STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00419120, IN00423550, and IN00427249. This visit included the Investigation of Residential Complaint IN00418622. Complaint IN00418622 - No deficiencies related to the allegations are cited. Complaint IN00419120 - Federal/State deficiencies related to the allegations are cited at F757. Complaint IN00423550 - Federal/State deficiencies related to the allegations are cited at F693 and F842. Complaint IN00427249 - Federal/State deficiencies related to the allegations are cited at F684, F686, and F757. Unrelated deficiency is cited. Survey dates: February 19 and 20, 2024 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Census Bed Type: SNF/NF: 18 SNF: 41 Residential: 26 Total: 85 Census Payor Type: Medicare: 33 Medicaid: 18 Other: 8	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lakeithia Webb	Executive Director	03/07/2024

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

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	Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/26/24.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure bandages were changed and treatments were completed as ordered by the Physician for a diabetic ulcer and a non pressure ulcer, for 1 of 3 residents reviewed for skin conditions. (Resident P) Finding includes: During a random observation on 2/19/24 at 7:40 a.m., Resident P was observed in bed. At that time, there were 2 bandages on the resident's right leg and right great toe with a date of 2/17/24. The resident indicated the bandages were not changed yesterday (2/18) and the doctor had told him they were to be changed every day. The record for Resident P was reviewed on 2/19/24 at 9:45 a.m. Diagnoses included, but were not limited to, osteomyelitis of right foot and ankle, type 2 diabetes, diabetic foot ulcer, and	F 0684	F 684 Quality of Care Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident P. is no longer at the	03/05/2024

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	cellulitis of the right lower limb. The Admission Minimum Data Set (MDS) assessment, dated 2/5/24, indicated the resident was not cognitively intact. The resident was at risk for pressure ulcers and had a diabetic foot ulcer. The Care Plan, dated 1/31/24, indicated the resident had a diabetic ulcer of the right great toe. The Care Plan, dated 2/14/24, indicated the resident had a skin tear to the right anterior calf. Physician's Orders, dated 2/14/24, indicated cleanse the right anterior calf with normal saline, pat dry, apply skin prep to the wound edges, and Silvasorb to the wound bed. Cover the area with a dry dressing daily and prn (as needed.) Cleanse the right great distal toe with normal saline, pat dry, apply skin prep to the wound edges, and Gentamicin (an antibiotic) ointment to the wound bed. Cover the area with a dry dressing daily and prn. Physician's Orders, dated 1/29/24, indicated Piperacillin Sod-Tazobactam (an antibiotic medication Solution reconstituted 3-0.375 grams, infuse intravenously every 8 hours for osteomyelitis infection of right great toe and cellulitis of right lower limb for 35 days. The 2/2024 Treatment Administration Record, indicated the treatments to the anterior calf and right great toe were signed out as being completed on 2/18/24, as well as the Gentamicin antibiotic topical ointment. During an interview on 2/19/24 at 8:11 a.m., RN 1 indicated she changed the resident's bandages on		facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practices. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nursing staff have been re-educated to ensure bandages are changed and treatments are completed as ordered. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Weekly for 4 months, the DON/designee will review 3 residents' and their treatment records to ensure bandages are changed and treatments are completed as ordered.	

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	Saturday 2/17/24. During an interview on 2/19/24 at 8:15 a.m., the Wound Care Nurse indicated the bandages were to be changed every day as ordered by the Physician. This citation relates to Complaint IN00427249. 3.1-37(a)		Don/designee will present a summary of the audits to the QA committee monthly for 4 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed: 3/5/24.**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary care and treatment to promote healing, related to treatments not completed as ordered, and bandages not secure and in place as ordered, for 1	F 0686	**F 686 Treatment Svcs to Prevent/ Heal Pressure Ulcers** Please accept the following as the facility's credible allegation of compliance. This plan of	03/05/2024

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	of 3 residents reviewed for pressure ulcers. (Resident O) Finding includes: During a random observation on 2/19/24 at 8:02 a.m., CNA 1 was observed standing at the bedside of Resident O and preparing to get her out of bed. At that time, he was asked to roll the resident over and remove her brief so her buttocks could be observed. The CNA removed the resident's brief and there was no bandage covering a pressure sore on the sacrum. The pressure ulcer was pink with an area of darker red, and some drainage was noted. During an interview at that time, CNA 1 indicated this was the first time he had removed her brief since coming on to his shift at 6 a.m. The record for Resident O was reviewed on 2/20/24 at 12:15 p.m. Diagnoses included, but were not limited to, congestive heart failure, kidney disease, and stroke. The resident was admitted to the facility on 1/16/24. The resident was admitted to the hospital on 1/18/24 and returned on 1/23/24. She was admitted again to the hospital on 2/4/24 and returned on 2/13/24. The 1/29/24 Admission Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for daily decision making, was at risk for pressure and had an unhealed Stage 3 pressure ulcer that was present on admission. A Care Plan, dated 1/24/24, indicated the resident had a left medial buttock pressure ulcer. Physician's Orders, dated 1/17/24 and		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident O is receiving her treatment as ordered. **How the facility will identify other residents having the potential to be affected by the same deficient practice;** All facility residents who have pressure ulcers have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nursing staff was in serviced on ensuring treatments are completed as ordered and bandages are secure and in place as ordered.	

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	discontinued on 1/19/24, indicated to cleanse the sacrum with normal saline, pat dry, apply calcium alginate to the wound bed and cover with dry dressing every Monday, Wednesday and Friday. Physician's Orders, dated 1/23/24 and discontinued on 2/6/24, indicated to cleanse the sacrum with normal saline, pat dry, apply calcium alginate to the wound bed and cover with dry dressing every Monday, Wednesday and Friday. Physician's Orders, dated 2/14/24, indicated to cleanse the left medial buttock pressure ulcer with normal saline, pat dry, apply skin prep to the peri wound, Silvasorb gel to the wound bed, and cover with dry dressing every Monday, Wednesday, and Friday and prn (as needed). The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for 1/2024, indicated there was no documentation the treatment to the sacrum was completed as ordered on 1/17 and 1/18/24. The first documentation the treatment to the sacrum was completed was on 1/24/24. The 2/2024 MAR indicated the treatment was not signed out as being completed on 2/2/24. During an interview on 2/19/24 at 8:15 a.m., the Wound Care Nurse indicated there should have been a bandage covering the pressure ulcer. This citation relates to Complaint IN00427249. 3.1-40(a)(2)		**Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.** The DON/ designee will observe 3 residents on various shifts with orders for pressure ulcer dressing changes weekly for four months to ensure treatments are completed as ordered and bandages are secure and in place as ordered. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for four months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going. **Date when corrective action(s) will be completed: 3-5-24**	
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills			

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Bldg. 00	§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure gastrostomy enteral feedings were infusing at the correct time, tubing was changed at least every 24 hours, stoma sites were cleaned as ordered, and medications were administered per facility policy, for 3 of 3 residents reviewed for peg tubes (a tube inserted into the stomach for nutrition). (Residents L, D, and M) Findings include: 1. The record for Resident L was reviewed on 2/20/24 at 11 a.m. Diagnoses included, but were not limited to, stroke, dysphagia, contractures, and a peg tube.	F 0693	**F 693 Tube feeding Mgmt./Restore Eating Skills** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **What corrective action(s) will be accomplished for those**	03/05/2024

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	The 11/10/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. The resident had a feeding tube and received 51% of nutrition through the tube. A Care Plan, updated on 2/13/24, indicated the resident may be at risk for complications secondary to requiring a peg tube. The approaches were to provide care to the peg tube site as ordered. Physician's Orders, dated 8/18/23 and discontinued on 12/3/23, indicated to cleanse the enteral feeding site with normal saline or soap and water, and may leave open to air unless drainage was present at the site, every shift. A Physician's Order, dated 2/15/24, indicated cleanse enteral feeding site with soap and water and may leave open to air every shift. The Medication Administration Record for the month of 9/2023, indicated the treatment to cleanse around the peg tube site was not signed out as being completed for the day shift on 9/13 and 9/20/23. The resident was admitted to the hospital on 12/1/23 and returned on 12/12/23. There were no Physician's Orders to clean around the peg tube site after she returned for the rest of 12/2023, 1/2024 and up until 2/15/24. During an interview on 2/20/24 at 3:00 p.m., the Director of Nursing (DON) indicated the stoma site for the peg tube was to be cleaned at least daily. 2. The closed record for Resident D was reviewed on 2/19/24 at 9:58 a.m. Diagnoses included, but		**residents found to be affected by the alleged deficient practice;** Resident L is receiving her treatment to the enteral feeding site as ordered. Resident D is no longer at the facility. No corrective actions can be taken. Resident M is receiving his enteral tube feeding, flushes, site treatment, medication administration, and bag change per physician's orders and policy. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All facility residents with orders for enteral tube feedings have the potential to be affected by the same deficient practice. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** A list of residents with orders for enteral tube feedings was compiled and orders have been reviewed. L.P.N. 1 received a competency with demonstration and return demonstration related to enteral tube feeding medications and	

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	were not limited to, stroke and peg tube. The 12/1/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact and had a peg tube for more than 51% of nutrition. A Care Plan, revised on 6/23/23, indicated the resident was at risk for complications secondary to requiring tube feeding. The approaches were to provide care to peg tube site as ordered. Physician's Orders, dated 8/16/23 and discontinued on 2/17/24, indicated to cleanse area around peg tube and apply Bacitracin and dry dressing three times daily. Physician's Orders, dated 9/24/21 and discontinued on 10/18/23, indicated to cleanse enteral feeding site with soap and water and may leave open to air unless drainage present at site every shift. Physician's Orders, dated 2/15/24, indicated to cleanse enteral feeding site, soap and water, and may leave open to air. There was no documentation on the Treatment or the Medication Administration Records the peg tube site was cleansed every shift and Bacitracin was applied for the months of 10/2023, 11/2023, 12/2023, 1/2024 and 2/2024. During an interview on 2/20/24 at 3:00 p.m., the DON indicated the peg tube site should have been cleaned as ordered by the Physician. 3. During a random observation on 2/19/24 at 4:45 a.m., Resident M was observed in bed. At that time, there was bag of enteral tube feeding with a		flushes. Licensed nurses and QMA's were in serviced on ensuring gastrostomy enteral feedings are infused at the correct time, bags and tubing are changed at least every 24 hours, stoma sites are cleaned as ordered, and medications were administered per facility policy. Licensed nurses and QMA's were in serviced on the policies titled Gastrostomy/Jejunostomy site care and Enteral Feeding Tube Medication Administration. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will observe 3 residents with orders for enteral tube feeding weekly for 4 months to ensure gastrostomy enteral feedings are infused at the correct time, bags and tubing are changed at least every 24 hours, stoma sites are cleaned as ordered, and medications were administered per facility policy. The DON/designee will present a summary of the audits to the QA committee monthly for 4 months. Thereafter, if determined by the QA committee, auditing and	

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	handwritten date of 2/17/24 of Jevity 1.5 infusing at 20 cubic centimeters (cc). During a medication pass observation, on 2/19/24 at 8:20 a.m., LPN 1 was observed preparing medication for the resident to be administered through the peg tube. At that time, she poured 2 tablets of Omeprazole 20 milligrams (mg), 1 tablet of Diltiazem 80 mg, 1 tablet of Carb Levodopa 25/100 mg, 1 tablet of Doxazosin 4 mg, and 30 cc of Prostat all into separate cups. She crushed each medication separately and placed them back into the cups and entered the room. The LPN performed hand hygiene and donned clean gloves to both hands. She checked for placement with an air bolus and stethoscope. She then poured the Prostat into the tube and added water. The supplement would not go down, so she tried to moving the tube around and that was not working either. She then placed the plunger into the tube and pushed the medication down. She removed the plunger and added another medication that was diluted with water. She then added another medication and then flushed with an unknown amount of water, added another medication, flushed with water and then added the final medication with water to follow. The last medication was not going down the tube, so she also pushed that medication down with the plunger. During an interview at that time, LPN 1 indicated she was aware the tube was to be flushed with water before, in between, and after medications were given. She also indicated the supplement would not go down the tube if she did not plunge it through. The record for Resident M was reviewed on 2/20/24 at 10:45 a.m. Diagnoses included, but were		monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date of Completion: 3-5-24**	

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	not limited to, Parkinson's disease, chronic kidney disease, peg tube and heart disease. The Admission Minimum Data Set (MDS) assessment, dated 11/14/23, indicated the resident was not cognitively intact. The resident had a feeding tube and received 51% or more of nutrition through the peg tube. The resident was admitted to the facility in 11/2023. Physician's Orders, dated 1/25/24, indicated enteral feed six times a day by feeding pump of Jevity 1.5 at 20 cc per hour. The feeding should be on at 8:00 a.m., off at 12:00 p.m., on at 4:00 p.m. off at 8:00 p.m., and on at 12:00 a.m., and off at 4:00 a.m. Physician's Orders, dated 2/15/24, indicated to cleanse enteral feeding site with soap and water and may leave open to air unless drainage present at site every shift. The Treatment and Medication Administration Records for 11/2023, 12/2023, 1/2024 and 2/2024 until 2/15/24 indicated there was no documentation the peg tube stoma site was cleaned. There was no Physician's Order to clean the stoma site until 2/15/24. During an interview on 2/20/24 at 8:45 a.m., the Nurse Consultant indicated she had done a 1 to 1 inservice with LPN 1 regarding peg tube medication administration. During an interview on 2/20/24 at 3:00 p.m., the DON indicated there was no documentation the peg tube site had been cleaned since admission.			

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	The current 2/15/21 "Gastrostomy/Jejunostomy Site Care" policy, provided by the Vice President of Operations on 2/20/24 at 2:45 p.m., indicated it was the facility's policy to provide gastrostomy site care to decrease the risk of infection. Staff were to obtain a Physician's Order for type of solution to cleanse with and frequency of treatment. The current 2/15/21 "Enteral Feeding Tube Medication Administration," provided by the Vice President of Operations on 2/19/24 at 2:37 p.m., indicated the nurse will flush the tube with 30 cc of water, mix crushed medication with 5 to 10 cc of water and flush the tube with 10 cc of water between each medication. This citation relates to Complaint IN00423550. 3.1-44(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately, related to not administering antibiotic and pain medication as ordered by the Physician, for 2 of 3 residents reviewed for infections and 1 of 3 residents reviewed for pain medications. (Residents B, P and L) Findings includes: 1. The record for Resident B was reviewed on 2/20/24 at 11:22 a.m. Diagnoses included, but were not limited to, type 2 diabetes, heart disease, osteoarthritis, heart failure, and an urinary tract infection (UTI). The 2/7/24 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. Physician Progress Notes, dated 1/17/24 at 2:01 p.m., indicated the resident's urinalysis was reviewed and was positive for ESBL (Extended Spectrum Beta-Lactamase) and Pseudomonas infections, and antibiotics were ordered. Physician's Orders, dated 1/17/24, indicated Cefdinir (an antibiotic) capsule 300 milligrams (mg), give 1 capsule by mouth two times a day for UTI for 3 days. The Medication Administration Record (MAR) for the month of 1/2024, indicated the Cefdinir was	F 0757	**F 757 Drug Regimen is Free from Unnecessary Drugs** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B's Physician was notified of medication administration. No new orders received. Resident P is no longer at the facility. No corrective actions can be taken. Resident L suffered no ill effects from the medication administration and is receiving her pain medication as ordered. **How will facility identify other**	03/05/2024

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	to be administered at 8:00 a.m. and 8:00 p.m. On 1/17/24 at 8:00 p.m. and 1/18/24 at 8:00 a.m., the antibiotic was coded with "9" (meaning see nurses' notes). The antibiotic was administered on 1/18 at 8:00 p.m., 1/19 at 8:00 a.m. and 8:00 p.m. and the last dose was on 1/20 at 8:00 a.m., for a total of 4 doses, rather than 6 that were ordered by the Physician. Nurses' Notes, dated 1/18/24 at 4:22 a.m., and 12:18 p.m., indicated they were waiting for the arrival of the Cefdinir antibiotic from pharmacy. During an interview on 2/20/24 at 3:00 p.m., the Director of Nursing (DON), indicated antibiotic medication should have been administered as ordered by the Physician. 2. The record for Resident P was reviewed on 2/19/24 at 9:45 a.m. Diagnoses included, but were not limited to, osteomyelitis of right foot and ankle, type 2 diabetes, diabetic foot ulcer, and cellulitis of the right lower limb. The Admission Minimum Data Set (MDS) assessment, dated 2/5/24, indicated the resident was not cognitively intact. The resident was at risk for pressure ulcers and had a diabetic foot ulcer. The Care Plan, dated 2/7/24, indicated the resident required IV (Intravenous) medications to treat osteomyelitis. The approaches were to administer the IV antibiotic per the Physician's Orders. Physician's Orders, dated 1/29/24, indicated Piperacillin Sod-Tazobactam (an antibiotic medicate Solution reconstituted 3-0.375 grams, infuse intravenously every 8 hours for osteomyelitis infection of right great toe and		**residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed Nurses and Qualified Medication Aides were educated on ensuring medications are administered as ordered. Emphasis was given related to antibiotics and pain medications. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will audit 3 medication passes weekly x 4 months on various shifts to ensure Nurses and QMA's are administering medications per Physicians orders. The DON/designee will present a summary of the audits to the QA committee monthly for 4 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly	

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	cellulitis of right lower limb for 35 days. The 2/2024 Medication Administration Record indicated the Piperacillin was blank and not signed out on 2/7/24 and 2/18/24 at 4:00 p.m. . During an interview with the Director of Nursing, on 2/20/24 at 3:00 p.m., she indicated the IV antibiotic was to be administered as ordered by the Physician. 3. The record for Resident L was reviewed on 2/20/24 at 11 a.m. Diagnoses included, but were not limited to, stroke, dysphagia, contractures, and a peg tube (a tube inserted into the stomach for nutrition). The 11/10/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was not cognitively intact. The resident had a feeding tube and received 51% of nutrition through the tube. Physician's Orders, dated 1/25/24, indicated Hydrocodone Acetaminophen Tablet 5-325 milligrams (mg), give 1 tablet by mouth at bedtime. The Medication Administration Record for 2/2024 indicated the pain medication was not signed out as being administered on 2/7 and 2/10/24 at 9:00 p.m. During an interview on 2/20/24 at 3:00 p.m., the Director of Nursing indicated the pain medication should have been administered as per the Physician's Orders. This citation relates to Complaints IN00419120 and IN00427249.		and present quarterly at the QA meeting. Monitoring will be ongoing. **By what date the systemic changes will be completed: 3-5-24**	

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F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral			

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	directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure clinical records were complete, related to the determination to discontinue 15 minute checks for a resident who was observed in his room with an unlit cigarette, for 1 of 3 residents reviewed for supervision. (Resident K) Finding includes: The closed record for Resident K was reviewed on	F 0842	F 842 Resident Records-Identifiable Information Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory	03/05/2024

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	2/20/24 at 1:45 p.m. Diagnoses included, but were not limited to, sepsis, Chronic Obstructive Pulmonary Disease (COPD), angina, high blood pressure, and paranoid schizophrenia. The Admission Minimum Data Set (MDS) assessment, dated 9/21/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assist with a 2 person physical assist for bed mobility and transfers. There was no Care Plan indicating the resident had attempted to smoke in his room. A Nurses' Note, dated 10/14/23 at 10:15 p.m., indicated the resident's room door would not open upon first attempt. The resident had used his wheelchair to barricade the door closed. After entering the room, the resident was observed asleep in the bed, with an unlit cigarette between his lips. The room was searched for any other smoking materials and none were found. The resident was educated that smoking was not allowed in the facility. The Director of Nursing (DON) and Physician were notified and 15 minute checks were to be initiated until further notice. A Physician's Progress Note, dated 10/21/23 at 10:46 p.m., identified as a late entry for 10/18/2023, indicated the resident was fine and staff had informed them the resident sometimes smoked in the bathroom in his room. When asked, the resident had denied the allegation. The 15 minute check list, dated and initiated on 10/14/23 at 10:30 p.m., indicated the resident was monitored through 10/17/23 at 10:00 p.m. There was no other documentation regarding the		requirement. The Facility respectfully requests paper compliance for this survey. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident K is no longer at the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practices. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Director of Nursing, Nursing Manager and Social Service Director have been re-educated to ensure clinical records are completed before discontinuing 15-minute checks. **How the corrective action(s) will be monitored to ensure the**	

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	determination by staff to end the 15 minute checks. During an interview on 2/20/24 at 4:45 p.m., the Administrator indicated they had discussed the resident on 10/18/24 in the morning meeting and determined he was ok and was to be removed from the 15 minute checks as he had no further episodes of cigarettes found in his room. There was no documentation in the clinical record regarding the decision to remove him from the 15 minute checks. This citation relates to Complaint IN00423550. 3.1-50(a)(1)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place.** Weekly for 4 months, the DON/designee will review 3 resident clinical records to ensure the clinical records are complete related to the determination to discontinue15 minute checks. Don/designee will present a summary of the audits to the QA committee monthly for 4 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed: 3/5/24.**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection			

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	prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the			

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	disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to cleaning of reusable equipment and hand hygiene after direct resident contact and glove removal, for random observations of infection control. (Residents P, D, R and S) Findings include: 1. During a random observation on 2/19/24 at 7:18 a.m., RN 1 was observed walking out of Resident P's room, carrying a blood pressure cuff, glucometer, and thermometer. She laid all of those items on top of the medication cart and donned a pair of clean gloves and cleaned the glucometer. After she cleaned the glucometer, she removed her gloves and did not perform hand hygiene. She took all of the items into Resident D's room, donned a pair of clean gloves to both hands, and checked his blood pressure and his blood sugar.	F 0880	**F 880 Infection Prevention Control** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	03/05/2024

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	She removed her gloves and performed hand hygiene at the medication cart. She did not clean the blood pressure cuff or thermometer after she had used them for Resident P. She entered the room again with the resident's Insulin. She donned clean gloves and the resident wanted his legs repositioned, so she did that first and removed the gloves. She did not perform hand hygiene and donned another pair of clean gloves to both hands and administered the Insulin. During an interview on 2/19/24 at 8:11 a.m., RN 1 indicated she was aware multi-use equipment was to be cleaned after every resident use, and hand hygiene was to be performed after glove removal. The 9/1/20 current "Hand Hygiene" policy provided by the Vice President of Operations on 2/19/24 at 2:37 p.m., indicated hand hygiene should be performed after glove removal. 2. During a medication administration pass observation on 2/19/24 at 12:02 p.m., RN 2 was observed preparing medication for Resident R. She indicated the resident's blood pressure needed to be checked first. She took a wrist blood pressure cuff and entered the resident's room and checked his pressure, removed the cuff, and walked out to the medication cart. After the administration of his medications, she moved onto another resident. She then prepared Resident S's medications, and again indicated she needed to check his blood pressure. She used the same wrist cuff as with Resident R and checked the resident's blood pressure. She did not clean the wrist blood pressure cuff in between residents. During an interview on 2/19/24 at 12:15 p.m., RN 2 indicated she had cleaned the wrist cuff with the hand sanitizer gel from the wall dispenser, while		Resident P is no longer at the facility. No corrective actions can be taken. Resident D did not suffer any ill effects from equipment use or hand hygiene. Resident R did not suffer any ill effects from equipment use. Resident S did not suffer any ill effects from equipment use. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**; Facility staff were in-serviced on the importance of cleaning and disinfecting reusable equipment, including blood pressure cuffs, after each resident use and performing hand hygiene after direct resident contact and glove removal. Facility staff completed a hand	

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	she performed hand hygiene to her hands, she rubbed the gel on the cuff. The current 9/1/20 "Infection Control and Prevention Program" policy, provided by the Vice President of Operations on 2/19/24 at 2:37 p.m., indicated the cleaning of reusable equipment such as blood pressure cuffs will be cleaned with the appropriate cleaners and disinfectants registered to be effective against c-difficile, norovirus, and SARS-COV2. During an interview on 2/20/24 at 3:00 p.m., the Director of Nursing indicated hand hygiene was to be completed after glove removal and the blood pressure cuffs were to be cleaned and disinfected after each resident use. 3.1-18(b)		washing competency. Facility staff were in serviced on the policy titled Hand Hygiene/Handwashing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON/designee will observe 3 staff members on various shifts weekly for four months to ensure reusable equipment, including blood pressure cuffs is cleaned and disinfected after each resident use and hand hygiene is performed after direct resident contact and glove removal. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for four months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 3-5-24**	
R 0000 Bldg. 00	This visit was for the Investigation of Residential	R 0000		

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SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Complaint IN00418622. This visit included the Investigation of Nursing Home Complaints IN00419120, IN00423550, and IN00427249. Complaint IN00418622 - No deficiencies related to the allegations are cited. Complaint IN00419120 - Federal/State deficiencies related to the allegations are cited at F757. Complaint IN00423550 - Federal/State deficiencies related to the allegations are cited at F693 and F842. Complaint IN00427249 - Federal/State deficiencies related to the allegations are cited at F684, F686, and F757. Unrelated deficiency is cited. Survey dates: February 19 and 20, 2024 Facility number: 010739 Residential Census: 26 Spring Mill Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00418622. Quality review completed on 2/26/24.			