

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 Bldg. 00	<p>This visit was for the Investigation of Complaints #IN00171003, #IN00171114, & #IN00171704.</p> <p>Complaint #IN00171003- Unsubstantiated due to lack of evidence.</p> <p>Complaint #IN00171114- Substantiated. Federal/State deficiencies related to the allegations are cited at F309, F314, & F318.</p> <p>Complaint #IN00171704- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey date: April 20, 21, 22, & 23, 2015</p> <p>Facility number: 000074 Provider number: 155154 AIM number: 100290050</p> <p>Census bed type: SNF- 14 SNF/NF- 96 Total- 110</p> <p>Census payor type: Medicare- 20 Medicaid- 65</p>	F 000	<p>May 5th, 2015 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian St Indianapolis, IN 46204 Dear Ms Rhoades, On April 23rd, a complaint survey was conducted at SpringMill Meadows. We respectfully request a face to face IDR for F314, and F318 as the facility disagrees with the scope and severity. Spring Mill Meadows then respectfully requests this document be submitted as the Plan of Correction and be considered for desk review by the staff of your division. If any questions arise regarding this request or attached documents, please feel free to contact me at your earliest convenience. Respectfully submitted, Austin Steele, HFA Cc: Bernie McGuinness, VP of Operations Sue Hornstein, Director of Compliance Martha Herron, Director of Clinical Services File</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: 155154		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 309 SS=D Bldg. 00	<p>Other- 25 Total- 110</p> <p>Sample- 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on April 30, 2015.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure weekly skin assessments were completed and failed to provide prevention interventions for further skin breakdown after</p>	F 309	F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELLBEING What corrective action(s) will be accomplished for those residents found to have been	05/06/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>identification of continued risk for skin breakdown, for 1 of 4 residents, in a sample of 7, reviewed for skin assessments. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 4/20/15 at 2:45 p.m. Diagnoses for Resident B included, but were not limited to, status post cerebrovascular accident, diabetes mellitus- type II, dysphagia, aphasia, gastrostomy status, multiple contractures, history of pneumonia, and incontinence.</p> <p>Nursing notes, for Resident B, indicated the following:</p> <p>11/25/14- "...towel placed under scrotum to keep dry and prevent skin breakdown." 11/26/14- "Since res (resident) prone to excoriation to scrotal area, preventative tx (treatment) of Calmoseptine (topical cream) to scrotum and wrap with 4x4 (gauze) qs (every shift) to prevent skin to skin contact." 11/27/14- "...gauze placed under scrotum to keep dry and prevent skin to skin contact." 11/30/14- "...gauze placed under scrotum to keep dry and prevent skin to skin contact." 12/02/14- "...gauze placed under scrotum to keep dry and prevent skin to skin</p>		<p>affected by the deficient practice? · Resident B no longer resides in this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · All residents were reviewed by a licensed nurse during a skin sweep, in which all residents were reviewed for skin integrity including but not limited to skin breakdown, pressure areas, and surgical sites. · All residents were reviewed and assessed to identify residents at risk for potential alteration in skin integrity. · All residents then reviewed to ensure plan of care reflects proper clinical interventions, and prevention orders written, care plans and profiles updated accordingly. · Staff was in-serviced by the Director of Nursing Services or designee by 5/5/15 on weekly skin assessments, notification of new areas, and prevention treatments. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Skin Assessment Audits will take place on a daily basis by the Unit Manager or designee to ensure that skin assessments are completed at least weekly. · Licensed nurses </p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>contact."</p> <p>12/04/14- "...gauze placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/06/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/07/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/09/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/11/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/16/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/17/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/18/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>12/18/14- "...moisture noted to incontinence pad each time writer has provided care or checked on resident due to sweating."</p> <p>12/20/14- "...cloth placed under scrotum to keep dry and prevent skin to skin contact."</p> <p>01/01/15- "...cloth placed under scrotum to keep dry and prevent skin to skin</p>		<p>will assess skin weekly to identify any area of compromised skin integrity. Any areas will be documented and physician will be notified accordingly. · Staff was in-serviced by the Director of Nursing Services or designee by 5/5/15 on weekly skin assessments, notification of new areas, and prevention treatments.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·To ensure compliance, the DNS/Designee is responsible for the completion of the Skin Management Program CQI tool weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</p> <p>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>contact." 01/13/15- "...cream placed to buttock and scrotum"</p> <p>The DNS indicated, during an interview on 4/21/15 at 1:10 p.m., Resident B's scrotum was elevated, as a nursing measure, to prevent skin breakdown and decrease swelling, because swelling and dermatitis were noted to that area, at that time (November, December 2014). She indicated assessment description documentation of scrotum swelling was not documented because they document by exception only. She indicated there was not a physician order or a care plan for this nursing measure.</p> <p>During an interview with the wound care nurse, on 4/21/15 at 1:20 p.m., She indicated around the time of admission, nursing staff elevated the residents scrotum because the resident's son requested that be done. She indicated this intervention was not continued and was unsure why this intervention had not continued. She indicated she was notified of a new skin concern to Resident B's scrotum on 3/23/15. Upon her assessment, no open skin was noted. She determined a pink discoloration was secondary to scarring and dermatitis. The wound care nurse indicated she diagnosed the dermatitis, along with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>wound team. Ointment was ordered for treatment, but prevention interventions were not added. During the interview, the wound care nurse indicated she was notified on 4/1/15 of another open area on Resident B's scrotum and completed an assessment. Orders for Xerofoam (dressing treatment), cut to fit, apply each day and as needed, were received. She indicated the scrotum dermatitis was expected to dry up with Xerofoam but due to the dermatitis being at the peri-area, the moisture would continue to exist from sweating in that area.</p> <p>During a care observation and interview on 4/20/15 at 5:55 p.m., LPN #1 indicated a physical barrier such as a cloth or towel was not required since Resident B was on a low air loss mattress with circulating air, therefore his scrotum laid on the low air loss mattress.</p> <p>During observations of provided care on 4/20/15 at 4:15 p.m., and 4/21/15 at 12:55 p.m., an elevation or barrier form was not noted to be in place, under Resident B's scrotum. The scrotal skin area was observed as red and vivid pink in color.</p> <p>This federal tag relates to Complaint #IN00171114.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=G Bldg. 00	<p>3.1-37(a)</p> <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 observations, record reviews, and interviews, the facility failed to identify pressure wounds until the wounds were assessed as unstageable, for 2 of 3 residents, in a sample of 7, reviewed for pressure sores.</p> <p>(Residents B & G) Resident B presented with 3 unstageable ulcers with no prior indication they were observed or assessed.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 4/20/15 at 2:45 p.m. Diagnoses for Resident B included, but were not limited to, status post cerebrovascular accident, diabetes mellitus- type II, dysphagia, aphasia, gastrostomy status, multiple contractures,</p>	F 314	<p>F 314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURESORES The facility respectively requests a face-to-face IDR for F314, F318 as the facility disagrees with the scope and severity of the deficiencies. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident B no longer resides in this facility. · Resident G no longer resides in this facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · All residents were reviewed by a licensed nurse during a skin</p>	05/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>history of pneumonia, malnutrition and incontinence.</p> <p>During the initial tour of the facility on 4/20/15, LPN #1 indicated Resident B was totally dependent on staff for care.</p> <p>An "Occupational Therapy Plan of Care (Evaluation Only)" dated 1/20/15 indicated "...Reason for Referral: Nsg [nursing] concerns regarding positioning needs and ability for pt [patient] to get up in Broda Chair. Therapy Necessity: Evaluation only for appropriateness of Broda Chair...Precautions: Multiple contractures BUE [Bilateral Upper Extremities], BLE [Bilateral Lower Extremities], trunk and pelvis...Discharge plans: Home with family following respite care. At this point, skilled OT [Occupational Therapy] services are not recommended. Pt [patient] presents with high risk for skin breakdown due to immobility and multiple flexion contractures, therefore it is not recommended for pt to get up in Broda...Completed assessment of bed positioning in which appropriate wedge cushions and pillows are used for support and for prevention of skin to skin contact...Functional Deficit Other...High risk for Skin breakdown due to pt very thin and multiple contractures/deformities...."</p>		<p>sweep, in which all residents were reviewed for skin integrity including but not limited to skin breakdown, pressure areas, and surgical sites. · All resident were reviewed and assessed to identify residents at risk for potential alteration in skin integrity. · All residents then reviewed to ensure plan of care reflects proper clinical interventions, and prevention orders written, care plans and profiles updated accordingly. · Staff was in-serviced by the Director ofNursing Services or designee by 5/5/15 on weekly skin assessments, notificationof new areas, and prevention treatments.</p> <p>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?</p> <p>· SkinAssessment Audits will take place on a daily basis by the Unit Manager ordesignee to ensure that skin assessments are completed at least weekly.</p> <p>· Licensednurses will assess skin weekly to identify any area of compromised skinintegrity. Any areas will be documented and physician will be notifiedaccordingly. · Staff was in-serviced by the Director ofNursing Services or designee by 5/5/15 on weekly skin assessments, notificationof new areas, and prevention treatments.</p> <p>How the corrective action(s) will be monitoredto ensure the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.) A document titled, Pressure Wound Skin Evaluation Report, dated 3/27/15, indicated a new skin alteration was assessed to Resident B's left inner knee. Measurement was 1.0 centimeter (cm) x 1.5 cm x 0.1 cm. The area presented as an unstageable pressure wound with necrotic/eschar (black, brown or tan tissue adheres to wound bed) tissue. The wound bed color was described as 80% granulation tissue, 20% eschar.</p> <p>Interdisciplinary Team notes, dated 3/27/15, indicated the following: "Resident currently with noted contractures to bilateral lower extremities, slight contractures to bilateral upper extremities which contributes to difficult positioning...recently diagnosed with pneumonia and started on IV Ceftriaxone (intravenous antibiotic)...New orders received for Santyl (dressing type) to left inner knee... Will have therapy screen for contractures...He will be placed on weekly wound rounds."</p> <p>During an interview on 4/21/15 at 2:30 p.m., the Director of Nursing Services (DNS) indicated the unstageable wound to Resident B's left inner knee was noted during a facility wide skin sweep (skin assessments to all residents) on 3/27/15.</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·To ensure compliance, the DNS/Designee is responsible for the completion of the Skin Management Program CQI tool weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director.</p> <p>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>b.) A pressure wound skin evaluation report, dated 3/30/15, indicated a new skin alteration was assessed to Resident B's right hip. The area presented as an unstageable pressure wound, 3.5 cm x 7 cm x 0.1 cm, with necrotic/eschar tissue. The wound bed color was described as eschar.</p> <p>c.) A pressure wound skin evaluation report, dated 4/08/15, indicated a new skin alteration was assessed to Resident B's right lateral malleolus. The area presented as an unstageable pressure wound with slough (yellow or white tissue adhering to ulcer bed) tissue, 1.0 cm x 0.5 cm x 0.1 cm. The wound bed color was described as slough.</p> <p>On 4/22/15 at 10:50 a.m., during an interview, the DNS indicated CNA's were expected to notify nurses if any skin concerns were observed during a shower or while providing care. Skin assessments were not to be completed or documented by CNA's. Documentation indicated Resident B's wound areas were not assessed until documentation indicated the wounds were unstageable. The DNS indicated unstageable wounds could present within 4 - 6 hours, for an immobile resident with severe contractures and delicate skin. Resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>B had varying color and discoloration to his body, therefore making it difficult to determine the possibility of a concern. Discoloration may or may not be present prior to wound rupture, especially with a deep tissue injury.</p> <p>Physician documentation, dated 4/10/15, indicated this was the physicians first assessment of wounds to Resident B's hip, knee, and ankle.</p> <p>2. The clinical record for Resident G was reviewed on 4/21/15 at 3:00 p.m. Diagnoses for Resident G included, but were not limited to, chronic kidney disease, hemiplegia affecting lower extremities, diabetes mellitus- type II, dysphagia, gastrostomy status, history of pneumonia, tracheostomy status, and peripheral vascular disease.</p> <p>A document titled, Pressure Wound Skin Evaluation Report, dated 2/18/15, indicated a new skin alteration was assessed to Resident G's right heel. The area presented as an unstageable pressure wound with necrotic/eschar tissue, 2.5 cm x 4.2 cm x 0 cm. The wound bed color was described as 100% eschar.</p> <p>The wound care nurse indicated once she was made aware of the skin concern, it was assessed as unstageable. Resident G</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>had a low air loss mattress for prevention of skin breakdown.</p> <p>A care plan, dated 2/4/15, indicated Resident G was at risk for skin breakdown due to extensive assist with ADL's (activities of daily living), diagnosis of CVA (cerebrovascular accident/stroke) and diabetes.</p> <p>A policy titled "Skin Management Program", dated 2/2015, presented on 4/22/15 at 11:00 a.m., by the DNS, indicated the following:</p> <p>"It is the policy of (name of the facility) to assess each resident to determine the risk of potential skin integrity impairment, upon admission, quarterly, annually, and with significant change. Residents will have a skin assessment completed no less than weekly by the licensed nurse in an effort to assess overall skin condition, skin integrity, and skin impairment...</p> <p>A head to toe assessment will be completed by a licensed nurse upon admission/re-admission and weekly...All alterations in skin integrity will be documented in the medical record...Pressure reduction devices are to be put in place...The wound care nurse will be notified of alterations in skin</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>integrity...Direct care givers will be notified of skin alterations and specific care needs...</p> <p>Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place...A care plan will be developed specific to the resident's needs including prevention interventions...Direct care givers will be notified of the resident's specific prevention interventions...</p> <p>Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises, open areas, redness, skin tears, blisters, and rashes.... The licensed nurse is responsible for assessing any and all skin alteration as reported by the direct caregivers on the shift reported, following the same protocol listed above...."</p> <p>This federal tag relates to Complaint #IN00171114.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318 SS=G Bldg. 00	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to assess and use prevention techniques for the further development of contractures for 1 of 1 residents, in a sample of 7, reviewed for contractures. (Resident B) Resident B was admitted to the facility and was assessed or treatment provided to prevent the development of severe contractures to his body.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 4/20/15 at 2:45 p.m. Diagnoses for Resident B included, but were not limited to, status post cerebrovascular accident, diabetes mellitus- type II, dysphagia, aphasia, gastrostomy status, multiple contractures, history of pneumonia, malnutrition and incontinence.</p>	F 318	<p>F 318 INCREASE/PREVENT DECREASE IN RANGE OF MOTION The facility respectively requests a face-to-face IDR for F314, F318 as the facility disagrees with the scope and severity of the deficiencies. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident B no longer resides in this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents who have contractures have the potential to be effected by the alleged deficient practice. · Residents who have contractures and identified as needing range of motion will be reviewed by Interdisciplinary Team and care plans will be 	05/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During the initial tour of the facility on 4/20/15, LPN #1 indicated Resident B was totally dependent on staff for care. Resident B was observed at 1:30 p.m. on 4/20/15. Contractures were noted to his bilateral feet, toes, fingers, mouth, eyes, bilateral wrists, bilateral knees, bilateral hips, neck, shoulders, bilateral upper and lower arms, and bilateral upper and lower legs. LPN #1 indicated Resident B's contractures were so severe that despite re-positioning every two hours, he contracts back to his contracted position.</p> <p>An admission assessment for November 2014, indicated Resident B had contractures to his bilateral legs. Additional admission assessment of the bilateral leg contractures or other contractures were not provided.</p> <p>Nursing notes indicated the following: 1/06/15- "...contractures noted" 1/21/15- "Resident has several contractures that make it difficult for positioning."</p> <p>An "Occupational Therapy Plan of Care (Evaluation Only)" dated 1/20/15 indicated "...Reason for Referral: Nsg [nursing] concerns regarding positioning needs and ability for pt [patient] to get up in Broda Chair. Therapy Necessity: Evaluation only for appropriateness of</p>		<p>updated accordingly. · Rehab Services Manager and MDS Coordinator or designee will audit all therapy recommendations for residents with contractures made in the past 3 months to ensure recommendations are reviewed and documented accordingly in clinical record</p> <p>·Therapy recommendations for range of motion services will be reviewed weekly by the Rehab Services Manager and/or MDS Coordinator in weekly Medicare meeting to ensure that previous week's recommendations have been addressed. If recommendation is not clinically appropriate; it will be documented accordingly in clinical record</p> <p>·MDS, Therapy and Restorative Nursing staff will be in-serviced on Restorative Nursing Program by the Director of Nursing or designee by 5/6/15</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·MDS, Therapy and Restorative Nursing staff will be in-serviced on Range of Motion Program by the Director of Nursing or designee by 5/6/15</p> <p>·Therapy recommendations for range of motion services will be reviewed weekly by the Rehab Services Manager and/or MDS Coordinator in weekly Medicare meeting to ensure that previous week's recommendations have</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Broda Chair...Precautions: Multiple contractures BUE [Bilateral Upper Extremities], BLE [Bilateral Lower Extremities], trunk and pelvis...Discharge plans: Home with family following respite care. At this point, skilled OT [Occupational Therapy] services are not recommended...not recommended for pt to get up in Broda...Completed assessment of bed positioning in which appropriate wedge cushions and pillows are used for support...Frequency /Duration:...Evaluation Only."</p> <p>At 11:00 a.m. on 4/22/15, during an interview, the DNS indicated Resident B was admitted in November 2014, for respite care, for one month, and was still at the facility. Therapy services were not provided for respite stays. The staff expected Resident B would return home after 30 days, therefore therapy services were not added. She indicated the facility did not have a policy related to respite care services.</p> <p>Physical therapy plan of care and Initial Assessment notes, dated 3/30/15, indicated Resident B "completes up to 25% of normal range" of motion to right and left upper extremities (arms), and to right and left lower extremities (legs). Muscle tone to right and left upper extremities and to right and left lower</p>		<p>been addressed. If recommendation is not clinically appropriate; it will be documented accordingly in clinical record.</p> <ul style="list-style-type: none"> ·MDS Coordinator or designee will audit daily that Range of Motion restorative programs are completed according to the plan of care. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·To ensure compliance, A Range of Motion CQI tool will be completed weekly times 4 weeks, monthly times 6 months and then until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Director of Nursing, Executive Director, and Medical Director. ·If threshold of 95% is not achieved an action plan will be developed to ensure compliance 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>extremities was described as hypertonic (extreme muscular tension).</p> <p>During an interview on 4/23/15 at 10:58 a.m., the Rehab Services Manager indicated Resident B was admitted for a respite stay. The facility did not have a policy related to respite care services. Therapy services were not offered during a respite stay, but, therapy services were started on 3/31/15, to address Resident B's wounds and positioning. These services were started secondary to the wounds and to prevent further injury. She added Resident B could not tolerate stretching exercises due to the severity of his contractures, at this time.</p> <p>This federal tag relates to Complaint #IN00171114.</p> <p>3.1-42(a)(2)</p>			