STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155154	A. BUILDING 00 B. WING	02/11/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00451659. Complaint IN00451659-Federal/State deficiencies related to the allegations are cited at F684. Survey date: February 11, 2025 Facility number: 000074 Provider number: 155154 AIM number: 100290050 Census bed type: SNF: 10 SNF/NF: 82 Total: 92 Census payor type: Medicare: 11 Medicaid: 54 Other: 27 Total: 92 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 19, 2025.	F 0000	Please accept State Form 2567, Plan of Correction, for the Complaint Survey conducted on February 11, 2025. The facility requests that the 2567 serve as the credible allegation of compliance. The facility also respectfully requests a face to face IDR process for F684 as we disagree with the severity assigned. Thank you for your consideration of these requests.	
F 0684 SS=G Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a resident received a medication for cancer as ordered, follow-up appointments with an oncologist were scheduled, and the facility's medical director did not discontinue a	F 0684	F684 It is the policy of this facility to provide care in accordance with professional standards of practice and to ensure residents with a cancer	03/05/2025

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

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	medication without consulting with the resident's oncologist for 1 of 2 residents reviewed for quality of care. (Resident B) This deficient practice resulted in Resident B having no follow-up oncology care to prevent further spread of the metastasis to the bone related to his prostate cancer. Findings include: An email, dated 1/16/25, indicated there were concerns with Resident B's treatment plan for his metastatic prostate cancer. In February 2023, the resident was placed on docetaxel (chemotherapy) and Nubeqa (a hormone therapy medication used to treat prostate cancer) at the cancer center. In April 2023, his pain was much improved, and his prostate-specific antigen had dropped which indicated the treatment was working well. In September 2023, Resident B continued to receive treatment, and his cancer medications were being provided/covered by the specialty pharmacy. In October 2023, the resident was admitted to the long-term care nursing facility. The clinical record for Resident B was reviewed on 2/11/25 at 2:30 p.m. The diagnoses included, but were not limited to, malignant neoplasm of prostate gland, post traumatic seizures, atrial fibrillation, and systolic heart failure. A hospital document, titled "After Visit Summary," dated 10/9/23, indicated the resident was being discharged to a long-term care facility and to schedule a follow-up with oncology related to a cancer diagnosis. A nursing progress note, dated 10/9/23 at 9:56 p.m., indicated the resident was admitted to the		diagnosis receive ordered cancer medications, ensure follow up appointments are scheduled with oncology, and facility physicians work in a collaborative manner with oncology physicians of the resident's choice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -Resident B attended an oncology appointment and the guardian has decided to choose hospice care. -The facility changed Medical Directors February 1, 2024. 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 who have a cancer diagnosis, who receive medications related to a cancer diagnosis, who have up appointments with oncology have the potential to be affected by this deficient practice. -DNS/designee completed a full house audit of all current residents with a cancer diagnosis to ensure cancer medications are ordered and received, oncology follow up appointments are scheduled, and the facility physician is aware of the cancer diagnosis and oncology plan of care. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? -The	

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	facility. The physician on call verified the resident's admission orders, the pharmacy was aware of the orders and the medications which needed sent to the facility. A physician's order, dated 10/9/23, indicated to start Nubeqa (darolutamide) 600 mg (milligram) orally twice a day on 10/10/23 for a diagnosis of malignant neoplasm of the prostate. The order indicated it was a telephone order taken by LPN 1. A nursing progress note, dated 10/11/23 at 3:53 p.m., indicated LPN 2 notified the pharmacy the resident's Nubeqa was missing. The pharmacy technician indicated a script was needed from the physician for the medication. LPN 2 notified the nurse practitioner Nubeqa needed a script. A nursing progress note, dated 10/12/23 at 3:43 p.m., indicated LPN 2 notified the pharmacy regarding the resident's missing Nubeqa. The pharmacy technician indicated the medication was a high-cost medication. A nurse practitioner progress note, dated 10/13/23 at 10:27 a.m., indicated Resident B's medications and orders were reviewed. She indicated he was to be given Nubeqa 600 mg orally twice a day for the diagnosis of metastatic prostate cancer. A physician's order, dated 10/19/23 at 8:17 a.m., indicated to discontinue the resident's Nubeqa 600 mg twice a day. The reason for discontinuing the medication was because it was a "High Cost Medication." There was no documentation the physician consulted with the resident's oncologist before discontinuing the medication.		DNS/designee has reviewed all residents with a cancer diagnosis with the Medical Director and updated the plan of care as needed. -The IDT was re-educated on the Admission/Readmission chart check process on 2-28-2025 by the DNS/ED. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? -Weekly Admission/Readmission QA tool will be utilized weekly x 8 weeks, monthly thereafter for months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of correction: 3-5-2025	

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	There was no documentation the resident had a follow-up appointment or any consultation with the oncologist until 1/16/25 which was 15 months after the resident admitted to the facility. A nursing progress note, dated 1/16/25 at 3:51 p.m., indicated the resident returned from his cancer center appointment. His next appointment with the cancer center would be on 1/30/25 at 12:30 p.m. A nursing progress note, dated 1/30/25 at 1:26 p.m., indicated LPN 1 spoke with Resident B's guardian and the prostate cancer had spread. She was deciding on whether to place the resident on hospice. A social service progress note, dated 2/3/25 at 4:27 p.m., indicated the social worker spoke with the resident's legal guardian who indicated Resident B would transition to hospice related to his cancer diagnosis. A nursing progress note, dated 2/3/25 at 6:46 p.m., indicated the resident was admitted to hospice. During an interview, on 2/11/25 at 1:50 p.m., the Director of Nursing indicated the resident's chemotherapy drug was ordered following his discharge from the hospital. The Medical Director at that time chose to discontinue the medication because it was a high-cost medication. When a resident was on a high-cost medication normally the facility placed the medication on hold until they were dismissed from the facility. She did not know the resident had an oncology referral appointment when he was discharged from the hospital. He had no oncology follow-up appointments as far as she knew until 1/16/25. The Medical Director who discontinued the			

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	medication was no longer employed at the facility. The facility had been unable to reach him to obtain any further information related to discontinuing Resident B's cancer medication or his cancer treatment since he was admitted in 2023. A current facility policy, titled "Nursing Admission/Return Admission Policy and Procedure," dated as revised 07/2024 and provided by the Director of Nursing on 2/11/25 at 1:30 p.m., indicated "...Physician orders...Upon admission, physician orders must be obtained...Transcribe the admission orders from the original orders sent from the hospital or physician's office...Transcribe the routine medication orders to include dosage route, frequency and diagnosis to support the use...Inquire about medications that the resident may still have at home prior to admission to the nursing facility and assure the resident/representative consults with the primary care physician or community pharmacist before taking previously prescribed, unused medications, including over-the-counter medications...Verification of orders...The admitting nurse must call the attending physician to verify all orders upon admission. Pharmacy notification...Pharmacy notified of new admit/readmit...Discharge Summary...Residents being admitted from the hospital must have a discharge summary. If not present at admission, contact the transferring facility for a copy...." "Darolutamide" (Last revised 9/15/22) and retrieved on 2/18/25 from the National Library of Medicine MedlinePlus website indicated "Darolutamide is also used to treat certain types of prostate cancer (cancer that begins in the prostate [a male reproductive gland]) that have			

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	spread to other parts of the body in men in combination with docetaxel. Darolutamide is in a class of medications called androgen receptor inhibitors. It works by blocking the effects of androgen (a male reproductive hormone) to stop the growth and spread of cancer cells...Do not stop taking darolutamide without talking to your doctor...Keep all appointments with your doctor and the laboratory. Your doctor may order certain lab tests to check your body's response to darolutamide...Brand names Nubeqa" This citation relates to Complaint IN00451659. 3.1-37(a)			