155764 B. WING		COMPLETED 08/11/2023
NAME OF PROVIDER OR SUPPLIER	TREET ADDRESS, CITY, STATE, ZIP COD 01 W 87TH AVE IERRILLVILLE, IN 46410	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TA	D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000		
This visit was for a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00413735 and IN00413771. This visit included a State Residential Licensure Survey and the Investigation of Residential Complaint IN00414473.  Complaint IN00413735 - No deficiencies related to the allegations are cited.  Complaint IN00413771 - No deficiencies related to the allegations are cited.  Complaint IN00414473 - State deficiencies related to the allegations are cited at R0036 and R0349.  Survey dates: August 7, 8, 9, 10, and 11, 2023  Facility number: 010739 Provider number: 155764 AIM number: 200856890  Census Bed Type: SNF/NF: 26 SNF: 29 Residential: 34 Total: 89  Census Payor Type: Medicare: 24 Medicaid: 17 Other: 14 Total: 55  These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.		

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

(X6) DATE

TITLE

Lakeithia Webb Executive Director 08/28/2023

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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155764 B. WING 08/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE. IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Quality review completed on 8/15/23. F 0554 483.10(c)(7) SS=D Resident Self-Admin Meds-Clinically Approp Bldg. 00 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and F 0554 **Spring Mill Health Campus** 08/28/2023 interview, the facility failed to ensure residents Annual Survey: 8-7-23 had Physician's Orders for medications and an assessment to self-administer their own Please accept the following as the medications for 1 of 1 residents reviewed for facility's credible allegation of self-administration of medication. (Resident 41) compliance. This plan of correction does not constitute an Finding includes: admission of quilt or liability by the facility and is submitted only in On 8/7/23 at 10:45 a.m., an Arnuity Ellipta 100 response to the regulatory micrograms inhaler and a Hylands Natural Restful requirement. Legs supplement was noted to be on the bedside The Facility Respectfully requests table in Resident 41's room. The resident paper compliance for this survey. indicated she had brought the supplement in from F554 Resident Self Admin home. **Meds-Clinically Appropriate** What corrective action(s) will On 8/8/23 at 1:13 p.m., an Arnuity Ellipta inhaler be accomplished for those and Hylands Natural Restful Legs supplement residents found to have been were noted to be sitting next to the television on affected by the deficient the table in Resident 41's room. practice. A self-administration assessment Resident 41's record was reviewed on 8/10/23 at was completed for Residents 41 11:35 a.m. Diagnoses included, but were not and MD order received for selflimited to, acute respiratory failure, end stage renal administration of medication. failure, and restless leg syndrome. Medication self- administration care plan was also completed for The Admission Minimum Data Set (MDS) Resident 41. assessment, dated 8/5/23, indicated the resident How the facility will identify was cognitively intact for daily decision making. other residents having the potential to be affected by the A Physician's Order, dated 8/1/23, indicated same deficient practice and

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	ETED
		155764	B. WING			08/11/	2023
		<u>l</u>	ST	REET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			B7TH AVE		
SPRING	MILL HEALTH CAN	MPUS			LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		inhalation aerosol powder			what corrective action will be	•	
		) micrograms/act, 1 puff inhale			taken.		
	orally one time a da	y.			All facility residents with		
	Tl	4			medication orders have the		
		dministration assessment esident to self-administer			potential to be affected by the		
	medications.	esident to self-administer			same alleged deficient practic		
	medications.				What measures will be put in	ito	
	There were no orde	rs for self-administration of			place or what systemic		
		ere was no order for the restful			changes will be made to ensure that the deficient		
	legs supplement.	tre was no order for the restrui			practice does not reoccur.		
	legs supplement.				Staff were educated on not lea	avina	
	Interview with the I	Director of Nursing on 8/10/23			medications at resident bedsic	_	
		ated the resident had brought			unless there is an order for	16	
		From home, however, she had			self-administration in place.		
		lers for the medications and			Licensed Nurses were also		
		ion of medications assessment			educated on the need for a		
	was not completed.	or			physician order and a medicat	ion	
					self-administration assessmen		
	A Policy titled, "Sel	lf-Administration of			when a resident self-administe		
	1	ally Appropriate," and noted			medication.		
		d "1. The resident has right to			MDS Nurses are educated on	the	
		lications if the interdisciplinary			need for care plans for any		
		d that this practice is clinically			resident who has a self-		
	appropriate3. A re	-			administration order.		
		lications after the IDT has			How the corrective action(s)		
	determined which n	nedications may be			will be monitored to ensure t	he	
	self-administered."				deficient practice will not		
					recur, i.e., what quality		
	3.1-11(a)				assurance programs will be	put	
					into place.		
					Facility Angel's will audit 5		
					residents 3 days per week to		
					ensure no medication is		
					improperly stored at the bedsi		
					The Director of Nursing/design	nee	
					will present a summary of the		
					audits to the Quality Assurance		
					committee monthly for 6 mont		
			1		Thereafter if determined by the	ie	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155764		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/11/2023
NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
			Quality Assurance committee, auditing and monitoring will be done quarterly and present at QA meeting. Monitoring will be going.  Date by which systemic corrections will be completed 8/28/23.	the e on
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			
	Based on observation, record review, and interview, the facility failed to ensure dependent residents received assistance with ADLs (activities of daily living) related to bathing, nail care, shaving, and clean clothing and linens for 2 of 4 residents reviewed for ADLs. (Residents 110 and 37)  Findings include:  1. Interview with Resident 110 on 8/7/23 at 10:16 a.m., indicated she had not received a shower since being admitted.  The record for Resident 110 was reviewed on 8/8/23 at 1:21 p.m. Diagnoses included, but were not limited to, stroke, lack of coordination, and	F 0677	Spring Mill Health campus  Annual Survey: 8-7-23  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response tothe regulatory requirement.  The Facility respectfully reques paper compliance for this surv	an the
	spinal stenosis. The resident was admitted to the facility on 7/20/23.  The Admission Minimum Data Set (MDS) assessment, dated 7/26/23, indicated the resident was cognitively intact and she required extensive assistance with bed mobility and transfers. The		F677 ADL Care Provided for Dependent Residents  What corrective action(s) will be accomplished for those resider found to have been af fected be the deficient practice;	nts

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155764 B. WING 08/11/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 101 W 87TH AVE SPRING MILL HEALTH CAMPUS MERRILLVILLE, IN 46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE resident was totally dependent on staff for bathing. Resident 37 had their fingernails cleaned, shaven and gown and A Care Plan, dated 7/24/23, indicated the resident linens changed. required assistance with ADLs (activities of daily Resident 110 had a shower living) including bed mobility, eating, transfers, provided and shower schedule toileting, and bathing. Interventions included, but adjusted to reflect preferences. were not limited to, assist with bathing as needed, offer a shower at least 2 times weekly, and offer How the facility will identify other full/partial bed bath on non-shower days or with residents having the potential to shower refusals. be affected by the same deficient practice and what The resident's shower days were Monday and corrective action will be taken; Thursday evenings. The August 2023 Bath and Skin Report sheet did not indicate the resident's All dependent residents, who preference for a bath or shower. require assistance with nail care, shaving, changing gowns and The Task section related to bathing was reviewed linens and showers, have the for the days of 7/21-8/8/23. The resident received potential to be affected by the a partial bed bath on 7/21, 7/24, 7/28, and 8/1/23. same alleged deficient practice. A complete bed bath was given on 7/23, 7/24, 7/25, and 8/7/23. The resident received a shower What measures will be put into on 7/31/23. place or what systemic changes will be made to ensure that The August 2023 Bath and Skin Report sheet, the deficient practice does not indicated the resident's skin was intact on 8/3 and recur: 8/7/23, however, the sheet did not list what type Staff were re-educated on of bathing the resident received, if any. providing dependent residents with assistance with ADL's per Interview with the Director of Nursing on 8/11/23 resident's plan of at 2:10 p.m., indicated she thought the resident's care/preferences, including Nail preference was a complete bed bath. She would Care, shaving, changing gowns check with the resident and update her bathing and linens and showers. preference. 2. On 8/7/23 at 11:09 a.m., Resident 37 was observed with facial hair, long dirty How the corrective action(s) will be fingernails, and there was food and stains all over monitored to ensure the deficient the sheet and the resident's gown. The resident practice will not recur, i.e., what indicated he liked to be clean shaven. quality assurance programs will be put into place; On 8/8/23 at 1:25 p.m., Resident 37's blanket and

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/11/2023
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO 87TH AVE	DD
SPRING	MILL HEALTH CAN	MPUS	MERR	ILLVILLE, IN 46410	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION PROPRIATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION gown had food and stains on them.		TAG		BATTE
	Resident 37's record 9:44 a.m. Diagnose	d was reviewed on 8/10/23 at sincluded, but were not limited d stage renal disease.		DON/Designee will Audi random residents weekl months, with a focus on dependent residents, re ADL assistance, to ensu	y for 3 quiring ure they
		mum Data Set (MDS) /29/23, indicated the resident		are being assisted with shaving, changing gowl linen and Showers per t	ns and
	making. The resider	paired for daily decision nt required extensive mobility, toileting, personal		residents' plan of care/p	
	hygiene, and bathin	g.		Director of Nursing/designersent a summary of the to the Quality Assurance	ne audits
	required assistance	5/12/22, indicated the resident with ADLs including bed nsfers, toileting and bathing.		committee monthly for 3 Thereafter, if determined Quality Assurance comm	d by the
	1	led, but were not limited to, ygiene including		auditing and monitoring done quarterly and pres quarterly at the QA mee	will be ent
		Director of Nursing on 8/10/23 ated she had no further ide.		Date by which systemic corrections will be comp 8/28/23	
	3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2) 3.1-38(b)(4)				
F 0684	483.25				
SS=D Bldg. 00	applies to all treat	a fundamental principle that ment and care provided to			
	facility must ensur treatment and car	sased on the sessment of a resident, the te that residents receive in accordance with lards of practice, the			
	comprehensive pe	erson-centered care plan,			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155764	B. WI	NG		08/11/	/2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ODDINO		40.10			87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were notified of the	d. The Physician and family			thedeficient practice does not		
	were notified of the	resident's fair.			recur;		
	There were no corre	esponding Neurochecks			Nurses were educated on		
	completed with the				completing post fall follow up		
					documentation which includes	s:	
		ed 7/9/23 at 12:40 p.m.,			Daily follow up fall assessment	ent	
		nt was observed laying on the			documentation per facility poli	су	
	_	de. The Physician and family			for 72 hours		
		ew orders for a left hip x-ray			Neurological checks per faci	lity	
	was ordered.				policy		
	The Post Fall Obset	vation Assessment, dated			Vital signs per facility policy		
		., included vital signs checked			How the corrective action(s) w	/ill be	
		m. and 10:35 a.m. for			monitored to ensure the defici		
	temperature, respira	ations, pulse, and blood			practice will not recur, i.e., wh		
	pressure.				quality assurance programs w	ill be	
					put into place;		
		pleted Neurochecks that					
	corresponded with t	the fall on $7/9/23$ in the record.			Nurse managers will audit clin		
	A Doct Fall Evaluat	ion on 7/15/23 at 12:43 p.m.,			documentation 2 times per we	eek,	
		nt had an unwitnessed fall at			for 3months to ensure follow up assessments and neuro		
		cian and family were notified.			checks are completed.		
	1	<b>,</b>					
	There were no comp	pleted Neurochecks that			The Director of Nursing/design	nee	
	corresponded with t	the fall on $7/15/23$ in the			will present a summary of the		
	record.				audits to the Quality		
		10///02			Assurance committee monthly	/ for	
		red 8/4/23 at 6:10 a.m.,			6 months. Thereafter, if		
		nt was noted on the floor on			determined by the Quality	~	
	the right side.				Assurance committee, auditin and monitoring will be done	y	
	A Nurses' Note. dat	red 8/4/2023 at 3:24 p.m.,			quarterly at the QA meeting.		
		nt had a fall in the dining area.			Monitoring will be on going.		
		5					
	The Neuro Check A	Assessment, dated 8/4/23 at			Date by which systemic		
	6:10 a.m., was inco	mplete.			corrections will be		
					completed:8/28/23		
	Interview with the I	Director of Nursing on 8/11/23	1				1

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU		TE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPLETED		
		155764	B. WING 08/11/2		/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R.			87TH AVE		
SPRING MILL HEALTH CAMPUS			MERRI	LLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	· ·	ated she had no other fall follow					
	ups or neurochecks	to provide.					
	3.1-37(a)						
F 0686	483.25(b)(1)(i)(ii)						
SS=D	Treatment/Svcs to	Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	§483.25(b) Skin Ir						
	§483.25(b)(1) Pre						
		prehensive assessment of					
		ility must ensure that- ives care, consistent with					
	* *	lards of practice, to prevent					
	•	nd does not develop					
	•	nless the individual's clinical					
	•	trates that they were					
	unavoidable; and	nation that they were					
		pressure ulcers receives					
	, ,	ent and services, consistent					
	•	standards of practice, to					
	promote healing, ¡	prevent infection and prevent					
	new ulcers from d	. •					
		view and interview, the facility	F 0	686	Spring Mill Health Campus		08/28/2023
		sident with pressure ulcers			Annual Survey: 8-7-23		
		ary treatment and services to					
		lated to treatments not			Please accept the following as	s the	
	-	ed and treatment orders not			facility's credible allegation of		
		2 of 2 residents reviewed for			compliance. This plan of		
	pressure ulcers. (R	esidents 49 and 212)			correction does not constitute		
	Findings include:				admission of guilt or liability by		
	i manigs include:				facility and is submitted only in response to the regulatory	1	
	1 Resident 49's rec	ord was reviewed on 8/9/23 at			requirement.		
		es included, but were not			The Facility respectfully reque	ests.	
	_	eomyelitis of the left femur,			paper compliance for this surv		
	· ·	cral region stage 4, cellulitis of			F686- Treatments/Svcs to	- <b>,</b> .	
	_	ere protein-calorie malnutrition,			Prevent/Heal Pressure Ulcers	s	
		ght hip, and heart failure.			What corrective action(s) wil	-	
					be accomplished for those		

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	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE BILLVILLE, IN 46410	
OI IVIIVO	INICE FILALITI OAN		IVILIA	10-10	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		LISC IDENTIFYING INFORMATION	TAG		DATE
		mum Data Set (MDS)		residents found to have been	1
		/22/23, indicated the resident		affected by the deficient	
		nct for daily decision making.  ve assistance with one person		practice.	and
	1 -	ed mobility, transfers,		Resident 212 was assessed, a no adverse effects were noted	
		nal hygiene. He had a		related to not having wound	
		n in range of motion to both		treatment updated timely.	
		He had 4 stage 4 pressure ulcers		Resident 49 was assessed, ar	nd l
		eep tissue injuries present		no adverse effects were noted	
	upon admission/ent			related to not having wound	
	apon admission en	.,.		treatment completed as ordere	- <sub>4</sub>
	A Physician's Order	c, dated 6/5/23, indicated		How the facility will identify	,u.
	1	nip with normal saline, pat dry,		other residents having the	
	and apply anasept antimicrobial gel, fill cavity			potential to be affected by the	Δ
	with fluff dry roll gauze, and cover with dry			same deficient practice and	
	dressing every day			what corrective action will be	
				taken.	
	A Physician's Order	r, dated 6/5/23, indicated		All residents with wounds can	be
	1	ack with normal saline, pat dry,		affected by the same alleged	
		ntimicrobial gel, fill cavity		deficient practice.	
	with fluff dry roll g	auze, and cover with dry		What measures will be put in	to
	dressing every day	shift.		place or what systemic	
				changes will be made to	
		c, dated 6/5/23, indicated		ensure that the deficient	
		n normal saline, pat dry, and		practice does not recur.	
		nicrobial gel, fill cavity with		Nursing staff were re-educated	d to
		and cover with dry dressing		ensure all wound treatments a	re
	every day shift.			updated in a timely manner an	d
				completed as ordered.	
		r, dated 6/5/23, indicated apply		How the corrective action(s)	
	-	al gel to the right hip topically		will be monitored to ensure t	he
	every day shift.			deficient practice will not	
		1 . 1 (/02/02 : 1 1		recur, i.e., what quality	
		c, dated 6/23/23, indicated		assurance programs will be p	put
		al foot with normal saline, pat		into place.	
	ary, apply betadine	and wrap with roll gauze daily.		DON/Designee to review all no	<b>I</b>
	A Disersisis I O I	. 4-4-4 (/22/22 :. 1' + 1		wound orders 5 times per wee	<b>I</b>
	1	c, dated 6/23/23, indicated		for 3 months to ensure all wou	
		with normal saline, pat dry,		treatments are updated in a tir	neiy
I	apply betadine and	wrap with roll gauze daily.	1	manner and completed as	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/11/2023
	PROVIDER OR SUPPLIER MILL HEALTH CAMPUS	101 W 8	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's Order, dated 5/23/23, indicated cleanse the right medial heel with normal saline, pat dry, apply betadine and wrap with roll gauze daily.  The July 2023 Treatment Administration Record (TAR) indicated the treatment to the left lateral hip, left lower back, sacrum, left distal foot, left foot, and right medial heel were not completed as ordered on 7/2/23, 7/4/23, and 7/21/23.  A Physician's Order, dated 6/5/23, indicated cleanse the left medial ankle with normal saline, pat dry, apply anasept gel to wound bed, fill cavity with fluff dry roll gauze, and cover with dry dressing daily.  A Physician's Order, dated 6/5/23, indicated cleanse the right lateral foot with normal saline, pat dry, apply anasept gel to wound bed, fill cavity with fluff dry roll gauze, and cover with dry dressing daily.  A Physician's Order, dated 7/1/23, indicated cleanse the right medial shin with normal saline, pat dry, apply anasept gel to wound bed, and cover with dry dressing daily.  A Physician's Order, dated 5/20/23, indicated cleanse left lateral ankle with normal saline, pat dry, apply betadine and wrap with roll gauze daily.  A Physician's Order, dated 7/1/23, indicated cleanse the left shin with normal saline, pat dry, apply betadine and wrap with roll gauze daily.  A Physician's Order, dated 7/1/23, indicated cleanse the left shin with normal saline, pat dry, apply skin prep and leave open to air daily.  The July 2023 TAR indicated the treatment to the left medial ankle, right lateral foot, right medial skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle, and left skin were not skin left lateral ankle.		ordered. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereaf if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going.  Date by which systemic corrections will be completed 8/28/23	
	shin, left lateral ankle, and left shin was not			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY PLETED 1/2023	
NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS		101 W 8	ADDRESS, CITY, STATE, ZIP COI 87TH AVE LLVILLE, IN 46410	)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	completed as ordere	ed on 7/2/23, 7/4/23, and 7/7/23.				
	cleanse the left dista pat dry, apply anase	c, dated 6/16/23, indicated al first toe with normal saline, opt gel to wound bed, fill v roll gauze, and cover with dry				
	cleanse the right lat	r, dated 5/20/23, indicated eral ankle with normal saline, ine and wrap with roll gauze				
	left distal first toe a	indicated the treatment to the nd right lateral ankle was not ed on 7/2/23 and 7/4/23.				
	following new orde - left distal first toe: xeroform and cover - left lateral: cleans of silvasorb gel, xer MAX silver, ABD p - left medial ankle: bordered gauze	cleanse, silvasorb gel, with a dry dressing e, fill with iodoform, application oform dressing, PolyMem				
	- right hip trochante film, silvasorb gel, silver, mepilex - right lateral ankle: bordered gauze - right lateral foot: o silvasorb gel, xerofo bordered gauze - right medial shin: iodoform, silvasorb silver, bordered gau	cleanse, no-sting barrier xeroform, PolyMem MAX cleanse, silvasorb gel, cleanse, no-sting barrier film, orm, PolyMem MAX silver, cleanse, no-sting barrier film, gel, xeroform, PolyMem MAX ze o-sting barrier film, iodoform,				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/11/2023	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	1
	bordered gauze	orm, PolyMem MAX silver,				
	distal medial foot, l ankle, right lateral f sacrum was not star 2023 Physician Ord	er for the left distal toe, left eft medial ankle, right lateral foot, right medial shin, and red until 7/21/23 per the July ler Summary (POS).				
	shin was never start  There were no orde Silver for any wour the left lower back,	rs for the PolyMem MAX and care treatments including for right hip trochanter, right edial shin, and sacrum.				
		Director of Nursing on 8/11/23 ted she had no further ide.				
	1:32 p.m. Diagnose to, hemiplegia (one right dominant side	cord was reviewed on 8/9/23 at s included, but were not limited sided weakness) affecting , adult failure to thrive, sure-induced deep tissue				
	Set (MDS) assessm resident was severe daily decision maki assistance with two bed mobility, transf	ent, dated 7/6/23, indicated the ly cognitively impaired for ng. He required extensive + persons physical assist for fers, toilet use, and personal stage 2 pressure ulcer and 1 er.				
	cleanse coccyx with	r, dated 5/20/23, indicated n normal saline, pat dry, apply th silver to wound bed and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/11/2023
	PROVIDER OR SUPPLIER  MILL HEALTH CAMPUS	101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  cover with dry dressing every Monday,		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	Wednesday, and Friday  The June 2023 Treatment Administration Record			
	indicated the treatment to the coccyx was not completed as ordered on 6/9/23.			
	A Physician's Order, dated 6/16/23, indicated cleanse the right heel with normal saline, pat dry, apply betadine and leave open to air daily.			
	The June 2023 Treatment Administration Record indicated the treatment to the right heel was not completed as ordered on 6/24/23 and 6/26/23.			
	A Physician's Order, dated 5/20/23, indicated cleanse the right heel with normal saline, pat dry, apply betadine, and wrap with roll gauze daily and PRN if loose or soiled.			
	The June 2023 Treatment Administration Record indicated the treatment to the right heel was not completed as ordered on 6/1/23, 6/6/23, 6/8/23, and 6/15/23.	d		
	A Physician's Order, dated 6/9/23, indicated cleanse the distal sacrum with normal saline, pat dry, and apply house barrier cream twice daily for wound care.			
	The June 2023 Treatment Administration Record indicated the treatment to the distal sacrum was not completed as ordered on 6/16/23 at 5 p.m., 6/24/23 at 8:00 a.m., 6/25/23 at 5:00 p.m., 6/26/23 8:00 a.m., and 6/27/23 at 8:00 a.m.	at		
	Interview with the Director of Nursing on 8/11/23 at 9:40 a.m., indicated she had no further information to provide.			

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NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
SS=D Bldg. 00	Increase/Prevent §483.25(c) Mobilit §483.25(c) (1) The resident who enter range of motion dereduction in range resident's clinical athat a reduction in unavoidable; and §483.25(c)(2) A remotion receives a services to increase prevent further de §483.25(c)(3) A rereceives appropriate assistance to main with the maximum unless a reduction demonstrably una Based on observation review, the facility was identified, treat were applied as ord reviewed for range 37 and 212).  Findings include:  1. On 8/7/23 at 11:0 observed in lying in he would benefit froof motion in his last The resident was undereduced.	facility must ensure that a rs the facility without limited bees not experience of motion unless the condition demonstrates range of motion is  esident with limited range of experience are range of motion and/or to crease in range of motion.  esident with limited mobility ate services, equipment, and intain or improve mobility a practicable independence in mobility is	F 0688	Spring Mil Health Campus Annual Survey: 8-7-23  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.	an y the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023		
	PROVIDER OR SUPPLIER	-		101 W 8	ADDRESS, CITY, STATE, ZIP COD B7TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG  TAG DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
		no range of motion in the last			The Facility Respectfully reque paper compliance for this surv		<b>5</b> 2
	indicated she workdhad not noticed any observation of the rindicated she would assessment complete contracted.  Resident 37's record 9:44 a.m. Diagnose to end stage renal design.	1 on 8/10/23 at 10:01 a.m., ed with the resident often and contractures. Upon esident at 10:06 a.m., she direach out to therapy to get an ted as the fingers were di was reviewed on 8/10/23 at sincluded, but were not limited isease, dementia, and			F688 Increase/Prevent Decrea in ROM/Mobility  What corrective action(s) will be accomplished for those reside found to have been affected be deficient practice:	oe nts	
	depressive disorders.  The Quarterly Minimum Data Set (MDS) assessment, dated 6/29/23, indicated the resident was moderately cognitively impaired for daily decision making.  The record lacked documentation, assessments, or monitoring regarding any contractures.  Interview with the Administrator and Director of				Resident 212 was assessed for any adverse effects related to having ordered splint in place also not having a monitoring or in place. No adverse effects noted.  Resident 37 was assessed, ar	not and rder	
	_	at 10:44 a.m., indicated the crapy to get an evaluation ontractures.			OT performed evaluation for contractures. OT evaluation indicated no further OT treatm required.	ent	
	2. On 8/7/23 at 3:33 p.m., Resident 212 was observed in his wheelchair in the dining area watching television. There was no splinting device noted on either hand.  On 8/8/23 at 1:28 p.m., Resident 212 was observed in bed sitting upright with a bolster on his left side. There was no splinting device noted on either hand.				How the facility will identify oth residents having the potential be affected by the same defici practice and what corrective a will be taken;	to ent	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/11/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	1:32 p.m. Diagnose to, hemiplegia (one cerebrovascular disc	rd was reviewed on 8/9/23 at sincluded, but were not limited sided weakness) following ease affecting right dominant munication deficit, adult failure e, and dementia.		All residents with adaptive equipment or contractures ha the potential to be affected by alleged deficient practice.			
	Set (MDS) assessm resident was severe daily decision maki assistance with two	ange in Status Minimum Data ent, dated 7/6/23, indicated the ly cognitively impaired for ng. He required extensive + persons physical assist for ers, toilet use, and personal		What measures will be put interplace or what systemic chang will be made to ensure that the deficient practice does not reconstructed.	ges ne		
	resting hand splint vin PM.  The CNA Tasks - B	r, dated 6/6/23, indicated right with device on in AM and off		Nurses were in- on ensuring adaptive equipment/devices a place as per orders as well as ensuring that there is a monit order in place for all residents have an order for a splint. Nu	s oring s who rses		
	removal of the hand	ented for application and a splint for the last 30 days.  A 2 on 8/9/23 at 4:36 p.m., and never wore a splinting aware of.		were also re-educated related whenever a change is noted to resident, they must call the M and obtain an order for OT to evaluate the resident.	to D		
	at 10:44 a.m., indication of the day orders for a smaller because it was paint splinting device. He documentation of the	Director of Nursing on 8/10/23 ated the splinting device was y before (8/9/23) and new carrot were put into place ful for him to wear the owever, there was no he splinting device being put r removed in the evening as Orders.		How the corrective action(s) we monitored to ensure the defic practice will not recur, i.e., who quality assurance programs we put into place;	ient nat		
	3.1-42(a)(2)			DON/Designee will audit 2 residents with adaptive equipment/devices, 2 times a week, for 3 months to ensure			

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PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/11/2023		
	PROVIDER OR SUPPLIE	R		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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)	ATE	(X5) COMPLETION DATE
					are in place as ordered as we a monitoring order to monitor splint placement.		
					DON/Designee will observe 5 residents, 2 times weekly, to identify the need for OT service		
					The Director of Nursing/desig will present a summary of the audits to the Quality Assurance committee monthly for 6 month 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: 8/28/23	ce ths. he , e	
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respi tracheostomy car The facility must of needs respiratory tracheostomy car is provided such of professional standard	neostomy Care and ratory care, including e and tracheal suctioning. ensure that a resident who care, including e and tracheal suctioning, care, consistent with dards of practice, the erson-centered care plan,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/11/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
the residents' goals and preferences, and 483.65 of this subpart.					
	Based on observation, record review, and interview, the facility failed to ensure oxygen was		F 0695	Spring Mill Health Campus Annual Survey: 8-7-23	08/28/2023
	being administered at the correct flow rate for 1 of 1 residents reviewed for oxygen. (Resident 24)			Please accept the following as facility's credible allegation of	s the
	Finding includes:			compliance. This plan of correction does not constitute admission of guilt or liability by	
	On 8/7/23 at 10:03 a.m., Resident 24 was observed sitting in her wheelchair. The resident was wearing oxygen via a nasal cannula with a flow			facility and is submitted only ir response to the regulatory requirement.	1
	rate set at 2.5 liters.			The Facility Respectfully requipaper compliance for this surv	
	sitting in her wheeld	m., Resident 24 was observed chair with the oxygen tubing in not was wearing oxygen via a		F695 Respiratory/Tracheosto	omy
	nasal cannula with a oxygen tubing was	a flow rate set at 2.5 liters. The not connected to the		What corrective action(s) wil	I
		sing aide was notified and ident's oxygen at 2.5 liters.		be accomplished for those residents found to have beer affected by the deficient	n
	in the dining hall we	.m., Resident 24 was observed earing oxygen via nasal		practice; Resident 24 was assessed, ar	
		rate set at 2.5 liters.  I was reviewed on 8/8/23 at		no adverse effects were noted related to not having oxygen of the correct setting.	
	limited to, hyperlipi	ses included, but were not demia (high cholesterol),		How the facility will identify other residents having the	
	Alzheimer's dement	blood pressure), non- iia, Parkinson's disease, llopathy (brain disorder), and		potential to be affected by the same deficient practice and what corrective action will be	
	chronic obstructive	pulmonary disease (COPD).		taken. All residents with an order for	
		mum Data Set (MDS) /4/23, indicated the resident intact.		oxygen can potentially be affe by the same alleged deficient practice.	cted
	A Care Plan, dated	7/24/23, indicated the resident		What measures will be put in place or what systemic	nto

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL		
		155764	B. W	ING		08/11/	2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<del>'</del>		
NAME OF I	PROVIDER OR SUPPLIER	8			87TH AVE			
SPRING	MILL HEALTH CAN	MPUS		MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
	had a potential for complications and shortness of				changes will be made to			
		lat related to: COPD, and			ensure that the deficient			
		ntions included, but were not			practice does not recur.			
		er oxygen per the physician's			Staff were re-educated to ens			
	order.				all oxygen concentrators are	set		
		1 . 110/06/00			on the correct setting for all			
		r, dated 12/26/22, indicated			residents who have an order t	or		
		er nasal cannula continuous			oxygen.	ļ		
	every shift for COP	D.			How the corrective action(s)			
					will be monitored to ensure	the		
	The July and Augus				deficient practice will not			
		ords (MAR) indicated oxygen			recur, i.e., what quality			
		3 liters was signed out every			assurance programs will be	put		
	shift.				in place.			
		D. (DOM)			DON/designee will perform			
		Director of Nursing (DON) on			observations on 5 residents, t			
		., indicated the resident's			weekly for 3 months to ensure			
	oxygen should have	e been set at 3 liters.			oxygen is on the correct settir	-		
	2.1.47(.)(6)				Director of Nursing/designee			
	3.1-47(a)(6)				present a summary of the aud	iits		
					to the Quality Assurance			
					committee monthly for 6 month			
					Thereafter, if determined by the			
					Quality Assurance committee			
					auditing and monitoring will be	<del>)</del>		
					done quarterly and present			
					quarterly at the QA meeting.			
					Monitoring will be on going.			
					Date by which systemic			
					corrections will be			
					completed:8/28/23			
					_			
F 0760	483.45(f)(2)							
SS=D	Residents are Fre	e of Significant Med Errors				ļ		
Bldg. 00	The facility must e	ensure that its-				ļ		
	§483.45(f)(2) Res	idents are free of any						
	significant medica	tion errors.						
	Based on record rev	view and interview, the facility	F 0'	760	Spring Mill Health Campus		08/28/2023	
	failed to ensure resi	dents were free of significant			Annual Survey: 8-7-23			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/11/2023		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  MERRILLVILLE, IN 46410			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		elated to timing of insulin of 1 residents reviewed for		Please accept the following a	is the	
	insulin. (Resident 1			facility's credible allegation of		
	Finding includes:			compliance. This plan of correction does not constitute		
	Interview with Resi	dent 18 on 8/7/23 at 2:19 p.m.,		admission of guilt or liability be facility and is submitted only it	-	
		at always receive her insulin		response to the regulatory		
	on time.	·		requirement.		
				The Facility Respectfully requ		
The record for Resident 18 was reviewed on 8/8/23			paper compliance for this sur	vey		
at 1:54 p.m. Diagnoses included, but were not						
limited to, type 2 diabetes mellitus.			F760 Residents are free of			
	The Admission Mir	nimum Data Set (MDS)		Significant Med Errors		
		/13/23, indicated the resident		What corrective action(s) wind be accomplished for those		
		act and she received insulin		residents found to have bee	n .	
	injections.			affected by the deficient	···	
	,			practice;		
	A Care Plan, dated	7/20/23, indicated the resident		Resident 18 was assessed, a	and	
	was at risk for comp	olications related to the		no adverse effects were note	d	
	•	es mellitus. Interventions		related to timing of insulin		
		not limited to, administer		administration.		
		as ordered by the doctor.		How the facility will identify		
	Monitor/document	side effects and effectiveness.		other residents having the		
	Physician's Orders	dated 7/9/23, indicated the		potential to be affected by the		
	-	ive Glargine insulin 30 units		same deficient practice and what corrective action will be		
		time daily at 8:00 a.m. The		taken;		
		receive Lispro insulin, inject		All residents with insulin orde	rs	
		th meals: if blood sugar 151 -		have the potential to be affec		
	200 = 2  units, 201-2	250=4 units, 251-300=6 units,		by the same alleged deficient	<b>I</b>	
	301-350=8 units, an	d call with blood sugar greater		practice.		
	than 351.			What measures will be put i	nto	
				place or what systemic		
	•	ication Administration Record		changes will be made to		
		ne resident received her insulin		ensure that the deficient		
	late on the following	g dates: ne and Lispro insulin was		practice does not recur;	,,,	
		a.m. Both insulins were		<ul> <li>RN's, LPN's, and QMA were educated on medication</li> </ul>		
	argined out at 11:40	a.m. Dom msums were		were educated on medication	'	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  08/11/2023	
	PROVIDER OR SUPPLIER		101 W	r address, city, state, zip cod / 87TH AVE RILLVILLE, IN 46410	
(X4) ID PREFIX TAG	REGULATORY OR scheduled for 8:00 a - 7/11/23 the Glargi 9:45 a.m. The insulir war - 7/12/23 the Lisprop.m. The insulin war - 7/14/23 the Glargi signed out at 9:51 a scheduled for 8:00 a - 7/15/23 the Glargi signed out at 9:38 a scheduled for 8:00 a - 7/16/23 the Glargi signed out at 10:22 scheduled for 8:00 a - 7/20/23 the Glargi signed out at 10:29 scheduled for 8:00 a - 7/23/22 the Glargi signed out at 10:29 scheduled for 8:00 a - 7/23/22 the Glargi signed out at 10:07 scheduled for 8:00 a Interview with the I at 12:05 p.m., indicishould have been si	ne insulin was signed out at in was scheduled for 8:00 a.m. insulin was signed out at 1:48 s scheduled for 12:00 p.m. ne and Lispro insulin was i.m. Both insulins were a.m. ne and Lispro insulins were a.m. Both insulins we	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  administration following the 5 rights of medication pass, wit emphasis on the correct time.  How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; Nurse manager/designee will randomly audit/observe 2 Nu administer insulin 3 times pe week, for 3 months to ensure proper insulin administration times.  DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. There if determined by the Quality Assurance committee, auditi and monitoring will be done quarterly at the QA meeting.  Date by which systemic corrections will be complete 8/28/23	th an  the  put  lurses r  and energy  energy
F 0773 SS=D Bldg. 00	§483.50(a)(2) The (i) Provide or obta when ordered by a assistant; nurse p specialist in accor including scope of	in laboratory services only a physician; physician ractitioner or clinical nurse dance with State law,			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155764	B. WING 08/11/2023			/2023	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	ROVIDER OR SUPPLIER				87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	physician assistant, nurse practitioner, or		+	TAG	DEFICIENC! )		DATE
		cialist of laboratory results					
		clinical reference ranges in					
		acility policies and					
		tification of a practitioner or					
	per the ordering p						
		view and interview, the facility	F 0	773	Spring Mill Health Campus		08/28/2023
		cimens for laboratory testing		113	Annual Survey: 8-7-23		00/20/2023
	were collected as ordered by the Physician for 1 of						
		d for laboratory services			Please accept the following as	s the	
	(Resident 49).				facility's credible allegation of		
					compliance. This plan of		
	Finding includes:				correction does not constitute	an	
					admission of guilt or liability by	/ the	
	Resident 49's record	d was reviewed on 8/9/23 at			facility and is submitted only ir	า	
	_	ses included, but were not			response to the regulatory		
		teomyelitis of the left femur,			requirement.		
	_	cral region stage 4, cellulitis of			The Facility Respectfully requ		
	_	ssure ulcer of right hip, and			paper compliance for this surv	ey ey	
	heart failure.			F773 Lab Svs Physicia			
		D			Orders/Notify of Results		
		mum Data Set (MDS)			What corrective action(s) wil	I	
	· ·	5/22/23, indicated the resident			be accomplished for those		
		act for daily decision making.			residents found to have been	า	
		essure ulcers that were present ry and 3 unstageable deep			affected by the deficient		
	_	ry and 3 unstageable deep ent upon admission/entry.			practice; Resident 49 had lab drawn. N	0	
	ussue injuries prese	in apon admission/entry.			adverse effects were noted du		
	A Physician's Order	r, dated 7/27/23, indicated			not having lab drawn prior to t		
	-	(BUN), creatinine, and			administration of an antibiotic.		
	_	n rate (eGFR) draw prior to			How the facility will identify		
	initiation of antibio				other residents having the		
					potential to be affected by th	е	
	The Laboratory Rep	port, dated 7/28/23, indicated			same deficient practice and		
	BUN, creatinine, eC	GFR were collected on 7/28/23			what corrective action will be	9	
	at 2:35 a.m. and rep	ported on 7/28/23 at 1:02 p.m.			taken;		
					All residents have the potentia	ıl to	
	-	r, dated 7/27/23, indicated			be affected by the alleged def	icient	
	_	vulanate (an oral antibiotic)			practice.		
	tablet 875-125 mill	igrams 1 tablet by mouth twice			What measures will be put ir	ito	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  08/11/2023	
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY:  (EACH DEFICIEN REGULATORY OR daily.  The July 2023 Med (MAR), indicated th administered on 7/2  A Physician's Order levaquin (an antibio tablet by mouth onc	ication Administration Record ae amoxicillin tablet was 7/23 at 8:00 a.m.  c, dated 7/27/23, indicated tic) oral tablet 750 milligrams 1 e daily.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses were educated on en that all lab orders are carried and results are received prio the administration of an antib How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality	DATE  suring out r to biotic.  the
	at 3:58 p.m., indicat have been complete antibiotics per the P 3.1-49(a)			assurance programs will be into place; DON/Designee will audit 2 residents with lab and antibic orders weekly for 3 months to ensure all ordered labs are be drawn, if needed, prior to the administration of an antibiotic Nurse manager/designee will present a summary of the aution to the Quality Assurance committee monthly for 3 more Thereafter, if determined by a Quality Assurance committee auditing and monitoring will be done quarterly at the QA medical programment of the programment	otic o eing c. I dits othe. the e, oe eting.
F 0880 SS=D Bldg. 00	infection prevention designed to provide	on & Control			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		A. BUIL	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00 B. WING			X3) DATE SURVEY COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIES			101 W 8	DDRESS, CITY, STATE, ZIP COD 7TH AVE LVILLE, IN 46410		
SPRING	MILL HEALTH CAI	WIPUS		VIERRIL	LVILLE, IN 404 IU		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
	· ·	and transmission of seases and infections.					
	program. The facility must of prevention and co	on prevention and control establish an infection entrol program (IPCP) that minimum, the following					
	identifying, report controlling infection diseases for all re- visitors, and other services under a based upon the fa- conducted accord	ystem for preventing, ing, investigating, and ons and communicable sidents, staff, volunteers, individuals providing contractual arrangement acility assessment ling to §483.70(e) and d national standards;					
	and procedures for include, but are not (i) A system of sure identify possible of infections before the persons in the fact (ii) When and to we communicable districted; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; incompanism involved.	rveillance designed to communicable diseases or they can spread to other cility; whom possible incidents of sease or infections should transmission-based followed to prevent spread visolation should be used luding but not limited to: duration of the isolation, the infectious agent or dt, and					
	(B) A requirement	t that the isolation should be e possible for the resident					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING				
		155764	B. WING		08/11/2023		
	PROVIDER OR SUPPLIER		101 W	r address, city, state, zip cod / 87TH AVE RILLVILLE, IN 46410			
	SUMMARY SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR Under the circums (v) The circumstar must prohibit emp communicable dis lesions from direct their food, if direct disease; and (vi)The hand hygic followed by staff in contact.  §483.80(a)(4) A sy incidents identified and the corrective facility.  §483.80(e) Linens Personnel must hat transport linens so of infection.  §483.80(f) Annual The facility will conits IPCP and update necessary.  Based on observation interview, the facility control guidelines wincluding those to p	MPUS  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  tances. Inces under which the facility loyees with a lease or infected skin at contact with residents or a contact will transmit the  ene procedures to be involved in direct resident  ystem for recording at under the facility's IPCP actions taken by the  standle, store, process, and as to prevent the spread  review. Induct an annual review of the their program, as  on, record review, and ty failed to ensure infection were in place and implemented, revent and/or contain		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Spring Mill Health Campus Annual Survey: 8-7-23  Please accept the following as	08/28/2023		
	reusable equipment between glove use, lancet for 1 of 6 res	to improper cleaning of , improper hand hygiene and improper disposal of a idents observed during		facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by	an y the		
	medication pass (Re	esident 45, LPN 1).		facility and is submitted only in response to the regulatory requirement.  The Facility Respectfully requ	ests		
	checking blood glue	.m., LPN 1 was observed cose levels of Resident 45.		POC F-880 Infection	-		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			COMPLETED
		155764	B. W	ING		08/11/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF I	PROVIDER OR SUPPLIER				87TH AVE	
SPRING	MILL HEALTH CAN	MPUS			LLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE
	gloves. She wiped the glucometer down with an				Prevention & Cont	rol
	_	aced the glucometer into a			Corrective actions which wi	
	_	moved her gloves and donned			be accomplished for those	"
		t performing hand hygiene in			residents found to have been	n
		She performed the finger stick			affected by the deficient	''
		sident's blood glucose			practice:	
		the room and placed the used				
		ar garbage can. LPN 1 then			Employees were immediately	
		f Novolog (an insulin). She			educated related to performing	
retrieved the medication from the cart, donned new gloves without performing hand hygiene					hand hygiene in between chai	nging
first. She wiped the vial with an alcohol swab,					gloves, the proper method in v	which
inserted a sterile syringe, and withdrew 30 units of					to dispose of lancets and the	
	_	donned new gloves without			correct way to clean a glucom	eter.
	_	giene first and entered the				
		administered the medication.			How the facility will identify	
					other residents having the	
	LPN 1 indicated at	the time, that she should have			potential to be affected by the	ie
	performed hand hyg	giene between glove use, the			same deficient practice:	
	lancet should have l	peen disposed of in the sharps			All	-14-
	container, and she v	vas unaware that an alcohol			All residents have the potentia	
		riate to clean the glucometer			be affected by the alleged def practice.	icient
	that was shared amo	ong residents in the facility.			practice.	
	Interview with the N	Nurse Consultant on 8/9/23 at			The measures the facility wil	II
		she had no further information			take or systems the facility v	vill
	to provide.	some macine raturer information			alter to ensure that the	
	to provide.				problem will be corrected an	d
	A Policy titled, "Gl	ucometer Cleaning" and noted			will not recur:	
		"3. To clean and disinfect			DON/Designee re-educated the	
		noistened germicidal or			staff related to performing har	nd
		/towel. 4. Wipe meter with			hygiene in between changing	
	_	surfaces of the glucometer are			gloves, the proper method in v	which
	visibly wet6. Place glucometer on a clean surface				to dispose of lancets and the	-1
	such as paper towel	and allow to air dry for no			correct way to clean a glucom	eter.
	less than 2 minutes,	or according to manufacturer			Quality Assurance Plane to	
	instructions."				Quality Assurance Plans to	to
					monitor facility performance make sure that corrections a	
		nd Washing/Hand Hygiene"			achieved and are permanent	
	and noted as current, indicated "4. When hands				The D O N or designed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE O		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155764	A. BUILDING	00	COMPLETED	
		100704	B. WING 08/11/2023			
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
SPRING	MILL HEALTH CA	MPUS		/ 87TH AVE RILLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION ed, employees may use an	TAG	will conduct surveillance	DATE	
	1	l rub (foam, gel, liquid)		observation audits 3 times we	eklv	
		60% alcohol in all of the		for 3 months to monitor staff for	•	
	following situation	s:c. before donning		handwashing, lancet disposal	and	
		preparing or handling		glucometer cleaning practices		
	medications;m. a	fter removing gloves"		Administrator/decigned	a dill	
	3.1-18(b)			<ul> <li>Administrator/designee present a summary of the aud</li> </ul>		
				to the Quality Assurance		
				committee monthly for 6 mont	hs.	
				Thereafter, if determined by the	ne	
				Quality Assurance committee		
				auditing and monitoring will be	•	
				done quarterly and present quarterly at the QA meeting.		
				Monitoring will be on going.		
				Dates when corrective action	1	
				will be completed		
				Completion date: 8/28/23		
F 0881	483.80(a)(3)					
SS=D	Antibiotic Steward	dship Program				
Bldg. 00		ion prevention and control				
	program.					
		establish an infection				
	I -	ontrol program (IPCP) that				
	must include, at a elements:	a minimum, the following				
	Cicilients.					
	§483.80(a)(3) An	antibiotic stewardship				
		udes antibiotic use protocols				
		monitor antibiotic use.				
		view and interview, the facility	F 0881	Spring Mill Health Campus	08/28/2023	
	_	ntibiotic stewardship by priate use of antibiotic therapy		Complaint Survey: 8-7-23		

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155764	B. WING			08/11/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L					
ODDINO	NAUL LIEALTILOAN	ADUIO			87TH AVE		
SPRING	MILL HEALTH CAN	//PUS		MERKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	12	DATE
	to reduce antibiotic	resistance related to a			Please accept the following as	the	
	practitioner prescrib	oing antibiotics for wounds			facility's credible allegation of		
		red for 1 of 2 residents			compliance. This plan of		
		re ulcers. (Resident 49).			correction does not constitute	an	
	1	- /			admission of guilt or liability by		
	Finding includes:				facility and is submitted only in		
					response to the regulatory	•	
	Resident 49's record	d was reviewed on 08/09/23 at			requirement.		
		es included, but were not			Toquiroment.		
	1	eomyelitis of the left femur,			The Facility respectfully reque	sts	
		cral region stage 4, cellulitis of			Paper Compliance for this sur		
	1 ~	ssure ulcer of right hip, and			Tuper compliance for this sur	voy.	
	heart failure.	source dieer of right hip, and			POC F-881 Antibiotic Steward	ehin	
	neart fairaic.				1 001 -001 Antibiotic Gleward	Silip	
	The Quarterly Mini	mum Data Set (MDS)			Corrective actions which will b	_	
		/22/23, indicated the resident		accomplished for those residents			
		act for daily decision making.			found to	1113	
		essure ulcers that were present			have been affected by the def	iciont	
		ry and 3 unstageable deep			-	ICIETIL	
	_	nt upon admission/entry.			practice:		
	ussue injuries prese	nt upon admission/entry.			Booldont 40 was assessed as		
	Wound Core Notes	dated 7/26/23, indicated a	Resident 49 was assessed, and no adverse effects were noted				
		completed on 7/19/23, which					
		•			related to	£	
		were detected in the right			antibiotics not meeting criteria		
		edial foot, and left lateral foot.			antibiotic stewardship program		
	_	in, and visit details indicated			How the facility will identify oth		
	_	ven for gentamicin sulfate			residents having the potential	το	
		all wound beds with every			be		
	dressing change.				affected by the same deficient		
	FI 4 : 2022 F				practice:		
	_	hysician Order Summary (POS)					
		n normal saline, pat dry, apply			All residents, on antibiotics, ha		
	_	external ointment 0.1% and			the potential to be affected by	the	
		bed cover with dry dressing			alleged		
		Wednesday to the left distal			deficient practice.		
		eral hip, left distal first toe, left					
		al medial foot, left lateral foot,			The measures the facility will t		
		medial first toe, left medial			or systems the facility will alter	r to	
		oot, left shin, right hip, right			ensure		
	lateral ankle, right l	ateral foot, right medial heel,			that the problem will be correct	ted	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023	
	NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	right medial shin, and sacrum.  There were no cultures completed for the left distal first toe, left distal foot, left lower back, left medial first toe, left medial ankle, left shin, right lateral ankle, right lateral foot, right medial heel, right medial shin, and sacrum.  Interview with the Director of Nursing on 8/11/23 at 3:58 p.m., indicated she would be in-servicing the Wound Nurse Practitioner regarding the use of antibiotics without cultures completed first.		and will not recur:  Infection Preventionist re-educe on McGreer's criteria for being prescribed antibiotics.  Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and apermanent:  • The DON/ designee will reviet the culture 2x per week for 3 months, for all residents prescribed an antibiot to ensure the resident meets McGreer's criteria for infections.  • Administrator/designee will present a summary of the audit to the Quality Assurance committee monthly 6 months. Thereafter, if determined by the Quality Assurance commit auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going.  Dates when corrective action to be completed Completion date: 8/28/23	are ew otic, its for tee,	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,				

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155764  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	residents, staff an Based on observation failed to ensure the clean and in good re ripped carpet on 2 of	fortable environment for d the public. on and interview, the facility residents' environment was epair related to urine odor and of 3 units. (Healthcare 2 Unit	F 09	921	Spring Mill Health Campus Annual Survey: 8/7/23		08/28/2023
	and TCU Unit)  Findings include:  During the Environmental Tour with the Director of Maintenance and the Housekeeping Supervisor on 8/11/23 at 9:45 a.m., the following was observed:  1. TCU Unit:				Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.	an y the	
		re was a rip in the carpet upon m. One resident resided in the			The Facility Respectfully requ paper compliance for this surv		
	Two residents resid Interview with the I Housekeeping Supe	room had a strong urine odor. led in the room.  Maintenance Director and ervisor at the time, indicated eed of cleaning and/or repair.			F921 Safe/Functional/Sanitary/Comble Environment What corrective action(s) will accomplished for those reside found to have been affected be deficient practice;	be ents	
					The foul odor was resolved.  The ripped carpet was repaire	ed.	

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

Event ID:

M3HU11 Facility ID: 010739

If continuation sheet Page 31 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER 155764	A. BUILDING 00 COMPLET  B. WING 08/11/20				
155764		D. WI			00/11/	2023	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
SPRING	MILL HEALTH CAN	MPUS .			LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	How the facility will identify oth	ner	DATE
					residents having the potential		
					be affected by the same defici		
					practice and what corrective a	ction	
					will be taken;		
					All residents have the potentia	ıl to	
					be affected by the same allege		
					deficient practice.		
					What measures will be put into		
					place or what systemic change		
					will be made to ensure that the deficient practice does not rec		
					denoient practice does not rec	ш,	
					0. "		
					Staff were re-educated on the procedure of notifying		
					maintenance/environmental		
					services of any necessary		
					repairs/cleaning needed.		
					How the corrective action(s) w	vill be	
					monitored to ensure the defici		
					practice will not recur, i.e., who quality assurance programs w		
					put into place;	III DE	
					, ,		
					Maintenance supervisor/desig		
					will audit the facility 3x per we		
					for 4 weeks, on alternating uni for Maintenance issues/smells		
					Any identified issues will be	··	
					corrected.		

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

Event ID:

M3HU11 Facility ID: 010739

If continuation sheet Page 32 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155764	A. BUILDING  B. WING	00 00	COMPLETED  08/11/2023		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
R 0000 Bldg. 00	Survey. This visit in Residential Complaint Included a Recertific Survey and the Inve Complaints IN00412 Complaint IN00414 to the allegations are Complaint IN00413 the allegations are complaint IN00413	771 - No deficiencies related to	R 0000	/designee will present a summ of the audits to the Quality Assurance committee monthly 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going.  Date by which systemic corrections will be completed: 8/28/23	y for g y at		

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 33 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155764  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER		(X2) MUL A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE : COMPL 08/11/	ETED
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ct 7, 8, 9, 10, and 11, 2023		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
R 0036 Bldg. 00	Survey dates: Augusta Facility number: 01 Residential Census: These State Resider accordance with 41 Quality review comes 410 IAC 16.2-5-1. Residents' Rights (k) The facility muresident's physical representation ticed: (1) a significant dephysical, mental, (2) a need to alteris, a need to discontreatment due to a commence a new Based on record revialled to ensure the an interested family of a fall for 1 of 4 m (Resident C) Finding includes: The record for Resident 12:00 p.m. Diagralimited to, unsteading the said of t	st 7, 8, 9, 10, and 11, 2023 0739 34 htial Findings are cited in 0 IAC 16.2-5. upleted on 8/15/23. 2(k)(1-2)	R 003		Spring Mill Health Campus Annual Survey: 8-7-23  R 036- Notification of Change What corrective action(s) will accomplished for those reside found to have been affected by the deficient pract Resident C family was notified	be ents ice?	08/28/2023
	An Assisted Living Level of Care Assessment, dated 8/6/23, indicated the resident was severely impaired for decision making.				the fall.  How will facility identify other		

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 34 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155764		 JILDING	00	COMPL 08/11/	ETED		
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	indicated the resider	ed 8/5/23 at 3:15 a.m., nt was witnessed walking in sistance. The nurse		residents who have the potent be affected by the same alleged deficient practice.  The deficient practice has the			
	chair and sat on the	floor. The resident was with the 3 staff members.		potential to affect all facility residents.			
	A Post Fall Observation, dated 8/5/23, indicated notification to the resident's Power of Attorney (POA) would be referred to the day shift.			What corrective measures will facility take or will alter to ensuthat the problem will not reoccur?			
	was notified of the	nentation the resident's POA fall.  Director of Nursing on 8/9/23 at		Licensed nursing staff educate on ensuring that family is notified any time a resident			
		there was no additional		has a fall.  What quality assurance plans	will		
	This State Residents IN00414473.	al tag relates to Complaint		be implemented to monitor factorization performance to ensure corrections are achieve and permanent?	ility		
				DON/Designee will audit all fall documentation 3 x per week for months, to ensure family is notified of the fall. A summary will be presented to Quality Assurance committee monthly x 3 months.	or 3		
				By what date the systemic changes will be completed: 8-28-23			
R 0092 Bldg. 00	410 IAC 16.2-5-1. Administration and Noncompliance (i) The facility mus						

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 35 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 155764  NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS  SIRRIET ADDRIESS, CITY, STATE, AIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410  SUMMARY STATEMENT OF DETICIENCIE PREFIX TAO  SUMMARY STATEMENT OF DETICIENCIE PREFIX TAO  Continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be held every year. When drils are conducted between 9 p.m. and 6 a.m., a coded announcement map be used instead of auditible alarms. (2) At least every six (6) months, an activity shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.  Based on record review and interview, the facility failed to ensure at least every 6 months, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. This had the potential to affect 34 residents who resided in the facility.  Finding includes:  There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months.  There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months.	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE WERRILLYILLE, IN 46410  SUMMARY STATEMENT OF DEFICIENCIE PRIEFIX TAG  SUMMARY STATEMENT OF DEFICIENCIE CINCATI DEPTICIENCY MUST III PRICCIDID IN YILL.  TAG  COMPLETION  disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement map be used instead of auditible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.  Based on record review and interview, the facility failed to ensure at least every 6 months, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. This had the potential to affect 34 residents who resided in the facility.  Finding includes:  The Fire and Disaster Drills reviewed on 8/9/23 at 9/53 a.m.  There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months.  STREET ADDRESS, CITY, STATE, 200  MERRILLYILLE, III A4410  DA TRILLYILLE, III	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				ETED	
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SPRING MILL HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATION ALS DEDITIONS INFORMATION TAG DESIGNATION AND ALS DESTROYS INFORMATION TAG DESIGNATION AND ALS DESTROYS INFORMATION DATE  disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.  (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.  Based on record review and interview, the facility failed to ensure at least every 6 months, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. This had the potential to be affected by the deficient practice. Fire Department involved in fire drill on 8-11-23. 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 deficient practice. What	NAMEOFI				STREET A	ADDRESS, CITY, STATE, ZIP COD		
SUMMARY STATEMENT OF DEFICIENCIE   TREATMENT OF DEFICIENCIE   TREATMENT OF DEFICIENCY MATERIAL PROPERTY   CHARLED PROPERTY   TAG   TREATMENT OF DEFICIENCY MATERIAL PROPERTY   TAG   TREATMENT OF DEFICIENCY MATERIAL PROPERTY   TAG   T	NAME OF I	PROVIDER OR SUPPLIEF	C		101 W 8	87TH AVE		
PREFIX TAG     REGULATORY OR LSC IDENTIFYING INFORMATION   TAG	SPRING	MILL HEALTH CAN	MPUS	_	MERRI	LLVILLE, IN 46410		
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in fire drill on 8-11-23. 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 deficient practice. What		F. 1				<u> </u>		
The Fire and Disaster Drills reviewed on 8/9/23 at 9:53 a.m.  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 deficient practice. What		Finding includes:						
9:53 a.m.  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 deficient practice. What		TI E' 1D' ( D'II ' 1 0/9/22 )						
by the same deficient practice and what corrective action will be taken; All Residents have the potential to be affected by the same deficient practice. What			of Diffis reviewed off 6/9/23 at					
There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months.  what corrective action will be taken; All Residents have the potential to be affected by the same deficient practice. What		9:33 a.m.						
department was invited to participate in at least 1 fire drill every 6 months.  taken; All Residents have the potential to be affected by the same deficient practice. What		There was no door	mentation the local fire				anu	
fire drill every 6 months.  potential to be affected by the same deficient practice. What								
same deficient practice. What		_						
						I -		
Interview with the Assistant Maintenance measures will be put into place or		Interview with the	Assistant Maintenance			· ·		

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 36 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155764	A. BUILDING B. WING	00	COMPLETED  08/11/2023
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD 87TH AVE	
SPRING	MILL HEALTH CAM	1PUS		LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Directed did not know if the fany of the fire drills find out.  Interview with the A Director on 8/9/23 a spoken to the Maint indicated he had embut never heard back He also indicated he well, but had no reco	t 10:07 a.m., indicated the or was on sick leave and he fire department participated in the but would give him a call and assistant Maintenance at 10:20 a.m., indicated he had enance Director, who ailed the local fire department, at, and did not have that email. It did remember calling them as ord of the phone call.		what systemic changes will be made to ensure that the deficipractice does not recur; Administrator and Maintenance Department educated about the need to in the fire department in fire drills the facility every 6 months. He 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; Maintenance/Designed ensure that the fire department involved in fire drills every 6 months at the facility. The nur supervisor/designee will presessummary of the audits to the Quality Assurance committee monthly for 3 months. Thereat if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 8/28/23	ent  volve s at  ow    will  tis  see ent a  fter,  g
R 0144 Bldg. 00		ety Standards - Deficiency			
ычу. 00	a state of good rep and shall provide r residents.	Il be clean, orderly, and in pair, both inside and out, reasonable comfort for all			
	failed to ensure the	on and interview, the facility residents' environment was epair related to marred walls	R 0144	Spring Mill Health Campus Annual Survey: 8/7/23	08/28/2023
	-	arpets, sewage odors, rusted		R 144- Sanitation and Safety	

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 37 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155764		A. BUILDING 00  B. WING			COMPLETED 08/11/2023		
NAME OF	PROVIDER OR SUPPLIEF	l .			DDRESS, CITY, STATE, ZIP COD		
SPRING	MILL HEALTH CAN	MPUS	MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	door frames, and do 2 of 2 units. (The Lunits)  Findings include:  On 8/9/23 at 2:25 p completed and the factor of the ceil bathroom door fram were 2 residents who bathroom.  b. Room 126 - The observed in the ceil bathroom door was marred. There was room and used the later of the ceil bathroom door was frame. There were 2 bathroom.  d. There was a stront hallway outside of the later of the was marred and but for the walls below the later of	a.m. the Environmental Tour was Collowing was observed:  The was debris and particles ing light in the bathroom. The ne and door was rusted. There no shared the room and  The was debris and particles ing light in the bathroom. The rusted brown in color and 1 resident who resided in the bathroom.  Toilet high rise seat was dirty ovement. There was debris and ng light in the bathroom. The marred and had a rusted door 2 residents who shared the  The marred and had a rusted door 2 residents who shared the the residents' rooms.			What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice;  Room 116, 126, 127 ceiling lighthe bathroom was cleaned. Room 116, 126, 127-bathroom door was repainted and cleaner Room 127 toilet seat was cleaned. Hallways free of foul odor. Wallpaper was cleaned and no longer bubbled. Walls repainted and no longer marred. Carpet in the dining room cleaner Floors in the parlor were cleaned and repainted.  How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;  All Residents have the potential be affected by the same deficient practice.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur;  Staff were re-educated to complete work orders.	n ht in hed. hed. hed	

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 38 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155764	A. BUILDING B. WING	00	COMPLETED 08/11/2023
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		parlor next to the dining room ed with scuff marks. The walls ty.		Housekeeping supervisor and maintenance will complete wa rounds daily.	III
	outside of the reside	Administrator on 8/10/23 at 1:05 f the above was in need of		How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance programs will be into place;  Maintenance/Housekeeping wensure that the facility is free of foul odors, and facility remains clean and good living condition.  The Housekeeping supervisor/designee will prese summary of the audits to the Quality Assurance committee monthly for 3 months. There if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going.  Date by which systemic corrections will be complete 8/28/23	put  vill  of s in ns.  ent a  ufter,  g y at vill
R 0217	410 IAC 16.2-5-2( Evaluation - Defici				
Bldg. 00	(e) Following comp facility, using appro members, shall ide	oletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as			

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 39 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/11/2023
	ROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  ALSO IDENTIFYING DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	(1) The services of resident shall be as (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of revised as appropresident and facility change. Either the request a service (3) The agreed up signed and dated of the service plan resident upon request a service (4) No identification services provided subsequent to the no need for a chall (5) If administration provision of reside both, is needed, a involved in identifithe services to be Based on record revenue.	a LSC IDENTIFYING INFORMATION  offered to the individual appropriate to the:  offered shall be reviewed and riate and discussed by the ty as needs or desires a facility or the resident may plan review.  on service plan shall be by the resident, and a copy in shall be given to the uest.  on and documentation of its needed if evaluations initial evaluation indicate inge in services.  on of medications or the cential nursing services, or licensed nurse shall be cation and documentation of	R 0217	Spring Mill Health Campus	08/28/2023
	the resident and the according to the res	y were revised and updated ident's change in condition for lewed for service plans.		Annual Survey: 8-7-2023  Please accept the following as	s the
	Findings include:	, , ,		facility's credible allegation of compliance.	
	8/8/23 at 2:25 p.m. not limited to, type pressure, depressive	esident 2 was reviewed on Diagnoses included, but were 2 diabetes, high blood e and bipolar disorder.  ated 8/6/23, was not signed by		This plan of correction does not constitute an admission of gui liability by the facility and is submitted only in response to	lt or

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 40 of 58

PRINTED: 09/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING  B. WING		00 (X3) DATE SURVEY  COMPLETED  08/11/2023		ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  101 W 87TH AVE  MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY (	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	the resident, only by	y facility staff.			regulatory requirement.		
		Administrator on 8/9/23 at 1:15 was unaware the service plans the resident.			R 217 Evaluation		
	<ul> <li>2. The record for Resident B was reviewed on 8/8/23 at 10:24 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, dementia with mild anxiety, major depressive disorder, and high blood pressure.</li> <li>A Physician's Order, dated 5/6/23, indicated hospice to evaluate and treat.</li> <li>The Service Plan, dated 8/6/23, was not signed by</li> </ul>				What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice;	nts	
					Service Plans signed by family members.	/	
		y facility staff. The service			Service plans updated as need	ded.	
	p.m., indicated she had to be signed by  Interview with the I	Director of Nursing on 8/9/23 at			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;		
	3. The record for Ro 8/8/23 at 12:00 p.m not limited to, unste	esident C was reviewed on  Diagnoses included, but were eadiness on feet, repeated falls, vioral disturbance, and			All facility residents have the potential to be affected by the same alleged deficient practice		
	hospice to evaluate				What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not rec	es e	
	current 8/2023 Orde	c, dated 12/31/21 and on the er Summary , indicated Seroquel					
	50 milligrams at be	u ume.			Director was educated on the		

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 41 of 58

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	the resident, only by	lated 8/6/23, was not signed by y facility staff. The Service s hospice care or the use of cation.			need to ensure that all service plans are signed by residents unable to sign their family members.		
	p.m., indicated she had to be signed by  Interview with the l	Director of Nursing on 8/9/23 at I there was no additional			Staff were educated to ensure service plans are updated with changes of condition.		
	8/8/23 at 3:30 p.m. not limited to deme	esident D was reviewed on Diagnoses included, but were entia without behavioral, anxiety disturbances, and high			How the corrective action(s) we monitored to ensure the defici- practice will not recur, i.e., who quality assurance programs we put into place;	ent at	
	the resident, only by Interview with the	Administrator on 8/9/23 at 1:15 was unaware the service plans			Nurse Supervisor/Designee will audit 5 residents service plans per week x 3 months to ensure that the service plans are being signed and updated.		
	on 8/8/23 at 8:25 a. were not limited to, disease, chronic respressure, legal blind heart failure, repeat disorders.  The Service Plan, dby the resident, only Interview with the American service with the American service plan, dby the resident, only Interview with the American service plan	Administrator on 8/9/23 at 1:15 was unaware the service plans			The Nurse Supervisor/designed will present a summary of the audits to the Quality Assurance committee monthly for 3 month. 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.	e hs. ie	

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  B. WING		(X3) DATE SURVEY COMPLETED 08/11/2023		
	PROVIDER OR SUPPLIER		101	ET ADDRESS, CITY, STATE, ZIP COD W 87TH AVE RRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	8/8/23 at 4:40 p.m. not limited to, Parki disorder, arthritis, a	esident F was reviewed on Diagnoses included, but were inson's disease, anxiety, bipolar nd major depressive disorder. ated 8/6/23, was not signed by		Date by which systemic corrections will be completed:8/28/23	
		Administrator on 8/9/23 at 1:15 was unaware the service plans			
R 0349 Bldg. 00	on each resident. maintained under employee of the fa	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that e records must be as cumented. sible.			
	Based on record reversal failed to ensure climaccurate related to form the documentation after checks completed, and administered only an interventions were assigned out as being residents reviewed and B, C, D, and F)  Findings include:  1. The record for F	view and interview, the facility ical records were complete and follow up assessment and r a fall with injury, neurological as needed (PRN) medication of the non-pharmacological attempted, and medications administered for 4 of 6 for clinical records. (Residents	R 0349	Spring Mill Health Campus Annual Survey: 8/7/2023  Please accept the following a facility's credible allegation of compliance.  This plan of correction does r constitute an admission of gu liability by the facility and is submitted only in response to regulatory requirement.	not uilt or o the
	administered only a interventions were a signed out as being residents reviewed B, C, D, and F)  Findings include:  1. The record for F	fter non-pharmacological attempted, and medications administered for 4 of 6 for clinical records. (Residents		This plan of correction does r constitute an admission of gu liability by the facility and is submitted only in response to	not illt or o the

State Form Event ID: M3HU11 Facility ID: 010739 If continuation sheet Page 43 of 58

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155764	B. W	'ING		08/11/	2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
CDDING	NAUL LIEALTH CAN	ADUE			B7TH AVE		
SPRING	MILL HEALTH CAN	//PUS		MEKKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		bolic encephalopathy,			paper compliance for this surv	ey ey	
		anxiety, major depressive					
	disorder, and high b	blood pressure.					
	A Nurses' Note, dated 7/10/23 at 10:26 p.m.,				R349 Clinical Records – Non		
		45 p.m., the resident was					
		or in front of the bathroom.					
		ted she had pain all over, but					
		ead. There was small bruise			What corrective action(s) will be		
		that measured 0.5 centimeters			accomplished for those reside		
	(cm) by 0.3 cm.				found to have been affected b	y the	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			deficient practice;		
		ation, dated 7/10/23, indicated					
		unwitnessed fall with injury to					
	her left arm.						
	A F 11 F 11 - TT A	1 4 1			Resident ,D, F were assessed	,	
	_	Assessment was completed on			and no adverse effects were		
		/11 at 12:03 a.m., 7/13 at 9:57			noted.		
	p.m., and 7/15/23 at	1 12:00 p.m.					
	There were no neur	ological checks initiated after					
	the unwitnessed fall	_			How the facility will identify oth	ner	
	the unwithessed fun				residents having the potential		
	A Nurses' Note dat	ed 7/21/23 at 1:58 p.m.,			be affected by the same defici		
		nt was observed by staff on			practice and what corrective a		
		the wheelchair. The fall was			will be taken;	Olion	
		e was unable to verbalize					
		ere were no apparent injuries					
		The resident had an old					
		to the left side of the			All residents with falls can be		
	forehead.				affected by the same alleged		
					deficient practice.		
	A Post Fall Observa	ation, dated 7/21/23 at 1:47			-		
	p.m., indicated the	resident had an unwitnessed					
	fall and was not abl	e to verbalize what had					
	happened. A neurol	ogical check was completed			What measures will be put into	0	
	-	e noted except she had an old			place or what systemic change	es	
	faded green bruise t	to the left forehead.			will be made to ensure that the	е	
					deficient practice does not rec	ur;	
	There was no docur	mentation or an assessment in					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155764	B. W	ING		08/11/	2023
				CTREET	ADDRESS OF A TE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ODDINO	NAUL LIEALTILOAN	ADLIG			87TH AVE		
SPRING	MILL HEALTH CAN	IPUS		MERKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the clinical record o	f any left forehead bruise after					
	the fall on 7/10/23.						
					p paraid="286295553"		
	There was no docur	nentation continued			paraeid="{a133d012-9642-430	)2-85	
	neurological checks	had been initiated.			bd-d1cd98b19886}{7}" >Nurse	es	
					were educated on completing	post	
	A Fall Follow Up A	ssessment, dated 7/24/23 at			fall follow up documentation a	nd	
		only one completed after the fall			when to use non- pharmacolo	gical	
	on 7/21/23.				interventions which includes:		
	A Nurses' Note, dat	ed 7/26/23 at 7:39 p.m.,					
	indicated discolorat	ion to the left side of the head			Daily follow up fall assessmen	t	
	remained and was s	ubsiding slowly.			documentation per facility poli	су	
				for			
	1	servations, dated 6/27 and					
	· ·	ne resident had no skin issues.					
		y skin observation completed			·Neurological checks per fac	ility	
		The 7/25/23 skin observation			policy		
		in progress and not					
	completed.						
					·Vital signs per facility policy		
		Director of Nursing on 8/9/23 at					
		neurological checks were to be					
		unwitnessed fall. A fall follow			·Utilize non-pharmacological		
		eted every shift for 72 hours.			interventions prior to using PR	N	
	She had no addition	al information to review.			Medication.		
	2.51 1.0 0						
		esident C was reviewed on					
	_	Diagnoses included, but were					
		adiness on feet, repeated falls,					
	arthritis.	vioral disturbance, and			Llow the competitive action (-)	ill ba	
	arumus.				How the corrective action(s) w monitored to ensure the deficient		
	An Accietad Livina	Level of Care assessment,			practice will not recur, i.e., what		
	_	ted the resident was severely			quality assurance programs w		
	impaired for decision				put into place;	ııı D <del>C</del>	
	impaned for decision	ni maxing.			put into piace,		
	Physician's Orders	dated 5/10/23, indicated					
	1 -	-anxiety medication) 2					
		milliliters (ml), give 0.25 ml			Nurse managers will audit clin	ical	
	I mingrams (mg) per	minimicis (mi), give 0.23 mi			Transe managers will addit Cill	ıvaı	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	l í	LDING	nstruction <u>00</u>	(X3) DATE COMPL <b>08/11</b> /	ETED
	PROVIDER OR SUPPLIER			101 W 8	DDRESS, CITY, STATE, ZIP COD 37TH AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	anxiety and restless  The Medication Ad the months of 6/202 PRN medication was	4 hours as needed (PRN) for ness.  ministration Record (MAR) for 23 and 7/2023, indicated the as signed out as administered ., 6/11 at 7:20 p.m., 6/24 at 7:09			documentation 2 times per we for 3months to ensure follow u assessments and neuro check are complete. The use of PRN medication will be audited twice week.	p ss	
	p.m., 6/25 at 2:02 p p.m., and 7/9 at 8:00 There was no docur	.m., 7/1 at 10:44 p.m., 7/4 at 3:22 3 p.m. mentation in Nurses' Notes on			The Director of Nursing/desigr will present a summary of the		
	attempted first befo Lorazepam.	al interventions were re administering the PRN			audits to the Quality Assuranc committee monthly for 6 monthsThereafter, if determine the Quality Assurance commit auditing and monitoring will be	ed by tee,	
	indicated the reside ambulating in the has his arms. The reside room and leaned or	allway and carrying briefs in ent stepped inside a resident wer towards a shelf, and ausing him to lose his balance			done quarterly at the QA meetingMonitoring will be on going.		
	by 0.2 cm open area	ocks. A 0.5 centimeters (cm) a was observed to the left al assessment was initiated.			Date by which systemic corrections will be completed:8/28/23		
	the resident was obs	d 6/18/23 at 9:22 a.m., indicated served with swelling to the d and his fingers had					
	Physician's Order, of hand X-ray.	lated 6/19/23, indicated left					
		d, dated 6/19/23, indicated the fourth proximal phalanx bone in the finger)					
		dated 6/19/23, indicated d swelling to left hand and					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	ľ	ILDING	NSTRUCTION  00	(X3) DATE COMPL 08/11/	ETED
	PROVIDER OR SUPPLIER			101 W 8	DDRESS, CITY, STATE, ZIP COD 87TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	fingers every shift in phalanx fracture.	related to acute fourth proximal					
	the month of 6/202, not signed as being shift on 6/28 and or 6/24, 6/25, 6/27 and The TAR for the m monitoring was not during the day shift	onth of 7/2023 indicated the signed as being completed on 7/17, the evening shift on ht shift on 7/3, 7/8, 7/9, 7/13,					
	1:15 p.m., indicated	Director of Nursing on 8/9/23 at d fall follow up was to be ift for 72 hours. She had no ion to review.					
	8/8/23 at 3:30 p.m. not limited to deme	esident D was reviewed on Diagnoses included, but were entia without behavioral, anxiety disturbances, and high					
	dated 8/6/23, indica	Level of Care assessment, ated the resident was d for decision making.					
	the resident had an sustained a hemator	ation, dated 6/4/23, indicated unwitnessed fall and ma (blood-filled localized of her scalp that measured by by 6 cm.					
	completed through	s were initiated on 6/4/23 and 6/5/23 at 5:10 a.m. They were every shift for 48 hours.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY PLETED 1/2023
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP 87TH AVE LLVILLE, IN 46410	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	p.m., indicated the reface. She sustained measured 3.1 cm by	resident had a fall and hit her a bruise to the right cheek that 7 2.8 cm.  Assessment, was only at 10:29 a.m., 7/29 at 11:01 a.m.				
	9:29 p.m.  There was no follow	30 at 6:53 a.m., 1:26 p.m., and v up assessment for the bruise				
	completed on 7/26/2 assessment complet					
	1:15 p.m., indicated completed for every up was to be compl	Director of Nursing on 8/9/23 at a neurological checks were to be unwitnessed fall. Fall follow eted every shift for 72 hours. all information to review.				
	8/8/23 at 4:40 p.m. not limited to, Park disorder, arthritis, a	esident F was reviewed on Diagnoses included, but were inson's disease, anxiety, bipolar and major depressive disorder.				
	indicated the reside dementia, some cor remembering conve	are Assessment, dated 8/6/23, and had mild impairment for affusion, and difficulty in ersations and forgetfulness.				
	Lorazepam (an anti milligrams, give 1 of for anxiety.	dated 3/23/23, indicated -anxiety medication) 0.5 every 12 hours as needed (PRN)				
	for the month of 6/2 Lorazepam was sign	ministration Record, (MAR) 2023, indicated the PRN ned out as being administered and 6/26 at 12:12 p.m.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       08/11/2023							
NAME OF PROVIDER OR SUPPLIER  SPRING MILL HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	Ε	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	WATE	DATE		
	signed out as being p.m. and 7/24/23 at The 8/2023 MAR, i	ndicated the medication was administered on 7/8 at 10:19 1:44 p.m.  Indicated the medication was administered on 8/3/23 at							
	There were no non-pharmacological interventions attempted first before the administration of the PRN Lorazepam.								
	a.m., indicated the r fall and was not abl happened. The resid	resident had an unwitnessed e to tell anyone how it dent sustained an abrasion the right brow that measured							
	assessment was con and 7:01 p.m., 4/12 and 4/14/23 at 2:20	assessment, indicated an inpleted on 4/11 at 11:01 a.m., at 8:33 p.m., 4/13 at 10:56 a.m., p.m. The Fall Follow Up not completed every shift for							
	-	s were initiated on 4/11/23 at e not fully completed.							
	1:15 p.m., indicated completed for every up was to be comple She had no addition	Director of Nursing on 8/9/23 at a neurological checks were to be a unwitnessed fall. Fall follow eted every shift for 72 hours. It information to review.							

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		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  155764 B. WING		00	COMPLETED 08/11/2023					
		155764	B. WI	NG		08/11/	2023	
NAME OF PROVIDER OR SUPPLIER				l	ADDRESS, CITY, STATE, ZIP COD			
SPRING MILL HEALTH CAMPUS				87TH AVE LLVILLE, IN 46410				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		Т	ID				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
R 0407	410 IAC 16.2-5-12	?(b)(1-4)						
	Infection Control -	Noncompliance						
Bldg. 00	(b) The facility mus	st establish an infection						
	control program th	at includes the following:						
	(1) A system that e	enables the facility to						
	analyze patterns o	f known infectious						
	symptoms.							
	(2) Provides orient	tation and in-service						
		tion prevention and control,						
	including universa							
	` '	information to residents,						
	including, but not l							
	transmission and i							
		municable disease to						
	public health author							
		on, record review, and	R 0	407	Spring Mill Health Campus		08/28/2023	
		ty failed to ensure proper			Annual Survey: 8-7-23			
	_	ormed before reusing a lancet						
	_	gar level, gloves were used for			R 407 Antibiotic Stewardship	1		
		f insulin, residents who			and Infection Control			
		had true infections, and			Diagona account the following ac-	41		
	_	nococcal vaccines were for 1 of 1 residents observed			Please accept the following as facility's credible allegation of	ıne		
		sidents reviewed for			compliance. This plan of			
		r 6 of 6 residents reviewed for			correction does not constitute	on		
		s 5, 2, B, C, D, E, and F)			admission of guilt or liability by			
	vaccines. (Residents	5 5, 2, B, C, D, L, and F)			facility and is submitted only in			
	Findings include:				response to the regulatory			
	i manigs merade.				requirement.			
	1. At 11:03 a.m. on	8/8/23, LPN 2 donned clean			Toquiroment.			
		s and walked into Resident 5's			What corrective action(s) will	l		
	•	r finger with an alcohol wipe,			be accomplished for those	·		
		's finger and no blood was			residents found to have been	, !		
		pricked her finger again with			affected by the deficient			
		nout cleaning the area again			practice;			
		e. She obtained the blood and			Infection Preventionist educate	∍d		
	-	glucometer. After completing			on the Antibiotic Stewardship			
		she removed her gloves and			program and the need to have	а		
	went out to the med	cart in the hallway. The LPN			true infection to prescribe an			
	drew up 12 units of	insulin from a multi-dose vial			antibiotic.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155764	B. WING 08/11/2023			08/11/2023	
Low			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	2			87TH AVE		
SPRING	MILL HEALTH CAN	MPLIS			LLVILLE, IN 46410		
OI INING	TWILL FILALITI OAN	vii 00		MEINI	LL VILLE, IIN 70710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	DATE	
		r verifying the insulin, she did			AL Nurse Manager educated	on	
	_	needle and she walked into the			the need to offer influenza,		
		ne did not perform hand			pneumonia and COVID		
		ves. LPN 2 informed the			immunizations annually and		
	_	ing to administer the injection			document it in the EMR.		
		arm. The needle was still had pulled down the resident's			AL Nurse educated on the pro		
		th the needle still exposed.			sanitation process to use whe	<b>I</b>	
	long sieeve sinit wi	in the needle sun exposed.			checking blood sugar and the of gloves when administering	use	
	Interview with the I	Director of Nursing on 8/9/23 at			insulin.		
		the nurse should have			i iii sulii i.		
	_	er finger again before reusing			How the facility will identify		
		worn gloves to administer the			other residents having the		
	insulin injection.	wern greves to uniminater the			potential to be affected by th	ne l	
	,				same deficient practice and		
	2. The record for Ro	esident B was reviewed on			what corrective action will be	e	
	8/8/23 at 10:24 a.m	. Diagnoses included, but were			taken;		
	not limited to, meta	bolic encephalopathy,			All facility residents can be		
	dementia with mild	anxiety, major depressive			affected by the same alleged		
	disorder, and high b	blood pressure.			deficient practice.		
	-	r, dated 3/21/23, indicated may			What measures will be put in	nto	
		nalysis, culture and sensitivity)			place or what systemic		
		complains of burning or had			changes will be made to		
	increased confusion	1.			ensure that the deficient		
		1.4/6/22 0.25			practice does not recur;		
		d 4/6/23 at 9:27 a.m., indicated			IP to monitor every resident p		
		en yelling and looking for			on an antibiotic and ensure the	at	
		t's daughter indicated when			the resident meets McGreer's		
		onfusion, it could mean she			criteria to be on the antibiotic.		
		nfection, so she requested a			DON/Designee to audit all ne		
	urinalysis.				admissions and re-admissions	ה נט	
	Δ uringlycic dated	4/8/23 (a partial report),			ensure that they were offered influenza, pneumonia and CO	MD	
	-	nt's urine was less than 10,000			iniliuenza, pneumonia and CO immunizations and that the	טוע	
	gram negative bacil				information is documented in t	the	
	514111 Hegative Daell	iii Oiguiiisiiis.			medical record.	uic	
	A Nurses' Note dat	ted 4/10/23 at 9:00 p.m.,			inicultar record.		
		was called and informed of			How the corrective action(s)		
		inalysis. A new order for Cipro			will be monitored to ensure t		
	1	,	1		20		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMP			COMPL	ETED
		155764	B. WING 08/11/2				
		1					
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					87TH AVE		
SPRING	MILL HEALTH CAN	MPUS		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		mg twice a day times 10 days			deficient practice will not		
	was noted and carri	ed out.			recur, i.e., what quality		
					assurance programs will be	put	
		d 5/27/23 at 8:05 p.m.,			into place;		
		nt had complaints of			DON/Designee will audit 100%	6 of	
		ncy with pain while passing			residents with a new order for		
		from the medical doctor was			antibiotics to ensure that they		
	obtained.				meet McGreer's Criteria to be		
					taking the antibiotic.		
		dated 5/27/23, indicated			DON/Designee will audit 100%		
	· ·	iotic) 100 milligrams (mg) by			new admissions and readmiss	sions	
		s and at bedtime for burning			to ensure that residents are be	· ·	
	_	increased confusion until			offered Influenza, Pneumonia		
	6/6/23.				COVID immunizations and tha		
					the documentation is in the EN	ЛR.	
		lysis results available for					
	review.				Administrator/designee will		
					present a summary of the aud	its	
		Director of Nursing on 8/9/23 at			to the Quality Assurance		
		there was no additional			committee monthly for 6 mont		
	information for revi	iew.			Thereafter, if determined by the		
					Quality Assurance committee,		
		d for Resident E was reviewed			auditing and monitoring will be		
		m. Diagnoses included, but			done quarterly and presented		
		anxiety, chronic kidney			the QA meeting. Monitoring w	/111	
		piratory failure, high blood			be on going.		
	-	dness, hearing loss, COPD,			Date by which systemic		
	_	ed falls, and depressive			corrections will be complete	d:	
	disorders.				8/28/23		
	Nurses' Notes date	d 4/10/23 at 2:32 p.m.,					
		ent was much more confused					
	per family. A new order to obtain an urine						
	specimen for UA C						
	permentor on c	as received.					
	A UA sample was a	collected on 4/12/23 with the					
	_	/14/23. The report indicated					
	•	leukocytes, negative for					
		bacteria. A hand written order					
	_	e lab report indicated Keflex (an					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155764		A. BUILDIN B. WING	G <u>00</u>	СО	MPLETED /11/2023	
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STA' W 87TH AVE	TE, ZIP COD	
SPRING	MILL HEALTH CAN	MPUS		RRILLVILLE, IN 4641	10	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE)	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
		three times a day for 7 days to				
	-	r, dated 4/15/23, indicated apsule by mouth three times a 3.				
	There was no urine	culture available for review.				
	Interview with the Director of Nursing on 8/9/23 at 1:15 p.m., indicated she had no additional information.					
	noted as current, ind microbiology cultur when possible so ar stopped when appro- antibiotics is only a practitioner determi- evaluation, that the patient's symptoms Resident C's record 12:00 p.m. Diagnos	atimicrobial Stewardship," and dicated "4iii Obtain res prior to starting antibiotics atibiotics can be adjusted or opriate. Treatment with ppropriate when the tines, on the basis of an most likely cause of the is a bacterial infection." 4. was reviewed on 8/8/23 at the included, but were not mess on feet, repeated falls,				
		mentation related to the ed the pneumococcal				
		Director of Nursing on 8/11/23 ated she had no further ide.				
	10:24 a.m. Diagnos	ord was reviewed on 8/8/23 at es included, but were not , major depressive disorder, ation.				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155764		A. BUIL B. WING	DING	00	COMPL 08/11/	ETED	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				101 W 8	DDRESS, CITY, STATE, ZIP COD 7TH AVE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		nentation related to the ed the pneumococcal					
	Interview with the Director of Nursing on 8/11/23 at 10:44 a.m., indicated she had no further information to provide.						
	2:25 p.m. Diagnose	rd was reviewed on 8/8/23 at s included, but were not limited s, high blood pressure, and					
	There was no documentation related to the resident being offered the pneumococcal vaccination.						
		Director of Nursing on 8/11/23 ated she had no further ide.					
		ord was reviewed on 8/8/23 at s included, but were not limited ure and dementia.					
		mentation related to the ed the pneumococcal or on.					
		Director of Nursing on 8/11/23 ated she had no further ide.					
	8:25 a.m. Diagnose	rd was reviewed on 8/9/23 at s included, but were not limited lisease, chronic respiratory ood pressure.					
		nentation related to the ed the pneumococcal or					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155764  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING  B. WING			COMPLETED 08/11/2023	
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION on.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	at 10:44 a.m., indical information to prov 9. Resident F's reco 4:40 p.m. Diagnose	Director of Nursing on 8/11/23 ated she had no further ide.  rd was reviewed on 8/8/23 at s included, but were not limited arkinson's disease, and bipolar			
	resident being offer influenza vaccination	Director of Nursing on 8/11/23 ated she had no further			
R 0414 Bldg. 00	hands after each	Deficiency st require staff to wash their direct resident contact for ng is indicated by accepted			
	Based on observation failed to ensure han before donning and medication pass for	on and interview, the facility d hygiene was performed after doffing gloves during 2 of 5 residents observed bass. (Residents 4 and 5)	R 0414	Spring Mill Health Campus  Annual Survey: 8-7-23	08/28/2023
	LPN 2 was observe	on pass on 8/8/23 at 10:59 a.m. d preparing medications for		R 414 Handwashing	
	resident's room and She did not perform the medication pass	time, she walked into the administered his medications. I hand hygiene before or after . The LPN then pushed the vn the hallway to Resident 5's		Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute a	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155764		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/11/2023				
	ROVIDER OR SUPPLIER MILL HEALTH CAN		STREET ADDRESS, CITY, STATE, ZIP COD 101 W 87TH AVE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	gloves to both hand room. She did not p wiped her finger wi	8/8/23, LPN 2 donned clean s and walked into Resident 5's erform hand hygiene. She th an alcohol wipe, pricked the I no blood was observed. The		admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.				
	and blood was obse and put the strip into towards the door, re and threw them awa	ger again with the same lancet rved. She obtained the blood o the glucometer. She walked moved her gloves in the room by in the resident's trash can.		What corrective action(s) will accomplished for those reside found to have been affected b deficient practice;  related to the hand washing	ents			
	removing her glove resident's insulin, th sharps container and hygiene.	s. She administered the rew the syringe into the did not perform hand		policy and the need to wash in between changing gloves.				
	eye drops to Reside clean gloves off of l resident's room. No before donning the After the administra doffed both gloves a	N 2 was observed administering and 5. She removed a pair of the cart and walked into the hand hygiene was performed gloves to both of her hands. Intion of the eye drops, she and threw them away in the m. She did not perform hand		How the facility will identify oth residents having the potential be affected by the same defic practice and what corrective a will be taken;	to ient			
	Interview with the I 1:30 p.m., indicated	y after glove removal.  Director of Nursing on 8/9/23 at the nurse should have giene before donning and after		All facility residents have the potential to be affected by the same alleged deficient practic	•			
	A Policy titled, "Ha and noted as current are not visibly soile alcohol-based hand containing at least 6 following situations	nd Washing/Hand Hygiene," t, indicated "4. When hands d, employees may use an rub (foam, gel, liquid) 10% alcohol in all of the the control in the contro		What measures will be put int place or what systemic chang will be made to ensure that the deficient practice does not reconstructed.  Staff re-in serviced related to	es e cur;			
	-	ns; h. before and after putting		Staff re-in serviced related to	the			

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	OF CORRECTION	IDENTIFICATION NUMBER  155764	A. BUILDING  B. WING	00 00	COMPLETED  08/11/2023
	PROVIDER OR SUPPLIER		101 W	ADDRESS, CITY, STATE, ZIP COD 87TH AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on and upon remova	al of PPE, including gloves"		handwashing policy and the note to wash hands in between changing gloves.	eed
				How the corrective action(s) we monitored to ensure the deficit practice will not recur, i.e., who quality assurance programs we put into place;	ent at
				DON/Designee will perform handwashing observations on employees, 3 x weekly for 4 months to ensure that they are following the handwashing pol and washing hands in betwee changing gloves.	e licy
				/designee will present a summ of the audits to the Quality Assurance committee monthly 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going.	y for g y at
				Date by which systemic corrections will be completed: 8/28/23	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155764	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/11/2023	
NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS				101 W 8	ADDRESS, CITY, STATE, ZIP COD B7TH AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE

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