

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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<br><br>Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00173085.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey.</p> <p>Complaint IN00173085-Substantiated. Federal deficiencys related to allegations are cited at F 312 and F 242.</p> <p>Survey dates: May 6, 7, 8, 11, 12, 13 and 14, 2015</p> <p>Facility number: 000074<br/>Provider number : 155154<br/>AIM number : 100290050</p> <p>Census bed type:<br/>SNF: 11<br/>SNF/NF: 93<br/>Total : 104</p> <p>Census payor type:<br/>Medicare: 16<br/>Medicaid: 63<br/>Other: 25<br/>Total: 104</p> <p>Sample : 12</p> | F 000 | <p>June 5, 2015</p> <p>Kim Rhoades, Director<br/>Long Term Care Division<br/>Indiana State Department of Health<br/>2 North Meridian St<br/>Indianapolis, IN 46204</p> <p>Dear Ms Rhoades,</p> <p>On May 14th, a complaint survey was conducted at Spring Mill Meadows. Spring Mill Meadows respectfully requests this document be submitted as the Plan of Correction and be considered for desk review by the staff of your division.</p> <p>If any questions arise regarding this request or attached documents, please feel free to contact me at your earliest convenience.</p> <p>Respectfully submitted,</p> <p>Austin Steele, HFA</p> <p>Cc: Bernie McGuinness, VP of Operations<br/>Sue Hornstein, Director of Compliance<br/>Martha Herron, Director of Clinical Services<br/>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:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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 242<br>SS=D<br>Bldg. 00 | <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.15(b)<br/>SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br/>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 interview and record review, the facility failed to honor a resident's preferences in regards to bathing choices for 1 of 1 residents interviewed for choices. ( Resident E)</p> <p>Findings include:</p> <p>On 5/11/15 at 10:48 a.m., the record review for Resident E was completed. Diagnoses included, but were not limited to, dementia, acute respiratory failure, status post gastric perforation with gastrostomy closure, questionable reopening, stroke, history of diabetes and seizures.</p> <p>The Preferences for Daily Customary</p> | F 242         | <p><b>F 242 SELF-DETERMINATION –RIGHT TO MAKE CHOICES</b><br/><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?_</b><br/>* Resident E bathing preference, profile, and care plan updated to indicate bed bath/shower twice a week and is receiving bathing per schedule.<br/><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b><br/><br/>*All residents have the potential to be affected by the alleged deficient practice.</p> | 06/10/2015           |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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>Routines document, dated 4/7/15, indicated the resident felt it was very important for him to choose the type of bathing. He indicated he wanted a bed bath in the evenings twice a week.</p> <p>On 5/8/15 at 10:36 a.m., the resident indicated he was supposed to be bathed two times a week and sometimes it did not get done.</p> <p>On 5/12/15 at 10:48 a.m., the resident had dry flaky skin around ears and hairline when observed and hair was oily.</p> <p>The Director of Nursing Services provided documentation regarding bathing on 5/12/15 at 11:50 a.m.</p> <p>The Activities of Daily Living documentation indicated the resident had not received bathing twice a week per his preference for:</p> <p>The first week of April 5th-11th the resident documentation indicated:<br/>4/7/15: 1:57 a.m. Complete bed bath</p> <p>The first week of May 3rd-9th the resident documentation indicated:<br/>5/8/15 : 10:52 a.m. Complete bed bath<br/>3:33 p.m. Shower</p> <p>As of the exit conference on 5/13/15 at</p> |               | <p>* All residents were interviewed by Customer Care Reps or designee for resident preferences related to bathing.</p> <p>* All residents preference, profiles, and care plans were updated as needed with resident preferred schedule for bathing.</p> <p>* Staff was in-serviced by Director of Nursing Services by 6/5/15 or designee on following resident preference, profile, and care plan related to preferred bathing schedule.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur?</b></p> <p>* Daily audits will be completed by Unit Manager or designee to verify residents are receiving bathing per resident preference.</p> <p>* Activities Director or designee will update resident preference, profile, and care plans related to bathing on a quarterly basis and per resident request.</p> <p>* Staff was in-serviced by Director of Nursing or designee by 6/5/15 on following resident preference related to bathing and documentation of resident bathing</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>* To ensure compliance, the</p> |                      |

|   |   |   |  |                      |   |
|---|---|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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 312<br>SS=D<br>Bldg. 00                               | <p>3:10 p.m., The DNS indicated that residents usually get bathed twice a week.</p> <p>This Federal tag relates to Complaint # IN00173085.</p> <p>3.1-3(u)(1)</p> <p>483.25(a)(3)<br/>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br/>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living services for bathing, oral care and perineal care for 3 of 4 residents reviewed for Activities of Daily Living (ADL). (Resident E, L, and J)</p> <p>Findings include:</p> <p>1. On 5/11/15 at 10:48 a.m., the record</p> | F 312   | <p>DNS/Designee is responsible for the completion of the Accommodation of Needs CQI tool weekly times 4 weeks, monthly times 6 months and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director</p> <p>* If threshold of 95% is not achieved an action plan will be developed to ensure compliance</p> <p><b>F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b><br/><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?_</b><br/>* Resident E bathing preference, profile, and care plan updated to indicate bed bath/shower twice a week and is receiving bathing</p> | 06/10/2015           |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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>review for Resident E was completed. Diagnoses included, but were not limited to, dementia, acute respiratory failure, status post gastric perforation with gastrostomy closure, questionable reopening, stroke, history of diabetes and seizures.</p> <p>On 5/8/15 at 10:36 a.m., the resident indicated he was supposed to be bathed two times a week and sometimes it did not get done.</p> <p>On 5/12/15 at 10:48 a.m., the resident had dry flaky skin around ears and hairline when observed and hair was oily.</p> <p>The Director of Nursing Services (DNS) provided documentation regarding bathing on 5/12/15 at 11:50 a.m.</p> <p>The Activities of Daily Living documentation indicated the resident had not received bathing twice a week for:</p> <p>The first week of April 5th-11th the resident documentation indicated:<br/>4/7/15: 1:57 a.m. Complete bed bath</p> <p>The first week of May 3rd-9th the resident documentation indicated:<br/>5/8/15 : 10:52 a.m. Complete bed bath<br/>3:33 p.m. Shower</p> |               | <p>perschedule.</p> <ul style="list-style-type: none"> <li>* Resident L isreceiving oral care per care plan.</li> <li>* Resident J isreceiving pericare per policy.</li> </ul> <p><b>How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>* All residents whoare dependent with bathing, oral care and perineal care have the potential tobe affected by the alleged deficient practice.</li> <li>* All residents that are dependent withbathing, oral care, and perineal care were reviewed by Unit Managers ordesignee for bathing preference, oral care per care plan, and perineal care perpolicy to ensure that resident care plans and profiles were updatedaccordingly.</li> <li>* Staff was in-serviced by Director ofNursing by 6/5/15 or designee onfollowing resident preference, profile and care plans related to bathing, providing oral care per care plan, andperforming perineal care per policy.</li> </ul> <p><b>What measures will be put intoplace or what systemic changes you will make to ensure the deficient practicedoes not recur?</b></p> <ul style="list-style-type: none"> <li>* Staff was in-serviced by Director of Nursingor designee by 6/5/15 on following resident preference, profile and care</li> </ul> |                      |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|---|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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>On 5/13/15 at 3:10 p.m., The DNS indicated that residents usually gets bathed twice a week.</p> <p>2. On 5/7/15 at 11:31 a.m., Resident L's upper and lower teeth around the bases of the teeth at the gumline had a white colored debris surrounding her teeth.</p> <p>On 5/11/15 at 11:08 a.m., the resident's upper and lower teeth around the bases of her teeth at the gumline had a white colored debris surrounding her teeth. Foul smelling breath was observed, at that time. At that time, Resident L indicated she had not gotten her teeth brushed today and she was not able to remember when she had her teeth brushed last.</p> <p>On 5/11/15 at 11:17 a.m., LPN #3 was observed to take a new box of toothpaste and a white colored toothbrush with no toothpaste residue observed in the bristles out of the resident's three drawer plastic storage container. LPN #3 indicated at that time, the toothpaste had not been opened and the toothbrush had not appeared to have been used. Resident L indicated at that time, she was unable to remember when she had her teeth brushed last.</p> <p>Resident L's record was reviewed on</p> |               | <p>plans related to bathing, providing oral care per care plan, and performing perineal care per policy.</p> <p>* Director of Nursing or designee will review bathing documentation and oral care documentation in Point of Care daily to ensure showers were offered and oral care performed and appropriate documentation occurred per resident preference.</p> <p>* Director of Nursing or designee will perform round every shift to ensure perineal care, oral care, and bathing for dependent residents performed per care plan and/or policy using the nurse rounds audit tool.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>* To ensure compliance, the DNS/Designee is responsible for the completion of the Accommodation of Needs 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> |                      |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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>5/13/15 at 2:37 p.m. Diagnoses included, but were not limited to, chronic pain, debility and osteoporosis.</p> <p>The resident's quarterly Minimum Data Set (MDS) assessment dated 3/21/15, indicated the resident required total assistance with two person physical assistance with personal hygiene, which included oral care.</p> <p>The resident had a Care Plan dated 3/24/15, which addressed the problem she required assistance and/or monitoring for ADL care. Approaches included, "...3/24/15--Tasks: AM Cares including bathing, dressing hair combing and oral care. 3/24/15--Tasks: PM Cares including bathing, dressing, hair combing and oral care. (evening shift)."</p> <p>The Profile Care Plan Approaches dated 5/11/15, indicated the ADL (Activities of Daily Living) Functional/Rehabilitation Potential was the problem and the approach indicated "3/24/15--Tasks: AM Cares including bathing, dressing, hair combing and oral care." The frequency of the approach was once a day.</p> <p>3. On 5/11/15 at 1:29 p.m., CNA #6 and CNA #7 with LPN #4 and the Assistant Director of Nursing Services (ADNS) in attendance transferred Resident J with a</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:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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 |
|--------------------|---|---------------|---|----------------------|
|                    | Stand to Sit lift into bed. Both CNA's had washed their hands and donned clean gloves prior to the transfer. After transferring the resident into bed, both CNA's moved the resident in the bed and removed her pants. The resident's brief smelled of a strong odor of urine and had a dark yellow colored urine observed on her brief when it was opened. CNA #6 used a wash cloth that was wrapped around her four fingers of her right hand and wiped the resident's anal area by washing her from the peri area, then washing towards the anal area. She repeated this step three times, while changing the wash cloth area she was washing the resident's anal area and inner buttocks each time. The resident complained of pain while CNA #6 was washing her anal area and the CNA stopped washing her. She was assessed for pain and LPN #4 indicated she was given pain medication prior to being placed in bed. The ADNS instructed CNA #6 at that time, to pat Resident J's buttocks and anal area, while washing and drying her bottom instead of wiping her. Resident J had no further complaints of pain. The ADNS applied Calmoseptamine ointment (a barrier ointment) to the resident's buttocks and she was covered up. The front of the resident's periaarea was not washed at that time. CNA #6 indicated at that time, she |               |   |                      |

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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>should have washed the front of Resident J's periaerea while giving her peri care.</p> <p>Resident J's record was reviewed on 5/11/15 12:58 p.m. Diagnoses included, but were not limited to, vascular dementia, peripheral neuropathy, acute cerebrovascular disease, hemiplegia and depressive disorder.</p> <p>A current policy titled "Skills Validation-CNA" dated 2/2010 and revised 3/2012, provided by the Director of Nursing Services on 5/11/15 at 5:05 p.m., indicated "Procedure Steps: ...5. Assist resident to supine position. 6. Drape resident as needed. 7. Fill wash basin with warm water... 8. Ask resident to spread legs and lift knees if possible. 9. Wet and soap folded wash cloth... Females: 12. Separate labia and wash urethral area first. 13. Wash between and outside labia in downward strokes. 14. Alternate from side to side-wipe from front to back and from center of perineum outward. 15. Use a clean area of the wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. (Proceed to #20)... 20. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 21. Gently pat area dry in same direction as when</p> |   |   |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155154 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>05/14/2015 |
|--|---|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>SPRING MILL MEADOWS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2140 W 86TH ST<br>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>washing. 22. Assist resident to turn onto side away. 23. Wet and soap wash cloth. 24. Clean anal area from front to back, using a clean area of wash cloth with each wipe. Do not rewipe area, unless using a clean area of the wash cloth. Change wash cloth as needed. 25. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. 26. Gently pat area dry in same direction as when washing. 27. Assist resident to run [sic] onto back and undrape resident...."</p> <p>This Federal tag relates to Complaint #IN00173065.</p> <p>3.1-38(a)(3)(A)<br/>3.1-38(a)(3)(C)</p> |               |   |                      |