern or allegation immediately.</p> <p>Interview with the Administrative Consultant on 3/20/13 at 11:20 a.m., indicated the resident had expressed her concern to the COTA on the Friday prior to 3/13/13. The Administrative Consultant indicated the COTA should have reported the concern immediately to the Administrator.</p> <p>2. Resident's #B clinical record was reviewed on 3/18/13 at 9:15 a.m. Resident #B was admitted to the facility on 12/3/12. Resident #B's diagnoses included, but were not limited to, stroke, legally blind, diabetes, narcolepsy, and sleep apnea.</p> <p>A Social Service note dated 12/26/12, indicated Resident #B's wife reported the resident was being handled roughly by an aide and was treated mean. The note indicated the wife</p>		<p>that our policy prohibits mistreatment, neglect and abuse of residents and misappropriation of resident property. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: the campus leadership (ED, DHS, SS1 and SS2) will interview interviewable residents weekly to ensure any allegations or report of potential abuse have been acted upon immediately. The monitoring schedule will be: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Results of monitoring will be shared with QAA monthly. (monitoring in conjunction with F225 through resident interviews)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>expressed the mistreatment of Resident #B had been going on since his arrival. The spouse indicated the resident was upset because he felt he was being mistreated and overlooked.</p> <p>On 12/26/12 at 7:00 p.m., a Resident Concern Form was initiated by SSD #2. The concern indicated the resident was placed in dirty clothes for bed, resident was wet and not changed, and that he was handled to rough. Family also reported that needs [sic] were not within reach due to the resident's visual impairment. The form did not indicate the mistreatment or an aide was handling the resident roughly.</p> <p>A Social Service note on 12/27/12, indicated family called and had spoken with the Nursing Consultant to apologize for the complaint from 12/26/12. Family indicated the complaint was a misunderstanding from the family.</p> <p>Interview with the Nursing consultant on 3/20/13 at 2:40 p.m., indicated she had worked the week of Christmas 2012. She indicated Resident #B's spouse had called into the facility indicating her complaint of abuse on 12/26/2012 was a misunderstanding. The Nursing Consultant indicated she</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>was not aware of the complaint until the phone call. SSD #2 did not inform the Nursing Consultant until 12/27/2012. The Nursing Consultant indicated she had educated the SSD #1 and SSD #2 on timeliness of reporting abuse allegations.</p> <p>Review of the facility Abuse and Neglect Procedural Guidelines, which were provided by the Clinical Nurse Specialist and identified as current, on 3/15/13 at 11:00 a.m., indicated the following: "Any person with knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal. Immediately notify the Executive Director. If the Executive Director is absent they may appoint a designee."</p> <p>3.1-28(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure the residents' dignity was maintained related to a Foley catheter drainage bag not being covered for 1 of 1 residents reviewed for urinary catheter use and posting of personal care signs for 2 of 3 residents reviewed for dignity of the 3 residents who met the criteria for dignity. (Residents #74, #84, and #102)</p> <p>Findings include:</p> <p>1. On 3/13/13 at 12:22 p.m., a sign was observed on Resident #84's wall which indicated, "Please turn Mrs. (resident's name) every 2 hours" A sign was posted above the head of the resident's bed which indicated, "Please use Mrs. (resident's name) own personal soaps, deodorants, lotions, and other hygiene items provided by the family."</p> <p>On 3/14/13 at 8:30 a.m. and 2:05 p.m., the personal care signs were observed in the resident's room as</p>	F000241	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Residents #102 and #84 have been discharged from this facility. Resident #74 - staff removed signs from the resident's room, added the interventions to the care plan, education with nursing and therapy staff. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all resident rooms were reviewed for signage that may impact resident dignity. If signs were found, they were either removed with information added to care plans and education provided to the family. Staff Inservices conducted to educate them on dignity and use of signage. We also reviewed all residents with catheter bags to make sure bags are covered with a dignity bag. We have inserviced nursing staff to cover the bag for dignity. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: inserviced nursing staff regarding</p>	04/19/2013
-----------------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>well as on 3/15/13 at 9:15 a.m., 1:00 p.m., and 1:53 p.m.</p> <p>Interview with the resident's daughters on 3/15/13 at 1:05 p.m., indicated they posted the signs on the resident's walls.</p> <p>The record for Resident #84 was reviewed on 3/15/13 at 1:54 p.m. The resident's diagnoses included, but were not limited to, cognitive communication deficit and aphasia.</p> <p>Review of the current plan of care, indicated there was no care plan related to the resident's family posting signs on the wall.</p> <p>Interview with the Director of Nursing on 3/19/13 at 11:30 a.m., indicated that she was aware of the laundry sign but not the other signs related to turning and repositioning and use of personal care items. She indicated the resident's family is very involved and she would notify the care plan coordinator to update the resident's care plan related to family posting personal care signs and the resident not being able to verbalize if this bothered her.</p> <p>2. On 3/13/13 at 8:50 a.m., Resident #102 was observed in her room. The</p>		<p>dignity with signage in the rooms and with catheter bags. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: rounding by the DHS or designee will be conducted based on the following schedule: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months with results from the monitoring shared with QA.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>resident's Foley catheter drainage bag was not covered with a dignity bag.</p> <p>On 3/18 at 8:55 a.m., and on 3/19/13 at 9:10 a.m., the resident was in her room and her Foley catheter drainage bag was not covered with a dignity bag.</p> <p>Interview with the Director of Nursing on 3/19/13 at 11:30 a.m., indicated the resident's Foley catheter drainage bag should have been covered with a dignity bag.</p> <p>3. On 3/13/13 at 8:48 a.m., there was a sign above Resident #74's bed that indicated "Please keep left arm elevated on pillow to decrease swelling."</p> <p>On 3/14/13 at 8:23 a.m., the same sign was located above the resident's bed.</p> <p>Interview with LPN #6 on 3/14/13 at 1:13 p.m., indicated she was not aware of any sign that was posted above the resident's bed.</p> <p>Interview with CNA #1 on 3/14/13 at 1:30 p.m., indicated the resident used to live downstairs and the sign probably moved with the resident. She indicated the therapy department</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>put the sign up on the wall, when she lived downstairs. The CNA indicated when she first got here she would have a lot swelling in her arm. She indicated the therapist came into the room one day and put the sign on the wall to remind staff to keep her left arm elevated.</p> <p>The record for Resident #74 was reviewed on 3/14/13 at 1:16 p.m. The resident was admitted to facility on 8/31/12.</p> <p>Review of the current plan of care dated 2/13 indicated there was no care plan for the sign to be posted above the resident's bed.</p> <p>Interview with COTA (Certified Occupational Therapist Assistant) #1 on 3/16/13 at 9:00 a.m., indicated she did remember the resident from therapy and from working with her. She further indicated she was the person who put the sign above her bed regarding keeping her left arm elevated on a pillow. She indicated she wanted to make sure the resident received the proper care, by elevating her arm. She was unaware she was not supposed to hang signs regarding resident care information in the resident's room.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	3.1-3(t)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure the residents' personal preference for shower frequency was honored for 2 of 3 residents reviewed for choices of the 4 residents who met the criteria for choices. (Residents #23 and #154)</p> <p>Findings include:</p> <p>1. Interview with Resident #23 on 3/13/13 at 9:08 a.m., indicated that she could not choose how many times a week she took a bath or shower. The resident indicated that she had only had two showers since she had been in the facility and that she would like more.</p> <p>The record for Resident #23 was reviewed on 3/14/13 at 10:08 a.m. Review of the Admission Minimum Data Set (MDS) assessment dated 2/18/13, indicated the resident's BIMS (Brief Interview for Mental Status)</p>	F000242	F242 D Self Determination - Right to Make Choices Corrective action accomplished for those residents found to have been affected by the deficient practice: resident #23 and #154 have been discharged from this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: we audited all resident preferences completed when they admitted to Spring Mill and compared it to the documentation we have in CareTracker. Any discrepancies were corrected and reviewed with resident and/or family as needed. Staff can now see resident preferences as described upon admission in the CareTracker profile. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: we are implementing a new process to make sure our residents personal preferences regarding shower frequency is honored. Upon admission, our	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>score was 11/15, indicating she was cognitively intact. Review of the Customary Routine and Preference section, indicated it was somewhat important for the resident to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>Review of the resident's shower sheets on 3/19/13 at 11:59 a.m., indicated the resident received a shower on 2/13/13 and 3/9/13.</p> <p>Interview with the Clinical Nurse Specialist on 3/20/13 at 10:00 a.m., indicated the resident should have been bathed according to her preference.</p> <p>2. Interview with Resident #154 on 3/12/13 at 2:03 p.m., indicated that she could not choose how many times a week she took a bath or shower. She also indicated that she could not choose between a shower, tub or bed bath. The resident indicated that she had not had a shower while residing at the facility and she would like one.</p> <p>The record for Resident #154 was reviewed on 3/18/13 at 11:32 a.m. The resident was admitted to the facility on 3/4/13. Review of the Resident Preference for Customary</p>		<p>staff will interview residents then enter the information directly into CareTracker. This allows CNAs and nurses to access information each time they document in CareTracker. Training for this new system will be conducted with all nursing staff. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring will be conducted by DHS or designee based on the following schedule: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. We will monitor for shower/bathing preferences entered into CareTracker and document on the admission audit. Results from the monitoring will be shared in monthly QA.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>Routine and Activities interview worksheet, indicated it was very important to the resident to choose between a bed bath, tub bath, shower or sponge bath.</p> <p>Review of the shower book on 3/19/13 at 9:10 a.m., indicated the resident should have received showers on Wednesday and Saturday evenings.</p> <p>Review of the care tracker sheet provided by the Director of Nursing on 3/19/13 at 2:20 p.m., indicated there were no showers documented for the resident since admission. Documentation on the sheet indicated the resident had received partial baths.</p> <p>Interview with CNA #1 on 3/19/13 at 9:00 a.m., indicated there was a shower book located at the nurses' station which listed the rooms and days for showers. She indicated a shower sheet was to be completed when a shower was given and then given to the nurse to sign off on.</p> <p>Interview with the Clinical Nurse Specialist on 3/20/13 at 10:00 a.m., indicated the resident should have been bathed according to her preference.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	3.1-3(u)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to the position of a foley catheter drainage bag for 1 of 1 residents reviewed for foley catheters, monitoring weights and reporting weight loss to the Registered Dietitian (RD) for 2 of 3 residents reviewed for nutrition for the 6 residents who met the criteria for nutrition, and monitoring pain for 1 of 3 residents reviewed for pressure ulcers of the 10 residents who met the criteria for pressure sores. (Residents #19, #102, #125, and #151)</p> <p>Findings include:</p> <p>1. On 3/18/13 at 8:55 a.m., Resident #102 was observed in her room in bed. The resident's foley catheter drainage bag was observed on top of her mattress.</p> <p>On 3/19/13 at 9:10 a.m., the resident was observed in her room sitting on the side of her bed. The resident's</p>	F000282	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #102 has been discharged; #19, #125, #151 were assessed to make sure their immediate needs. All care plans and resident profiles have been updated with individual needs and preferences. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All other residents have been assessed for similar needs and care plans were updated. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Weights and nutrition will be monitored with daily CCM/nursing meetings, weekly visits by RD and our weekly Clinical at Risk (CAR) meetings. Notes from the weekly CAR meeting will be available and our primary tool for documenting communication to our RD for weight loss and prevention of pressure ulcers. When weights are obtained, they will be entered into CareTracker for team access and review. Results of these</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>foley catheter drainage bag was on top of her mattress.</p> <p>The record for Resident #102 was reviewed on 3/19/13 at 11:15 a.m.</p> <p>The plan of care dated 2/2/13, indicated the resident had an alteration in urinary elimination as evidenced by having an indwelling catheter. Review of the interventions indicated the foley catheter drainage bag was to be positioned below the level of the bladder.</p> <p>Interview with the Director of Nursing on 3/19/13 at 11:30 a.m., indicated the resident's foley catheter drainage bag should have been positioned below the resident's bladder.</p> <p>2. On 3/14/13 at 8:20 a.m., Resident #19 was observed eating breakfast in dining room on the second floor. The resident was observed feeding herself and was served hot cereal, bacon, a biscuit and eggs.</p> <p>On 3/14/13 12:46 a.m., the resident was</p>		<p>weekly meetings will be shared with our QA for 6 months. Monitoring tool will be used to document review of these systems. Additionally, nursing staff have been inserviced on appropriate placement of foley catheter with catheter bag placed below the bladder and that the catheter bag covered with dignity. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring will be conducted by DHS or designee based on the following schedule: all residents with Foley catheters will be monitored on the following schedule to make sure correct placement of the Foley catheter bag - 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. We will monitor for shower/bathing preferences enter into CareTracker and will also interview the resident to make sure we are adhering to their requests. Results from the monitoring will be shared in monthly QA.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>observed in the dining room eating lunch. She was served pork, rice, vegetables, and cornbread.</p> <p>On 3/15/13 at 8:25 a.m., the resident was observed eating breakfast. She was served eggs, toast, sausage, juice and coffee.</p> <p>The record for Resident #19 was reviewed on 3/18/13 at 8:52 a.m. The resident was admitted to the facility on 12/12/12. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, high cholesterol, and hypothyroidism.</p> <p>Review of the weight record indicated the resident weighed 162 pounds on 12/16/12. Further review of the weight record was as follows: 12/22 162 pounds 12/29 161 pounds 1/6/13 160 pounds 1/13/13 161 pounds 2/3/13 160 pounds 3/3/13 157 pounds 3/10/13 152 pounds 3/17/13 151 pounds</p> <p>The resident had a 5.3% significant weight loss from 2/3/13 to 3/10/13.</p> <p>Review of the current 2/6/13 care plan</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>indicated the resident was at risk for alteration in nutrition and/or hydration status related to significant change in weight; gain. The Nursing approaches were to provide the diet as ordered by Physician, assist resident with meal set up, monitor/report to Physician any signs or symptoms of weight loss, diet intolerance, and fluid imbalance, and monitor weight for changes every month and as needed. Consult the RD as needed.</p> <p>Interview with the Director of Nursing on 3/18/13 at 10:00 a.m., indicated there were no other RD notes or Dietary Tech notes in the resident's chart. She further indicated, the weekly and monthly weights were given to her and she was to provide the RD with the weights and inform her of any weight losses.</p> <p>3. On 3/14/13 at 8:11 a.m. Resident #125 was eating breakfast. The resident asked for a piece of raisin toast. Further observation indicated that was all the resident ate.</p> <p>On 3/15/13 at 8:43 a.m., the resident was observed eating only toast for breakfast.</p> <p>The record for Resident #125 was reviewed on 3/15/13 at 10:26 a.m. The resident's diagnoses included, but were</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>not limited to, dementia, anemia, high blood pressure, hypothyroidism, and reflux disease.</p> <p>Review of Physician Orders on the current 3/13 recap indicated the residents was receiving a mechanical soft diet. The resident was not receiving any nutritional supplements.</p> <p>Review of the weight record indicated the resident weighed 162 pounds on 11/4/12. Further review of the weight record was as follows:</p> <p>11/18 160 pounds 11/25 159 pounds 12/12 159 pounds 1/6/13 158 pounds 1/13 157 pounds 1/20 156 pounds 2/3 157 pounds 2/10 157 pounds 2/17 156 pounds 2/24 153 pounds 3/3 141 pounds 3/10 141 pounds 3/17 142 pounds</p> <p>The resident had lost 16 pounds in 30 days from 2/3 until 3/3/13 which was an 11.3% weight loss. The resident had a 15 pound weight loss in 90 days from 12/08/12 from 156 pounds to 3/3/13 to 141 which was 10.6% weight loss.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Interview with the Director of Nursing on 3/18/13 at 10:00 a.m., indicated there were no other RD notes or Dietary Tech notes in the resident's chart. She further indicated, the weekly and monthly weights were given to her and she was to provide the RD with the weights and inform her of any weight losses.</p> <p>4. Resident #151's clinical record was reviewed on 3/14/13 at 9:05 a.m. Resident #151's diagnoses included, but were not limited to, status post left hip fracture, hypertension, congestive obstructive pulmonary disease (lung disease).</p> <p>A care plan for pain was initiated on 2/22/13. The care plan interventions indicated to make a referral to the resident's physician to consider pre-medication for pain prior to activity, monitor signs and symptoms of pain, and report changes in pain to the physician.</p> <p>Review of the 14 day MDS (Minimum Data Set) Assessment dated 2/27/13, indicated the resident had pain daily and it affects his daily activities and sleep. The MDS indicated the resident had prn (as needed) pain medication and no scheduled pain medication.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>The March MAR (Medication Administration Record) indicated the resident had prn vicodin and tramadol for pain.</p> <p>A dressing change was observed on 3/14/13 at 10:50 a.m. Resident #151 indicated to LPN #1 prior to the dressing change that his heal was tender and sore. LPN #1 did not assess the resident's pain or asked the resident if he wanted pain medication.</p> <p>Interview with LPN #1 at 11:00 a.m., acknowledged she should had assessed the residents pain prior to the dressing change.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to provide the necessary treatment and services related to pain medication and hospitalizations for 1 of 3 residents reviewed for hospitalization of the 5 residents who met the criteria for hospitalization and for 1 of 3 residents reviewed for pressure ulcers of the 32 residents who met the criteria for pressure ulcers. (Residents #11 & #151)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 3/14/13 at 11:14 a.m. The resident was admitted to the facility on 1/29/13. The resident was discharged from the facility to the hospital on 2/12/13.</p> <p>The resident's diagnoses included, but were not limited to, metabolic encephalopathy, reflux disease, dehydration, major depressive disorder, acute bronchitis, congestive</p>	F000309	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #11 has been discharged from the facility; Resident #151's pain was addressed at the time of the survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all current residents with symptoms or complaints of pain have been addressed, physicians contacted and we have received orders as needed. Also, all MDSs that produced CAAs have been reviewed to assure residents who triggered have been assessed per our guidelines. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: all licensed nurses have been inserviced on our policy and guidelines for pain with treatments or dressing changes with pain medications given prior to the treatment if indicated. Additionally, nurses have been</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>heart failure, pulmonary embolism, fracture femur and debility.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 2/5/13 indicated the resident was not alert and oriented, she had no behaviors, and was an extensive assist with one person assist for all her activities of daily living. The resident was also receiving anticoagulant therapy seven days a week.</p> <p>Review of the current 2/5/13 plan of care indicated the resident was at risk for bleeding and bruises related to anticoagulant use. The Nursing approaches were to provide anticoagulant medication as ordered, educate family and resident on potential risks, report lab results to Physician and follow Physician recommendations for abnormal labs. They were to report any negative outcomes, observe for signs and symptoms of bleeding: nose bleeds and tarry black stools and report to Physician any abnormal bleeding.</p> <p>Review of Physician Orders dated 1/29/13 indicated the resident was receiving Coumadin 2.5 milligrams (mg) every night. Review of a coagulation test performed by the</p>		<p>trained to follow our policy for physician notification. We will also provide training to nurses to provide relevant medical history to the physician. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring for this will include daily nursing meetings (M-F) to review 24 hour reports for residents complaint of pain. We will also conduct audits of MARs and PRN medications on the following schedule: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Nursing facility indicated on 2/5/13 an INR (International Normalized Ratio) was completed. The Physician was notified of the results and new orders to give Coumadin 5 mg one time dose was obtained. Nursing staff were to continue the Coumadin 2.5 mg and recheck the INR in one week.</p> <p>Review of the change in condition form dated 2/7/13 4:19 a.m. indicated the resident was observed vomiting black times one. A large amount with one bowel movement, black pasty stool. The Physician was notified and new orders were obtained to obtain a Complete Blood Count and obtain a stool for occult blood. The Physician also ordered, Compazine (a medication used for vomiting) 25 milligrams (mg) every 12 hours for nausea and vomiting as needed. There was no evidence of documentation the Physician was informed of the current Coumadin dose.</p> <p>Review of the lab results dated 2/8/13 indicated the Complete Blood Count had been completed and the Physician was notified. There were no results for the stool for occult blood.</p> <p>Review of the Change of condition</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>form on 2/12/13 at 3:30 a.m. indicated the resident was observed with black tarry emesis and black tarry stool coming from nose and mouth. The resident was sent to the Emergency Room for evaluation.</p> <p>Review of the Medication Administration Record for the month of 2/13 indicated the Coumadin 2.5 mg was signed out as being given 2/6-2/11/13.</p> <p>Review of the lab results for the stool for occult blood indicated it had been done stat (immediately) at hospital on 2/12/13 at 4:50 a.m., when the resident arrived. The results of the lab test were positive for blood.</p> <p>Interview with the Director of Nursing on 3/15/13 at 12:45 p.m., indicated the only stool for occult blood completed was on 2/12/13 in the hospital. She further indicated it was unclear if the nurse who notified the physician on 2/7/13 informed him the resident was on Coumadin.</p> <p>2. Resident #151's clinical record was reviewed on 3/14/13 at 9:05 a.m. Resident #151's diagnoses included, but were not limited to, status post left hip fracture, hypertension, congestive obstructive pulmonary disease (lung</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

	<p>disease).</p> <p>A care plan for pain initiated was initiated on 2/22/13. The care plan interventions indicated to make a referral to the resident's physician to consider pre-medication for pain prior to activity, monitor signs and symptoms of pain, and report changes in pain to the physician.</p> <p>Review of the 14 day MDS (Minimum Data Set) Assessment dated 2/27/13, indicated the resident had pain daily and it affects his daily activities and sleep. The MDS indicated the resident had prn (as needed) pain medication and no scheduled pain medication.</p> <p>The March MAR (Medication Administration Record) indicated the resident had prn vicodin and tramadol for pain.</p> <p>A dressing change was observed on 3/14/13 at 10:50 a.m. Resident #151 indicated to LPN #1 prior to the dressing change that his heal was tender and sore. LPN #1 did not assess the resident's pain or asked the resident if he wanted pain medication.</p> <p>Interview with LPN #1 at 11:00 a.m.,</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>acknowledged she should had assessed the residents pain prior to the dressing change.</p> <p>A Wound Pain Assessment Guideline, undated, was provided by the Nursing Consultant on 3/18/13 at 12:00 p.m. The guidelines indicated "...Health professionals should ask the resident about pain and the resident's self-report should be the primary source of assessment. The self-report should include a description of the pain, location, intensity and aggravating and relieving factors...Pain medication should be scheduled for administration prior to treatment intervention when possible..."</p> <p>Review of nursing notes and medication administration sheets on 3/20/13 at 10:00 a.m., indicated no pain medication was given to patient on 3/14/13 after the dressing change and there was no documentation indicating the resident had discomfort with the dressing change.</p> <p>3.1-37(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure 2 of 3 residents reviewed for pressure sores of the 10 who met the criteria for pressure sores received the necessary assessment, treatment and services to promote healing related to implementation of nutritional supplements in a timely manner and wound assessment. (Residents #84 and #151)</p> <p>Findings include:</p> <p>1. The record for Resident #84 was reviewed on 3/15/13 at 1:54 p.m. The resident's diagnoses included, but were not limited to, cerebrovascular disease, hemiplegia, and cognitive communication deficit.</p> <p>A Physician's order dated 2/24/13, indicated the resident had a wound to</p>	F000314	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #84 has been discharged from this facility. Resident #151 was assessed and the physician was updated in regards to the pressure ulcer and treatment. New orders were obtained. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all current residents with pressure ulcers have been assessed to ensure the wound is improving with the current order. We did not identify any new residents with skin issues that had not been previously identified. Other interventions have also been assessed such as the potential need for nutritional supplements. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>her right buttock. The area was to be cleansed with wound cleanser, patted dry, apply silvasorb, and cover with optifoam daily.</p> <p>A Physician's order dated 3/7/13, indicated the resident was to have Calmoseptine (a skin ointment) applied to the left buttock pressure ulcer every shift and as needed. Continue optifoam to right buttock pressure ulcer.</p> <p>Review of the Weekly Pressure Ulcer Sheets, indicated the areas were Stage 1 and Stage 2.</p> <p>Review of the Registered Dietitian (RD) progress note on 3/8/13, indicated Promod (a protein supplement) was recommended for wound healing.</p> <p>A Physician's order dated 3/13/13, indicated add 30 ml (milliliters) (1 oz) Promod liquid protein supplement bid (twice a day) for wound healing.</p> <p>Interview with the Clinical Nurse Specialist on 3/18/13 at 2:12 p.m., indicated there was no specific policy related to implementing dietary recommendations. She indicated she would expect staff to act upon the recommendations within 48-72 hours.</p>		<p>licensed nursing staff have been inserviced regarding our expectations for physician notification if no improvement in a pressure ulcer. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: DHS or designee will review wounds weekly to ensure wounds are improving with current treatment. Physician will be notified when no improvement is seen after two weeks with a goal to obtain a new treatment. Results of these weekly rounds will be shared with the QA process for six months as needed thereafter.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Interview with RN #1 on 3/19/13 at 10:47 a.m., indicated when the RD makes a recommendation, they call the physician usually the same day when they receive the recommendations from the Director of Nursing.</p> <p>Interview with the Director of Nursing on 3/19/13 at 11:30 a.m., indicated the dietary recommendations should have been implemented in a more timely manner.</p> <p>2. Resident #151's clinical record was reviewed on 3/14/13 at 9:05 a.m. Resident #151's diagnoses included, but were not limited to, status post left hip fracture, hypertension, congestive obstructive pulmonary disease (lung disease).</p> <p>Individualized Assessment and Review dated 2/20/13 indicated the resident was not at risk for skin breakdown.</p> <p>A Nursing Admission assessment on 2/20/13 indicated the resident had a blister on the left heel. There was no indication of a redden area on the resident's right heel.</p> <p>A weekly skin assessment dated 2/20/13, indicated a blister on left heel</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>measuring 3.5 x 2.0 cm. The area was pink in color with no exudate and the treatment indicated to monitor.</p> <p>A care plan dated 2/22/13, indicated the resident had a skin condition of a blister to the left heel.</p> <p>A new weekly wound assessment dated 2/26/13, initially indicated a suspected deep tissue injury to the right heel that was not present on admission. The assessment indicated the pressure ulcer to be a Stage I (non blanchable skin). There were no measurements indicated. The treatment on the assessment indicated to elevate heels and apply skin prep with a dressing. The wound assessment was crossed out and changed to indicate a left heel pressure ulcer with eschar (black, dead tissue) that was present on admission. There was no documentation to indicate if the right heel assessment was written in error.</p> <p>A physician order dated 2/26/13, indicated to elevate the heels while in the bed.</p> <p>The Admission MDS (Minimum Data Set) Assessment dated 2/27/13, indicated the resident needed extensive assistance of one person</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>for bed mobility and transferring. The assessment also indicated the resident had an unstageable heel ulcer but did not give dimensions.</p> <p>Below the 2/26/13 assessment, a new wound assessment dated 2/27/13 indicated eschar (black, dead tissue) written above SOTI (soft tissue injury) with a line through it, measuring 1.9 x 1.0 x UD (undetermined depth). The color tissue type indicated purple and red. There were no percentage or location indicated.</p> <p>A physician order dated 2/27/13, indicated to apply skin prep to the left heel every shift.</p> <p>A care plan dated 2/28/13, indicated the resident had an alteration in skin integrity as evidenced by a pressure ulcer described as a reddened area to the right heel.</p> <p>A physician order dated 3/2/13, indicated to discontinue treatment to the left heel.</p> <p>Nursing Note dated 3/2/13 at 9:40 a.m. indicated the left heel to be a blister.</p> <p>A nursing note dated 3/3/13 at 2:30 p.m., indicated the resident had an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>open area to left heel measuring (L) 2.2cm (centimeter) x (W) 1.8cm. The tissue was yellow in color with surrounding tissue pink in color and scant amount of drainage. A new treatment to the left heel was initiated.</p> <p>A physician order dated 3/3/13, indicated to start santyl (debriding ointment) to the left heel daily.</p> <p>A weekly wound assessment dated 3/6/13, indicated eschar for pressure/stage measuring (L) 2.0 x (W) 2.5. x (D)UD with a thin, scant amount of tan exudate, and no odor. There was 10% pink tissue and 90% yellow tissue but no location indicated.</p> <p>LPN #1 was observed performing a dressing change on the resident's left heel on 3/12/13 at 11:06 a.m. The left heel was observed to be necrotic with yellow edges. LPN #2 did not remove the sock to observe the right heel.</p> <p>A weekly wound assessment dated 3/13/13, indicated eschar and Stage III measuring (L) 2.2 x (W) 2.3 with (D)<0.2cm. There was no exudate and the resident had slight discomfort. There was 95% of red tissue and 5% of green slough (dead</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>tissue). No location indicated.</p> <p>Interview with MDS Coordinator on 3/14/13 at 10:15 a.m., indicated the copy of the wound assessment sheet was not the same sheet that was located in the wound assessment book. She indicated the nursing note on 3/2/13, indicating a blister on the left heel had to be wrong. The MDS Coordinator had only the wound assessment sheet dating 2/26/13 with corrections of location of heel and stage. She did not have the 2/20/13 wound assessment sheet that indicated the blister.</p> <p>LPN #1 was observed performing a dressing change on the resident's left heel on 3/14/13 at 10:50 a.m. There was no dressing to remove and area was pale and scabbed. The resident complained of discomfort at the site. The LPN did not remove the sock from the right foot to observe the right heel. The LPN did not document the resident's discomfort or the change in appearance to his left heel.</p> <p>Observation of the resident's right heel with the Nursing Consultant on 3/14/13 at 11:35 a.m., indicated an area on his right, lateral heel. The Nursing Consultant assessment indicated eschar with surrounding</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>pink tissue to the right side of the heel, that was acquired after admission, measuring 1 x 0.4cm with depth undetermined. The Nursing Consultant cannot determine at the time if this was the same pressure area that was observed and documented by LPN #7 on 2/26/13. The Nursing Consultant indicated both heels should be observed during dressing changes and/or weekly skin assessments.</p> <p>A telephone interview with LPN #7 on 3/15/13 at 12:20 a.m., indicated she did not cross out or make corrections on her wound assessment and she did see a purple/pink/red area on the right heel. She indicated the area did not have a blister or eschar.</p> <p>A Pressure/Stasis Wound Condition Report Guidelines, undated, was provided by the Nursing Consultant on 3/18/13 at 12:00 p.m. The guidelines indicated to "...Complete one form for each impaired area...Initiate the form when an area of impairment is identified...Document description of wound using the Documentation Key...Note 'healed' when the wound no longer requires treatment and monitoring..."</p> <p>Interview with LPN #8, on 3/19/13 on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>12:15 p.m., indicated she had spoken with LPN #1 and they both observed the right heel wound on 2/27/13. LPN #8 indicated they did not see the pressure area and she changed the sheet without consulting with LPN#7. LPN #8 acknowledged the description does not match with resident having a blister. LPN #8 indicated she did not do the wound rounds the prior week for having to work on the floor.</p> <p>3.1-40(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure measures were taken to prevent a urinary tract infection for a resident with a foley catheter for 1 of 1 residents reviewed with a foley catheter. (Resident #102)</p> <p>Findings include:</p> <p>On 3/13/13 at 8:50 a.m., Resident #102 was observed in her room in bed. The resident's foley catheter drainage bag was on the floor. The drainage bag was not covered with a dignity bag.</p> <p>On 3/18/13 at 8:55 a.m., the resident was observed in her room in bed. The resident's foley catheter drainage bag was positioned on top of her mattress. At 11:15 a.m., the resident was in her room yelling for help, the</p>	F000315	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #102 has been discharged from this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all current residents with a foley catheter have been assessed to assure the catheter is positioned properly below level of the bladder and that catheter bags are covered with a dignity bag.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: nursing staff have been inserviced on appropriate placement of foley catheter with catheter bag placed below the bladder, and that catheter bag should be covered for dignity.</p> <p>How the corrective actions will be</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>resident indicated that she did not feel well.</p> <p>On 3/19/13 at 9:10 a.m., the resident was observed in her room sitting on the side of her bed. The resident indicated that she was not feeling well. The resident's foley catheter drainage bag was positioned on top of her mattress. Cloudy yellow urine was observed in the foley catheter tubing. At 10:15 a.m., the foley catheter drainage bag on was on the floor next to the resident's bed. The drainage bag was not covered with a dignity bag.</p> <p>The record for Resident #102 was reviewed on 3/19/13 at 11:15 a.m. The resident's diagnosis included, but was not limited to, urinary retention.</p> <p>A Physician's order dated 3/15/13, indicated to insert new foley catheter 16 french/5 cc (cubic centimeter) due to resident removal of previous foley.</p> <p>A Physician's order dated 3/17/13, indicated the foley was to be changed on the 15th of every month.</p> <p>The plan of care dated 2/2/13, indicated the resident had an alteration in urinary elimination as evidenced by having an indwelling</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: DHS or designee will round to ensure all residents with foley catheters are properly placed and that catheter bags are covered. This monitoring will occur on the following schedule: : 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Results from rounding will be shared with QA committee monthly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>catheter. Review of the interventions indicated the foley catheter drainage bag was to be maintained below the level of the resident's bladder.</p> <p>A Physician's order dated 3/18/13, indicated a urinalysis with a culture and sensitivity was to be collected. Review of the urinalysis results dated 3/18/13 indicated there were greater than 100 white blood cells (normal 0-5), 20-50 red blood cells (normal 0-2), 1+ mucus, 1+ bacteria, and 1+ blood. Color yellow, clarity cloudy.</p> <p>The Physician was notified of the results on 3/19/13 and orders were obtained for AZO Cranberry 450 mg (milligrams) 1 tablet by mouth every day for UTI (urinary tract infection) prevention. Wait for culture results of urinalysis.</p> <p>Interview with the Director of Nursing on 3/19/13 at 11:30 a.m., indicated the resident had previously had the catheter for hematuria, she had also indicated the resident was being treated for a UTI. She indicated the resident's foley catheter drainage bag should have been covered with a dignity bag and the drainage bag should have been positioned below the resident's bladder.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	3.1-41(a)(2)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to the timely implementation of nutritional supplements and monitoring weight loss and reporting to the Registered Dietitian (RD) for 2 of 3 residents reviewed for nutrition of the 6 residents who met the criteria for nutrition and for 1 of 1 residents reviewed for dialysis. (Residents #19, #125, and #154)</p> <p>Findings include:</p> <p>1. The record for Resident #154 was reviewed on 3/18/13 at 11:32 a.m. The resident's diagnosis included, but was not limited to, End Stage Renal Disease (ESRD).</p> <p>Review of the Registered Dietitian (RD) progress note dated 3/8/13,</p>	F000325	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: resident #154 has been discharged from our facility. Residents #19 and #125 have been assessed to assure adequate nutrition and supplements are being offered to these residents, and that their weight is being monitored and reported to the RD. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents on our health center have been assessed for weight loss and any residents who met the criteria for unacceptable parameters of nutrition were reported to our RD in a timely manner.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: weekly weights are obtained one day per week and recorded in the binder at</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>indicated "resident with increased nutritional needs due to receiving dialysis and pressure wounds while controlling nutrition/hydration for diabetes, congestive heart failure, and ESRD . No labs available to assess nutritional status. Assessed oral intake, inadequate for meeting estimated needs. Interventions: clarify diet-NAS (no added salt) with diet condiments and no high potassium foods. Add 1 can Nepro bid (twice a day) between meals. Add Nephrovite supplement daily."</p> <p>(Order obtained for supplements on 3/13/13, added to MAR but not signed out as given)</p> <p>A Physician's order dated 3/13/13, indicated to change diet to NAS with diet condiments. No bananas, oranges, prunes, melon, non-boiled potatoes/sweet potatoes, yogurt, tomatoes, tomato juice. Nepro 1 can by mouth bid and Nephrovite supplement 1 tablet daily.</p> <p>Review of the 3/13 Medication Administration Record (MAR), indicated the Nepro and Nephrovite were added to the MAR on 3/13/13, however, the supplements had not been signed out as given.</p>		<p>the nurses station, then these weights are transferred to CareTracker which is available to our RD and Diet Tech for every visit.</p> <p>Residents with significant weight loss and /or weight gain will also be reviewed during our weekly CAR meetings. All licensed nurses have been inserviced on our guidelines for reporting changes to the RD in a timely manner using the nursing dietary communication form..</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place:</p> <p>weekly weights are obtained one day per week and recorded in the binder at the nurses station, then these weights are transferred to CareTracker which is available to our RD and Diet Tech for every visit.</p> <p>When the RD and/or Tech visit, they will generate a report that lists all significant weight changes.</p> <p>Residents with significant weight loss and /or weight gain will also be reviewed during our weekly CAR meetings. This monitoring tool (same tool as F282) will be in place for the next 6 months to assure our systems are working efficiently and our residents are receiving the nutrition interventions they need for their highest practicable level of functioning. (attach monitoring tool). Nursing will also complete the Nursing Dietary Communication form which will alert the RD team to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Interview with the Clinical Nurse Specialist on 3/18/13 at 2:12 p.m., indicated there was no specific policy related to implementing dietary recommendations. She indicated she would expect staff to act upon the recommendations within 48-72 hours.</p> <p>Interview with RN #1 on 3/19/13 at 10:47 a.m., indicated when the RD makes a recommendation, they call the physician usually the same day when they receive the recommendations from the Director of Nursing.</p> <p>Interview with the Director of Nursing on 3/19/13 at 11:30 a.m., indicated the dietary recommendations should have been implemented in a more timely manner.</p> <p>2. On 3/14/13 at 8:20 a.m., Resident #19 was observed eating breakfast in dining room on the second floor. The resident was observed feeding herself and was served hot cereal, bacon, a biscuit and eggs.</p> <p>On 3/14/13 12:46 a.m., the resident was observed in the dining room eating lunch. She was served pork, rice, vegetables, and cornbread.</p> <p>On 3/15/13 at 8:25 a.m., the resident was observed eating breakfast. She</p>		nutritional status changes for our residents.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>was served eggs, toast, sausage, juice and coffee.</p> <p>The record for Resident #19 was reviewed on 3/18/13 at 8:52 a.m. The resident was admitted to the facility on 12/12/12. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, high cholesterol, and hypothyroidism.</p> <p>Review of Physician's Orders on the current 3/13 recap indicated the resident was receiving a no added salt mechanical soft diet. The resident was currently not receiving any nutritional supplements.</p> <p>Review of the weight record indicated the resident weighed 162 pounds on 12/16/12. Further review of the weight record was as follows: 12/22 162 pounds 12/29 161 pounds 1/6/13 160 pounds 1/13/13 161 pounds 2/3/13 160 pounds 3/3/13 157 pounds 3/10/13 152 pounds 3/17/13 151 pounds</p> <p>The resident had a 5.3% significant weight loss from 2/3/13 to 3/10/13.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>Review of the Dietary Progress Notes dated 12/18/12 by the Registered Dietitian (RD) indicated the resident's weight at admission was 162 pounds. The resident has a Body Mass Index (BMI) of 28.7. The RD addressed the resident's labs, medications caloric intake.</p> <p>The next documented and last Dietary Progress Note was by the Dietary Tech on 2/6/13 in which she addressed the resident's diet, and her weight.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 12/19/12 indicated the resident was not alert and oriented. It further indicated her behavior fluctuates comes and goes with altered level of consciousness. The resident's weight was 162 pounds and there was no weight loss or gain. The resident had no swallowing problems or oral problems.</p> <p>Review of the quarterly MDS assessment dated 2/2/13 indicated the resident's weight was 160 pounds which indicated no weight loss or gain. The resident was receiving a mechanically altered and therapeutic diet.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Review of the current 2/6/13 care plan indicated the resident was at risk for alteration in nutrition and/or hydration status related to significant change in weight; gain. The Nursing approaches were to provided the diet as ordered by Physician, assist resident with meal set up, monitor/report to Physician any signs or symptoms of weight loss, diet intolerance, and fluid imbalance, and monitor weight for changes every month and as needed. Consult the RD as needed.</p> <p>Review of the Nursing assessment dated 2/8/13 indicated the resident had no edema noted anywhere. Review of the Nursing assessment dated 2/20/13 indicated the resident had no edema. There were no other Nursing Notes or assessments regarding the resident and any other problems.</p> <p>Review of the food consumption sheets for the month of 2/13 indicated there were incomplete. The food consumption was completed for 2/5-2/8, 2/11, 2/13, 2/14, 2/18, 2/21, 2/26, and 2/27/13. The food consumption for the lunch meal was also incomplete. The staff documented the food consumption for the lunch meal on 2/5-2/8, 2/11, 2/13,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>2/14, 2/18, 2/21, and 2/27/13. It was documented the resident consumes between 50-100% of most meals.</p> <p>Interview with the Director of Nursing on 3/18/13 at 10:00 a.m., indicated there were no other RD notes or Dietary tech notes in the resident's chart. She further indicated, the weekly and monthly weights were given to her and she was to provide the RD with the weights. She indicated she usually will have the resident's reweighed if there was a three pound or more weight loss noted. She indicated she did not notify the RD or the Dietary tech of the resident's weight loss from 2/13 to 3/13. She then indicated the RD visits every Friday and the Dietary Tech visits every Thursday. They had both been at the facility five times since 3/1/13.</p> <p>The Dietary Tech reviewed the resident's record on 3/18/13 after the weight loss was brought to staff's attention. She indicated the resident had a 5.7% weight loss in one month which was significant. The resident's BMI was 24.4 and within desirable weight range. She recommend nutrition 2.0 supplement four ounce twice a day and to weigh weekly times 4 weeks. She also indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>Nursing Notes indicated there was edema to the resident's lower extremities.</p> <p>Interview with LPN #4 on 3/19/13 at 9:10 a.m., indicated she noticed a change of condition in the resident yesterday. She indicated the resident was a little sluggish yesterday, had some edema noted to her lower extremities, and had some crackles in her lungs. She indicated she notified the Physician and new orders were obtained. She indicated this was the first time the resident was observed with edema to her lower extremities.</p> <p>3. 2. On 3/14/13 at 8:11 a.m. Resident #125 was eating breakfast. The resident asked for a piece of raisin toast. Further observation indicated that was all the resident ate.</p> <p>On 3/15/13 at 8:43 a.m., the resident was observed eating only toast for breakfast.</p> <p>The record for Resident #125 was reviewed on 3/15/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, dementia, anemia, high blood pressure, hypothyroidism, and reflux disease.</p> <p>Review of Physician Orders on the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>current 3/13 recap indicated the residents was receiving a mechanical soft diet. The resident was not receiving any nutritional supplements.</p> <p>Review of the weight record indicated the resident weighed 162 pounds on 11/4/12. Further review of the weight record was as follows: 11/18 160 pounds 11/25 159 pounds 12/12 159 pounds 1/6/13 158 pounds 1/13 157 pounds 1/20 156 pounds 2/3 157 pounds 2/10 157 pounds 2/17 156 pounds 2/24 153 pounds 3/3 141 pounds 3/10 141 pounds 3/17 142 pounds</p> <p>The resident had lost 16 pounds in 30 days from 2/3 until 3/3/13 which was an 11.3% weight loss. The resident had a 15 pound weight loss in 90 days from 12/08/12 from 156 pounds to 3/3/13 to 141 which was 10.6% weight loss.</p> <p>Review of the 10/23/12 updated 3/18/13 care plan for nutrition indicated the resident was at risk for alteration in nutrition. The Nursing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>approaches were to consult the RD as needed and monitor weight for changes every month.</p> <p>Review of the RD Progress Note dated 11/27/12 indicated the resident's current weight was 158.9 pounds which was down 3 pounds. The RD addressed the resident's labs and pressure sore. She recommended a multi vitamin and daily supplement of 2.0 Nutritional supplement three ounces (90 cc) twice a day.</p> <p>The next Rd note was on 12/18/12 in which the resident was reviewed for skin breakdown. The RD addressed the resident's weight and new pressure sore. She recommended obtaining a pre albumin to assess healing.</p> <p>The next note was by the Dietary Tech dated 1/8/13 in which the resident's labs and weight were addressed. She indicated the resident was receiving Promod (a protein supplement) 30 cubic centimeters (cc) twice a day with 2.0 Nutrition supplement.</p> <p>The next Dietary Progress Notes was again by the Dietary Tech dated 2/28/13 which indicated the resident's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>weight of 157 pounds. The Dietary Tech indicated the resident's weight had been stable between 157-163 over the past 6 months. She addressed the resident's labs and that she was receiving the supplement of 2.0 90 cc twice a day and the Promod 30 cc twice a day.</p> <p>The last Dietary Progress Note was by the RD on 3/1/13 in which the resident was reviewed for gradual weight loss. The RD indicated the February weekly weights were as follows: 2/3 157, 2/10 157, 2/17 156 and 2/24 153. The resident was eating 87% of meals. She further indicated the resident's thyroid medication was increased on 2/6/13. The resident's Thyroid levels were slightly increased which could affect her weight. She indicated no recommendations.</p> <p>Review of Physician Orders dated 11/28/12 indicated 2.0 nutritional supplement give 3 oz 90 cc twice a day between meals.</p> <p>Further review of Physician Orders dated 1/10/13 indicated Promod give 30 cc liquid twice a day at 10 am and 2 p.m. Review of the Medication Administration Record for 2/13 indicated both supplements were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>signed out as being given on 2/1, 2/2, and 2/3/13.</p> <p>The resident was admitted to the hospital on 2/3/13 and returned back to facility on 2/5/13.</p> <p>Review of the 2/5/13 Physician Orders upon return indicated that both nutritional supplements were not reordered when she came back.</p> <p>Review of Nursing Progress Notes from 3/1-3/18/13 indicated there was no documentation of the resident's weight loss or if the resident was having any health problems.</p> <p>Interview with the Director of Nursing on 3/18/13 at 10:00 a.m., indicated the RD comes in every Friday and the Dietary Tech comes in every Thursday. She indicated they have been here in the facility on 3/1, 3/7, 3/8, 3/14 and 3/16/13. She indicated she monitors the resident's weight and identifies if there was a three pound weight loss. She indicated she usually notifies the RD of any weight changes and the RD also reviews the weight book. She indicated the RD has not seen the resident this month, and will not be in until Friday. She further indicated that she was going to call the RD and see what if any</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>recommendations were needed. She further indicated nursing staff should be monitoring the resident and what she eats.</p> <p>Review of the Dietary Tech progress note dated 3/18/13 after the weight loss was identified, indicated the resident's current weight was down 9.3% in past month. The resident's BMI was 23.6 and within desirable weight. She recommended to add Nutritional 2.0 supplement four ounces three times a day and to continue weekly weights times four weeks. She also indicated she had discussed those recommendations with RD per telephone.</p> <p>3.1-46(a)(1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to implement a c-pap machine for sleep apnea in a timely manner after the resident returned from the hospital for 1 of 1 resident reviewed for respiratory needs. (Resident #B)</p> <p>Findings include:</p> <p>Resident's #B clinical record was reviewed on 3/18/13 at 9:15 a.m. Resident B's diagnoses included, but were not limited to, stroke, legally blind, diabetes, narcolepsy, and sleep apnea.</p> <p>Resident #B was admitted to the facility on 12/3/12 with orders for c-pap at night.</p> <p>The January 2013 MAR (Medication Administration Record) between 1/1/13 to 1/9/13 indicated the cpap</p>	F000328	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #B has been discharged from this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all other residents have been assessed for current c-pap machine. No other residents have been affected by this practice. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: all residents who are admitted or readmitted will be reassessed for c-pap needs. This information will be captured by our admission or re-admission assessment. These assessments will be monitored weekly to make sure we are capturing important medical needs for our residents. Licensed nurses have been inserviced on our</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>was applied on the 11p-7a shift.</p> <p>The resident was sent to the emergency room on 1/10/13 where he was admitted until 1/16/13. Hospital records during this time indicated the resident had sleep apnea and required a cpap at night. Resident #B returned to the facility on 1/16/13.</p> <p>A nursing readmission assessment was completed on 1/16/13 at 9:00 p.m. The respiratory assessment does not indicate oxygen or cpap needs. The respiratory plan of care was not initiated. A nursing note during this time indicated the resident's arrival only. Signature of nurse unidentifiable.</p> <p>A nursing note on 1/19/13 (no time) indicated, "Resident BiPap [sic] machine administered accordingly per settings..." Signature of nurse unidentifiable.</p> <p>Physician orders dated 1/21/13, indicated "cpap at night-run on historically used settings, oxygen at 4L (liters)/min (minute) per NC (nasal canula) for cpap, change o2 (oxygen) tubing and H2O (water) bottle weekly on Sunday."</p>		<p>guidelines for admissions or readmissions for c-pap.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place:</p> <p>Monitoring schedule for assessing medical needs will be as follows: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>A physician clarification order dated 1/21/13, indicated oxygen at four liters per nasal canula as needed for oxygen saturations <90%, check oxygen saturations every shift for three days, then call ordering physician with results.</p> <p>The MAR (Medication Administration Form) dated 1/16/13 to 1/21/13 did not indicate if the resident was receiving his cpap at night. The 3p-11p shift indicated the cpap started from 1/21/13 to 1/31/13 with the exception of 1/29/13. The 11p-7a shift indicated the cpap started from 1/22/13 to 1/31/13 with 1/25/13, 1/27/13, and 1/28/13 not signed out.</p> <p>A nursing note dated 1/19/13 at 8:13 p.m. indicated the resident bi-pap [sic] machine administered accordingly per settings.</p> <p>A telephone interview with the complainant on 3/20/13 at 10:30 a.m., indicated the cpap was brought in from home. She indicated sometimes when she came in to visit at night, the cpap would not be plugged in or there would be no water in the bottle. She indicated that was a fire hazard due to a plate located under the water. The complainant indicated the cpap was left at the facility when the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>resident went to the hospital. Upon return, his belonging had been packed away in a box because the facility did not think he would be returning.</p> <p>Interview with SSD #1 and the Nursing Consultant, (who was the Interim DoN during the residents stay) on 3/20/13 at 2:00 p.m., indicated they remembered the spouse bringing in the cpap machine and was not able to recall if the resident's belongings were boxed up when he went to the hospital or if the cpap machine was at the facility upon his return.</p> <p>This Federal tag relates to complaint #IN00123605.</p> <p>3.1-47(a)(6)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to ensure each resident was free from unnecessary medication related to monitoring the resident while receiving a hypnotic medication, gradual dose reductions for an antipsychotic medication, and the duration of an anti-fungal medication for 3 of 10 residents reviewed for unnecessary medications. (Residents #31, #101, and # 156)</p>	F000329	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident #101 has been discharged. Residents #31 and #156 have been assessed to ensure they are free from unnecessary medications per pharmacy recommendations. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all other residents have been reviewed by pharmacist to identify any potential gradual dose</p>	04/19/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Findings include:</p> <p>1. The Record for Resident #31 was reviewed on 3/14/13 at 8:24 a.m. The resident was admitted to facility on 7/6/12. The resident's diagnoses included, but were not limited to, delusional disorder, dementia with behavior disturbance, and depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 1/19/12 indicated the resident was alert and oriented times three. The resident had mood problems with feeling down, had trouble falling asleep, and had little energy. The resident had no behaviors exhibited. The resident was receiving an antipsychotic medication for seven days and an antidepressant medication for seven days.</p> <p>Review of the Physician Orders dated 7/6/12 indicated the resident was receiving Risperidone .25 milligrams (mg) twice a day.</p> <p>Review of the Behavioral notes by the clinical Psychiatrist indicated the last note was dated 2/18/13. The Behavioral note indicated the resident had concerns of the amount of times she gets up in the middle of the night</p>		<p>reductions that might benefit the resident.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: : pharmacist visits at least monthly and provides recommendations for gradual dose reductions. Nursing will review these recommendations and contact the resident's physician with the recommendation.</p> <p>Additionally, our social workers have received training on gradual dose reductions and monitoring.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place Monitoring for the pharmacy recommendations will be monthly x 6 months with results shared with the QAA team.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>to use the bathroom. She reported it leaves her feeling tired and not very rested. There were no behaviors documented.</p> <p>Review of another Behavioral note dated 11/24/12 indicated the resident's biggest problem was feeling tired all the time.</p> <p>Review of Social Service Progress Notes and Nursing Progress Notes indicated there was no documentation of any behaviors. There was no documentation the resident had dementia with behaviors or delusions with behaviors.</p> <p>Further review of Social Service Notes dated 12/12, 1/13, and 2/13 indicated there was no documentation indicating any type of gradual dose reduction attempted for the Risperidone.</p> <p>Interview with Social Service Employee #1 on 3/14/13 at 10:46 a.m., indicated she was not quite sure of the Social Service's involvement with gradual dose reductions.</p> <p>Further interview with Social Service Employee #2 on 3/14/13 at 11:50 a.m., indicated pharmacy gives a print off of the psychotropic medications</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>and gives them to nursing. It was nursing's responsibility to call and notify the physician for the gradual dose reductions. Social Services was then notified of the change or no change in the resident's medications. She indicated at this time, they really had no involvement in gradual dose reductions.</p> <p>Interview with the Director of Nursing on 3/14/13 indicated there had been no recommendation for the Risperidone to be reduced from Pharmacy. She further indicated the facility had not tried a gradual dose reduction for the Risperidone either.</p> <p>Interview with LPN #6 on 3/14/13 at 1:10 p.m., indicated the resident was alert and oriented and has never had any behaviors since she has worked here. She even indicated she used to take care of the resident at home while doing home health.</p> <p>Interview with CNA #1 on 3/14/13 at 1:29 p.m., indicated the resident has not ever had behaviors.</p> <p>2. Resident #101's record was reviewed on 3/19/13 at 11:30 a.m. Resident #101's diagnoses included, but were not limited to, congestive obstructive pulmonary disease (lung disease), hypertension, insomnia,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>seizure activity, anxiety and depression.</p> <p>A consultation report from the hospital dated 2/15/13, indicated the resident was allergic to ambien and it caused the resident to have nightmares. The allergy was not on the discharge summary or on the MAR (Medication Administration Record).</p> <p>An Admission Nursing Assessment on 2/26/13, did not indicate if the resident has a history of trouble falling asleep or staying asleep.</p> <p>A nursing assessment on 2/26/13 between 3pm to 11pm, did not indicate the resident's sleep patterns.</p> <p>On 2/27/13 at 4:00 a.m., the resident was found on the floor. The Fall Circumstance report indicated the resident had recent agitation or restlessness, cognitive impairment, history of falls and confusion earlier in the shift due to the resident indicating she had been arguing with her husband .</p> <p>A nursing assessment note on 2/27/13 between 7am to 3pm, indicated the resident sleeps through the night.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>A nursing assessment note on 2/27/13 between 3pm to 11pm, did not indicate the resident's sleep patterns.</p> <p>A physician order dated 2/27/13 at 5:00 p.m., indicated for the resident to have a urinalysis to check for a urinary tract infection and for the resident to receive ambien 5mg (milligrams) every night for insomnia.</p> <p>On 2/28/13, the pharmacist reviewed the resident's medications and did not address the ambien as a possible allergy.</p> <p>Interview with LPN #9 on 3/19/13 at 1:30 p.m., indicated the nurses review the admission paperwork from the hospital when a resident was newly admitted. LPN #9 indicated she did not remember seeing a physician's note in the hospital records indicating the resident had an allergy to ambien or that it caused the resident nightmares.</p> <p>Interview with Nursing Consultant on 3/19/13 at 1:45 p.m., acknowledged the allergy for ambien was not verified and was overlooked by the pharmacist. Review of the March 2013 MAR (Medication Administration Record), the resident had received</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>the ambien every night until she was discharged to home on 3/16/13.</p> <p>2. Resident #156's clinical record was reviewed on 3/14/13 at 9:30 a.m. Resident #156's diagnoses included, but were not limited to, renal insufficiency, osteomyelitis, infected right foot, status post right below the knee amputation, diabetes, and ulcerations to feet/leg.</p> <p>Resident #156 was admitted to the hospital for an infected foot ulcer with gangrenous changes on 2/24/13. A hospitalization consult dated 2/24/13, indicated the resident was on diflucan (anti-fungal) and levofloxacin (anti-biotic). The resident was admitted to the Transitional Care Unit at the facility on 3/1/13, with an order for vancomycin and diflucan.</p> <p>A New Admission Medication Regimen Review form dated 3/1/13 indicated a request for a stop date for the diflucan. A check mark in the acceptance column and "x 7 days" was written under the request. There was no order written to stop diflucan.</p> <p>On 3/5/13, the resident was discharged to the hospital for a scheduled surgery, on the diflucan. The resident returned to the facility on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>3/8/13 to the Health Care Unit #1, then transferred back to the Transitional Care Unit on 3/10/13. The diflucan was not discontinued until 3/15/13.</p> <p>An Infection Assessment and Review sheet undated was reviewed and observed to be incomplete. The type of infection, symptoms, treatment required, vital signs, environmental and equipment inspection, notification, infection risk re-assessment, and IDT (Interdisciplinary Team) review were not indicated. The infection update had required treatment of difulcan 200mg for 7 days and to stop the medication on 3/15/13. There were no orders indicating a stop date for the diflucan.</p> <p>Interview with LPN #10 on 3/20/13 at 9:49 a.m., indicated an order should have been written to stop the diflucan prior to the resident going to the hospital. LPN #10 indicated the nurses generally obtain orders from the physicians for stop dates. LPN #10 indicated the night shift usually manages the recommendations from pharmacy.</p> <p>3.1-48(a)(6)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure the food was stored and prepared under sanitary conditions related to the lack of facial hair covering, soiled fry baskets, soiled stove, oven and utensil drawer. This had the potential to affect 45 of 46 residents in the facility, who received food prepared in the kitchen for 1 of 1 kitchens. (Health Care Kitchen)</p> <p>Findings include:</p> <p>1. Observation during the brief Kitchen Sanitation Tour of the Health Center Kitchen on 3/12/13 at 9:01 a.m., with the Assistant Director of Food Services indicated the following:</p> <p>a. The deep fryer had 2 frying baskets. There was an accumulation of food debris on both of the baskets. Interview with Dietary Staff #1 on 3/12/13 at 9:07 a.m., indicated the fryer was to be cleaned each evening. She indicated the baskets were in</p>	F000371	<p>Corrective action accomplished for this deficient practice: equipment identified during the brief kitchen sanitation tour of the health center kitchen were immediately cleaned/corrected. This included frying baskets, facial hair not covered, grease on sides of stove, oven needed to be cleaned, utensil drawer cleaned.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all equipment was reviewed and cleaned if necessary.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Cleaning schedules have been reviewed and updated as needed to be more specific to meet sanitation expectations. We also inserviced staff and reviewed expectations for covering facial hair in the kitchen. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place: sanitation inspections will be</p>	04/19/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>need of cleaning.</p> <p>2. The Kitchen Sanitation Tour of the Health Center Kitchen was completed on 3/14/13 at 10:46 a.m., with Chef #1 and the Assistant Director of Food Services. The following was observed.</p> <p>a. Chef #1 had a moustache and a beard, he had no beard or moustache guard on his face.</p> <p>b. There was grease on the sides of the stove, the stove was in need of cleaning.</p> <p>c. The oven had burnt on food debris on the bottom of the inside of the oven, the metal edge under the oven door was soiled with food spillage.</p> <p>d. The drawer with scoops, spatulas, and measuring spoons was observed. The bottom of the drawer was soiled and in need of cleaning.</p> <p>Interview with Chef #1 at the time of the tour indicated the above areas were in need of cleaning.</p> <p>3. Food temperatures were obtained on 3/14/13 at 11:45 a.m., by Chef #1. Chef #1 had a full beard and moustache. Interview with Chef #1 at</p>		<p>conducted by RD, Diet Tech, Dining Services Support and/or Executive Director at the following schedule: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Immediate intervention and education will be provided to the kitchen staff if equipment is found dirty or facial hair is found not covered. Results of monitoring will be shared with QAA.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>that time, indicated that during his training he was informed that as long as the facial hair was 1/4 inch or less it did not have to be covered. He was not wearing a beard guard.</p> <p>Interview with Chef #1 on 3/14/13 at 1:56 p.m., indicated that he was mistaken regarding the need for a beard guard. He indicated facial hair of any length needed to be covered with a beard guard in the kitchen.</p> <p>3.1-21(i)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure medications were disposed according to the facility's policy and procedure for 2 of 4 licensed staff and for 2 of 5 residents observed during medication pass. The facility also failed to ensure all medications were not stored past their expiration dates, related to insulin, suppositories, tuberculin testing vials and Influenza vaccines for 2 of 3 medication rooms and for 2 residents who received tuberculin testing. This deficient practice had the potential to effect 12 residents who resided on the</p>	F000425	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: all residents were assessed to assure no residents received expired meds. We also inserviced nurses to assure they were retrained on our medication destruction policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: immediate interventions and inservice training with licensed nurses will assure our residents receive pharmaceutical services to meet the needs of each resident. What measures will be put into</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Transitional Care Unit and 9 residents who resided on the Health Center 1. (Residents #19, # 147, #55, #156, Transitional Care Unit Medication Room and Health Center 1 Medication Room)</p> <p>Findings include:</p> <p>1. The medication room on the Transitional Care Unit was observed on 3/12/13 at 10:45 a.m. In the medication room refrigerator, there was a Pharmacy Emergency Drug Kit. There were 5 insulin vials observed in the Pharmacy Emergency Drug Kit. One vial of Novolin 70/30 insulin had a manufacturer's expiration date of 1/13.</p> <p>There were 2 bisacodyl suppositories (a laxative) observed in the Pharmacy Emergency Drug Kit. Both of the suppositories had a manufacturer's expiration date of 1/13.</p> <p>Interview with LPN #1 at that time, indicated the insulin and the bisacodyl suppositories were expired and should have been discarded and replaced.</p> <p>2. The refrigerator in the Health Center 1 medication room was observed on 3/12/13 at 10:55 a.m.</p>		<p>place or what systemic changes will be made to ensure the deficient practice does not recur: All nurses will be trained on expired medications and labeling medications, as well as our medication destruction policy. Monitoring will be in place to review refrigerators containing medications, EDK boxes to assure medications are not expired. How the corrective actions will be monitored to assure the deficient practice will not recur, i.e., what QA program will be put into place: Frequency of monitoring will be 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>There was one vial of Tuberculin Purified Protein Derivative (Mantoux) (tuberculin testing solution) that was opened. There was a label on the vial that indicated the vial was opened on 12/14/13.</p> <p>There were 2 vials of Influenza Vaccine observed in the refrigerator. The vials had labels on them that indicated the vials had been opened on 1/10/13.</p> <p>The policy titled, "Vials and Ampules of Injectable Medications" dated 3/1/07, was provided by the Director of Nursing on 3/12/13. She indicated the policy was current.</p> <p>The policy indicated: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use and disposal. Procedures (Facility procedure will take precedence) - Vials and ampules sent from the provider pharmacy in a box or container with the label on the outside are kept in that box or container. -The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>vial label or an accessory label affixed for that purpose).</p> <ul style="list-style-type: none"> - The solution in multidose vials is inspected prior to each use for unusual cloudiness, precipitation, or foreign bodies. The rubber stopper is inspected for deterioration. - Medication in multidose vials may be used according to the facility policy for thirty days if inspection reveals no problems during that time. <p>Interview with the Director of Nursing on 3/12/13 at 10:58 a.m., indicated multidose vials could be used for 30 days after they were opened. She indicated the vials of Influenza Vaccine and Tuberculin Purified Protein Derivative were expired and should have been discarded 30 days after they were opened.</p> <p>Interview with the Clinical Nurse Specialist on 3/15/14 at 11:05 a.m., indicated 2 residents on the Health Center 1 unit received tuberculin testing since 1/13/13. Resident #55 received a tuberculin skin test on 2/18/13 and Resident #156 received a tuberculin skin test on 3/2/13. She indicated no residents received the influenza vaccine on the Health Care 1 unit after 2/9/13.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>3. LPN #2 was observed administering medications to resident #147 on 3/14/13 at 7:52 a.m. During medication set up, the LPN dropped the resident's Calcitrol (calcium supplement) onto the medication cart. She picked up the medication and discarded it in the sharps container. She did not obtain another nurse as a witness and she did not document that the medication was discarded.</p> <p>Interview with LPN #2 on 3/14/13 at 1:58 p.m., indicated she did not obtain a witness or document the medication was dropped and discarded. She indicated she only would document the destruction if the medication was a controlled medication.</p> <p>4. LPN #3 was observed administering medication to Resident #19 at 9:13 a.m. on 3/14/13. She dropped the resident's Lipitor (medication to lower cholesterol). She picked up the medication and placed it into the sharps container. She did not obtain another nurse as a witness and she did not document that the medication was discarded.</p> <p>Interview with LPN #3 on 3/14/13 at 9:26 a.m., indicated there was no policy and no form to document the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>destruction of a dropped medication, she indicated it needed to be placed in the sharps container.</p> <p>Interview with the Clinical Nurse Specialist on 3/14/13 at 11:40 a.m., indicated if a medication was dropped she would expect the nurse to get another nurse as a witness, dispose of the medication in the sharps container and document the destruction on the back of the Medication Administration Record.</p> <p>The Policy titled "Disposal of Medications and Medication-Related Supplies" dated 2/1/10 was provided by the Clinical Nurse Specialist on 3/14/13 at 12:24 p.m. She indicated the policy was current. The policy indicated: -Medication destruction occurs only in the presence of two individuals, including two licensed nurses or one licensed nurse and a pharmacist if permitted by state regulations. The nurse(s) and/or pharmacist witnessing the destruction ensures that the following information is entered on the medication disposition form; -Date of destruction -Resident's name -Name and strength of medication -Prescription number</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	-Amount of medication destroyed -Signature of witness 3.1-25(o)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure pharmacy recommendations were carried out in a timely manner related to the indication for the use of medications as well as the duration for the use of the medication and gradual dose reductions for psychoactive medications for 4 of 10 residents reviewed for unnecessary medications. (Residents #31, #118, #125, and #156)</p> <p>Findings include:</p> <p>1. The record for Resident #118 was reviewed on 3/14/13 at 2:21 p.m. The resident's diagnoses included, but were not limited to, history of metastatic prostate cancer and depression.</p> <p>Review of the Pharmacy recommendations dated 1/20 and 2/16/13, indicated "may we add '(do not give more than 4 grams</p>	F000428	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: all pharmacy recommendations for the residents identified have been reviewed to assure those recommendations have been forwarded to the physician for consideration.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: we have reviewed and acted upon all pharmacy recommendations that we have received for current residents. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: nurse managers have been inserviced on following up from pharmacy recommendations. Medical Records has been trained and will track recommendations for response in a timely manner.</p> <p>How the corrective actions will be monitored to assure the deficient</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Acetaminophen (APAP) in 24 hours)' to prn (as needed) Tylenol and Norco directions?"</p> <p>Review of the Pharmacy recommendation dated 2/16/13, indicated "resident is on Megace 40 mg (milligrams) BID (twice a day) for appetite stimulation." Megace was added to the BEERS criteria as a medication to be avoided in the elderly due to potential side effects. Please consider discontinuation to avoid potential side effects. (for example: Thromboembolism, insulin resistance, adreanalcortical insufficiency) If the medication was to be continued, please document the risks versus benefits that have been considered. Also, 40 mg dose was not an appropriate dose for appetite stimulation (400 mg-800 mg was appetite stimulate dose).</p> <p>The resident's Megace was discontinued on 3/13/13.</p> <p>Interview with the Clinical Nurse Specialist on 3/18/13 at 2:14 p.m., indicated the facility "consultant pharmacist report" policy does not indicate a turnaround time. She indicated she would expect staff to complete the recommendations within a weeks time frame.</p>		<p>practice will not recur, i.e., what QA program will be put into place: Monitoring for this will be to review monthly pharmacy recommendations to ensure recommendations were carried out in a timely manner related to the indication for the use of medications as well as the duration of the use of the medication and gradual dose reductions for psychoactive medications. Monitoring will be completed monthly by DHS or designee monthly x 6 months with results reported to the QAA committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>2. The record for Resident #31 was reviewed on 3/14/13 at 8:24 a.m. The resident's diagnoses included, but were not limited to, delusional disorder, Alzheimer's disease, dementia with behavior disturbance, and depression.</p> <p>Review of Physician Orders dated 7/7/12 indicated Sertraline (Zoloft, a medication used for depression) 50 milligrams (mg) one twice a day.</p> <p>Review of the Pharmacy Review Notes, by the Pharmacy Consultant dated 2/12/13, indicated "Patient on Sertraline 50 milligrams since 7/12 time for dose reduction assessment, per new regulations."</p> <p>Review of the Medication Administration Record (MAR) for the month of 3/13 indicated the resident was still receiving the 50 mg of Sertraline twice a day.</p> <p>Interview with Social Service Employee #2 on 3/14/13 at 10:46 a.m., indicated she was not quite sure of the role Social Service plays with gradual dose reductions.</p> <p>Interview with the Director of Nursing on 3/14/13 indicated none of the Pharmacy Recommendation for the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>months of 1/13 or 2/13 had been completed.</p> <p>3. The record for Resident #125 was reviewed on 3/15/13 at 10:26 a.m. The resident was admitted to facility on 7/30/12. The resident diagnoses included, but were not limited to, GERD (gastroesophageal reflux disease).</p> <p>Review of the Pharmacy Consultant review dated 2/12/13, indicated the resident was on Prevacid Solu Tab prior to the hospital admission and during the hospital stay since she has a crush medication order. However, when the resident was readmitted, Prevacid 30 milligrams (mg) was ordered every day. The Pharmacy Consultant requested to change the Prevacid 30mg daily to the Prevacid Solu Tab daily.</p> <p>Interview with the Director of Nursing on 3/15/13 at 11:00 a.m., indicated the pharmacy recommendations from 1/13 and 2/13 have not been completed.</p> <p>Interview with the Clinical Nurse Specialist on 3/15/13 at 11:10 a.m., indicated Pharmacy recommendations should be completed within one week from the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>date they were received.</p> <p>4. Resident #156's clinical record was reviewed on 3/14/13 at 9:30 a.m. Resident #156's diagnoses included, but were not limited to renal insufficiency, osteomyelitis, infected right foot, status post right below the knee amputation, diabetes, and ulcerations to feet/leg.</p> <p>Resident #156 was admitted to the hospital for an infected foot ulcer with gangrenous changes on 2/24/13. A hospitalization consult dated 2/24/13, indicated the resident was on diflucan (anti-fungal) and levofloxacin (anti-biotic). The resident was admitted to the facility on 3/1/13, with an order for vancomycin and diflucan.</p> <p>A New Admission Medication Regimen Review form dated 3/1/13 indicated a request for a stop date for the diflucan. A check mark for acceptance and "x 7 days" was written under the request. There was no order written to stop diflucan.</p> <p>On 3/5/13, the resident was discharged to the hospital for a scheduled surgery, on the diflucan. The resident returned to the facility on 3/8/13 to the Health Care Unit one</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>prior to coming to Transitional Care Unit on 3/10/13. The diflucan was not discontinued until 3/15/13.</p> <p>An Infection Assessment and Review sheet undated was reviewed and observed to be incomplete. The type of infection, symptoms, treatment required, vital signs, environmental and equipment inspection, notification, infection risk re-assessment, and IDT (Interdisciplinary Team) review were not indicated. The infection update had required treatment of diflucan 200mg for 7 days and to stop the medication on 3/15/13. There were no orders indicating a stop date for the diflucan.</p> <p>Interview with LPN #10 on 3/20/13 at 9:49 a.m., indicated an order should have been written to stop the diflucan prior to the resident going to the hospital. LPN #10 indicated the nurses generally obtain orders from the physicians for stop dates. LPN #10 indicated the night shift usually manages the recommendations from pharmacy.</p> <p>3.1-25(i) 3.1-25(j)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
F000441 SS=D	<p>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.</p> <p>(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.</p> <p>(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. (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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	Corrective action accomplished for those residents found to have	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>ensure infection control practices were being maintained during wound care for 1 of 2 residents observed. (Resident #151).</p> <p>Findings include:</p> <p>Resident #151's clinical record was reviewed on 3/14/13 at 9:05 a.m. Resident #151's diagnoses included, but were not limited to, status post left hip fracture, hypertension, congestive obstructive pulmonary disease (lung disease).</p> <p>On 3/12/13 at 11:06 a.m., LPN #1 was observed to walk into the resident's room without washing hands, applied gloves, retrieved scissors from her pocket without cleaning them first, cut the kerlix, and put the scissors back into her pocket. LPN #1 removed her gloves and walked out of the room and returned without washing hands and reapplied gloves. LPN #1 put medicated ointment into a plastic medicine cup, cleansed the left heal, dried it, used the gloved finger to apply the ointment to the heel, applied a foam sponge, put the soiled dressing in the residents wheelchair, removed the tape from her pocket with the gloves still on, put the tape back in her pocket and repeated this a second</p>		<p>been affected by the deficient practice: the resident #151 identified in this survey has been assessed for potential infection control needs related to wound treatment, hand washing and use of gloves when appropriate. This resident has no signs or symptoms of any infection related to any deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all residents have been assessed to assure a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: All staff have been inserviced on infection control with hand washing and licensed nurses have been inserviced on basic infection control and hand washing. How the corrective actions will be monitored to assure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring will occur in two separate phases. Licensed nurses will be monitored be 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. This monitoring will occur. Infection control will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>time. LPN #1 removed the scissors from her pocket and cut the extra tape from the resident's foot, and placed the scissors back into her pocket without washing it. LPN #1 removed the gloves, reapplied new gloves, and sprayed wound cleanser to a 4x4 gauze dressing and removed an old dressing from the left arm. LPN #1 cleansed the area on the arm and used her gloved pinky finger to apply the medicated ointment to the wound, applied a new dressing, and took the soiled dressings out of the residents room without placing it in a bag. LPN #1 put the soiled dressings in the treatment cart trash receptacle located at the side of the cart. LPN #1 removed her gloves, put the medicated tubes of ointment in the treatment cart drawer, came back into the resident's room, reapplied the resident's sock, and washed her hands.</p> <p>On 3/14/13 at 10:50 a.m., LPN #1 was observed to change the resident's heel dressing. LPN #1 removed the resident's sock, door was left open, and hands were not washed prior to applying gloves. LPN #1 sprayed the 4x4 gauze dressing with wound wash, clean and dried area. LPN #1 then placed a 4x4 gauze dressing on top of the</p>		<p>monitored for all staff with the schedule of be 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Results of this monitoring will be reported to QAA.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

	<p>resident's sock on the bed. The medication ointment was in a plastic medication cup and LPN #1 used her gloved finger to apply the ointment to the wound two times. LPN #1 applied the foam dressing, which was on the package laying on the bed. LPN #1 removed her gloves and removed the tape from her pocket. LPN #1 did not wash her hands after dressing change in the resident's bathroom. Interview with LPN #1 at this time indicated she had been here for 6 months and has been inserviced on dressing changes. LPN #1 indicated she did not know if the facility had tongue depressors or other applicators. LPN #1 was observed to have walked into the unit's dining area and wash her hands at the sink.</p> <p>Interview with the Nursing Consultant on 3/14/13 at 11:30 a.m., indicated LPN #1 should have washed her hands, had a working field not on the bed, and sterile q-tips were provided for applications of ointments. The Nursing Consultant indicated she would do some one on one education with LPN #1.</p> <p>General Guidelines for Dressing Changes, dated December 2009, was provided by the Nursing Consultant on 3/18/13 at 12:00 p.m. The</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>guidelines indicated to "...Place plastic bag near to dispose the soiled dressing. Create a clean field with towel or towelette drape. Remove old adhesive with adhesive remover, if necessary, taking care not to get solution into wound. Open dressing pack. Wash hands with soap and water. Put on first pair of disposable gloves. Remove soiled dressing and discard in plastic bag. Dispose of gloves in plastic bag. Wash hands with soap and water. Put on second pair of disposable gloves. Follow doctors recommendations for treatment. Apply dressing and secure with tape when done with treatment. If using scissors, make sure it is clean with antiseptic after contact with soiled dressings. Remove gloves and discard with all unused supplies in plastic bag. Wash hands with soap and water...Discard soiled dressings per protocol."</p> <p>3.1-18(l)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
F000465 SS=C	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary environment was maintained related to soiled ceiling vents, soiled ceiling tiles, soiled ceiling lights, soiled wall, soiled oven hood, lime build up on appliances and wall edging in need of repair. This had the potential to affect the 45 of 46 residents in the facility who received food prepared in the kitchen. (The Health Center Kitchen)</p> <p>Findings include:</p> <p>1. Observation during the brief Kitchen Sanitation Tour of the Health Center Kitchen on 3/12/13 at 9:01 a.m. with the Assistant Director of Food Services indicated the following:</p> <p>a. Two of two ceiling vents in the kitchen area above the food prep area, had rust and black mars and were in need of cleaning or replacement.</p> <p>b. The ice maker had a buildup of lime on the outside of the machine.</p> <p>c. The dish washer had a build up of</p>	F000465	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: the areas identified during this observation have been cleaned and/or replaced.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all the areas and equipment in the kitchen were assessed, cleaning schedules were updated. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: dietary staff inserviced on expectations of cleaning and sanitation. New cleaning schedules developed. DFS and ADFS will be responsible for monitoring cleaning.</p> <p>How the corrective actions will be monitored to assure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring will occur in conjunction with F371 with frequency of 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Immediate intervention and education will be provided to the kitchen staff if equipment, walls,</p>	04/19/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>lime stains on front of the machine.</p> <p>Interview with the Assistant Director of Food Services at the time of the tour indicated the above areas were in need of repair or cleaning.</p> <p>2. The Kitchen Sanitation Tour of the Health Center Kitchen was completed on 3/14/13 at 10:46 a.m. with Chef #1 and the Assistant Director of Food Services. The following was observed:</p> <p>a. The ceiling tiles above the cook line had liquid food spatters and were in need of replacement or cleaning.</p> <p>b. The wall behind the stove and the appliances were soiled with food spillage and splatter and were in need of cleaning.</p> <p>c. The oven hood had grease splatters on the drip rail.</p> <p>d. A six foot by 4 inch piece of edging on the wall corner near the hand washing sink. was pulling away from the wall and was in need of repair.</p> <p>e. The dry storage room that contained the dietary paper products was observed. The ceiling vent had an accumulation of dust and the</p>		<p>vents are found dirty. RD, Diet Tech, Dining Services Support or Executive Director will be responsible for conducting these audits. Results of monitoring will be shared with QAA.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>ceiling light had dark specks of dirt.</p> <p>Interview with Chef #1 at the time of the tour indicated the above areas were in need of repair or cleaning.</p> <p>3.1-19(f)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
F000505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interviews, the facility failed to ensure the Physician was promptly notified of abnormal lab findings related to a Phenytoin (a level to measure the amount of Dilantin (a seizure medication) in the blood stream) level for 1 of 10 residents reviewed for unnecessary medications. (Resident #125)</p> <p>Findings include:</p> <p>The record for Resident #125 was reviewed on 3/15/13 at 10:26 a.m. The resident's diagnoses included, but were not limited to, seizure disorder,</p> <p>Review of the current 3/13 Physician's recap indicated a Dilantin level was to be drawn every month.</p> <p>Further review of Physicians Orders indicated the resident was receiving Dilantin 100 milligrams (mg) two caps every morning and an extra 300 mg of Dilantin on Monday, Tuesday, and Wednesday.</p> <p>Review of the Phenytoin level drawn</p>	F000505	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: Resident # 125 was reviewed at the time of the survey, physician was notified, new orders received. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all current residents have been reviewed to ensure labs have been drawn, received, and communicated timely and appropriately. A 30 day look back for labs has been completed. No other concerns have been identified with this look back audit. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: licensed nurses were inserviced on our policies to ensure communication with doctors. How the corrective actions will be monitored to assure the deficient practice will not recur, i.e., what QA program will be put into place: Monitoring will occur 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months.</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>on 2/19/13 at 4:05 a.m. indicated the results of 6.0 (a low level). The normal range was between 10-20. The lab was sent to the facility on 2/19/13 at 5:47 a.m. to Health Care Unit 1.</p> <p>At the bottom of the lab results page indicated "Date Received" 2/20/13, "Dr. Notified" 2/21/13. "New orders received, See telephone order." The Physician was not notified until 2/21/13, two days after the lab was sent to the facility.</p> <p>Review of Physician Orders dated 2/21/13, indicated a new order for Dilantin. The order indicated to give 300 milligrams (mg) of Dilantin on that day and start Dilantin 300 mg every Monday, Tuesday, Wednesday, and Thursday.</p> <p>Interview with LPN #5 on 3/18/13 at 2:45 p.m., indicated the Physician should be notified of abnormal lab results immediately.</p> <p>3.1-49(f)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify pharmacy recommendations were carried out in a timely manner related to the indication for use of medications as well as the duration for the use of the medication, and gradual dose reductions for psychoactive medications through the quality assurance protocol. (Residents #31, #118, #125, and #156)</p>	F000520	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: the campus leadership team reviewed goals and expectations for our QAA committee in their goal to correct quality deficiencies.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: we have reviewed and acted upon all pharmacy recommendations that we have</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Findings include:</p> <p>1. The record for Resident #118 was reviewed on 3/14/13 at 2:21 p.m. The resident's diagnoses included, but were not limited to, history of metastatic prostate cancer and depression.</p> <p>Review of the Pharmacy recommendations dated 1/20 and 2/16/13, indicated "may we add '(do not give more than 4 grams Acetaminophen (APAP) in 24 hours)' to prn (as needed) Tylenol and Norco directions?"</p> <p>Review of the Pharmacy recommendation dated 2/16/13, indicated "resident is on Megace 40 mg (milligrams) BID (twice a day) for appetite stimulation." Megace was added to the BEERS criteria as a medication to be avoided in the elderly due to potential side effects. Please consider discontinuation to avoid potential side effects. (for example: Thromboembolism, insulin resistance, adreanalcortical insufficiency) If the medication was to be continued, please document the risks versus benefits that have been considered. Also, 40 mg dose was not an appropriate dose for appetite stimulation (400 mg-800 mg was</p>		<p>received for current residents. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: QA committee members have been inserviced on items that need to be reviewed during the monthly meeting.</p> <p>How the corrective actions will be monitored to assure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring will occur with monthly QA minutes with results from pharmacy recommendation monitoring log.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>appetite stimulate dose).</p> <p>The resident's Megace was discontinued on 3/13/13.</p> <p>Interview with the Clinical Nurse Specialist on 3/18/13 at 2:14 p.m., indicated the facility "consultant pharmacist report" policy does not indicate a turn around time. She indicated she would expect staff to complete the recommendations within a weeks time frame</p> <p>2. The record for Resident #31 was reviewed on 3/14/13 at 8:24 a.m. The resident's diagnoses included, but were not limited to, delusional disorder, Alzheimer's disease, dementia with behavior disturbance, and depression.</p> <p>Review of Physician Orders dated 7/7/12 indicated Sertraline (Zoloft, a medication used for depression) 50 milligrams (mg) one twice a day.</p> <p>Review of the Pharmacy Review Notes, by the Pharmacy Consultant dated 2/12/13, indicated "Patient on Sertraline 50 milligrams since 7/12 time for dose reduction assessment, per new regulations."</p> <p>Review of the Medication</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Administration Record (MAR) for the month of 3/13 indicated the resident was still receiving the 50 mg of Sertraline twice a day.</p> <p>Interview with Social Service Employee #2 on 3/14/13 at 10:46 a.m., indicated she was not quite sure of the role Social Service plays with gradual dose reductions.</p> <p>Interview with the Director of Nursing on 3/14/13 indicated none of the Pharmacy Recommendation for the months of 1/13 or 2/13 had been completed.</p> <p>3. The record for Resident #125 was reviewed on 3/15/13 at 10:26 a.m. The resident was admitted to facility on 7/30/12. The resident diagnoses included, but were not limited to, GERD (gastroesophageal reflux disease).</p> <p>Review of the Pharmacy Consultant review dated 2/12/13, indicated the resident was on Prevacid Solu Tab prior to the hospital admission and during the hospital stay since she has a crush medication order. However, when the resident was readmitted, Prevacid 30 milligrams (mg) was ordered every day. The Pharmacy Consultant requested to change the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>Prevacid 30mg daily to the Prevacid Solu Tab daily.</p> <p>Interview with the Director of Nursing on 3/15/13 at 11:00 a.m., indicated the pharmacy recommendations from 1/13 and 2/13 have not been completed.</p> <p>Interview with the Clinical Nurse Specialist on 3/15/13 at 11:10 a.m., indicated Pharmacy recommendations should be completed within one week from the date they were received.</p> <p>4. Resident #156's clinical record was reviewed on 3/14/13 at 9:30 a.m. Resident #156's diagnoses included, but were not limited to renal insufficiency, osteomyelitis, infected right foot, status post right below the knee amputation, diabetes, and ulcerations to feet/leg.</p> <p>Resident #156 was admitted to the hospital for an infected foot ulcer with gangrenous changes on 2/24/13. A hospitalization consult dated 2/24/13, indicated the resident was on diflucan (anti-fungal) and levofloxacin (anti-biotic). The resident was admitted to the facility on 3/1/13, with an order for vancomycin and diflucan.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>A New Admission Medication Regimen Review form dated 3/1/13 indicated a request for a stop date for the diflucan. A check mark for acceptance and "x 7 days" was written under the request. There was no order written to stop diflucan.</p> <p>On 3/5/13, the resident was discharged to the hospital for a scheduled surgery, on the diflucan. The resident returned to the facility on 3/8/13 to the Health Care Unit one prior to coming to Transitional Care Unit on 3/10/13. The diflucan was not discontinued until 3/15/13.</p> <p>An Infection Assessment and Review sheet undated was reviewed and observed to be incomplete. The type of infection, symptoms, treatment required, vital signs, environmental and equipment inspection, notification, infection risk re-assessment, and IDT (Interdisciplinary Team) review were not indicated. The infection update had required treatment of difulcan 200mg for 7 days and to stop the medication on 3/15/13. There were no orders indicating a stop date for the diflucan.</p> <p>Interview with LPN #10 on 3/20/13 at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>9:49 a.m., indicated an order should have been written to stop the diflucan prior to the resident going to the hospital. LPN #10 indicated the nurses generally obtain orders from the physicians for stop dates. LPN #10 indicated the night shift usually manages the recommendations from pharmacy.</p> <p>Interview with the Administrator on 3/20/13 at 2:39 p.m., indicated the facility's Quality Assurance Committee meets every month and consists of himself, the Director of Nursing, and department heads as well as the Medical Director. The Administrator indicated at the time, as he started with the facility on January 2nd, 2013 and had reviewed the minutes from the past meetings. The Administrator indicated at the time, that pharmacy recommendation being followed in a timely manner has not been discussed, addressed or identified as being a problem in Quality Assurance. The Administrator indicated he was not familiar of the company's policy and procedure of Pharmacy recommendations.</p> <p>Interview with the Nursing Consultant on 3/20/13 at 3:15 p.m., indicated this problem with following pharmacy</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
R000000	<p>recommendations in a timely manner had not been addressed in the Quality Assurance meetings.</p> <p>3.1-52(b)(2)</p> <p>The following State Residential findings are in accordance with 410 IAC 16.2-5.</p>	R000000	<p>The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintain it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to ensure a fire and disaster drill was held in conjunction with the local fire department at least every six months.</p> <p>Findings include:</p> <p>The fire drill inservices, dated 01/12 through 12/12 were reviewed on 03/12/13 at 10:55 a.m.</p>	R000092	<p>No residents were negatively affected by this deficiency. We have contacted the fire department to schedule a fire and disaster drill.</p> <p>Plant Ops Director and Assistant have been inserviced and understand the expectation of conducting these drills at least every six months.</p> <p>Executive Director will monitor for completion and report to QAA.</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>There was a lack of documentation to indicate the facility had attempted to hold a fire and disaster drill in conjunction with the local fire department at least every six months.</p> <p>During an interview on 03/12/13 at 11:10 a.m., the Director of Plant Operations indicated he had not contacted the local fire department for a fire and disaster drill.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
R000145	<p>410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents.</p> <p>Based on observation, record review, and interview, the facility failed to maintain equipment in a safe condition, related to an accumulation of lint in 2 of 2 dryers for 1 of 2 residential laundry rooms. (Legacy Unit)</p> <p>Findings include:</p> <p>During an environmental tour on 03/12/13 at 3:30 p.m., with the Director of Plant Operations (DPO) present, There were two dryers in the Legacy Unit Laundry Room with an accumulation of lint on the lint screens and the floor of the lint compartment of the dryers.</p> <p>The form to document the cleaning of the dryer lint compartments, indicated the last cleaning had been done at 8:53 a.m. after the table linens were dried.</p> <p>During an interview at the time of the observation, the DPO indicated the lint compartments should be cleaned after each load and they looked like they had not been cleaned.</p>	R000145	No residents were negatively affected by this deficiency. Dryers were checked for excessive lint and corrected immediately. Staff has been inserviced about frequency of cleaning dryers for lint. Environmental Director will monitor for compliance at least weekly.	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	A policy, dated 08/07/12, titled, "Legacy Laundry Instructions", received from the DPO as current, indicated, "...Check/remove dryer lint after every load-make sure to sign off in the dryer book located on the counter in the clean linen room."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
R000153	<p>410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.</p> <p>Based on observation and interview, the facility failed to store oxygen cylinders safely in facility, related to oxygen cylinders not securely stored to prevent the cylinders from tipping over, for 1 of 1 oxygen storage rooms. (first floor)</p> <p>Findings include:</p> <p>During an observation on 03/12/13 at 3:20 p.m. with the Director of Plant Operations present, there were 32 small oxygen cylinders stored on the floor in the oxygen closet. The cylinders were not in a secure rack and several of the cylinders were tipped over onto other cylinders.</p> <p>During an interview at the time of the observation, the Residential Unit Manager indicated some of the cylinders were full of oxygen and some of them were empty.</p>	R000153	<p>No residents were negatively affected by this deficiency. All oxygen that had been stored on Assisted Living has been removed from the storage rooms. Environmental Director and Plant Ops Director will monitor for compliance monthly.</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the food was stored and prepared under sanitary conditions related to lack of facial hair covering, soiled fry baskets, soiled ceiling vents, soiled ceiling tiles, soiled ceiling lights, lime build up on appliances, soiled stove and oven, soiled wall, soiled oven hood, soiled utensil drawer and wall edging in need of repair. This had the potential to affect 38 residents who resided in the Assisted Living Unit who received food prepared in the Health Center Kitchen. (Health Center Kitchen)</p> <p>Findings include:</p> <p>1. Observation during the brief sanitation tour of the Health Center Kitchen on 3/12/13 at 9:01 a.m., with the Assistant Director of Food Services, indicated the following:</p> <p>a. The deep fryer had 2 frying baskets. There was an accumulation of food debris on both of the baskets.</p>	R000154	<p>Corrective action accomplished for those residents found to have been affected by the deficient practice: the areas identified during this observation have been cleaned and/or replaced.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all the areas and equipment in the kitchen were assessed, cleaning schedules were updated. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: dietary staff inserviced on expectations of cleaning and sanitation. New cleaning schedules developed. DFS and ADFS will be responsible for monitoring cleaning.</p> <p>How the corrective actions will be monitored to assure the deficient practice will not recur, i.e., what QA program will be put into place: monitoring will occur in conjunction with F371 with frequency of 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Immediate intervention and education will be provided to</p>	04/19/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>Interview with Dietary Staff #1 on 3/12/13 at 9:07 a.m., indicated the fryer was to be cleaned each evening. She indicated the baskets were in need of cleaning.</p> <p>b. Two of two ceiling vents in the kitchen area above the food prep area, had rust and black mars and were in need of cleaning or replacement.</p> <p>c. The ice machine had a buildup of lime on the outside of the machine.</p> <p>d. The dish washer had a build up of lime stains on the front of the machine.</p> <p>Interview with the Assistant Director of Food Services at the time of the tour, indicated the above areas were in need of repair or cleaning.</p> <p>2. The Kitchen Sanitation Tour of the Health Care Kitchen was completed on 3/14/13 at 10:46 a.m., with Chef #1 and the Assistant Director of Food Services. The following was observed:</p> <p>a. The ceiling tiles above the cook line had liquid food spatters and were in need of replacement or cleaning.</p>		<p>the kitchen staff if equipment, walls, vents are found dirty. RD, Diet Tech, Dining Services Support or Executive Director will be responsible for conducting these audits. Results of monitoring will be shared with QAA.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>b. Chef #1 had a moustache and a beard with no beard or moustache guard.</p> <p>c. There was grease on the sides of the stove, the stove was in need of cleaning,</p> <p>d. The oven had burnt on food debris on the bottom of the inside of the oven, the metal edge under the oven door was soiled with food spillage.</p> <p>e. The wall behind the stove and the appliances were soiled with food spillage and splatter and were in need of cleaning.</p> <p>f. The oven hood had grease splatters on the drip rail.</p> <p>g. A six foot by 4 inch piece of edging on the wall corner near the hand washing sink. was pulling away from the wall and was in need of repair.</p> <p>h. The dry storage room with the dietary paper products was observed. The ceiling vent had an accumulation of dust and the ceiling light had dark specks of dirt.</p> <p>i. The drawer with scoops, spatulas, and measuring spoons was observed. The bottom of the drawer was soiled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>and in need of cleaning.</p> <p>Interview with Chef #1 at the time of the tour indicated the above areas were in need of repair or cleaning.</p> <p>3. Food temperatures were obtained on 3/14/13 at 11:45 a.m. by Chef #1. Chef #1 had a full beard and moustache. Interview with Chef #1 at that time, indicated that during his training, he was informed that as long as the facial hair was 1/4 inch or less it did not have to be covered. He was not wearing a beard guard.</p> <p>Interview with Chef #1 on 3/14/13 at 1:56 p.m., indicated that he was mistaken regarding the need for a beard guard. He indicated facial hair of any length needed to be covered with a beard guard in the kitchen.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
R000246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure QMA's (Qualified Medication Aides) received authorization from a Licensed Nurse for as needed (PRN) medications prior to the administration of the medications for 1 of 7 residents reviewed for PRN medications in a total sample of 7. (Resident #30, QMA #1 and QMA #2)</p> <p>Findings include:</p> <p>Resident #30's record was reviewed on 03/12/13 at 12:10 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and anxiety.</p> <p>The Physician's Recapitulation Orders, dated 03/13, indicated the following PRN orders: Lorazepam (anti-anxiety) 0.5 mg (milligram), one tablet at bedtime for</p>	R000246	<p>No residents were adversely affected by this deficiency. All licensed nurses and QMAs will be inserviced that a licensed nurse must co-sign a PRN medication. This should be done prior to the medication administration. Unit Manager will review and audit the 24 hour reports. All licensed nurses will chart any PRN medications given. PRN Medication Tracking log will be completed for all meds. Unit Manager will audit to make sure a licensed nurse approved and co-signed PRN medications. This will be audited monthly and results reported to the QAA committee for 6 months.</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>agitation, originally ordered on 02/08/13</p> <p>Acetaminophen 500 mg, two tablets orally every six hours as needed for discomfort, originally ordered on 10/22/12</p> <p>Arthritis Pain Relief 650 mg, one tablet orally every four hours as needed for pain, originally ordered on 12/16/10</p> <p>Hydrocodone (narcotic pain medication) 7.5/325 mg, one tablet every six hours as needed for pain, originally ordered on 12/17/12.</p> <p>The MAR (Medication Administration Record), dated 02/13, indicated QMA #1 administered the acetaminophen 500 mg, two tablets on February 9 and 16, 2013, the arthritis pain relief on February 2, 3, 10, 15, 17, and 20, 2013, the hydrocodone on February 23, 2013, and the lorazepam 0.5 mg on February 9, 10, 15, 16, 17, 20, 23, 24, 25, and 27, 2013.</p> <p>There was a lack of documentation on the MAR, the PRN Medication Tracking form and the progress notes to indicate a Licensed Nurse had given the QMA authorization to administer the PRN medications.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>The MAR, dated 03/13, indicated QMA #1 administered the lorazepam 0.5 mg on March 2, 3, and 10, 2013, the acetaminophen 500 mg, two tablets on March 2 and 3, 2013, and the arthritis pain relief on March 10, 2013.</p> <p>The MAR, dated 03/13, indicated QMA #2 administered the lorazepam 0.5 mg on March 4, 2013.</p> <p>There was a lack of documentation on the MAR, the PRN Medication Tracking form and the progress notes to indicate a Licensed Nurse had given the QMA authorization to administer the PRN medications.</p> <p>During an interview on 03/12/13 at 12:20 p.m., the Residential Unit Manager indicated there was no prior authorization from a Licensed Nurse given before the PRN medications were administered by the QMA's.</p> <p>An undated facility policy, titled, "Administration of PRN Medications Guideline", received from the Residential Unit Manager as current on 03/12/13 at 2:30 p.m., indicated, "...If PRN medication is to be administered by a QMA the Standards of Practice for PRN</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>medication administration by a Qualified Medication Assistant shall be observed..."</p> <p>The Qualified Medication Aide Basic Curriculum, dated 10/03, indicated, "...Scope of practice...Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure food was stored and prepared in accordance with sanitary food handling standards, related to dirty shelves, equipment, walls, and drawers, full garbage can without a lid, and sanitizer not being at the correct level for 1 of 2 kitchens (Legacy Unit) this had the potential to affect 21 residents who eat meals from the Legacy Unit Kitchen; unlabeled/undated food in the refrigerator in 1 of 2 lounges (lounge by the Main Dining Room); and lack of facial hair covering, soiled fry baskets, soiled stove, oven and utensil drawer. This had the potential to affect 38 residents in the facility, who resided in the Assisted Living Unit who received food prepared in the Health Center Kitchen. (Health Center Kitchen)</p> <p>Findings include:</p> <p>1. During an observation of the Legacy Unit kitchen on 03/12/13 at 10 a.m., with Cook #3 and Legacy Unit Manager present, the following was</p>	R000273	<p>Corrective action accomplished for this deficient practice: equipment identified during the brief kitchen sanitation tour of the health center kitchen were immediately cleaned/corrected. This included frying baskets, facial hair not covered, grease on sides of stove, oven needed to be cleaned, utensil drawer cleaned.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: all equipment was reviewed and cleaned if necessary.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Cleaning schedules have been reviewed and updated as needed to be more specific to meet sanitation expectations. We also inserviced staff and reviewed expectations for covering facial hair in the kitchen.</p> <p>Also inserviced staff on proper dating dating when prepared or opened.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what QA program will be put into place:</p>	04/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>observed:</p> <p>a. There was grease accumulation on the side of the stove.</p> <p>b. There were black splatters on the hose behind the slotted grill.</p> <p>c. The drawers which store, clean and ready to use cooking utensils were dirty.</p> <p>d. The slotted grill was dirty. Cook #3 indicated during this time, the grill was to be cleaned on Fridays.</p> <p>e. A tray which held bottles of cooking oil, on the bottom shelf of the prep table was dirty with spilled oils.</p> <p>f. The shelf where the meat slicer was kept, was dirty with spills and crumbs.</p> <p>g. The scale had an accumulation of crumbs on it.</p> <p>i. There were two cracked and melted plastic containers stored clean and ready to use.</p> <p>j. The garbage can was full of trash and food and also had no lid.</p> <p>k. There were brown splatters on the</p>		<p>sanitation inspections will be conducted by RD, Diet Tech, Dining Services Support and/or Executive Director at the following schedule: 3 x per week for 4 weeks, then 2 x per week for 4 weeks, then 1 x per week for 4 weeks, then 1 x per month for 3 months. Immediate intervention and education will be provided to the kitchen staff if equipment is found dirty or facial hair is found not covered. Results of monitoring will be shared with QAA.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>Igloo drink holders and on the wall behind the drink holders.</p> <p>l. The shelf where the coffee maker and juice machine was stored was sticky.</p> <p>m. There was a waffle maker, stored on the shelf in the storage room, which had dried batter on the inside and outside of the unit. Cook #3 indicated she was unsure the last time the waffle make had been used.</p> <p>n. There was trash and debris under the shelves in the storage room.</p> <p>o. The shelf under the prep table was dirty.</p> <p>p. The sanitizer measured at a zero when Cook #3 inserted the test strip. Cook #3 indicated the test strip should read at 100 ppm (parts per million). She indicated it is checked every day, but they do not write it down.</p> <p>2. During an observation on 03/12/13 at 2 p.m. with Cook #3 present, the trash can in the Legacy Kitchen was full of trash and food and there was no lid on the trash can. Cook #3 indicated "they" were bringing her a lid for the trash can.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>3. During an observation of the resident lounge next to the Main Dining Room with the Director of Plant Operations present on 03/12/13 at 3:25 p.m., there was unlabeled and undated cookies/snacks and one opened, undated bag of whip topping in the refrigerator.</p> <p>The Director of Plant Operations indicated the refrigerator is used by the Activity Department for the residents.</p> <p>4. Observation during the brief Kitchen Sanitation Tour of the Health Center Kitchen on 3/12/13 at 9:01 a.m., with the Assistant Director of Food Services indicated the following:</p> <p>a. The deep fryer had 2 frying baskets. There was an accumulation of food debris on both of the baskets. Interview with Dietary Staff #1 on 3/12/13 at 9:07 a.m., indicated the fryer was to be cleaned each evening. She indicated the baskets were in need of cleaning.</p> <p>5. The Kitchen Sanitation Tour of the Health Center Kitchen was completed on 3/14/13 at 10:46 a.m., with Chef #1 and the Assistant Director of Food Services. The following was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410			
(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			
	<p>observed:</p> <p>a. Chef #1 had a moustache and a beard, he had no beard or moustache guard on his face.</p> <p>b. There was grease on the sides of the stove, the stove was in need of cleaning.</p> <p>c. The oven had burnt on food debris on the bottom of the inside of the oven, the metal edge under the oven door was soiled with food spillage.</p> <p>d. The drawer with scoops, spatulas, and measuring spoons was observed. The bottom of the drawer was soiled and in need of cleaning.</p> <p>Interview with Chef #1 at the time of the tour indicated the above areas were in need of cleaning.</p> <p>6. Food temperatures were obtained on 3/14/13 at 11:45 a.m., by Chef #1. Chef #1 had a full beard and moustache. Interview with Chef #1 at that time, indicated that during his training he was informed that as long as the facial hair was 1/4 inch or less it did not have to be covered. He was not wearing a beard guard.</p> <p>Interview with Chef #1 on 3/14/13 at</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>1:56 p.m., indicated that he was mistaken regarding the need for a beard guard. He indicated facial hair of any length needed to be covered with a beard guard in the kitchen.</p> <p>7. Observation during the brief sanitation tour of the Health Center Kitchen on 3/12/13 at 9:01 a.m., with the Assistant Director of Food Services, indicated the following:</p> <p>a. The deep fryer had 2 frying baskets. There was an accumulation of food debris on both of the baskets. Interview with Dietary Staff #1 on 3/12/13 at 9:07 a.m., indicated the fryer was to be cleaned each evening. She indicated the baskets were in need of cleaning.</p> <p>b. Two of two ceiling vents in the kitchen area above the food prep area, had rust and black marks and were in need of cleaning or replacement.</p> <p>c. The ice machine had a buildup of lime on the outside of the machine.</p> <p>d. The dish washer had a build up of lime stains on the front of the machine.</p> <p>Interview with the Assistant Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

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

(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
	<p>of Food Services at the time of the tour, indicated the above areas were in need of repair or cleaning.</p> <p>8. The Kitchen Sanitation Tour of the Health Care Kitchen was completed on 3/14/13 at 10:46 a.m., with Chef #1 and the Assistant Director of Food Services. The following was observed:</p> <p>a. The ceiling tiles above the cook line had liquid food spatters and were in need of replacement or cleaning.</p> <p>b. Chef #1 had a moustache and a beard with no beard or moustache guard.</p> <p>c. There was grease on the sides of the stove, the stove was in need of cleaning,</p> <p>d. The oven had burnt on food debris on the bottom of the inside of the oven, the metal edge under the oven door was soiled with food spillage.</p> <p>e. The wall behind the stove and the appliances were soiled with food spillage and splatter and were in need of cleaning.</p> <p>f. The oven hood had grease splatters on the drip rail.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410		
(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	
	<p>g. A six foot by 4 inch piece of edging on the wall corner near the hand washing sink. was pulling away from the wall and was in need of repair.</p> <p>h. The dry storage room with the dietary paper products was observed. The ceiling vent had an accumulation of dust and the ceiling light had dark specks of dirt.</p> <p>i. The drawer with scoops, spatulas, and measuring spoons was observed. The bottom of the drawer was soiled and in need of cleaning.</p> <p>Interview with Chef #1 at the time of the tour indicated the above areas were in need of repair or cleaning.</p> <p>9. Food temperatures were obtained on 3/14/13 at 11:45 a.m. by Chef #1. Chef #1 had a full beard and moustache. Interview with Chef #1 at that time, indicated that during his training, he was informed that as long as the facial hair was 1/4 inch or less it did not have to be covered. He was not wearing a beard guard.</p> <p>Interview with Chef #1 on 3/14/13 at 1:56 p.m., indicated that he was mistaken regarding the need for a beard guard. He indicated facial hair</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2013
---	--	--	--

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

(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
	of any length needed to be covered with a beard guard in the kitchen.			