STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00436754 and IN00442676. This visit included a State Residential Licensure Survey. Complaint IN00436754 - No deficiencies related to the allegations are cited. Complaint IN00442676 - No deficiencies related to the allegations are cited. Survey dates: September 3, 4, 5, 6, 9, and 10, 2024 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 19 SNF: 34 Residential: 15 Total: 68 Census Payor Type: Medicare: 16 Medicaid: 16 Other: 21 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/16/24.	F 0000		
F 0561 SS=D	483.10(f)(1)-(3)(8) 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure a resident's preferences were honored related to allowing the resident to leave their room while in contact isolation for 1 of 1 resident reviewed for choices. (Resident 261) Finding includes: During a random observation on 9/3/24 at 10:31 a.m., Resident 261 indicated she had been confined to her room due to an infection on her back. On 9/4/24 at 3:12 p.m., the resident was observed in her room sitting in her wheelchair. She indicated to LPN 3, who was also in the room, that she was unable to leave her room due to her isolation status. During an interview at the time, LPN 3 indicated she was unsure if the resident could leave her room. LPN 3 was told in shift report that the resident was in contact isolation, but she was a new nurse and was unsure if that meant the resident could not leave her room. The record for Resident 261 was reviewed on 9/4/24 at 11:15 a.m. The diagnoses included, but were not limited to, lymphedema (swelling in arms or legs), hypoxia (inadequate oxygen), difficulty walking, kidney failure, anemia (decrease in red blood cells), and cellulitis (bacterial infection). The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. Eating,	F 0561	**Spring Mill Nursing and Rehabilitation** **Complaint Survey: 9/10/24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F561 – Self -Determination** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 261 preference was honored, and the resident was informed that she could leave her room. **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 to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Facility conducted an audit on all residents in isolation to ensure resident's preferences are honored	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	personal hygiene, and oral hygiene required set up and clean up assistance. Partial/moderate assistance was required for toileting and shower/bathing, and lower body dressing. A Physician's Order, dated 9/1/24, indicated to place the resident in Contact Isolation related to Methicillin-resistant Staphylococcus aureus (MRSA) in the wound. During an interview on 9/4/24 at 3:16 p.m., CNA 1 indicated the resident used to leave her room all the time, and she had noticed the resident had not left her room in a couple days. She was unaware what contact isolation required and did not know why the resident was not allowed to leave her room. During an interview on 9/4/24 at 3:19 p.m., the ADON indicated as long as the resident's wound was covered, she could leave her room. She was not aware a staff member told the resident otherwise, but she would in-service the staff immediately. During an interview on 9/4/24 at 3:40 p.m., the ADON indicated the wound nurse had told the resident she did not have to leave her room to go to activities. The resident was feeling embarrassed by how much her legs were weeping when they were wrapped. The wound nurse indicated activities could come to her room for a 1:1. The resident had probably misunderstood and thought she had to stay in her room. During an interview on 9/6/24 at 1:59 p.m., the DON and Nurse Consultant indicated they understood the concern with staff not understanding contact isolation and they had no additional information to provide.		related to allowing residents to leave their room while in contact isolation. Staff was educated on transmission-based precautions/isolation guidelines, including on how to locate information in medical records regarding isolation information. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 5 residents in isolation weekly for 6 months to ensure the preference to leave their rooms are being honored. The DON/Designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 10/01/24**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0578 SS=D Bldg. 00	3.1-3(u)(1) 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on record review and interview, the facility failed to ensure staff were knowledgeable regarding the residents' code status for 3 of 5 residents reviewed for advanced directives. (Residents 160, 50, and 261) Findings include: 1. The record for Resident 160 was reviewed on 9/4/24 at 3:28 p.m. The resident was admitted to the facility on 8/15/24. Diagnoses included, but were not limited to, non traumatic subarachnoid hemorrhage, type 2 diabetes, asthma, stroke, depressive disorder, and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, completed on 8/28/24, indicated the resident was moderately impaired for daily decision making. During an interview on 9/4/24 at 11:08 a.m., the Assistant Director of Nursing indicated she was not aware of the resident's code status because there was no documentation in the clinical record or in the advance directive binder located at the nursing station. During an interview on 9/4/24 at 11:11 a.m., the Social Service Director (SSD) indicated he would go look on his desk to see if the resident had completed a POST (Physician's Orders for Scope of Treatment) form.	F 0578	**Spring Mill Nursing and Rehabilitation** **Complaint Survey: 9/10/24** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance.** **F578 – Request /Refuse /Discontinue Trmn; Formlte Adv Dir** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 160, 50 and 261 code status has been reviewed and uploaded in their medical record. **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 to be affected by the same alleged	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 9/4/24 at 11:18 a.m., the SSD indicated he had the POST form on his desk which was signed by the resident and signed by the Director of Nursing and another nurse, it was not signed by a Physician or a Nurse Practitioner. The POST form indicated the resident was a full code. When asked why the information had not been passed onto nursing staff, the SSD had no additional information to provide. 2. Resident 50's record was reviewed on 9/3/24 at 3:28 p.m. Diagnoses included, but were not limited to, communication deficit, end stage renal disease, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease. The Admissions Minimum Data Set (MDS) assessment, dated 7/26/24, indicated the resident was cognitively intact. Resident 50 was admitted on 7/20/24. There was no code status order and no advanced directives documentation in Resident 50's electronic record or in the advanced directives binder. During an interview on 9/4/24 at 1:35 p.m., RN 1 indicated she could not locate a code status for Resident 50. She was not aware that she did not have access to the code status for this resident. During an interview on 9/4/24 at 1:45 p.m., the Social Service Director (SSD) indicated the resident had a POST form in his office, signed by the resident on 7/23/24 and by the physician on 8/1/24, which indicated their code status wishes. He was not able to provide any information on why the POST form was not in the resident's chart or why nursing staff were not made aware of their code status. 3. The record for Resident 261 was reviewed on 9/4/24 at 11:15 a.m. The diagnoses		deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** 100% audit completed on advance directives to ensure that the resident's most recent advance directive is signed, order is in place, code status is on the face sheet and POST form is uploaded into PCC. Staff was educated on process of obtaining advance directives and where to locate resident's code status in the medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Social Services/Designee to audit 5 residents bi-weekly x 1 month, then weekly for 6 mos to ensure that the most recent advance directive is signed, order is in place, code status is on the face sheet and POST form is uploaded into PCC. The Social Services Director/Designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, but were not limited to, lymphedema (swelling in arms or legs), hypoxia (inadequate oxygen), difficulty walking, kidney failure, anemia (decrease in red blood cells), and cellulitis (bacterial infection). The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact for daily decision making. There was no code status order and no POST form found in the electronic medical record (EMR) for Resident 261. During an interview on 9/4/24 at 1:35 p.m., RN 1 indicated she could not locate a code status for Resident 261. She was not aware that she did not have access to the code status for this resident. During an interview on 9/4/24 at 1:45 p.m., the SSD indicated all 3 residents had POST forms signed by the resident and the Physician indicating their code status wishes. He was not able to provide any information on why the POST forms were not in the resident's chart or why nursing staff were not made aware of their code statuses. A facility policy, titled, "Advance Directives", provided by the Director of Nursing as current, indicated ".... the resident, the legal representative, or the individual who has been authorized as the resident's health care representative will be asked if an Advance Directive, as recognized under the state law, has been executed. Documentation concerning this inquiry and the individual response shall include the date the entry was made and the individual making the inquiry. This information shall then be included in the resident's medical record ...."		the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:10/01/24**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=D Bldg. 00	3.1-4(f)(5) 483.20(g) Accuracy of Assessments Based on observation, record review, and interview, the facility failed to ensure the comprehensive assessment was accurate related to dental status for 1 of 17 residents whose comprehensive assessments were reviewed. (Resident 6) Finding includes: During an observation on 9/3/24 at 11:02 a.m. Resident 6's teeth were observed to be caried and broken off. The resident indicated at that time that he was supposed to get new dentures. The record for Resident 6 was reviewed on 9/5/24 at 8:20 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance, type 2 diabetes, epilepsy, paranoid schizophrenia, depressive disorders, anxiety disorder, high blood pressure, and PTSD (post traumatic stress disorder) The 3/11/24 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and had no oral or dental problems. The Modification of the Quarterly MDS assessment, dated 7/25/24, indicated the resident was cognitively intact for daily decision making and had no dental issues. There was no care plan for dental care. During an interview on 9/6/24 at 2:30 p.m., the	F 0641	**Spring Mill Nursing and Rehabilitation** **Annual Survey: 09/10/2024** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility request paper compliance.** **F641 Accuracy of Assessment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 6 comprehensive MDS assessment was modified to reflect accurate dental status. **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;**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	MDS Coordinator indicated she was unaware the resident's teeth were broken off, discolored, and caried. During an interview on 9/9/24 at 3:00 p.m., the MDS Nurse Consultant indicated she had no additional information to provide. 3.1-31(i)		All facility residents have the potential to be affected by the same alleged deficient practice. **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 an audit of comprehensive MDS assessment submitted in the past 90 days to ensure accuracy of coding of resident's dental status. MDS staff educated on performing dental status assessment of residents during observation period and accuracy of coding resident's dental status on comprehensive MDS. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** MDS staff/designee will audit 5 comprehensive MDS weekly x 6 months to ensure accuracy related to dental status. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed: 10/01/2024**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure dependent residents received at least 2 baths a week and had their hair washed at least weekly for 2 of 4 residents reviewed for activities of daily living. (Residents 41 and 158) Findings include: 1. During an interview on 9/3/24 at 11:20 a.m., Resident 41 indicated he sometimes did not get a bed bath 2 times a week and did not get his hair washed at least weekly. The resident's hair was observed to be greasy. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on 7/18/24. Diagnoses included, but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS)	F 0677	**Spring Mill Nursing and Rehabilitation** **Annual Survey: 09/10/2024** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility request paper compliance.** **F 677 ADL Care –Dependent residents**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. The Care Plan, dated 7/19/24, indicated the resident required assistance with activities of daily living for bathing. The approaches were to assist with personal hygiene and grooming as needed. The Shower Book indicated the resident was to receive a shower or complete bed bath on Mondays and Thursdays. The resident did not have a complete bed bath on 8/5 and 8/22/24. During an interview on 9/5/24 at 2:45 p.m., the Assistant Director of Nursing indicated she had just brought up shower caps for the residents to get their hair washed. The resident should be bathed at least 2 times a week and be offered to have their hair washed. During an interview on 9/9/24 at 10:30 a.m. , the Director of Nursing indicated the resident was to have at least 2 complete bed baths weekly and be offered to have his hair washed. 2. During an interview on 9/3/24 at 2:03 p.m., Resident 158 indicated she had not had her hair washed since she had been at the facility. The record for Resident 158 was reviewed on 9/5/24 at 1:55 p.m. The resident was admitted to the facility on 8/12/24. Diagnoses included but were not limited to, type 2 diabetes, obesity, heart		**What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice.** Resident 41 and 158 received a bath and hair washed. **How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice?** All residents residing in the facility have the potential to be affected by this alleged deficient practice. **What corrective measures will the facility take, or will the facility alter to ensure that the problem will not occur?** Staff were re-educated on the importance of providing ADL care to include showers and hair washing as needed. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Director of Nursing or Designee will complete observation on 10 residents twice a week x 2weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	failure, chronic kidney disease, anemia, cardiac pacemaker, osteoarthritis, and high blood pressure. The 8/18/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making was dependent on staff for bathing. The Care Plan, dated 8/13/24, indicated the resident required assistance with activities of daily living including bathing. The Shower Book indicated the resident was to receive a bath on Wednesdays and Saturday. The resident did not receive a complete bed bath on 8/14 and 8/17/24 During an interview on 9/5/24 at 2:30 p.m., the Assistant Director of Nursing indicated she was not aware the resident had not had her hair washed since admission and should have received a completed bed bath at least 2 times a week. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B)		then 5 residents a week for 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **By what date will the systemic changes be completed?** **Date of Completion: 10/01/2024**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure surgical bandages were changed as ordered by the physician for 1 of 2 resident reviewed for skin conditions non-pressure. (Resident 41) Finding includes: On 9/3/24 at 11:25 a.m., Resident 41 was observed	F 0684	**Spring Mill Nursing and Rehabilitation** **Annual Survey: 09/10/2024** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lying in bed wearing a hospital gown. At that time, a surgical bandage was observed to his abdomen with a date of 8/30/24. At 11:35 a.m., the Assistant Director of Nursing (ADON) was asked to come to the room and observe the date on the bandage. During an interview at that time, the ADON indicated the bandage was supposed to be changed three times a week on Monday, Wednesday, and Friday. On 9/6/24 at 12:49 p.m., the Wound Nurse was observed changing the bandage to the surgical wound. The wound was pink and was healing. During an interview at that time, the Wound Nurse indicated the bandage should have been changed on 9/2/24 and she was off that day. Nursing staff were to change the bandages when she was not in the facility. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on 7/18/24. Diagnoses included but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. The Care Plan, revised on 9/5/24, indicated the		**by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance.** **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 41 surgical bandage was changed as ordered. **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 facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nursing staff have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had a mid abdomen surgical wound. Physician's Orders, dated 8/28/24, indicated to cleanse the surgical incision to the mid abdomen with normal saline or wound cleanser and pat dry. Cut wound sized pieces of Hydrofera Blue and moisten with normal saline, apply to wound bed and cover with dry dressing every Monday, Wednesday, and Friday. The Treatment Administration Record for 9/2024 indicated the treatment was signed out as being completed on 9/2/24. The surgical wound was last measured by the Wound Nurse Practitioner on 9/4/24. The wound was 9 centimeters (cm) by 0.8 cm and was pink. The wound had decreased in size and was improving. During an interview on 9/6/24 at 2:15 p.m., the Director of Nursing indicated the bandage to the surgical wound should have been changed as ordered by the physician. 3.1-37(a)		re-educated to ensure bandages are changed and treatments are 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 put into place;** DON/designee will review 5 residents with non pressure skin injuries weekly x 6 months to ensure bandages are changed and treatments are completed as ordered. Don/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed:10/01/2024**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure a resident	F 0686	**Spring Mill Nursing and Rehabilitation**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with a pressure ulcer had interventions in place related to not floating their heels when in bed for 1 of 3 residents reviewed for pressure ulcers. (Resident 31) Finding includes: On 9/4/24 at 10:10 a.m. and 3:07 p.m., Resident 31 was observed awake lying in bed. The resident's heels were not floated off the bed. On 9/05/24 at 10:07 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. The record for Resident 31 was reviewed on 9/04/24 at 9:35 p.m. The diagnoses included, but were not limited to, diabetes, hemiplegia (paralysis on one side), encephalopathy (swelling in the brain), dementia, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of his lower extremities and used a wheelchair. The resident had a stage 2 pressure ulcer. A Care Plan, dated 4/18/24, indicated the resident had impaired skin integrity. A Physician's Order, dated 1/27/24, indicated to suspend or offload heels when in bed every shift. A Physician's Order, dated 1/27/24, indicated to administer Balsam Peru-Castor Oil External Ointment (Balsam Peru-Castor Oil) to right and left heels topically one time a day for supplement.		Annual Survey: 09/10/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance. F686 Treatment/Pressure Ulcer What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 31 heels were floated while in bed. 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;What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nursing staff have been re-educated to ensure heels are floated when residents are in bed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The undated Wound Rounds summary tab in the EMR (electronic medical record) indicated the resident had a deep tissue pressure injury to the left heel that was resolved on 3/7/24. During an interview on 9/6/24 at 1:58 p.m., the Director of Nursing (DON) indicated Resident 31 should have had his heels floated. No additional information was provided. 3.1-40(a)(2)		Nursing staff were also reminded to ensure that all pressure ulcer prevention devices are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/designee will review 5 residents with pressure ulcer bi-weekly for 1 month, then weekly up to 6 months, to ensure pressure ulcer interventions are implemented as ordered and per plan of care. DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. Date by which systemic corrections will be completed: 10/01/2024	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, record review, and interview, the facility failed to ensure a peg tube (a tube inserted into the stomach for nutrition) was	F 0693	**Spring Mill Health Campus Annual Survey: 9/10/24**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cleaned on a daily basis and according to facility policy for 1 of 2 residents reviewed for peg tubes. (Resident 41) Finding includes: On 9/3/24 at 11:22 a.m., Resident 41 was observed lying in bed wearing a hospital gown. At that time, there was a tube observed near a bandage on his abdomen. The area under the flange had dried crusty blood noted. During an interview at that time, the resident indicated the wound nurse cleaned around the tube when she changed his bandages. On 9/6/24 at 12:49 p.m., the Wound Nurse was observed changing the resident's surgical bandage on his abdomen. During an interview at that time, the Wound Nurse indicated the peg tube was solely placed for decompression and was not used for feeding or flushes. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on 7/18/24. Diagnoses included, but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and		Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. **F693 Tube Feeding Mgmt./Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident 41 peg tube was cleaned according to the facility policy. **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 facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur.** The Wound Nurse was educated to make sure all residents have an order to monitor and clean the peg tube site in accordance to facility policy. MDS Coordinator was educated to ensure that care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lower extremities. He had 1 surgical wound upon admission. There was no care plan for the care of the peg tube. There were no physician's orders for the care of or to monitor the peg tube. During an interview on 9/6/24 at 1:00 p.m., the Wound Nurse indicated she cleaned around the peg tube and stoma site when she changed his bandages. On the days she worked, which was Monday through Friday, she saw the resident just to make sure the bandage was clean and in place. During those visits, she did look at the peg tube, however, if there was no drainage and it looked okay, she would not clean around it. When she did clean around the peg tube, there was no place in the clinical record to document she had completed the care. During an interview on 9/6/24 at 1:04 p.m., LPN 1 indicated she was aware the resident had a peg tube, however, she had never cleaned around the stoma site because she had always thought the wound nurse completed the task. During an interview on 9/6/24 at 1:06 p.m., the Assistant Director of Nursing indicated there were no orders to monitor, assess or clean the peg tube site on a daily basis. During an interview on 9/6/24 at 2:15 p.m., the Director of Nursing (DON) indicated the peg tube was to be cleaned at least daily. The current 2/15/21 "Gastrostomy/Jejunostomy Site Care" policy, provided by the DON on 9/9/24 at 10:30 a.m., indicated it was the policy of the		plans are in place for residents with enteral tube. Licensed Nurses were educated on ensuring that PEG tube sites were cleaned 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 put into place.** DON/designee will audit 3 residents with enteral tubes bi-weekly x 1 month, then weekly up to 6 months to ensure PEG sites are cleaned as ordered. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 10/01/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility to provide gastrostomy and jejunostomy site care to decrease the risk of infection. The procedure was to obtain a physician order to include the following information resident room and number, type of solution for cleansing and frequency of treatment. 3.1.44(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review, and interview, the facility failed to ensure a resident's PICC (peripherally inserted central catheter) line had Physician's Orders for the care and monitoring of a PICC line for 1 of 1 residents reviewed for PICC lines. (Resident 31) Finding includes: During an observation on 9/3/24 at 11:21 a.m., Resident 31's PICC line bandage was dated 8/29/24 and was peeling off on the top of the dressing. During an observation on 9/4/24 at 10:11 a.m., the PICC line bandage was dated 8/29/24 and was peeling off on the top of the dressing. The record for Resident 31 was reviewed on 9/4/24 at 9:35 p.m. The diagnoses included, but were not limited to, diabetes, hemiplegia (paralysis on one side), encephalopathy (swelling in the brain), dementia, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated the resident was severely impaired for daily decision making.	F 0694	**Spring Mill Health Campus Annual Survey: 9/10/24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the 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 to monitor and clean resident 31 PICC line. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident had impairment on both sides of his lower extremities and used a wheelchair. There was no Care Plan for a PICC line or Intravenous therapy. There were no active orders for PICC line care or intravenous therapy. During an interview on 9/6/24 at 1:58 p.m., the DON indicated there should have been PICC line orders for Resident 31. No additional information was provided. 3.1-47(a)(2)		**taken.** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur.** Licensed Nurses were in-service on the policy for providing PICC line care and monitoring. Licensed Nursing Staff was educated to ensure that all residents with PICC line have an order for PICC line care and dressing changes, MDS coordinator was re-educated to ensure care plans are in place for residents with PICC line. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** The Director of Nursing /Designee will audit 3 residents with PICC lines weekly for 6 months, to ensure PICC line care is performed per order. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Date by which systemic corrections will be completed: 10/01/2024	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the failed to ensure a PRN (as needed) psychotropic medication was not ordered longer than 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 25) Finding includes: The record for Resident 25 was reviewed on 9/5/24 at 10:35 a.m. Diagnoses included, but were not limited to, left lung cancer, type 2 diabetes, stroke, osteoarthritis, heart disease, depressive disorder, repeated falls, high blood pressure, paranoid schizophrenia, and atrial fibrillation. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 7/16/24, indicated the resident was cognitively intact for daily decision making and received insulin, an antipsychotic, an anxiolytic, an antidepressant, an anticoagulant, and hypoglycemic medications. Physician's Orders, dated 7/17/24, indicated Alprazolam (Xanax, an anti-anxiety medication) 0.5 milligrams (mg), give 1 tablet by mouth every 8 hours as needed for anxiety. The Medication Administration Record (MAR) for the month of 8/2024 indicated the Alprazolam was administered five times and on the 9/2024 MAR, the medication was administered two times. During an interview on 9/6/24 at 2:42 p.m., the	F 0758	**Spring Mill Nursing and Rehabilitation** **Annual Survey: 09/10/2024** **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility requests paper compliance.** **F 758 – Unnec Psychotropic Meds/PRN Use** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** PRN psychotropic medication was discontinued for Resident 22. **How the facility will identify other residents having the**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Assistant Director of Nursing indicated the scheduled dose of Xanax was discontinued in July and was then ordered as prn. The resident did ask for the medication and the daughter would call to make sure she had received it. The current 9/2/20 "Psychotropic Medication-Gradual Dosage Reduction" policy, provided by the Director of Nursing on 9/9/24 at 10:30 a.m., indicated " ... PRN hypnotic, antianxiety, or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and extended duration..." 3.1-48(a)(2)		**potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with orders for PRN psychotropic medications have the potential to be affected by the same alleged deficient practice. **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 on ensuring PRN psychotropic medications have an order end date of 14 days, and can only be renewed until the physician evaluates the need for the medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will review 5 residents with PRN psychotropic bi-weekly for 1 month, then weekly up to 6 months, to ensure PRN order has a 14 day stop date. DON/designee will present a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed: 10/01/2024**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review, and interview, the facility failed to store medicated creams and loose pills properly for 1 of 1 resident and 1 of 2 medication carts observed during medication storage. (Resident 41 and Health Care 2 medication cart) Findings include: 1. During random observations on 9/3/24 at 11:26 a.m. and 3:04 p.m., Resident 41 was observed lying in bed. The resident was severely contracted for both his upper and lower extremities and was unable to use them. At that time, there was a tube of Diclofenac cream (a cream used to reduce swelling in joints and muscles) on the over bed table. During an interview on 9/3/24 at 11:26 a.m., the resident indicated he used the cream for his severe rheumatoid arthritis.	F 0761	Spring Mill Nursing and Rehabilitation Annual Survey: 09/10/24 **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by 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) will be accomplished for those residents found to have been affected by the deficient**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During random observations on 9/4/24 at 11:18 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. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on 7/18/24. Diagnoses included, but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. There was no care plan for the medicated cream to be kept at the bedside. Physician's Orders, dated 7/19/24, indicated Diclofenac Sodium External Gel 1 % (medicated cream), apply to both lower legs topically every 6 hours as needed for pain. There were no physician's order to keep the medication at the bedside. During an interview on 9/6/24 at 1:06 p.m., the Assistant Director of Nursing indicated the family would bring in creams for him and did not tell the nursing staff. During an interview on 9/6/24 at 2:15 p.m., the		**practice;** Health Care 2 medication cart was cleaned, and loose pills were removed and discarded accordingly. Resident 41 medicated cream 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 residing in the facility have the potential to be affected by this alleged deficient practice. An audit of all medication carts was completed to ensure medications were properly stored. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** License staff was re-educated on the importance proper storage of medications and cleaning the medication carts. All staff in-serviced on proper storage of medication I.E medications being left at the resident's bedside without proper	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director of Nursing (DON) indicated the resident was not able to self-administer the medicated cream due to his contractures. The family brought in the creams and the nursing staff were unaware. There was no order to keep the medicated cream at the bedside. The current 9/1/20 "Medication Storage" policy, provided by the DON on 9/9/24 at 10:30 a.m., indicated the facility should ensure that all medications and biologicials, including treatment items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors.2. On 9/5/24 at 9:58 a.m., LPN 2 was observed at the HC 2 medication cart preparing to pass medications. The cart was observed to have 10 loose pills, varying in size, shape, and color. The pills were located in the bottom 3 drawers of the medication cart. LPN 2 removed the pills from the cart and disposed of them in the drug buster container. During an interview at that time, LPN 2 indicated she knew the pills should not be loose in her cart and she cleaned her cart daily. A current facility policy, titled " Medication Storage", indicated ".... Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding ...." 3.1-25(m)		assessment and an order for self-administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 2 medication carts weekly for 6 months, to ensure absence of loose pills in the medication carts. Members of the interdisciplinary team will audit 3 residents' room weekly for 6 months, to observe the presence of medications at bedside. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **Date by which systemic corrections will be completed: 10/01/2024**	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, record review, and interview, the facility failed to ensure the	F 0921	**Spring Mill Health Campus** Annual Survey: 9/10/24	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility Respectfully requests paper compliance for this survey. F921 Safe/Functional/Sanitary/Comfortable 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 to be affected by the same alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All Staff were re-educated on the procedure of properly storing bed pans. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** All members of the Interdisciplinary Team will audit the facility 5 x per week, for 6 months , on alternating units. Any identified issues will be corrected. Members of the interdisciplinary team will audit 3 residents' room weekly for 6 months, to ensure that continence supplies are stored and contained properly. **Admin/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 10/01/2024**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00436754 and IN00442676. Complaint IN00436754 - No deficiencies related to the allegations are cited. Complaint IN00442676 - No deficiencies related to the allegations are cited. Survey dates: September 3, 4, 5, 6, 9 and 10, 2024 Facility number: 010739 Residential Census: 15 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/16/24.	R 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to promptly notify the resident's physician and/or family of significant changes in status related to high blood sugar levels and a fall for 2 of 7 residents reviewed. (Residents 2 and 6) Findings include: 1. The record for Resident 2 was reviewed on 9/9/24 at 3:35 p.m. Diagnoses included, but were not limited to, diabetes and high blood pressure. Physician's Orders, dated 5/31/24, indicated blood glucose monitoring three times a day at 8:00 a.m., 1:00 p.m., and 6:00 p.m. Notify the Physician if the blood glucose level was below 70 or above 250. The Medication Administration Record (MAR), dated 7/2024, indicated the resident's blood sugars were as follows: - 7/5/24 at 1 p.m.: 265 - 7/6/24 at 1 p.m.: 259 - 7/27/24 1 p.m.: 262 The 8/2024 MAR indicated the resident's blood sugars were as follows: - 8/10/24 at 1:00 p.m.: 259 - 8/12/24 at 6:00 p.m.: 256 - 8/20/24 at 1:00 p.m.: 252 There was no documentation in nursing progress notes the physician was notified of the blood sugars above 250. During an interview on 9/10/24 at 1:45 p.m., the AL Director indicated there was no documentation the physician was notified of the high blood	R 0036	**Spring Mill Health Campus** **Annual Survey: 9/10/24** **R 036- Notification of Change** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Physician and family of resident 2 were notified. Resident 6 is no longer in the facility. **How will the 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 will the facility take or will alter to ensure that the problem will not reoccur?** Licensed nursing staff are educated on ensuring that family and MD are notified any time a	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sugars. 2. Resident 6's record was reviewed on 9/10/24 at 9:28 a.m. Diagnoses included, but were not limited to, Parkinsonism, anxiety disorder, bipolar disorder, and breast cancer. The most recent Service Plan, updated on 8/21/24, indicated the resident was an elopement risk/wanderer due to cognitive impairment, was on hospice care, and was at risk for falls. A Post Fall Observation, dated 8/19/2024 at 5:32 a.m., indicated the resident had an unwitnessed fall in her room. The resident was unable to verbalize what had happened. She had evidence of a possible head injury with an abrasion to the left forehead and left eye area. The Physician and the resident were notified. There was no documentation related to the family or resident representative being notified of the fall. During an interview on 9/10/24 at 11:11 a.m., the Assisted Living Director indicated the family was notified, as they were in the building daily visiting the resident, however there was an error in the documentation.		resident has a fall or change in status. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** AL Director/Designee will audit all fall and change in status documentation 2 x per week for 6 months, to ensure family and MD are notified. A summary will be presented to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the QA committee, 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**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure resident service plans were updated and/or signed by the resident or representative, for 2 of 7 service plans reviewed. (Residents 6 & 3) Findings include:	R 0217	**Spring Mill Health Campus Annual Survey: 9/10/24** **R 217 Evaluation** **What corrective action(s) will**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Resident 6's record was reviewed on 9/10/24 at 9:28 a.m. Diagnoses included, but were not limited to, Parkinsonism, anxiety disorder, bipolar disorder, and breast cancer. The most recent Service Plan, updated on 8/21/24, indicated the resident was an elopement risk/wanderer due to cognitive impairment, was at risk for complications secondary to urinary incontinence, and was on hospice care. A Nurses' Note, dated 5/20/24 at 12:20 p.m., indicated a Service Plan was mailed to the address on file to be signed/emailed at the earliest convenience by a family member or Power of Attorney (POA). A Nurses' Note, dated 7/23/24 at 8:48 p.m., indicated the resident returned from the hospital with a Foley catheter draining by gravity containing yellow clear urine. A hospice nurse was present at the time for admission to hospice services. The Service Plan was not updated to reflect the presence of a urinary catheter and there was no Service Plan signed by the resident or the resident's representative. During an interview on 9/10/24 at 11:11 a.m., the Assisted Living Director indicated the Service Plan should have been signed by the responsible party and updated to reflect the change of condition. The resident's family members visited the resident daily, so they were aware of the resident's condition. 2. Resident 3's record was reviewed on 9/9/24 at 3:37 p.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, anxiety disorder, severe with psychotic features, and mood		**be accomplished for those residents found to have been affected by the deficient practice?** Resident 3 service plan was signed by his family representative. Resident 6 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 will the facility take or will alter to ensure that the problem will not reoccur?** Assisted Living Director educated on ensuring service plans are reviewed with resident and family. After reviewing a signed copy must be uploaded into their medical record. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/Designee will audit 5 residents service plans twice a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disturbance. A Service Assessment was completed on 4/23/23. It was not signed by the resident or responsible party. During an interview with the Assistant Living Director on 9/10/24 at 2:10 p.m., she indicated the service plans and health statement did not transfer over from the health care side to the assistant living side and should have been added.		week x 6 months to ensure family and residents are aware of their service plan. A summary will be presented to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the QA committee, 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**	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the clinical record was complete and accurately documented related to blood pressure medications administered outside of parameters, blanks on medication administration records, and the lack of documentation for Foley (urinary) catheter care for 2 of 7 residents reviewed. (Residents 2 and 6) Findings include: 1. The record for Resident 2 was reviewed on 9/9/24 at 3:35 p.m. Diagnoses included, but were not limited to, diabetes and high blood pressure. Physician's Orders, dated 5/31/24, indicated Hydralazine (a medication used to lower the blood pressure) 10 milligrams three times a day. Hold the medication if the systolic blood pressure was	R 0349	**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 order was reviewed with the Physician and the order was updated with no parameters. Resident 6 is no longer in the facility.	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	greater than 150 and the diastolic blood pressure was greater than 90. The 7/2024 Medication Administration Record (MAR) indicated the Hydralazine was administered on 7/23/24 at 1 p.m. and the blood pressure was 154/106. The 8/2024 MAR indicated the Hydralazine was administered on the following days: - 1:00 p.m. on 8/9/24 and the blood pressure was 152/75 - 1:00 p.m. on 8/25/24 and the blood pressure was 155/66 - 6:00 p.m. on 8/1/24 and the blood pressure was 166/131 - 6:00 p.m., on 8/2/24 and the blood pressure was 151/81 The medication was not signed out as being administered on 8/2, 8/8 and 8/29/24 at 1:00 p.m., and on 8/10 and 8/24/24 at 6:00 p.m. During an interview on 9/10/24 at 1:45 p.m. the AL Director indicated the order for the Hydralazine was not correct, however, physician's orders were not followed. Medications should be signed out after they were administered. 2. Resident 6's record was reviewed on 9/10/24 at 9:28 a.m. Diagnoses included, but were not limited to, Parkinsonism, anxiety disorder, bipolar disorder, and breast cancer. The most recent Service Plan, updated on 8/21/24, indicated the resident was an elopement risk/wanderer due to cognitive impairment, at risk for complications secondary to urinary incontinence. and on hospice care. A Physician's Order, dated 7/24/24, indicated the		**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 will the facility take or will alter to ensure that the problem will not reoccur?** Assisted Living Director educated on ensuring blood pressure and orders with parameters are being monitored and medication administered as ordered. AL Nursing Staff were educated to ensure that all medications are administered as ordered and documented completely in the MAR. HR to ensure that all nursing staff from SNF have access to residential side, to ensure medication administration is documented appropriately. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Assisted Living Director/Designee will audit 5 residents' MAR weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident received morphine sulfate 20 milligrams (mg) per 5 milliliters (ml), 0.25 ml by mouth every four hours. The August 2024 Medication Administration Record (MAR) was blank for the morphine sulfate administration on the following dates and times: - 12:00 a.m. on 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/8, 8/9, 8/11, 8/12, 8/13, 8/14, and 8/15/24 - 4:00 a.m. on 8/1, 8/2, 8/3, 8/4, 8/5, 8/6, 8/8, 8/9, 8/11, 8/12, 8/13, 8/14, and 8/15/24 - 12:00 p.m. on 8/2, 8/3, and 8/8/24 A Physician's Order, dated 8/16/24, indicated the resident received morphine sulfate 100 mg per 5 ml, 0.25 ml by mouth four times a day. The August 2024 Medication Administration Record (MAR) was blank for the morphine sulfate administration on 8/19/24 at 9:00 p.m. A Physician's Order, dated 8/20/24, indicated morphine sulfate 100 mg per 5 ml, 0.25 ml by mouth every 6 hours. The August 2024 Medication Administration Record (MAR) was blank for the morphine sulfate administration on 8/27/24 at 12:00 a.m. A Physician's Order, dated 7/24/24, indicated Depakote 125 mg tablet three times a day. The August 2024 Medication Administration Record (MAR) was blank for the Depakote administration on 8/2, 8/3, 8/8, and 8/14/24 at 1:00 p.m. A Nurses' Note, dated 7/23/24 at 8:48 p.m., indicated the resident returned from the hospital with a Foley catheter draining by gravity		x 6 months, to ensure BP parameters for administration are followed and ordered medications are administered and documented in the MAR. A summary will be presented to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the QA committee, 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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	containing yellow clear urine. A hospice nurse was present at the time for admission to hospice services. There were no Physician's orders or a related Service Plan for a Foley catheter. During an interview on 9/10/24 at 11:11 a.m., the Assisted Living Director indicated they did not have a nurse working on the assisted living side of the building at night, so they would not have administered any of the nighttime medications unless someone from the health care side came over. Sometimes when they did have a nurse come over from the health care side, the staff members did not have access to document medications administered. They had been working to discontinue the nighttime morphine sulfate for this resident due to the lack of nurses on the night shift. The resident should have had orders for a Foley catheter and an updated Service Plan.			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure an annual health statement was obtained which indicated the residents showed no evidence of tuberculosis in an infectious stage for 5 of 7 resident records reviewed. (Residents 2, 4, 6, 3, and 1) Findings include: 1. The record for Resident 2 was reviewed on 9/9/24 at 3:35 p.m. Diagnoses included, but were not limited to, diabetes and high blood pressure. There was no annual health statement in the record indicating the resident was free from	R 0409	**Spring Mill Health Campus Annual Survey: 9/10/24** **R 409 Infection Control –Non Compliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tuberculosis in an infectious stage. During an interview on 9/10/24 at 1:45 p.m. the AL Director indicated the communicable disease health statements were not carried over to the Physician Order Summary. 2. The record for Resident 4 was reviewed on 9/10/24 at 10:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anxiety, depression, high blood pressure, and altered mental status. There was no annual health statement in the record indicating the resident was free from tuberculosis in an infectious stage. During an interview on 9/10/24 at 1:45 p.m. the AL Director indicated the communicable disease health statements were not carried over to the Physician Order Summary.3. Resident 6's record was reviewed on 9/10/24 at 9:28 a.m. Diagnoses included, but were not limited to, Parkinsonism, anxiety disorder, bipolar disorder, and breast cancer. The resident admitted to the facility on 3/22/23. The record lacked documentation of the Annual Health Statement indicating the resident was free of communicable disease. During an interview on 9/10/24 at 11:11 a.m., the Assisted Living Director indicated there was no documentation regarding the Annual Health Statement in the chart. 4. Resident 3's record was reviewed on 9/9/24 at 3:37 p.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, anxiety disorder, severe with psychotic features, and mood disturbance.		Residents 2, 4 and 3 order updated to reflect that resident is free of communicable diseases. Resident 6 and 7 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 will the facility take or will alter to ensure that the problem will not reoccur?** A 100% audit was completed on all resident to ensure residents are free of communicable disease. Tuberculosis Screening was completed for all residents. Assisted Living Director educated on residents receiving annual health assessment to ensure residents are free of communicable diseases. AL Director educated that new resident will require a 2 step TB test and all other residents will need yearly TB Screening. **What quality assurance plans will be implemented to monitor facility performance to ensure**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 3's record lacked a health statement to indicate the resident was free of communicable diseases. During an interview with the Assistant Living Director on 9/10/24 at 2:10 p.m., she indicated the service plans and health statement did not transfer over from the health care side to the assistant living side. She indicated the health statement should have appeared on the POS. 5. The record for Resident 1 was reviewed on 9/9/24 at 3:45 p.m. Diagnoses included, but were not limited to, anxiety, diabetes, falls and high blood cholesterol. There was no annual health statement in the record indicating the resident was free from communicable diseases. During an interview on 9/10/24 at 1:45 p.m. the Assisted Living Director indicated the communicable disease health statements were not carried over to the Physician Order Summary.		**corrections are achieved and permanent?** Assisted Living Director/Designee will audit the 3 residents clinical record weekly for 6 mos, to ensure documentation on communicable diseases and TB test/screening is available per guidelines. A summary will be presented to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the QA committee, 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**	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure a resident had an annual tuberculin (TB) assessment for 1 of 7 residents reviewed for ad TB test or screenings. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 9/10/244 at 9:47 a.m. Diagnoses included, but were not limited to, dementia, depression, anxiety,	R 0410	**Spring Mill Health Campus Annual Survey: 9/10/24** **R 410 Infection Control – Non Compliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sleep disorder, high blood pressure, and kidney disease. There was no documentation the resident had an annual TB assessment. During an interview on 9/10/24 at 1:43 p.m., the Assisted Living Director indicated the resident did not have a TB risk assessment on file.		**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 will the facility take or will alter to ensure that the problem will not reoccur?** A 100% audit was completed on all resident to ensure Tuberculosis Screening was completed for all residents. Assisted Living Director educated on residents administer Tuberculin assessment to ensure residents are free of communicable diseases. AL Director educated that new resident will require a 2 step TB test and all other residents will need yearly TB Screening. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Assisted Living Director/Designee will audit the 3 residents clinical record weekly for 6 mos, to ensure documentation on TB test/screening is available per guidelines. A summary will be presented to the Quality Assurance committee monthly x 6 months. Thereafter, if determined by the QA committee, 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**	