STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155126	A. BUILDING 00 B. WING	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS VALLEY MEADOWS	457 S SR 145 FRENCH LICK, IN 47432

(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. Survey dates: February 24, 25, 26, 27, 2025 Facility number: 000054 Provider number: 155126 AIM number: 100287850 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 3 Medicaid: 47 Other: 21 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 6, 2025.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Springs Valley Meadows desires this Plan of Correction to be considered the facility's Allegation of Compliance.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 1 of 4 medication carts observed. The narcotic box lid inside the cart was not closed completely to engage the lock. (South Long Hall Medication Cart) Finding includes:	F 0761	**1 1. What corrective action will be accomplished for residents affected?** No residents were affected by this alleged deficient practice. The identified narcotic box was immediately locked and LPN 24 was immediately educated on	03/29/2025

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

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	On 2/26/25 at 9:45 A.M., the South Long Hall Medication Cart was observed. The lid was not closed completely to engage the lock. Narcotics were observed stored in the box at the time. At that time, Licensed Practical Nurse (LPN) 24 indicated it was not broken and should have been closed and locked. During an interview, on 2/26/25 at 1:44 P.M., the Director of Nursing (DON) indicated all narcotics should be double locked. On 2/26/25 at 2:36 P.M., a current Medication Storage Policy, revised 6/30/23, was provided by the DON and indicated " ... The community should store Schedule II-V controlled substances [narcotics] and other medications deemed by the community as at-risk for abuse or diversion in a separately locked, affixed compartment in a cart ... " 3.1-25(n)		requirement of locking narcotic box at all times when not being accessed by authorized nurse. **2 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. DNS/Designee observed all other medication carts to ensure narcotic box was locked. **3 3. What measures will be put into place to ensure this practice does not recur?** All licensed nurses were educated on the requirement of ensuring the narcotic box is always locked when not being accessed by an authorized nurse. Licensed nurses were also educated on the Medication Storage Policy. DNS/Designee to complete daily audit/inspection of medication carts to ensure narcotic box is locked when not being accessed by an authorized nurse. **4 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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			assurance program will be put into place? DNS/Designee will complete Medication Storage Review QAPI Tool weekly x 4, monthly x 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to provide meals at an acceptable temperature for 1 of 1 lunch trays sampled on 1 of 2 units. Food was served cold. (South Hall) Finding includes: During an interview on 2/24/25 at 11:33 A.M., an anonymous resident indicated the food was not served hot. During an interview on 2/26/25 at 1:35 P.M., an anonymous resident indicated the food was not served hot.	F 0804	**1 1. What corrective action will be accomplished for residents affected?** No residents were affected by this alleged deficient practice. All residents will be provided with food that is of proper temperature. **2 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?**	03/29/2025

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	During an observation on 2/26/25 at 11:46 A.M., the South Hall meal trays were being distributed to resident rooms from a meal cart. The individual meals were covered with an insulated dome with a base. At 11:52 A.M., a hall tray was sampled. The cheeseburger temperature was 113 degrees Fahrenheit. It was cold to the touch and tasted cold, and the cheese was not melted on the hamburger. During an interview on 2/26/25 at 2:11 P.M., Cook 25 indicated cheeseburgers should be a minimum of 145 degrees Fahrenheit when they are served to the residents. On 2/26/25 at 1:21 P.M., a current Food Temperatures policy, revised 6/2023, was provided by the Administrator and indicated, "...Hot foods that are potentially hazardous will be held for service at or above 135 degrees Fahrenheit..." 3.1-21(a)(2)		All residents have the potential to be affected by the alleged deficient practice. CDM/Designee to in-service all culinary staff on Food Temperatures policy. SDC/Designee to in-service all nursing staff on Meal Service and Distribution policy. **3 3. What measures will be put into place to ensure this practice does not recur?** CDM/Designee to complete daily audit of food temperatures at the time of serving to ensure all food is served at correct temperatures. **4 4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** CDM/Designee to complete the Test Tray QA tool weekly x 4 weeks, monthly x 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to	

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			and including termination of responsible employee.	