| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | SURVEY | |
|--|-----------------------|-----------------------------------|----------------------------|----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155764 | B. W | NG | _ | 09/10/ | 2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | 87TH AVE | | |
| SPRING | MILL HEALTH CAN | /IPUS | | | LLVILLE, IN 46410 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΤE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | | DATE |
| F 0000 | | | | | | | |
| Bldg. 00 | | | | | | | |
| Diag. 00 | This visit was for a | Recertification and State | F 00 | 000 | | | l |
| | | nd the Investigation of | 1 00 | ,00 | | | |
| | - | pplaints IN00436754 and | | | | | |
| | | visit included a State | | | | | |
| | Residential Licensu | | | | | | |
| | | | | | | | |
| | | 7754 - No deficiencies related to | | | | | |
| | the allegations are c | ited. | | | | | |
| | Complaint IN00442 | 2676 - No deficiencies related to | | | | | |
| | the allegations are c | | | | | | |
| | the anegations are e | neu. | | | | | |
| | Survey dates: Septe | mber 3, 4, 5, 6, 9, and 10, 2024 | | | | | |
| | Facility number: 01 | 0739 | | | | | |
| | Provider number: 1 | | | | | | |
| | AIM number: 2008 | 356890 | | | | | |
| | | | | | | | |
| | Census Bed Type: | | | | | | |
| | SNF/NF: 19 | | | | | | |
| | SNF: 34 | | | | | | |
| | Residential: 15 | | | | | | |
| | Total: 68 | | | | | | |
| | Census Payor Type: | : | | | | | |
| | Medicare: 16 | | | | | | |
| | Medicaid: 16 | | | | | | |
| | Other: 21 | | | | | | |
| | Total: 53 | | | | | | |
| | | | | | | | |
| | | reflect State Findings cited in | | | | | |
| | accordance with 410 | U IAC 16.2-3.1. | | | | | |
| | Quality review com | pleted on 9/16/24. | | | | | |
| F 0561 | 483.10(f)(1)-(3)(8) | | | | | | l |
| SS=D | Self-Determination | | | | | | |
| | | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Lakeithia Webb **Executive Director** 09/27/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DA | | | (X3) DATE | SURVEY | |
|--|---|------------------------------------|-------|---------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155764 | B. W | ING | | 09/10/ | 2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | | 87TH AVE | | |
| SPRING | MILL HEALTH CAN | //PUS | | | LLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| Bldg. 00 | | | | | | | |
| | Based on observation | on, record review, and | F 0: | 561 | Spring Mill Nursing and | | 10/01/2024 |
| | interview, the facili | ty failed to ensure a resident's | | | Rehabilitation | | |
| | preferences were ho | onored related to allowing the | | | Complaint Survey: 9/10/24 | | |
| | resident to leave the | eir room while in contact | | | | | |
| | isolation for 1 of 1 i | resident reviewed for choices. | | | Please accept the following as | s the | |
| | (Resident 261) | | | | facility's credible allegation of | | |
| | | | | | compliance. This plan of | | |
| | Finding includes: | | | | correction does not constitute | an | |
| | | | | | admission of guilt or liability by | y the | |
| | During a random ob | oservation on 9/3/24 at 10:31 | | | facility and is submitted only in | า | |
| | a.m., Resident 261 i | indicated she had been | | | response to the regulatory | | |
| | confined to her room due to an infection on her | | | | requirement. | | |
| | back. | | | | F561 – Self -Determination | | |
| | | | | | What corrective action(s) wil | I | |
| | On 9/4/24 at 3:12 p. | .m., the resident was observed | | | be accomplished for those | | |
| | in her room sitting i | n her wheelchair. She indicated | | | residents found to have been | n | |
| | to LPN 3, who was | also in the room, that she was | | | affected by the deficient | | |
| | unable to leave her | room due to her isolation | | | practice; | | |
| | status. | | | | Resident 261 preference was | | |
| | | | | | honored, and the resident was | 3 | |
| | During an interview | at the time, LPN 3 indicated | | | informed that she could leave | her | |
| | she was unsure if th | e resident could leave her | | | room. | | |
| | room. LPN 3 was to | old in shift report that the | | | How the facility will identify | | |
| | resident was in cont | act isolation, but she was a | | | other residents having the | | |
| | new nurse and was | unsure if that meant the | | | potential to be affected by th | ie | |
| | resident could not le | eave her room. | | | same deficient practice and | | |
| | | | | | what corrective action will be | е | |
| | | dent 261 was reviewed on | | | taken; | | |
| | 9/4/24 at 11:15 a.m. | . The diagnoses included, but | | | All residents have the potentia | al to | |
| | were not limited to, | lymphedema (swelling in arms | | | be affected by the same allege | ed | |
| | or legs), hypoxia (ir | nadequate oxygen), difficulty | | | deficient practice. | | |
| | walking, kidney fail | lure, anemia (decrease in red | | | What measures will be put ir | nto | |
| | blood cells), and cel | Ilulitis (bacterial infection). | | | place or what systemic | | |
| | | | | | changes will be made to | | |
| | The Admission Mir | nimum Data Set (MDS) | | | ensure that the deficient | | |
| | assessment, dated 8 | /20/24, indicated the resident | | | practice does not recur; | | |
| | was cognitively inta | act for daily decision making. | | | Facility conducted an audit on | all | |
| | The resident had no | impairment of the upper and | | | residents in isolation to ensure | e | |
| | lower extremities an | nd used a wheelchair. Eating, | | | resident's preferences are hor | nored | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---------------------------------------|---------------------------------|---------------------------------|--------|---|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETED | | | ETED | |
| | | 155764 | B. W | ING | | 09/10/2 | 2024 |
| | | | | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| ODDINO | NAUL LIEAL TIL 0 A B | 451.10 | | | B7TH AVE | | |
| SPRING | MILL HEALTH CAN | MPUS | | MERRII | LLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | personal hygiene, a | nd oral hygiene required set | | | related to allowing residents to | o | |
| | | istance. Partial/moderate | | | leave their room while in conta | act | |
| | assistance was requ | ired for toileting and | | | isolation. | | |
| | shower/bathing, and | d lower body dressing. | | | Staff was educated on | | |
| | | | | | transmission-based | | |
| | A Physician's Order | r, dated 9/1/24, indicated to | | | precautions/isolation guideline | es, | |
| | place the resident in | Contact Isolation related to | | | including on how to locate | | |
| | Methicillin-resistan | t Staphylococcus aureus | | | information in medical records | ; | |
| | (MRSA) in the wor | ınd. | | | regarding isolation information | ı. | |
| | | | | | How the corrective action(s) | | |
| | During an interview | on 9/4/24 at 3:16 p.m., CNA 1 | | | will be monitored to ensure t | the | |
| | | nt used to leave her room all | | | deficient practice will not | | |
| | · · · · · · · · · · · · · · · · · · · | nd noticed the resident had not | | | recur, i.e., what quality | | |
| | left her room in a co | ouple days. She was unaware | | | assurance programs will be | put | |
| | | on required and did not know | | | into place; | | |
| | why the resident wa | as not allowed to leave her | | | DON/Designee will audit 5 | | |
| | room. | | | | residents in isolation weekly fo | or 6 | |
| | | | | | months to ensure the preferer | nce | |
| | _ | on 9/4/24 at 3:19 p.m., the | | | to leave their rooms are being | | |
| | | long as the resident's wound | | | honored. | | |
| | | ould leave her room. She was | | | The DON/Designee will prese | nt a | |
| | | ember told the resident | | | summary of the audits to the | | |
| | | vould in-service the staff | | | Quality Assurance committee | | |
| | immediately. | | | | monthly for 6 months. Therea | after, | |
| | | | | | if determined by the Quality | | |
| | _ | on 9/4/24 at 3:40 p.m., the | | | Assurance committee, auditing | g | |
| | | e wound nurse had told the | | | and monitoring will be done | | |
| | | have to leave her room to go | | | quarterly and present quarterly | - | |
| | | sident was feeling embarrassed | | | the QA meeting. Monitoring w | vill | |
| | 1 - | egs were weeping when they | | | be on going. | | |
| | | wound nurse indicated | | | | | |
| | | ne to her room for a 1:1. The | | | Date by which systemic | | |
| | _ | ly misunderstood and | | | corrections will be complete | d: | |
| | thought she had to s | stay in her room. | | | 10/01/24 | | |
| | D | 0/6/24 + 1.50 | | | | | |
| | _ | on 9/6/24 at 1:59 p.m., the | | | | | |
| | | onsultant indicated they | | | | | |
| | understood the cond | | | | | | |
| | | act isolation and they had no | | | | | |
| | additional informati | ion to provide. | 1 | | | J | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 09/10/2024 | | |
|--|---------------------------------------|---|--|--|------------|
| | | 100/04 | _ | | 09/10/2024 |
| | PROVIDER OR SUPPLIEF | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE | |
| SPRING MILL HEALTH CAMPUS | | | MERR | ILLVILLE, IN 46410 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | , | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | 3.1-3(u)(1) | | | | |
| F 0578 SS=D Bldg. 00 | Dir Based on record rev | Oscntnue Trmnt;FormIte Adv | F 0578 | Spring Mill Nursing and | 10/01/2024 |
| | regarding the reside | if were knowledgeable ents' code status for 3 of 5 for advanced directives. | | Rehabilitation Complaint Survey: 9/10/24 Please accept the following | |
| | (Residents 160, 50, | | | the facility's credible allegat of compliance. This plan of | |
| | Findings include: | | | correction does not constitu an admission of guilt or liab | ility |
| | | esident 160 was reviewed on | | by the facility and is submitt | ed |
| | _ | The resident was admitted to | | only in response to the | |
| | - | /24. Diagnoses included, but non traumatic subarachnoid | | regulatory requirement. The | |
| | · · · · · · · · · · · · · · · · · · · | diabetes, asthma, stroke, | | facility requests paper compliance. | |
| | | , and cognitive communication | | compliance. | |
| | | | | F578 – Request /Refuse | |
| | | nimum Data Set (MDS) | | /Discontinue Trmn; Formite | Adv |
| | _ | eted on 8/28/24, indicated the | | Dir | |
| | decision making. | ately impaired for daily | | What corrective action(s) will be accomplished for those | ll |
| | decision making. | | | residents found to have been | n |
| | During an interview | v on 9/4/24 at 11:08 a.m., the | | affected by the deficient | " |
| | _ | of Nursing indicated she was | | practice; | |
| | | sident's code status because | | Resident 160, 50 and 261 cod | de |
| | there was no docum | nentation in the clinical record | | status has been reviewed and | |
| | or in the advance di | irective binder located at the | | uploaded in their medical reco | ord. |
| | nursing station. | | | How the facility will identify | |
| | | | | other residents having the | |
| | | v on 9/4/24 at 11:11 a.m., the | | potential to be affected by the | ne |
| | | ctor (SSD) indicated he would | | same deficient practice and | |
| | _ | to see if the resident had | | what corrective action will b | e |
| | • | (Physician's Orders for Scope | | taken; | |
| | of Treatment) form | • | | All residents have the potentia | |
| | 1 | | İ | be affected by the same alleg | ea |

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Event ID:

C9AE11

Facility ID: 010739

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | | |
|--|--|-----------------------------------|--|----------------------------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED |
| | | 155764 | B. W | ING | | 09/10/2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | 1 |
| NAME OF I | PROVIDER OR SUPPLIEF | 2 | | | 87TH AVE | |
| SPRING | MILL HEALTH CAN | MPUS | | | LLVILLE, IN 46410 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DROVIDEDIC DI ANI DE CORRECTIONI | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE |
| | During an interview | on 9/4/24 at 11:18 a.m., the | | | deficient practice. | |
| | SSD indicated he ha | ad the POST form on his desk | | | What measures will be put in | nto |
| | which was signed b | y the resident and signed by | | | place or what systemic | |
| | the Director of Nurs | sing and another nurse, it was | | | changes will be made to | |
| | not signed by a Phy | sician or a Nurse Practitioner. | | | ensure that the deficient | |
| | The POST form inc | licated the resident was a full | | | practice does not recur; | |
| | code. When asked v | why the information had not | | | 100% audit completed on adv | ance |
| | | ursing staff, the SSD had no | | | directives to ensure that the | |
| | additional informat | _ | | | resident's most recent advance | ce |
| | 2. Resident 50's rec | ord was reviewed on 9/3/24 at | | | directive is signed, order is in | |
| | 3:28 p.m. Diagnose | s included, but were not limited | | | place, code status is on the fa | ce |
| | to, communication | deficit, end stage renal disease, | | | sheet and POST form is uploa | |
| | hypertensive chronic kidney disease with stage 1 | | | | into PCC. | |
| | through stage 4 chr | onic kidney disease. | | | Staff was educated on proces | s of |
| | | • | | | obtaining advance directives a | |
| | The Admissions Mi | inimum Data Set (MDS) | | | where to locate resident's cod | |
| | assessment, dated 7 | /26/24, indicated the resident | | | status in the medical record. | |
| | was cognitively inta | act. Resident 50 was admitted | | | How the corrective action(s) | |
| | on 7/20/24. | | | | will be monitored to ensure | |
| | | | | | deficient practice will not | |
| | There was no code | status order and no advanced | | | recur, i.e., what quality | |
| | directives documen | tation in Resident 50's | | | assurance programs will be | put |
| | electronic record or | in the advanced directives | | | into place; | |
| | binder. | | | | Social Services/Designee to a | nudit |
| | | | | | 5 residents bi-weekly x 1 mon | |
| | During an interview | on 9/4/24 at 1:35 p.m., RN 1 | | | then weekly for 6 mos to ensu | ire |
| | indicated she could | not locate a code status for | | | that the most recent advance | |
| | Resident 50. She wa | as not aware that she did not | | directive is signed, order is in | | |
| | have access to the c | ode status for this resident. | | | place, code status is on the fa | ce |
| | | | | | sheet and POST form is uploa | aded |
| | During an interview | on 9/4/24 at 1:45 p.m., the | | | into PCC. | |
| | Social Service Dire | ctor (SSD) indicated the | | | The Social Services | |
| | resident had a POS | Γ form in his office, signed by | | | Director/Designee will present | ta |
| | the resident on 7/23 | /24 and by the physician on | | | summary of the audits to the | |
| | 8/1/24, which indic | ated their code status wishes. | | | Quality Assurance committee | |
| | He was not able to | provide any information on | | | monthly for 6 months. Therea | after, |
| | why the POST form | n was not in the resident's chart | | | if determined by the Quality | |
| | | f were not made aware of their | | | Assurance committee, auditin | g |
| | | record for Resident 261 was | | | and monitoring will be done | - |
| | reviewed on 9/4/24 | at 11:15 a.m. The diagnoses | | | quarterly and present quarterly | v at |

| (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/10/2024 |
|--|--|
| STREET ADDRESS, CITY, STATE 101 W 87TH AVE MERRILLVILLE, IN 46410 | , ZIP COD |
| ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO TAG DEFICIEN | CTION SHOULD BE COMPLETION THE APPROPRIATE |
| the QA meeting. be on going. | |
| Date by which sy corrections will be completed:10/01/ | oe e |
| | |
| | |
| | |
| | |
| | |
| | STREET ADDRESS, CITY, STATE 101 W 87TH AVE MERRILLVILLE, IN 46410 ID PREFIX CROSS-REFERENCED TO DEFICIEN the QA meeting. be on going. Date by which sy corrections will to |

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Event ID:

C9AE11 Facility ID: 010739

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | A. BUILDING 00 COMPLETED B. WING 09/10/2024 | | | | |
|--|---|---|------|---------------------|---|----------------------|
| | ROVIDER OR SUPPLIER | | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY) | (X5) COMPLETION DATE |
| TAG | 3.1-4(f)(5) | LISC IDENTIFT ING INFORMATION | | IAG | | DATE |
| F 0641 SS=D Bldg. 00 | 483.20(g) Accuracy of Asses | ssments | | | | |
| | interview, the facili comprehensive asse to dental status for | on, record review, and ty failed to ensure the ssment was accurate related I of 17 residents whose | F 06 | 541 | Spring Mill Nursing and Rehabilitation Annual Survey: 09/10/2024 | 10/01/2024 |
| | comprehensive assessments were reviewed. (Resident 6) Finding includes: | | | | Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitu an admission of guilt or liab | ion Ite |
| | Resident 6's teeth w broken off. The res | on on 9/3/24 at 11:02 a.m. rere observed to be caried and ident indicated at that time d to get new dentures. | | | by the facility and is submitt only in response to the regulatory requirement. The facility request paper | red |
| | at 8:20 a.m. Diagno limited to, dementia | dent 6 was reviewed on 9/5/24 ses included, but were not with psychotic disturbance, lepsy, paranoid schizophrenia, | | | compliance. F641 Accuracy of Assessment | ent |
| | type 2 diabetes, epilepsy, paranoid schizophrenia, depressive disorders, anxiety disorder, high blood pressure, and PTSD (post traumatic stress disorder) | | | | What corrective action(s) w be accomplished for those residents found to have bee | ill |
| | assessment, indicate | or daily decision making and | | | affected by the deficient practice; | ne |
| | assessment, dated 7 | f the Quarterly MDS /25/24, indicated the resident act for daily decision making ssues. | | | Resident 6 comprehensive M assessment was modified to reflect accurate dental status. How the facility will identify other residents having the potential to be affected by the | |
| | There was no care p | olan for dental care. You on 9/6/24 at 2:30 p.m., the | | | same deficient practice and what corrective action will b taken: | |

PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 09/10/2024 | |
|--|---------------------------------|--|--------------------------|--|--|
| | PROVIDER OR SUPPLIER | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | resident's teeth were caried. | ndicated she was unaware the e broken off, discolored, and on 9/9/24 at 3:00 p.m., the | | All facility residents have the potential to be affected by the same alleged deficient practic | e |
| | _ | tant indicated she had no | | What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; | |
| | | | | MDS Coordinator completed audit of comprehensive MDS assessment submitted in the 90 days to ensure accuracy coding of resident's dental stamps staff educated on performental status assessment of residents during observation and accuracy of coding residental status on comprehens MDS. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; | past of atus. rming period ent's ive) the |
| | | | | MDS staff/designee will audit comprehensive MDS weekly months to ensure accuracy related to dental status. The DON/designee will prese summary of the audits to the Quality Assurance committee monthly for 6 months. Therea if determined by the Quality | x 6 ent a |

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Event ID:

C9AE11 Facility ID: 010739

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 09/10/202 | | ETED | | |
|---|--|---|--|---------------------|---|------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | | | 101 W 8 | ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| c | REGUESTION I ON | | | c | Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will ongoing. Date by which systemic corrections will be completed 10/01/2024 | g / at II be | |
| F 0677 SS=D Bldg. 00 | Based on observation interview, the facility residents received at their hair washed at residents reviewed for (Residents 41 and 1). Findings include: 1. During an interviewed for Resident 41 indicates bed bath 2 times a washed at least weed observed to be greated to be greated to be greated at 2:50 p.m. The resident for Resident 41 indicates bed bath 2 times a washed at least weed observed to be greated | ew on 9/3/24 at 11:20 a.m., and he sometimes did not get a week and did not get his hair kly. The resident's hair was say. Ident 41 was reviewed on 9/5/24 ident was admitted to the Diagnoses included, but were surgical procedure to the teoarthritis of both knees and | F 06 | 677 | Spring Mill Nursing and Rehabilitation Annual Survey: 09/10/2024 Please accept the following a the facility's credible allegati of compliance. This plan of correction does not constitue an admission of guilt or liability the facility and is submitted only in response to the regulatory requirement. The facility request paper compliance. F 677 ADL Care –Dependent residents | on te lity ed | 10/01/2024 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C9AE11 Facility ID: 010739

If continuation sheet Page 9 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | VEY |
|--|-----------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETE. | D |
| 155764 B. WING 09/10/202 | 24 |
| STREET ADDRESS, CITY, STATE, ZIP COD | |
| NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE | |
| SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 | |
| OF KING WILL FILALITI CAWIFUS | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION | (X5) |
| | OMPLETION |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) | DATE |
| assessment indicated the resident was cognitively | |
| intact for daily decision making and was | |
| dependent on staff all activities of daily living What corrective action(s) will | |
| (ADLs) including eating, toileting, repositioning, be accomplished for those | |
| bathing and personal hygiene. The resident had residents found to be affected | |
| range of motion impairment to both upper and by the alleged deficient | |
| lower extremities. He had 1 surgical wound upon practice. | |
| admission. | |
| Resident 41 and 158 received a | |
| The Care Plan, dated 7/19/24, indicated the bath and hair washed. | |
| resident required assistance with activities of | |
| daily living for bathing. The approaches were to How will the facility identify | |
| assist with personal hygiene and grooming as other residents who have the | |
| needed. potential to be affected by the | |
| same alleged deficient | |
| The Shower Book indicated the resident was to practice? | |
| receive a shower or complete bed bath on | |
| Mondays and Thursdays. The resident did not All residents residing in the facility | |
| have a complete bed bath on 8/5 and 8/22/24. have the potential to be affected | |
| by this alleged deficient practice. | |
| During an interview on 9/5/24 at 2:45 p.m., the | |
| Assistant Director of Nursing indicated she had What corrective measures will | |
| just brought up shower caps for the residents to the facility take, or will the | |
| get their hair washed. The resident should be facility alter to ensure that the | |
| bathed at least 2 times a week and be offered to problem will not occur? | |
| have their hair washed. | |
| During an interview on 9/9/24 at 10:30 a.m., the Staff were re-educated on the importance of providing ADL care | |
| | |
| | |
| have at least 2 complete bed baths weekly and be washing as needed. | |
| | |
| What quality assurance plans 2. During an interview on 9/3/24 at 2:03 p.m., will be implemented to monitor | |
| 2. During an interview on 9/3/24 at 2:03 p.m., Resident 158 indicated she had not had her hair will be implemented to monitor facility performance to ensure | |
| washed since she had been at the facility. | |
| permanent? | |
| The record for Resident 158 was reviewed on | |
| 9/5/24 at 1:55 p.m. The resident was admitted to Director of Nursing or Designee | |
| the facility on 8/12/24. Diagnoses included but will complete observation on 10 | |
| were not limited to, type 2 diabetes, obesity, heart residents twice a week x 2weeks | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | A. BUILD | | nstruction <u>00</u> | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 09/10/2024 | | | |
|--|--|---|---------|-------------------------|---|-------------------------|----------------------|--|
| | | 100/64 | B. WING | | | 09/10/ | 2024 | |
| | PROVIDER OR SUPPLIER | | 10 | 01 W 8 | ddress, city, state, zip cod 37TH AVE LVILLE, IN 46410 | | | |
| (X4) ID PREFIX TAG | failure, chronic kidr pacemaker, osteoard pressure. The 8/18/24 Admiss assessment indicate intact for daily decistaff for bathing. The Care Plan, date resident required as daily living includin. The Shower Book is receive a bath on W resident did not receive a bath o | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ney disease, anemia, cardiac thritis, and high blood sion Minimum Data Set (MDS) d the resident was cognitively sion making was dependent on d 8/13/24, indicated the sistance with activities of ng bathing. Indicated the resident was to rednesdays and Saturday. The eive a complete bed bath on or on 9/5/24 at 2:30 p.m., the of Nursing indicated she was ent had not had her hair sion and should have ded bed bath at least 2 times a | | D EFIX AG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) then 5 residents a week for 6 months. The results of these audits will reviewed in Quality Assurance Meeting monthly for 6 months until an average of 90% compliance or greater is achie x3 consecutive months. The C Committee will identify any tre or patterns and make recommendations to revise the plan of correction as indicated By what date will the system changes be completed? Date of Completion: 10/01/20 | I be e or eved QA nds e | (X5) COMPLETION DATE | |
| F 0684 SS=D Bldg. 00 | interview, the facili bandages were char physician for 1 of 2 conditions non-pres Finding includes: | on, record review, and ty failed to ensure surgical aged as ordered by the resident reviewed for skin sure. (Resident 41) | F 0684 | | Spring Mill Nursing and Rehabilitation Annual Survey: 09/10/2024 Please accept the following the facility's credible allegati of compliance. This plan of correction does not constitu an admission of quilt or liabi | on te | 10/01/2024 | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | (X3) DATE SURVEY | |
|--|---|---|--|---------------|---|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED B. WING 09/10/2024 | | | COMPLETED |
| | | 155764 | B. W | ING | | 09/10/2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | 87TH AVE | |
| SPRING | MILL HEALTH CAN | MPUS | | | LLVILLE, IN 46410 | |
| | Г | | 1 | ID | · · · · · · · · · · · · · · · · · · · | (V5) |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| TAG | ` | CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| IAG | | g a hospital gown. At that time, | | IAG | by the facility and is submitt | |
| | 1 | was observed to his abdomen | | | only in response to the | eu |
| | with a date of 8/30/2 | | | | regulatory requirement. The | |
| | With a date of 0/30/ | 2 | | | facility requests paper | |
| | At 11:35 a.m., the A | Assistant Director of Nursing | | | compliance. | |
| | | to come to the room and | | | | |
| | 1 ' | the bandage. During an | | | | |
| | | ne, the ADON indicated the | | | | |
| | | sed to be changed three times | | | F684 Quality of Care | |
| | | Wednesday, and Friday. | | | _ | |
| | | | | | What corrective action(s) wi | ili e |
| | On 9/6/24 at 12:49 | p.m., the Wound Nurse was | | | be accomplished for those | |
| | observed changing the bandage to the surgical | | | | residents found to have been | n |
| | wound. The wound was pink and was healing. | | | | affected by the deficient | |
| | | | | | practice; | |
| | _ | at that time, the Wound | | | | |
| | | bandage should have been | | | | |
| | _ | and she was off that day. | | | Resident 41 surgical bandage | was |
| | _ | to change the bandages when | | | changed as ordered. | |
| | she was not in the fa | acility. | | | How the facility will identify | |
| | Th | 1 1 0/5/24 | | | other residents having the | |
| | | dent 41 was reviewed on 9/5/24 sident was admitted to the | | | potential to be affected by the | ie |
| | _ | Diagnoses included but were | | | same deficient practice and | |
| | 1 | surgical procedure to the | | | what corrective action will be | • |
| | _ | steoarthritis of both knees and | | | taken; | |
| | | ion, kidney disease, | | | All facility residents have the | |
| | | , and type 2 diabetes. | | | potential to be affected by the | |
| | | , Jr = | | | same alleged deficient practic | |
| | The 7/24/24 Admis | sion Minimum Data Set (MDS) | | | | |
| | | d the resident was cognitively | | | | |
| | | sion making and was | | | | |
| | 1 | all activities of daily living | | | What measures will be put | |
| | (ADLs) including e | ating, toileting, repositioning, | | | into place or what systemic | |
| | | al hygiene. The resident had | | | changes will be made to | |
| | | pairment to both upper and | | | ensure that the deficient | |
| | | He had 1 surgical wound upon | | | practice does not recur; | |
| | admission. | | | | | |
| | | | | | | |
| | The Care Plan, revi | sed on 9/5/24, indicated the | | | Licensed nursing staff have be | een |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 09/10/2024 | |
|---|---|---|--------------------------|---|-------------------------------|
| | PROVIDER OR SUPPLIEF | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410 | |
| (X4) ID PREFIX TAG | resident had a mid a Physician's Orders, cleanse the surgical with normal saline Cut wound sized pi moisten with norma and cover with dry Wednesday, and Fr The Treatment Adn indicated the treatm completed on 9/2/2 The surgical wound Wound Nurse Pract was 9 centimeters (The wound had dec improving. During an interview Director of Nursing | ninistration Record for 9/2024 ment was signed out as being 4. I was last measured by the citioner on 9/4/24. The wound cm) by 0.8 cm and was pink. reased in size and was Y on 9/6/24 at 2:15 p.m., the cindicated the bandage to the uld have been changed as | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) re-educated to ensure bandage are changed and treatments a completed as ordered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be printo place; DON/designee will review 5 residents with non pressure skinjuries weekly x 6 months to ensure bandages are changed treatments are completed as ordered. Don/designee will present a summary of the audits to the Committee monthly for 6 month. Thereafter, if determined by the QA committee, auditing and monitoring will be done quartee and present quarterly at the QA meeting. Monitoring will be ongoing. Date by which systemic corrections will be completed:10/01/2024 | es re he out And OA ns. e |
| F 0686 SS=D Bldg. 00 | Ulcer Based on observation | o Prevent/Heal Pressure on, record review, and ty failed to ensure a resident | F 0686 | Spring Mill Nursing and | 10/01/2024 |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 09/10/2024 | |
|--|---|---|--------------------------|--|-------|
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP COD 87TH AVE | |
| SPRING | MILL HEALTH CAN | //PUS | | ILLVILLE, IN 46410 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | |
| TAG | | LISC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | - | er had interventions in place | | Annual Survey: 09/10/2024 | |
| | | ng their heels when in bed for 1 wed for pressure ulcers. | | Diagon accept the following of | a tha |
| | (Resident 31) | wed for pressure dicers. | | Please accept the following a facility's credible allegation of | |
| | (Resident 31) | | | compliance. This plan of | |
| | Finding includes: | | | correction does not constitute | e an |
| | 6 | | | admission of guilt or liability b | |
| | On 9/4/24 at 10:10 | a.m. and 3:07 p.m., Resident 31 | | facility and is submitted only | - |
| | was observed awak | e lying in bed. The resident's | | response to the regulatory | |
| | heels were not float | ed off the bed. | | requirement. The facility requ | iests |
| | | | | paper compliance. | |
| | | a.m., the resident was | | | |
| | observed in bed. CNA 1 lifted the resident's blanket by his feet and the resident did not have his heels floated off the bed. | | | | |
| | | | | | |
| | | | | F686 Treatment/Pressure Uld | cer |
| | The record for Resi | dent 31 was reviewed on | | What corrective action(s) will | he |
| | | . The diagnoses included, but | | accomplished for those residence | |
| | _ | diabetes, hemiplegia (paralysis | | found to have been affected I | |
| | | halopathy (swelling in the | | deficient practice; | -, |
| | brain), dementia, an | nd hypertension (high blood | | ' ' | |
| | pressure). | | | | |
| | | | | Resident 31 heels were floate | ed |
| | | mum Data Set (MDS) | | while in bed. | |
| | · | /1/24, indicated the resident | | | |
| | | red for daily decision making. | | | . |
| | | pairment on both sides of his | | How the facility will identify of | |
| | | nd used a wheelchair. The | | residents having the potentia | |
| | resident had a stage | 2 pressure ulcer. | | be affected by the same defice practice and what corrective a | |
| | A Care Plan dated | 4/18/24, indicated the resident | | will be taken; What measures | |
| | had impaired skin in | | | be put into place or what syst | |
| | Impaired Skill II | | | changes will be made to ensu | |
| | A Physician's Order | r, dated 1/27/24, indicated to | | that the deficient practice doe | |
| | - | heels when in bed every shift. | | recur; | |
| | A Dlaveicient O. 1 | . dated 1/07/04 !1: 1: | | | |
| | - | r, dated 1/27/24, indicated to Peru-Castor Oil External | | Licensed nursing staff have | noon |
| | | Peru-Castor Oil External Peru-Castor Oil) to right and left | | Licensed nursing staff have be re-educated to ensure heels | |
| | , | time a day for supplement. | | floated when residents are in | |
| 1 | neers topically offe | anne a day for supplement. | 1 | I modred when residents are ill | bou. |

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PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | A. BUILDING B. WING | 00 | COMPLETED 09/10/2024 | | |
|--|---|--|--|--|----------------------------------|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | DATE | |
| | EMR (electronic me resident had a deep left heel that was res During an interview Director of Nursing | on 9/6/24 at 1:58 p.m., the (DON) indicated Resident 31 heels floated. No additional | | Nursing staff were also remind to ensure that all pressure ulce prevention devices are in place. How the corrective action(s) we monitored to ensure the deficite practice will not recur, i.e., who quality assurance programs we put into place; | er e. vill be ent at | |
| | 3.1-40(a)(2) | | | DON/designee will review 5 residents with pressure ulcer bi-weekly for 1 month, then we up to 6 months, to ensure pressure ulcer interventions ar implemented as ordered and plan of care. DON/designee will present a summary of the audits to the Committee monthly for 6 month Thereafter, if determined by th QA committee, auditing and monitoring will be done quarte and present quarterly at the Qameeting. Monitoring will be ongoing. Date by which systemic corrections will be completed: 10/01/2024 | re per QA hs. ne | |
| F 0693 SS=D Bldg. 00 | Based on observation interview, the facility | on, record review, and by failed to ensure a peg tube (a le stomach for nutrition) was | F 0693 | Spring Mill Health Campus Annual Survey: 9/10/24 | 10/01/2024 | |

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Event ID:

C9AE11

Facility ID: 010739

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | |
|---|---|----------------------------------|----------------------------|---------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155764 | B. WI | NG | | 09/10/ | 2024 |
| | | | <u> </u> | OTD FET | ADDRESS SITE OF | | |
| NAME OF F | PROVIDER OR SUPPLIER | t . | | | ADDRESS, CITY, STATE, ZIP COD | | |
| ODDINO | NAUL LIEALTILOAN | 451.10 | | | 87TH AVE | | |
| SPRING | MILL HEALTH CAN | MPUS | | MERRII | LLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | cleaned on a daily b | pasis and according to facility | | | Please accept the following as | s the | |
| | policy for 1 of 2 residents reviewed for peg tubes. | | | | facility's credible allegation of | | |
| | (Resident 41) | | | | compliance. This plan of | | |
| | | | | | correction does not constitute | an | |
| | Finding includes: | | | | admission of guilt or liability by | / the | |
| | | | | | facility and is submitted only ir | า | |
| | | a.m., Resident 41 was observed | | | response to the regulatory | | |
| | lying in bed wearin | g a hospital gown. At that time, | | | requirement. | | |
| | there was a tube ob | served near a bandage on his | | | The Facility Respectfully requ | ests | |
| | abdomen. The area | under the flange had dried | | | paper compliance for this surv | ey. | |
| | crusty blood noted. | | | | | | |
| | | | | | F693 Tube Feeding | | |
| | During an interview at that time, the resident | | | | Mgmt./Restore Eating Skills | | |
| | indicated the wound | d nurse cleaned around the | | | What corrective action(s) wil | I | |
| | tube when she chan | ged his bandages. | | | be accomplished for those | | |
| | | | | | residents found to have beer | า | |
| | | p.m., the Wound Nurse was | | | affected by the deficient | | |
| | observed changing | the resident's surgical | | | practice. | | |
| | bandage on his abd | omen. | | | Resident 41 peg tube was clea | aned | |
| | | | | | according to the facility policy. | | |
| | _ | at that time, the Wound | | | How the facility will identify | | |
| | | peg tube was solely placed | | | other residents having the | | |
| | • | and was not used for feeding | | | potential to be affected by th | е | |
| | or flushes. | | | | same deficient practice and | | |
| | | | | | what corrective action will be | 9 | |
| | | dent 41 was reviewed on 9/5/24 | | | taken. | | |
| | | sident was admitted to the | | | All facility residents have the | | |
| | | Diagnoses included, but were | | | potential to be affected by the | | |
| | 1 | surgical procedure to the | | | same alleged deficient practic | | |
| | | steoarthritis of both knees and | | | What measures will be put in | ito | |
| | | tion, kidney disease, | | | place or what systemic | | |
| | rheumatoid arthritis | s, and type 2 diabetes. | | | changes will be made to | | |
| | | | | | ensure that the deficient | | |
| | | sion Minimum Data Set (MDS) | | | practice does not reoccur. | | |
| | | d the resident was cognitively | | | The Wound Nurse was educa | | |
| | 1 | sion making and was | | | to make sure all residents hav | | |
| | | all activities of daily living | | | order to monitor and clean the | | |
| | | ating, toileting, repositioning, | | | tube site in accordance to faci | lity | |
| | | al hygiene. The resident had | | | policy. MDS Coordinator was | | |
| | range of motion imp | pairment to both upper and | | | educated to ensure that care | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTI | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-------------------------|---|----------------------------|--|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILD | ING | 00 | COMPLETED | |
| | | 155764 | B. WING | | | 09/10/2024 | |
| | | | ST | REET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | B7TH AVE | | |
| SPRING | MILL HEALTH CAN | MPUS | | | LVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | II |) | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PRE | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TA | AG | DEFICIENCY) | | DATE |
| | | He had 1 surgical wound upon | | | plans are in place for residents | S | |
| | admission. | | | | with enteral tube. | | |
| | and and | 1 6 4 64 | | | Licensed Nurses were educate | | |
| | _ | plan for the care of the peg | | | on ensuring that PEG tube site | es | |
| | tube. | | | | were cleaned as ordered. | | |
| | TEI 1 | | | | How the corrective action(s) | | |
| | | sician's orders for the care of or | | | will be monitored to ensure t | ne | |
| | to monitor the peg t | tube. | | | deficient practice will not | | |
| | Duning : . | or on 0/6/24 at 1:00 4 | | | recur, i.e., what quality | 4 | |
| | | on 9/6/24 at 1:00 p.m., the ated she cleaned around the | | | assurance programs will be | put | |
| | | | | | into place. | | |
| | | site when she changed his | | | DON/designee will audit 3 | | |
| | _ | ays she worked, which was | | | residents with enteral tubes | LL | |
| | | riday, she saw the resident just | | | bi-weekly x 1 month, then wee | - | |
| | | ndage was clean and in place. | | | up to 6 months to ensure PEG | , | |
| | _ | she did look at the peg tube, | | | sites are cleaned as ordered. | | |
| | | as no drainage and it looked | | | The Director of Nursing/design | nee | |
| | | t clean around it. When she | | | will present a summary of the | _ | |
| | | e peg tube, there was no place d to document she had | | | audits to the Quality Assurance | | |
| | | | | | committee monthly for 6 mont | | |
| | completed the care. | | | | Thereafter, if determined by the | | |
| | During on intervious | y on 0/6/24 at 1:04 n m I DN 1 | | | Quality Assurance committee, | | |
| | _ | w on 9/6/24 at 1:04 p.m., LPN 1 ware the resident had a peg | | | auditing and monitoring will be | 7 | |
| | | had never cleaned around the | | | done quarterly and present quarterly at the QA meeting. | | |
| | | she had always thought the | | | Monitoring will be on going. | | |
| | wound nurse compl | | | | Date by which systemic | | |
| | would harse compi | the tipe. | | | corrections will be complete | d٠ | |
| | During an interview | v on 9/6/24 at 1:06 p.m., the | | | 10/01/2024 | u. | |
| | _ | of Nursing indicated there were | | | 10/0 1/2027 | | |
| | | or, assess or clean the peg tube | | | | | |
| | site on a daily basis | | | | | | |
| | and an addity outling | • | | | | | |
| | During an interview | on 9/6/24 at 2:15 p.m., the | | | | | |
| | | (DON) indicated the peg tube | | | | | |
| | was to be cleaned a | | | | | | |
| | TTI | NO 1 1 1 | | | | | |
| | | "Gastrostomy/Jejunostomy | | | | | |
| | | provided by the DON on 9/9/24 | | | | | |
| | L at 10:30 a.m., indic: | ated it was the policy of the | | | | | I |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BU | (X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPI B. WING 09/10 | | | ETED | |
|---|--|--|---|--|---|-----------|------------|
| | | 155764 | B. WI | NG | | 09/10/ | 2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| F 0694 SS=D Bldg. 00 | site care to decrease procedure was to ob include the followin and number, type of frequency of treatments and 1.44(a)(2) 483.25(h) Parenteral/IV Fluid | ds | | | | | |
| | interview, the facilit PICC (peripherally) had Physician's Ord monitoring of a PIC reviewed for PICC I Finding includes: During an observati Resident 31's PICC 8/29/24 and was performed and the period of the facility of the period of the facility of the period of the facility of the pressure). The record for Resident 9:35 p.m. The dial limited to, diabetes, side), encephalopath dementia, and hyperpressure). The Quarterly Minitals of the property of the pressure of the facility of the pressure of the pr | C line for 1 of 1 residents lines. (Resident 31) on on 9/3/24 at 11:21 a.m., line bandage was dated bling off on the top of the on on 9/4/24 at 10:11 a.m., the was dated 8/29/24 and was up of the dressing. dent 31 was reviewed on 9/4/24 gnoses included, but were not hemiplegia (paralysis on one my (swelling in the brain), | F 06 | 594 | Spring Mill Health Campus Annual Survey: 9/10/24 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. F694 Parenteral/IV Fluids What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The Facility received an order monitor and clean resident 31 PICC line. How the facility will identify other residents having the potential to be affected by th same deficient practice and what corrective action will be | an the | 10/01/2024 |

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Event ID:

C9AE11 Facility ID: 010739

If continuation sheet Page 18 of 38

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 09/10/2024 | |
|--|--|--|--------------------------|---|--|
| | PROVIDER OR SUPPLIER | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | |
| | (EACH DEFICIEN REGULATORY OR The resident had im lower extremities at There was no Care Intravenous therapy There were no activintravenous therapy During an interview DON indicated there | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION pairment on both sides of his nd used a wheelchair. Plan for a PICC line or re orders for PICC line care or | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | al to ged nto vice CC ensed o PICC ne cated ace) the put |
| | | | | performed per order. The Director of Nursing/desig will present a summary of the audits to the Quality Assuran- committee monthly for 6 mon | ce |
| | | | | Thereafter, if determined by t Quality Assurance committee auditing and monitoring will b done quarterly and present quarterly at the QA meeting. Monitoring will be on going. |) , |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | A. BUI | A. BUILDING <u>00</u> C | | | 3) DATE SURVEY COMPLETED 09/10/2024 | |
|--|---|--|-------------------------|--|---|-------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIE | | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | Р | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | | | | | Date by which systemic corrections will be complete 10/01/2024 | d: | |
| F 0758 SS=D Bldg. 00 | 483.45(c)(3)(e)(1 Free from Unnec Use |)-(5) Psychotropic Meds/PRN | | | | | |
| | Based on record re to ensure a PRN (a medication was no for 1 of 5 residents medications. (Residents) | sident 25 was reviewed on 9/5/24 noses included, but were not g cancer, type 2 diabetes, stroke, t disease, depressive disorder, a blood pressure, paranoid | F 07: | 58 | Spring Mill Nursing and Rehabilitation Annual Survey: 09/10/2024 Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitu an admission of guilt or liab by the facility and is submitt only in response to the regulatory requirement. The facility requests paper compliance. | ion ite ility ied | 10/01/2024 |
| | Set (MDS) assessing the resident was condecision making an antipsychotic, an an anticoagulant, and Physician's Orders: Alprazolam (Xanamilligrams (mg), ghours as needed for the Medication Active month of 8/202 administered five to | of the Quarterly Minimum Data ment, dated 7/16/24, indicated orginitively intact for daily and received insulin, an anxiolytic, an antidepressant, an hypoglycemic medications. 1. dated 7/17/24, indicated x, an anti-anxiety medication) 0.5 give 1 tablet by mouth every 8 ar anxiety. 2. dministration Record (MAR) for 2.4 indicated the Alprazolam was times and on the 9/2024 MAR, is administered two times. | | | F 758 – Unnec Psychotropic Meds/PRN Use What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice; PRN psychotropic medication was discontinued for Residen | ill n | |
| | During an interview | w on 9/6/24 at 2:42 p.m., the | | | How the facility will identify other residents having the | | |

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764 | (X2) MULTIPLE C A. BUILDING B. WING | construction 00 | (X3) DATE SURVEY COMPLETED 09/10/2024 |
|--------------------------|---|---|-------------------------------------|---|---|
| | ROVIDER OR SUPPLIER | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE ULLVILLE, IN 46410 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | DATE |
| | scheduled dose of X July and was then o | of Nursing indicated the Canax was discontinued in Indered as prn. The resident Ication and the daughter would the had received it. | | potential to be affected by the same deficient practice and what corrective action will be taken; | |
| | provided by the Dir 10:30 a.m., indicate | l Dosage Reduction" policy, ector of Nursing on 9/9/24 at d" PRN hypnotic, lepressant medications shall | | All residents with orders for P psychotropic medications have potential to be affected by the same alleged deficient practice. | ve the |
| | | oner indicates the clinical ed use and extended | | What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; | |
| | | | | License Nurses were in service ensuring PRN psychotropic medications have an order er date of 14 days, and can only renewed until the physician evaluates the need for the medication. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; | nd be the |
| | | | | DON/designee will review 5 residents with PRN psychotrobi-weekly for 1 month, then wup to 6 months, to ensure PR order has a 14 day stop date. DON/designee will present a | reekly N |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 09/10/2024 | |
|--|---|--|--------------------------|---|------------------------|
| | ROVIDER OR SUPPLIER | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| | | | | summary of the audits to the Committee monthly for 6 mont Thereafter, if determined by the QA committee, auditing and monitoring will be done quarter and present quarterly at the Questing. Monitoring will be ongoing. Date by which systemic corrections will be complete 10/01/2024 | hs. ne erly A |
| F 0761 SS=D Bldg. 00 | interview, the facility creams and loose pit and 1 of 2 medication medication storage. 2 medication cart) Findings include: 1. During random of a.m. and 3:04 p.m., in bed. The resident both his upper and I unable to use them. of Diclofenac cream swelling in joints are table. During an interview resident indicated his | bservations on 9/3/24 at 11:26 Resident 41 was observed lying was severely contracted for ower extremities and was At that time, there was a tube in (a cream used to reduce ad muscles) on the over bed | F 0761 | Spring Mill Nursing and Rehabilitation Annual Survey: 09/10/24 Please accept the following the facility's credible allegat of compliance. This plan of correction does not constitute an admission of guilt or liability the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance. F 761 Label/Store Drugs and Biologicals What corrective action(s) with the accomplished for those residents found to have been complianted. | te lity ed |
| | severe rheumatoid a | | | residents found to have been affected by the deficient | n |

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Event ID:

C9AE11 Facility ID: 010739

If continuation sheet Page 22 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | | SURVEY | | |
|--|---|--|--------------------|------------------------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | COMPLETED | |
| | | 155764 | B. WING 09/10/2024 | | | /2024 | |
| | | | | CTREET | ADDRESS SITY STATE ZID SOD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| ODDINO | NAUL LIEALTILOAN | ADUIO. | | | 87TH AVE | | |
| SPRING | MILL HEALTH CAN | MPUS | | MERKI | LLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORREC | | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | During random observations on 9/4/24 at 11:18 | | | | practice; | | |
| | a.m. and 2:50 p.m., | and on 9/5/24 at 8:09 a.m., 10:20 | | | | | |
| | a.m., and 11:45 a.m., the medicated cream was | | | | | | |
| | observed inside the | night stand drawer. | | | Health Care 2 medication cart | was | |
| | | | | | cleaned, and loose pills were | | |
| | The record for Resi | dent 41 was reviewed on 9/5/24 | | | removed and discarded | | |
| | at 2:50 p.m. The res | sident was admitted to the | | | accordingly. | | |
| | facility on 7/18/24. | Diagnoses included, but were | | | Resident 41 medicated cream | was | |
| | not limited to, post | surgical procedure to the | | | removed and stored properly. | | |
| | digestive system, os | steoarthritis of both knees and | | | | | |
| | hips, disc degenerat | tion, kidney disease, | | | | | |
| | rheumatoid arthritis | s, and type 2 diabetes. | | | How the facility will identify | | |
| | | | | | other residents having the | | |
| | The 7/24/24 Admis | sion Minimum Data Set (MDS) | | | potential to be affected by th | ie | |
| | assessment indicate | ed the resident was cognitively | | | same deficient practice and | | |
| | intact for daily deci | sion making and was | | | what corrective action will be | е | |
| | dependent on staff a | all activities of daily living | | | taken; | | |
| | | ating, toileting, repositioning, | | | | | |
| | | al hygiene. The resident had | | | | | |
| | | pairment to both upper and | | | All residents residing in the fa | cility | |
| | | He had 1 surgical wound upon | | | have the potential to be affect | ed | |
| | admission. | | | | by this alleged deficient practi | ce. | |
| | | | | | An audit of all medication cart | S | |
| | • | olan for the medicated cream to | | | was completed to ensure | | |
| | be kept at the bedsic | de. | | | medications were properly sto | | |
| | | | | | What measures will be put ir | ito | |
| | - | dated 7/19/24, indicated | | | place or what systemic | | |
| | | External Gel 1 % (medicated | | | changes will be made to | | |
| | /· * * * | th lower legs topically every 6 | | | ensure that the deficient | | |
| | hours as needed for | pain. | | | practice does not recur; | | |
| | | | | | | | |
| | | sician's order to keep the | | | l | | |
| | medication at the be | edside. | | | License staff was re-educated | | |
| | | 0/6/04 + 1.06 | | | the importance proper storage | ot | |
| | - | on 9/6/24 at 1:06 p.m., the | | | medications and cleaning the | | |
| | | of Nursing indicated the family | | | medication carts. | | |
| | _ | ms for him and did not tell the | | | All staff in-serviced on proper | | |
| | nursing staff. | | | | storage of medication I.E | | |
| | <u> </u> | 0/6/04 2-1-7 | | | medications being left at the | | |
| | During an interview | on 9/6/24 at 2:15 p.m., the | | | resident's bedside without pro | per | |

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|---------------------------|---|----------------------------------|--------|---------------------------------------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155764 | B. W | ING _ | | 09/10/ | /2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| SPRING | MILL HEALTH CAN | MPUS | | 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | |
| | T | | | | | | ı |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | • | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | _ | g (DON) indicated the resident | | | assessment and an order for | | |
| | | -administer the medicated | | | self-administration. | | |
| | | ntractures. The family brought | | | How the corrective action(s) | | |
| | | ne nursing staff were unaware. | | | will be monitored to ensure | the | |
| | | to keep the medicated cream | | | deficient practice will not | | |
| | at the bedside. | | | | recur, i.e., what quality | | |
| | | | | | assurance programs will be | put | |
| | | "Medication Storage" policy, | | | into place; | | |
| | provided by the DON on 9/9/24 at 10:30 a.m., | | | | | | |
| | | y should ensure that all | | | | | |
| | | ologicials, including treatment | | | DON/Designee will audit 2 | | |
| | | y stored in a locked | | | medication carts weekly for 6 | | |
| | cabinet/cart or locked medication room that was | | | | months, to ensure absence of | | |
| | - | dents and visitors.2. On 9/5/24 | | | loose pills in the medication c | | |
| | | was observed at the HC 2 | | | Members of the interdisciplina | - | |
| | _ | paring to pass medications. | | | team will audit 3 residents' ro | | |
| | | ved to have 10 loose pills, | | | weekly for 6 months, to obser | | |
| | | pe, and color. The pills were | | | the presence of medications a | at | |
| | | m 3 drawers of the medication | | | bedside. | | |
| | | ed the pills from the cart and | | | The results of these audits wi | | |
| | disposed of them in | the drug buster container. | | | reviewed in Quality Assurance | | |
| | | | | | Meeting monthly for 6 months | or | |
| | _ | v at that time, LPN 2 indicated | | | until an average of 90% | | |
| | _ | should not be loose in her cart | | | compliance or greater is achie | | |
| | and she cleaned her | cart daily. | | | x3 consecutive months. The | | |
| | | | | | Committee will identify any tre | ends | |
| | | olicy, titled " Medication | | | or patterns and make | | |
| | _ | " Facility should ensure that | | | recommendations to revise th | | |
| | | ologicals are stored in an | | | plan of correction as indicated | i. | |
| | | eabinets, drawers, carts, | | | Date by which systemic | | |
| | _ | rs of sufficient size to prevent | | | corrections will be complete | d: | |
| | crowding" | | | | 10/01/2024 | | |
| | 21.25() | | | | | | |
| | 3.1-25(m) | | | | | | |
| E 0024 | 492.00(:) | | | | | | |
| F 0921 SS=D | 483.90(i) | anitary/Comfortable Environ | | | | | |
| | Sale/Functional/S | anitary/Comfortable Environ | | | | | |
| Bldg. 00 | Rosed on absorvati | on, record review, and | E | 221 | Spring Mill Health Commission | | 10/01/2024 |
| | | ty failed to ensure the | F 09 | 921 | Spring Mill Health Campus | | 10/01/2024 |
| | I mierview, the facili | ty ranicu to chisure the | 1 | | Annual Survey: 9/10/24 | | I |

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | ISTRUCTION 00 | (X3) DATE SURVEY COMPLETED 09/10/2024 | |
|--------------------------|---|---------------------|--|--|--|
| | PROVIDER OR SUPPLIER MILL HEALTH CAMPUS | 101 W 87 | DDRESS, CITY, STATE, ZIP COD 7TH AVE LVILLE, IN 46410 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| IAU | resident's environment was clean and sanitary related to an uncontained bed pan for 1 of 3 units. (Health Care Center 2) Finding includes: During random observations on 9/5/24 at 8:09 a.m.,10:20 a.m., and 11:45 a.m., an uncontained bed pan was observed lying on a cloth chair in room 2206. During an interview on 9/5/24 at 8:09 a.m., the resident who resided in the room indicated he had diarrhea 8 times yesterday and during the nigh,t and had used the bed pan. During an interview on 9/6/24 at 2:30 p.m., the Director of Nursing (DON) indicated the bed pan was to be contained and put away after each use. The current 3/21/21 "Space and Equipment" policy, provided by the DON on 9/10/24 at 2:58 p.m., indicated the facility will provide areas of space for storing devices and supplies used for continence. 3.1-19(f) | | Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. F921 Safe/Functional/Sanitary/Comble Environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The uncontained bed pan was removed and stored properly. How the facility will 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 be affected by the same allegedeficient practice. | forta I I I I I I I I I I I I I | |
| | | | | | |

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Event ID:

C9AE11 Facility ID: 010739

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PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---------------------|-------------------------------|--------------------------------|--------|---|-------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | COMPL | COMPLETED | |
| | | 155764 | B. WI | NG | | 09/10/2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | 87TH AVE | | |
| SPRING | MILL HEALTH CA | MPUS | | | LLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID PROVIDER'S PLAN OF CORRECT. | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIE) | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE. | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; All Staff were re-educated on procedure of properly storing pans. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; All members of the Interdisciplinary Team will aud the facility 5 x per week, for 6 months, on alternating units, identified issues will be corrected. Members of the interdisciplinateam will audit 3 residents' row weekly for 6 months, to ensure | the bed the put dit Any | |
| | | | | | that continence supplies are stored and contained properly | | |
| | | | | | Admin/designee will present summary of the audits to the Quality Assurance committe monthly for 6 months. |) | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C9AE11

Facility ID: 010739

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PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 09/10/2024 | | | |
|--------------------------|---|--|--|--|---------------------------------------|--|--|--|
| | ROVIDER OR SUPPLIER MILL HEALTH CAN | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | | | |
| | | | | Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quart the QA meeting. Monitor will be on going. | erly | | | |
| | | | | Date by which systemic corrections will be complete 10/01/2024 | ed: | | | |
| R 0000 | | | | | | | | |
| Bldg. 00 | Survey. This visit is State Licensure Sur Nursing Home Com IN00442676. | State Residential Licensure ncluded a Recertification and vey and the Investigation of aplaints IN00436754 and | R 0000 | | | | | |
| | Complaint IN00442 the allegations are c | 2676 - No deficiencies related to cited. | | | | | | |
| | Survey dates: Septe | mber 3, 4, 5, 6, 9 and 10, 2024 | | | | | | |
| | Facility number: 01 | 0739 | | | | | | |
| | Residential Census: | 15 | | | | | | |
| | These State Resider accordance with 410 | ntial Findings are cited in 0 IAC 16.2-5. | | | | | | |
| | Quality review com | pleted on 9/16/24. | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|----------------------------------|-------|------------------------|--|-----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED |
| | | 155764 | B. W | ING _ | | 09/10/2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> |
| NAME OF F | PROVIDER OR SUPPLIER | t | | | 87TH AVE | |
| SPRING | MILL HEALTH CAN | MPUS | | MERRILLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE |
| R 0036 | 410 IAC 16.2-5-1. | 2(k)(1-2) | | | | |
| | Residents' Rights- Deficiency | | | | | |
| Bldg. 00 | | | | | | |
| | | view and interview, the facility | R 0 | 036 | Spring Mill Health | 10/01/2024 |
| | | notify the resident's physician | | | Campus | |
| | | mificant changes in status | | | Annual Survey: 9/10/24 | |
| | _ | d sugar levels and a fall for 2 | | | | |
| | of 7 residents review | wed. (Residents 2 and 6) | | | | |
| | Findings include: | | | | R 036- Notification of Chang | e |
| | | | | | | |
| | 1. The record for Resident 2 was reviewed on | | | | | |
| | 1 | Diagnoses included, but were | | | What corrective action(s) wi | II |
| | not limited to, diabetes and high blood pressure. | | | | be accomplished for those | |
| | | | | | residents found to have bee | n |
| | 1 | dated 5/31/24, indicated blood | | | affected by the deficient | |
| | | three times a day at 8:00 a.m., | | | practice? | |
| | _ | p.m. Notify the Physician if the | | | | |
| | blood glucose level | was below 70 or above 250. | | | The Physician and family of | |
| | | | | | resident 2 were notified. Resident | dent |
| | | ministration Record (MAR), | | | 6 is no longer in the facility. | |
| | | ated the resident's blood | | | l | |
| | sugars were as follo | | | | How will the facility identify | |
| | - 7/5/24 at 1 p.m.: 2 | | | | other residents who have the | |
| | - 7/6/24 at 1 p.m.: 2 - 7/27/24 1 p.m.: 26 | | | | potential to be affected by the | ne |
| | - //2//24 1 p.m.: 20 | 02 | | | same alleged deficient | |
| | The 8/2024 MAD :. | ndicated the resident's blood | | | practice? | |
| | sugars were as follo | | | | The deficient practice has the | |
| | - 8/10/24 at 1:00 p.i | | | | potential to affect all facility | |
| | - 8/12/24 at 6:00 p.i | | | | residents. | |
| | - 8/20/24 at 1:00 p.i | | | | Todiucitis. | |
| | - 0/20/24 at 1:00 p.i | II 232 | | | What corrective measures w | ,ill |
| | There was no docur | nentation in nursing progress | | | the facility take or will alter t | |
| | | was notified of the blood | | | ensure that the problem will | |
| | sugars above 250. | nounce of the oroote | | | not reoccur? | |
| | | | | | | |
| | During an interview | on 9/10/24 at 1:45 p.m., the AL | | | Licensed nursing staff are | |
| | | here was no documentation | | | educated on ensuring that far | _{nilv} |
| | | otified of the high blood | | | and MD are notified any time | - I |

State Form Event ID: C9AE11 Facility ID: 010739 If continuation sheet Page 28 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---|--|------|---|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPL | |
| | | 155764 | B. W | ING | | 09/10/ | 2024 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DROWIDERIC DLANLOF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG CROSS-REFERENCED TO THE APPROP | | | DATE |
| | U | 6's record was reviewed on | | | resident has a fall or change i | n | |
| | | . Diagnoses included, but were | | | status. | | |
| | | insonism, anxiety disorder, | | | | | |
| | bipolar disorder, and breast cancer. The most recent Service Plan, updated on 8/21/24, | | | | What quality assurance plan | | |
| | | | | | will be implemented to moni | | |
| | | | | | facility performance to ensure corrections are achieved and | | |
| | indicated the resident was an elopement risk/wanderer due to cognitive impairment, was on | | | | permanent? | 1 | |
| | hospice care, and w | - | | | permanent: | | |
| | nospice care, and was at risk for fails. | | | | AL Director/Designee will aud | it all | |
| | A Post Fall Observation, dated 8/19/2024 at 5:32 | | | | fall and change in status | | |
| | a.m., indicated the resident had an unwitnessed | | | | documentation 2 x per week for | or 6 | |
| | fall in her room. The resident was unable to | | | | months, to ensure family and | MD | |
| | verbalize what had happened. She had evidence | | | | are notified. | | |
| | - | njury with an abrasion to the | | | | | |
| | | ft eye area. The Physician and | | | A summary will be presented to | | |
| | the resident were no | otified. | | | the Quality Assurance commit | | |
| | Tl | | | | monthly x 6 months. Thereafte | | |
| | | nentation related to the family tative being notified of the | | | determined by the QA commit auditing and monitoring will be | | |
| | fall. | tative being notified of the | | | done quarterly and present | <i>'</i> | |
| | 1411. | | | | quarterly at the QA meeting. | | |
| | During an interview | on 9/10/24 at 11:11 a.m., the | | | Monitoring will be ongoing. | | |
| | Assisted Living Dir | rector indicated the family was | | | | | |
| | notified, as they we | re in the building daily visiting | | | By what date the systemic | | |
| | | er there was an error in the | | changes will be completed: | | | |
| | documentation. | | | | 10/01/2024 | | |
| | | | | | | | |
| R 0217 | 410 100 46 2 5 2/ | o)(1.5) | | | | | |
| 11.0211 | 410 IAC 16.2-5-2(Evaluation - Defic | | | | | | |
| Bldg. 00 | Evaluation - Dello | ichoy | | | | | |
| 3. 00 | Based on record rev | view and interview, the facility | R 0 | 217 | Spring Mill Health Campus | | 10/01/2024 |
| | | dent service plans were | | , | Annual Survey: 9/10/24 | | -0.01.2021 |
| | updated and/or sign | ed by the resident or | | | _ | | |
| | • | 2 of 7 service plans reviewed. | | | | | |
| | (Residents 6 & 3) | | | | R 217 Evaluation | | |
| | F. 1 | | | | | | |
| | Findings include: | | | | | | |
| | | | | | What corrective action(s) will | .I | |

State Form Event ID: C9AE11 Facility ID: 010739 If continuation sheet Page 29 of 38

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|-----------|--|---|--------|------------------------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED |
| | | 155764 | B. W | NG | | 09/10/2024 |
| | | <u> </u> | | CTDEET | ADDRESS, CITY, STATE, ZIP COD | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | 87TH AVE | |
| SDDIVIC | MILL HEALTH CAN | ADLIS | | MERRILLVILLE, IN 46410 | | |
| SPRING | WILL DEALID CAN | VIF US | | IVIERRI | LLVILLE, IIN 404 IU | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE |
| | | rd was reviewed on 9/10/24 at | | | be accomplished for those | |
| | _ | s included, but were not limited | | | residents found to have been | n |
| | to, Parkinsonism, anxiety disorder, bipolar disorder, and breast cancer. | | | | affected by the deficient | |
| | | | | | practice? | |
| | | | | | | |
| | | rvice Plan, updated on 8/21/24, | | | Resident 3 service plan was | |
| | | nt was an elopement | | | signed by his family | |
| | | o cognitive impairment, was at | | | representative. Resident 6 is | no |
| | risk for complications secondary to urinary | | | | longer in the facility. | |
| | incontinence, and w | vas on hospice care. | | | | |
| | | 1.7/00/04 | | | How will facility identify other | er |
| | A Nurses' Note, dated 5/20/24 at 12:20 p.m., | | | | residents who have the | |
| | indicated a Service Plan was mailed to the address | | | | potential to be affected by th | ie e |
| | on file to be signed/emailed at the earliest | | | | same alleged deficient | |
| | | amily member or Power of | | | practice? | |
| | Attorney (POA). | | | | | |
| | A Ni | 17/22/24 -4 9:49 | | | The deficient practice has the | |
| | | red 7/23/24 at 8:48 p.m., nt returned from the hospital | | | potential to affect all facility | |
| | | er draining by gravity | | | residents. | |
| | - | lear urine. A hospice nurse | | | What corrective measures w | .iu |
| | | ime for admission to hospice | | | the facility take or will alter to | |
| | services. | me for admission to nospice | | | ensure that the problem will | |
| | services. | | | | not reoccur? | |
| | The Service Plan w | as not updated to reflect the | | | inct recodults | |
| | | y catheter and there was no | | | Assisted Living Director educa | ated |
| | * | by the resident or the | | | on ensuring service plans are | |
| | resident's representa | | | | reviewed with resident and far | milv. |
| | 1 | | | | After reviewing a signed copy | - I |
| | During an interview | on 9/10/24 at 11:11 a.m., the | | | must be uploaded into their | |
| | - | rector indicated the Service | | | medical record. | |
| | _ | een signed by the responsible | | | | |
| | | o reflect the change of | | | What quality assurance plan | s |
| | | lent's family members visited | | | will be implemented to monit | |
| | the resident daily, s | o they were aware of the | | | facility performance to ensur | |
| | resident's condition. 2. Resident 3's record was | | | | corrections are achieved and | |
| | reviewed on 9/9/24 at 3:37 p.m. Diagnoses | | | | permanent? | |
| | | not limited to, bipolar disorder, | | | | |
| | | sorder, anxiety disorder, | | | DON/Designee will audit 5 | |
| | | tic features, and mood | | | residents service plans twice a | a |

State Form Event ID: C9AE11 Facility ID: 010739 If continuation sheet Page 30 of 38

| | T OF DEFICIENCIES DF CORRECTION | | | (X3) DATE SURVEY COMPLETED 09/10/2024 | | | |
|--------------------------|--|--|--|---------------------------------------|--|----------------------------|----------------------------|
| | ROVIDER OR SUPPLIER MILL HEALTH CAN | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION |] | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| | It was not signed by party. During an interview Director on 9/10/24 service plans and he transfer over from the service plans are transfer over from the servic | ent was completed on 4/23/23. If the resident or responsible If with the Assistant Living at 2:10 p.m., she indicated the ealth statement did not the health care side to the and should have been added. | | | week x 6 months to ensure far and residents are aware of the service plan. A summary will be presented to the Quality Assurance commit monthly x 6 months. Thereafted determined by the QA committiauditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. By what date the systemic changes will be completed: 10/01/2024 | o tee er, if tee, | |
| R 0349 | 410 IAC 16.2-5-8. Clinical Records - | , | | | | | |
| Bldg. 00 | failed to ensure the and accurately docu pressure medication parameters, blanks or records, and the lack (urinary) catheter careviewed. (Resident Findings include: 1. The record for Resident 1. The record for | riew and interview, the facility clinical record was complete mented related to blood as administered outside of on medication administration of documentation for Foley are for 2 of 7 residents as 2 and 6) resident 2 was reviewed on Diagnoses included, but were setes and high blood pressure. dated 5/31/24, indicated ication used to lower the blood arms three times a day. Hold the stolic blood pressure was | R 03 | 349 | Spring Mill Health Campus Annual Survey: 9/10/24 R 349 Clinical Record- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 2 BP medication ordowas reviewed with the Physicia and the order was updated wit parameters. Resident 6 is no longer in the facility. | er an | 10/01/2024 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | (X3) DATE SURVEY | |
|--|---|---|------------------------------|----------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 00 | COMPLETED |
| | | 155764 | B. W | ING | _ | 09/10/2024 |
| NAME OF T | DROLUDED OF CURRY TO | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | 87TH AVE | |
| SPRING | MILL HEALTH CAN | /IPUS | | MERRI | LLVILLE, IN 46410 | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LISC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE |
| | was greater than 150 and was greater than 90 | d the diastolic blood pressure | | | How will facility identify other | er |
| | was greater than 70. | | | | residents who have the | |
| | The 7/2024 Medication Administration Record | | | | potential to be affected by the same alleged deficient | le |
| | (MAR) indicated th | | | | practice? | |
| | administered on 7/23/24 at 1 p.m. and the blood pressure was 154/106. | | | | practice: | |
| | | | | | The deficient practice has the | |
| | F-555415 W45 15 W1 | | | | potential to affect all facility | |
| | The 8/2024 MAR in | ndicated the Hydralazine was | | | residents. | |
| | administered on the | | | | | |
| | | 4 and the blood pressure was | | | What corrective measures w | ill [|
| | 152/75 | • | | | the facility take or will alter t | o l |
| | - 1:00 p.m. on 8/25/24 and the blood pressure was | | | | ensure that the problem will | |
| | 155/66 | | | | not reoccur? | |
| | - 6:00 p.m. on 8/1/2 | 4 and the blood pressure was | | | | |
| | 166/131 | | | | Assisted Living Director educa | ated |
| | - 6:00 p.m., on 8/2/2 | 24 and the blood pressure was | | | on ensuring blood pressure ar | nd |
| | 151/81 | | | | orders with parameters are be | eing |
| | | | | | monitored and medication | |
| | | s not signed out as being | | | administered as ordered. | |
| | | , 8/8 and 8/29/24 at 1:00 p.m., | | | AL Nursing Staff were educate | |
| | and on 8/10 and 8/2 | 4/24 at 6:00 p.m. | | | ensure that all medications are | e |
| | | 0/10/04 + 1.45 | | | administered as ordered and | |
| | _ | on 9/10/24 at 1:45 p.m. the AL | documented completely in the | | | • |
| | | he order for the Hydralazine | | | MAR. | |
| | | wever, physician's orders were | | | UD to analyze that all more in a | toff |
| | after they were adm | cations should be signed out | | | HR to ensure that all nursing s from SNF have access to | Stati |
| | 1 | rd was reviewed on 9/10/24 at | | | residential side, to ensure | |
| | | s included, but were not limited | | | medication administration is | |
| | _ | nxiety disorder, bipolar | | | documented appropriately. | |
| | disorder, and breast | | | | accumented appropriately. | |
| | , ши отошь | | | | What quality assurance plan | s |
| | The most recent Ser | rvice Plan, updated on 8/21/24, | | | will be implemented to moni | |
| | | nt was an elopement | | | facility performance to ensur | I |
| | risk/wanderer due to cognitive impairment, at risk | | | | corrections are achieved and | |
| | for complications secondary to urinary | | | | permanent? | |
| | incontinence. and o | | | | | |
| | | | | | Assisted Living Director/Desig | nee |
| | A Physician's Order | r, dated 7/24/24, indicated the | | | will audit 5 residents' MAR we | I |

State Form Event ID: C9AE11 Facility ID: 010739 If continuation sheet Page 32 of 38

PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764 | | A. BUILDING B. WING | 00 | COMPLETED 09/10/2024 | |
|--|--|---|-------|---|-------------------------------------|
| NAME OF P | ROVIDER OR SUPPLIER | | 101 W | ADDRESS, CITY, STATE, ZIP COD 87TH AVE | |
| SPRING | MILL HEALTH CAN | MPUS | MERRI | LLVILLE, IN 46410 | |
| | SUMMARY S (EACH DEFICIENCE REGULATORY OR resident received me (mg) per 5 milliliter four hours. The August 2024 M Record (MAR) was administration on the 12:00 a.m. on 8/1, 8/11, 8/12, 8/13, 8/1 - 4:00 a.m. on 8/1, 8/11, 8/12, 8/13, 8/1 - 12:00 p.m. on 8/2, A Physician's Order resident received me ml, 0.25 ml by mount The August 2024 M Record (MAR) was administration on 8/4 A Physician's Order morphine sulfate 10 mouth every 6 hours. The August 2024 M Record (MAR) was administration on 8/4 A Physician's Order morphine sulfate 10 mouth every 6 hours. The August 2024 M Record (MAR) was administration on 8/4 A Physician's Order Depakote 125 mg tarendal manual contents. | APUS STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Orphine sulfate 20 milligrams is (ml), 0.25 ml by mouth every dedication Administration blank for the morphine sulfate is following dates and times: 8/2, 8/3, 8/4, 8/5, 8/6, 8/8, 8/9, 4, and 8/15/24 8/3, 8/4, 8/5, 8/6, 8/8, 8/9, 4, and 8/15/24 8/3, and 8/8/24 c, dated 8/16/24, indicated the orphine sulfate 100 mg per 5 th four times a day. dedication Administration blank for the morphine sulfate (19/24 at 9:00 p.m. c, dated 8/20/24, indicated 0 mg per 5 ml, 0.25 ml by s. dedication Administration blank for the morphine sulfate blank for the morphine sulfate 100 mg per 5 ml, 0.25 ml by s. | 101 W | | are ions nted to ttee er, if ttee, |
| | indicated the resider | ed 7/23/24 at 8:48 p.m., nt returned from the hospital or draining by gravity | | | |
| | a i oicy caillett | a araning of gravity | | | |

State Form Event ID: C9AE11 Facility ID: 010739 If continuation sheet Page 33 of 38

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---|---|----------|----------------------------------|---|--------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155764 | B. W | NG | | 09/10/ | 2024 |
| NAME OF B | DOWNER OF GUIDNIED | | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 101 W 8 | 87TH AVE | | |
| SPRING | MILL HEALTH CAN | IPUS | | MERRII | LLVILLE, IN 46410 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | re | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | | DATE |
| | containing yellow clear urine. A hospice nurse was present at the time for admission to hospice | | | | | | |
| | services. | me for admission to hospice | | | | | |
| | There were no Physician's orders or a related | | | | | | |
| | | | | | | | |
| | Service Plan for a F | | | | | | |
| | | • | | | | | |
| | During an interview | on 9/10/24 at 11:11 a.m., the | | | | | |
| | _ | ector indicated they did not | | | | | |
| | | ng on the assisted living side | | | | | |
| | | ght, so they would not have | | | | | |
| | • | the nighttime medications | | | | | |
| | unless someone from the health care side came over. Sometimes when they did have a nurse come | | | | | | |
| | | a care side, the staff members | | | | | |
| | | to document medications | | | | | |
| | | had been working to | | | | | |
| | - | attime morphine sulfate for | | | | | |
| | this resident due to | the lack of nurses on the night | | | | | |
| | | hould have had orders for a | | | | | |
| | Foley catheter and a | ın updated Service Plan. | | | | | |
| R 0409 | 410 IAC 16.2-5-12 | ?(d) | | | | | |
| | Infection Control - | • • | | | | | |
| Bldg. 00 | | | | | | | |
| | | riew and interview, the facility | R 0 | 409 | | | 10/01/2024 |
| | | innual health statement was | | | Spring Mill Health Campus | | |
| | | cated the residents showed no | | | Annual Survey: 9/10/24 | | |
| | | losis in an infectious stage for ds reviewed. (Residents 2, 4, 6, | | | | | |
| | 3, and 1) | ds leviewed. (Residents 2, 4, 0, | | | R 409 Infection Control –Non | | |
| | <i>5</i> , and 1) | | | | Compliance | | |
| | Findings include: | | | | Compilation | | |
| | 1 The manual for D | esident 2 was reviewed on | | | Mihat aannaatius astisus(s) | | |
| | | Diagnoses included, but were | | | What corrective action(s) will be accomplished for those | 1 | |
| | | etes and high blood pressure. | | | residents found to have been | , | |
| | not infined to, diabe | and high olood pressure. | | | residents found to have been affected by the deficient | | |
| | There was no annual health statement in the | | | | practice? | | |
| | record indicating the | e resident was free from | | | - | | |
| | | | 1 | | İ | | |

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PRINTED: 10/11/2024 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155764 | | ľ í | UILDING | onstruction 00 | (X3) DATE COMPI 09/10 | LETED | |
|--|--|---|---------|------------------------------|---|-------|------------|
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD 87TH AVE | | |
| SPRING | MILL HEALTH CAN | MPUS | | | ILLVILLE, IN 46410 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | | | DATE |
| | tuberculosis in an in | nfectious stage. | | | Residents 2, 4 and 3 order | 4:- | |
| | During on intervious | v on 9/10/24 at 1:45 p.m. the AL | | | updated to reflect that resider free of communicable disease | | |
| | _ | he communicable disease | | | Resident 6 and 7 is no longer | | |
| | | vere not carried over to the | | | the facility. | 111 | |
| | Physician Order Su | | | | the facility. | | |
| | | | | | How will facility identify other | er | |
| | 2. The record for Resident 4 was reviewed on | | | | residents who have the | | |
| | 9/10/24 at 10:30 a.m. Diagnoses included, but were | | | | potential to be affected by the | ne | |
| | not limited to, Alzheimer's disease, anxiety, | | | | same alleged deficient | | |
| | depression, high blood pressure, and altered | | | | practice? | | |
| | mental status. | | | | | | |
| | | | | | The deficient practice has the | | |
| | There was no annual health statement in the | | | | potential to affect all facility | | |
| | record indicating the resident was free from | | | | residents. | | |
| | tuberculosis in an in | nfectious stage. | | | | | |
| | | 0/40/04 | | | What corrective measures w | | |
| | _ | v on 9/10/24 at 1:45 p.m. the AL | | | the facility take or will alter t | | |
| | | he communicable disease | | | ensure that the problem will | | |
| | | were not carried over to the mmary.3. Resident 6's record | | | not reoccur? | | |
| | l - | 10/24 at 9:28 a.m. Diagnoses | | | A 100% audit was completed | on | |
| | | not limited to, Parkinsonism, | | | all resident to ensure resident | | |
| | | polar disorder, and breast | | | free of communicable disease | | |
| | 1 | t admitted to the facility on | | Tuberculosis Screening was | | | |
| | 3/22/23. | Ž | | completed for all residents. | | | |
| | | | | | | | |
| | The record lacked of | locumentation of the Annual | | | Assisted Living Director educa | ated | |
| | | ndicating the resident was free | | | on residents receiving annual | | |
| | of communicable d | isease. | | | health assessment to ensure | | |
| | | | | | residents are free of | | |
| | _ | v on 9/10/24 at 11:11 a.m., the | | | communicable diseases. AL | | |
| | | rector indicated there was no | | | Director educated that new | | |
| | | arding the Annual Health | | | resident will require a 2 step 7 | | |
| | | art. 4. Resident 3's record was | | | test and all other residents will | II | |
| | | at 3:37 p.m. Diagnoses not limited to, bipolar disorder, | | | need yearly TB Screening. | | |
| | | sorder, anxiety disorder, | | | What quality accurance plan | | |
| | | tic features, and mood | | | What quality assurance plan will be implemented to moni | | |
| | disturbance. | no reatures, and mood | | | facility performance to ensu | | |
| | aistarbance. | | 1 | | lacinty periorinance to ensu | 16 | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---|---|------------------------|----------|---|-------------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | JILDING | 00 | COMPL | ETED |
| | | 155764 | B. W | ING | | 09/10/ | 2024 |
| | | <u> </u> | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | 87TH AVE | | |
| SPRING | MILL HEALTH CAN | /IPUS | MERRILLVILLE, IN 46410 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | + | TAG | | | DATE |
| | Pagidant 2's record | lacked a health statement to | | | corrections are achieved and | 1 | |
| | | t was free of communicable | | | permanent? | | |
| | diseases. | was nee of communication | | | Assisted Living Director/Desig | nee | |
| | discuses. | | | | will audit the 3 residents clinic | | |
| | During an interview | with the Assistant Living | | | record weekly for 6 mos, to en | | |
| | _ | at 2:10 p.m., she indicated the | | | documentation on communica | | |
| | | ealth statement did not | | | diseases and TB test/screening | | |
| | _ | he health care side to the | | | available per guidelines. | J | |
| | assistant living side | . She indicated the health | | | | | |
| | statement should ha | ve appeared on the POS. 5. | | | A summary will be presented t | io | |
| | The record for Resi | dent 1 was reviewed on 9/9/24 | | | the Quality Assurance committee | | |
| | at 3:45 p.m. Diagnoses included, but were not | | | | monthly x 6 months. Thereafte | ∍r, if | |
| | · · | diabetes, falls and high blood | | | determined by the QA commit | | |
| | cholesterol. | | | | auditing and monitoring will be | ; | |
| | | | | | done quarterly and present | | |
| | | l health statement in the | | | quarterly at the QA meeting. | | |
| | _ | e resident was free from | | | Monitoring will be ongoing. | | |
| | communicable disea | ases. | | | | | |
| | D | 0/10/04 + 1.45 | | | By what date the systemic | | |
| | _ | on 9/10/24 at 1:45 p.m. the | | | changes will be completed: | | |
| | Assisted Living Dir | ase health statements were not | | | 10/01/2024 | | |
| | | Physician Order Summary. | | | | | |
| | carried over to the r | nysician Order Summary. | | | | | |
| R 0410 | 410 IAC 16.2-5-12 | ?(e)(f)(a) | | | | | |
| | Infection Control - | | | | | | |
| Bldg. 00 | | | | | | | |
| | | | R 0 | 410 | Spring Mill Health Campus | | 10/01/2024 |
| | Based on record rev | riew and interview, the facility | | | Annual Survey: 9/10/24 | | |
| | failed to ensure a re | sident had an annual | | | _ | | |
| | tuberculin (TB) asso | essment for 1 of 7 residents | | | | | |
| | reviewed for ad TB | test or screenings. (Resident | | | R 410 Infection Control - No | n | |
| | 7) | | | | Compliance | | |
| | Finding includes: | | | | | | |
| | Finding includes: | | | | What compating action(s)!! | | |
| | The record for Dogi | dent 7 was reviewed on | | | What corrective action(s) will be accomplished for those | 1 | |
| | The record for Resident 7 was reviewed on 9/10/244 at 9:47 a.m. Diagnoses included, but | | | | residents found to have beer | , | |
| | | dementia, depression, anxiety, | | | affected by the deficient | • | |
| | | atmenta, aspission, unviety, | | | anocted by the delicient | | |

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| AND PLAN OF CORRECTION IDENTIFY | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 09/10/2024 | | |
|---------------------------------|---|---|---|--|---------------------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) practice? | | (X5) COMPLETION DATE | | |
| | | | | Practice? Resident is no longer in the facility. How will facility identify other residents who have the potential to be affected by the same alleged deficient practice? The deficient practice has the potential to affect all facility residents. What corrective measures with facility take or will alter the ensure that the problem will not reoccur? A 100% audit was completed all resident to ensure Tuberco. | rill to | | |
| | | | | Screening was completed for residents. Assisted Living Director eduction residents administer Tube assessment to ensure resider are free of communicable diseases. AL Director educate that new resident will require step TB test and all other residents will need yearly TB Screening. What quality assurance plan will be implemented to monifacility performance to ensure corrections are achieved an permanent? | ated rculin nts ed a 2 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 09/10/2024 | | |
|--|--|---|--|--|---|----------------------------|--|
| | PROVIDER OR SUPPLIE | | STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE | |
| | | | | Assisted Living Director/Design will audit the 3 residents clinic record weekly for 6 mos, to end documentation on TB test/screening is available per guidelines. A summary will be presented the Quality Assurance commit monthly x 6 months. Thereafte determined by the QA commit auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. By what date the systemic changes will be completed: 10/01/2024 | al nsure to tee er, if tee, | | |

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