PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155126		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/27/2025		
NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP COD 457 S SR 145 FRENCH LICK, IN 47432				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
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.		F 00	000	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	Quality review com 483.45(g)(h)(1)(2) Label/Store Drugs						
Bldg. 00	review, the facility secure storage of momedication carts ob inside the cart was n	on, interview and record failed to maintain safe and edications for 1 of 4 served. The narcotic box lid not closed completely to outh Long Hall Medication	F 07	761	1. What corrective action will be accomplished for residents affected?     No residents were affected by this alleged deficient practic.  The identified narcotic be was immediately locked and L 24 was immediately educated.	ed ce. ox PN	03/29/2025

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/27/2025 155126 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 457 S SR 145 SPRINGS VALLEY MEADOWS FRENCH LICK, IN 47432 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE requirement of locking narcotic On 2/26/25 at 9:45 A.M., the South Long Hall box at all times when not being Medication Cart was observed. The lid was not accessed by authorized nurse. closed completely to engage the lock. Narcotics were observed stored in the box at the time. At that time, Licensed Practical Nurse (LPN) 24 2. How will the facility indicated it was not broken and should have been identify other residents having closed and locked. the potential to be affected by the same practice and what During an interview, on 2/26/25 at 1:44 P.M., the corrective action will be taken? Director of Nursing (DON) indicated all narcotics All residents have the should be double locked. potential to be affected by this alleged deficient practice. On 2/26/25 at 2:36 P.M., a current Medication DNS/Designee observed all Storage Policy, revised 6/30/23, was provided by other medication carts to ensure the DON and indicated " ... The community narcotic box was locked. should store Schedule II-V controlled substances 3. What measures will be [narcotics] and other medications deemed by the put into place to ensure this community as at-risk for abuse or diversion in a practice does not recur? separately locked, affixed compartment in a cart ... All licensed nurses were educated on the requirement of ensuring the narcotic box is 3.1-25(n)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. How corrective action(s) will be monitored to ensure the

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deficient practice will not recur, i.e. what quality

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	r of health and hu! R medicare & medic				FORM APPRO OMB NO. 0938	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155126			(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/27/2025	
	PROVIDER OR SUPPLIER		457 S	ADDRESS, CITY, STATE, ZIP COD SR 145 CH LICK, IN 47432		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5 COMPLE DATE	TION
				assurance program will be printo place?  DNS/Designee will complement of the program will be provided into place?  DNS/Designee will complement of the provided into the provided into the provided into planta in	ete API nd 2 ss D. If ved, ed.	
F 0804 SS=E Bldg. 00	Temp Based on observation review, the facility acceptable temperates sampled on 1 of 2 un (South Hall) Finding includes:  During an interview	opear, Palatable/Prefer on, interview, and record failed to provide meals at an ture for 1 of 1 lunch trays mits. Food was served cold.	F 0804	<ol> <li>1. What corrective action will be accomplished for residents affected?         No residents were affected by this alleged deficient practice.     </li> <li>All residents will be provided with food that is of proper temperature.</li> <li>2. How will the facility</li> </ol>	ed ce.	2025

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served hot.

During an interview on 2/26/25 at 1:35 P.M., an

anonymous resident indicated the food was not

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identify other residents having

the potential to be affected by

the same practice and what corrective action will be taken?

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED	
	155126		B. W	NG		02/27/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD		_
NAME OF I	PROVIDER OR SUPPLIE	R		457 S S			
SPRING	S VALLEY MEADO	ows			CH LICK, IN 47432		
					1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
	_	tion on 2/26/25 at 11:46 A.M.,			All residents have the		
		ll trays were being distributed			potential to be affected by the		
		rom a meal cart. The individual			alleged deficient practice.		
		d with an insulated dome with a			CDM/Designee to in-serv	ice	
		1., a hall tray was sampled. The			all culinary staff on Food		
		erature was 113 degrees			Temperatures policy.		
		cold to the touch and tasted			SDC/Designee to in-serv		
		e was not melted on the			all nursing staff on Meal Servi	се	
	hamburger.				and Distribution policy.		
	l				3 3. What measures will b	е	
	_	w on 2/26/25 at 2:11 P.M., Cook			put into place to ensure this		
		eburgers should be a minimum			practice does not recur?		
	_	renheit when they are served to					
	the residents.						
	0 2/26/25 + 1 21	D. 4. F. 1			CDM/Designee to comple		
	On 2/26/25 at 1:21 P.M., a current Food Temperatures policy, revised 6/2023, was				daily audit of food temperature		
		-			the time of serving to ensure a	ill	
		Iministrator and indicated,			food is served at correct		
	"Hot foods that are potentially hazardous will be held for service at or above 135 degrees				temperatures.	./->	
	Fahrenheit"	of above 133 degrees			4 4. How corrective action		
	ramemen				will be monitored to ensure to deficient practice will not	ile	
	3.1-21(a)(2)				recur, i.e. what quality		
					assurance program will be p		
					into place?	ut	
					o piaco:		
					CDM/Designee to comp	ete	
					the Test Tray QA tool weekly		
					weeks, monthly x 6 months ar		
					then quarterly until continued		
					compliance is maintained for 2	,	
					consecutive quarters.		
					The results of these aud	its	
					will be reviewed by the QAPI		
					committee overseen by the EI	D. If	
					threshold of 100% is not achie		
					an action plan will be develope		
					Deficiency in this practice will		
					result in disciplinary action up	to	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155126	B. WI	B. WING			02/27/2025	
NAME OF PROVIDER OR SUPPLIER SPRINGS VALLEY MEADOWS				457 S S	ADDRESS, CITY, STATE, ZIP COD SR 145 H LICK, IN 47432			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG DEFICIENCY)			(X5) COMPLETION DATE	
					and including termination of responsible employee.			

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