STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155154	A. BUILDING 00 B. WING	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00429846, IN00435561, IN00439059, IN00439436 and IN00440642. Complaint IN00429846-Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00435561-Federal/State deficiencies related to the allegations are cited at F660. Complaint IN00439059-Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00439436-No deficiencies related to the allegations are cited. Complaint IN00440642-No deficiencies related to the allegations are cited. Survey dates: August 21, 22, 23, 26, 27 and 28, 2024. Facility number: 000074 Provider number: 155154 AIM number: 100290050 Census Bed Type: SNF/NF: 74 SNF: 8 Total: 82 Census Payor Type: Medicare: 10 Medicaid: 52 Other: 20 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept the submission of Plan of Correction responses noted on state form 2567 for alleged deficiancies sited during the Recertification and State Licensure survey which included complaints IN000429846. IN000435561, IN00439059, IN00439436, and IN00440642 for Spring Mill Meadows. The facility is requesting desk review in lieu of a PSR after 9/25/2024. Thank you for considering this request.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia Tarbutton	Executive Director	09/19/2024

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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	Quality review was completed on September 6, 2024.			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process Based on record review and interview, the facility failed to ensure a facility arranged transfer for a resident included the correct address of the receiving facility for 1 of 1 resident reviewed for discharge. (Resident F). The deficient practice was corrected on 5/23/24, prior to the start of the survey, and therefore was past noncompliance. Finding includes: During an interview, on 8/23/24 at 9:42 a.m., Resident F's daughter indicated the resident was supposed to go to an assisted living facility right down the street from the long-term care facility. The facility had a transport company take the resident to the assisted living facility since she and her brother were working. The transport company did not take her to the assisted living facility and instead took her to the place she lived prior. The transport company driver left the resident in her wheelchair in the driveway of the house next to her previous address. The person who lived in the residence remembered the resident and called her family to let them know the resident was in her driveway. Her brother left work and went to pick up the resident. The long-term care facility told them the Social Services Director (SSD) had made a mistake and put the wrong address down for the transport company. During an interview, on 8/23/24 at 10:02 a.m., Residents F's son indicated the resident was supposed to go to her previous assisted living	F 0660	The facility achieved past non-compliance and no plan of correction is required.	08/28/2024

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	facility which was just a block down the street. When she was discharged, the transport company took her to her old home address and left her in the driveway in her wheelchair with her belongings. The person who lived in the house next door to her old home address called his sister. The person in the house next door tried to flag the driver down and he just left. The sister notified him, and he went to the address to get the resident. The resident had soiled her clothes. He had to clean her and change her clothes before he could take her to the assisted living facility. The clinical record for Resident F was reviewed on 8/22/24 at 3:57 p.m. The diagnoses included, but were not limited to, malignant neoplasm of an unspecified part to the lung, a fracture of the left femur with routine healing, unspecified dementia without behavioral disturbance, and generalized muscle weakness. A Brief Interview for Mental Status (BIMS) assessment, dated 4/29/24, indicated the resident had a severe cognitive impairment. A progress note, dated 5/17/24 at 5:17 p.m., indicated the Director of Nursing at the assisted living memory care was notified of the resident's discharge date. The resident would not be able to return on the weekend and would need to return on a Monday. The son was notified of the Monday discharge and indicated he would not be able to transport the resident. The son asked the facility to set up the transportation for the resident. A progress note, dated 5/20/24 at 10:07 a.m., indicated the resident planned to discharge home today and would return to her assisted living memory care. The transport company would			

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	transport the resident back to the Assisted Living at 1:00 p.m. A progress note, dated 5/20/24 at 12:46 p.m., indicated Resident F was discharged back to her assisted living facility and all belongings were sent with the resident. The progress note did not include who was present with the resident to take her out of the facility and to the assisted living facility. A facility typed statement from the Payroll/Benefits Coordinator, dated 5/20/24, indicated she received a phone call at approximately 1:44 p.m., from Resident F's son. He was asking why his mother was dropped off in a driveway instead of her assisted living facility. At approximately 1:50 p.m., a caller who stated she was Resident F's previous neighbor called to ask why the resident was left in her driveway. The transport driver left the resident there alone and she had memory issues. The neighbor tried to yell and motion to the driver, and he just pulled away from the driveway. While on the phone, the neighbor indicated the son had arrived to pick up the resident. A facility typed statement from the Business Office Manager (BOM), dated 5/20/24, indicated at approximately 12:25 p.m., she was notified the transport company had arrived to pick up Resident F to transport her to her assisted living. The transport driver was waiting for the resident and put her in the van with her personal items. They left the facility at approximately 12:35 p.m. She was notified by the receptionist, at approximately 1:33 p.m., the resident was dropped off at a residential address instead of her assisted living facility. A person identified as the neighbor			

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	had called twice and indicated the resident was at her address. The address given to the transportation company was checked and it was noted the resident was sent to a previous home address and not the assisted living facility. The transport company was notified they were given the wrong address. The transport company dispatched a driver back to the address where the resident was left. The resident was not there when the transport company arrived. A printed email message from the owner of the transport company, dated 5/20/24 at 3:52 p.m., indicated she was addressing an incident from 5/20/24. The driver dropped off Resident F at the address given to the transport company. The driver left the resident in the driveway and a lady from the house was outside. The resident did not tell the driver she was at the wrong address. When the driver arrived back to the address, the resident was not there. The driver was notified the resident's son had picked her up. This was not the first time the transport company was given the wrong address. During an interview, on 8/22/24 at 4:18 p.m., the Director of Nursing at the assisted living facility indicated the resident returned to their facility, on 5/20/24 at 4:30 p.m., by family car. The family brought the resident. During an interview, on 8/23/24 at 10:52 a.m., the Social Services Assistant (SSA) indicated the Social Services Director (SSD) made the arrangements for the transfer. The transport company provided the transportation for residents in wheelchairs. The facility had a contract with the transportation company and would pay them for transporting residents. The transport company was given the address on the			

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	resident's face sheet instead of the address to the assisted living facility. During an interview, on 8/23/24 at 10:59 a.m., the Executive Director (ED) indicated the facility made a human error and gave the resident's old address to the transport company instead of her assisted living facility address. The resident was taken to the old address, the neighbor saw the resident being dropped off and waved to the driver. The driver just left and did not talk to the neighbors. A current policy, titled "Discharge/Transfer," dated 11/15 and received from the ED on 8/27/24 at 11:22 a.m., indicated "...Before a facility transfers or discharges a resident, the facility shall...Notify the resident and, if known, a family member or legal representative of the resident, in writing of the transfer or discharge and the reasons for the relocation in a language and manner they understand...Record the reasons in the resident's clinical record...Contents of the notice...The reason for transfer or discharge...The location to which the resident is transferred or discharged...." The deficient practice was corrected by 5/23/24, after the facility implemented a systemic plan which included audits, changes in the transportation procedure, and education to staff and transport companies. This citation relates to Complaint IN00435561. 3.1-36(a)(3)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility	F 0684	F684 It is the policy of this facility	09/25/2024

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	failed to ensure the physician was notified as ordered according to the physician's ordered parameters, to hold medications according to the physician's ordered hold parameters, and to ensure medications were given as ordered for 5 of 5 residents reviewed for quality of care. (Resident J, H, K, B and 37) Findings include: 1. The clinical record for Resident J was reviewed on 8/22/24 at 3:44 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease, and dementia. A care plan, dated 9/15/23 and last reviewed on 6/13/24, indicated the resident was at risk for adverse effects of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) related to the use of glucose lowering medication and the diagnosis of diabetes mellitus. Interventions included, but were not limited to, document the abnormal findings and to notify the physician. A physician's order, with a start date of 1/16/24 and discontinued on 8/14/24, indicated to check Resident J's blood sugar twice a day (BID), with special instructions to notify the physician if the blood sugar was below 70 or greater than 350. The Medication Administration Record (MAR), for July 2024, indicated on 7/10/24, 7/11/24, and 7/12/24, the residents blood sugars were above 350. A physician's order, with a start date of 8/16/24, indicated to check Resident J's blood sugar BID, with special instructions to notify the physician if the blood sugar was below 70 or greater than 350.		to ensure physicians are notified according to parameters, medications are held according to physician ordered parameters, and medications are given as ordered by the physician. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 37 physician was notified regarding medications missed. Residents with accuchecks are being monitored and the MD is notified of out of range per special instructions. Residents with blood pressure medications are receiving meds per order and physicians notified if out of ordered parameters. The physician was notified of resident B missing medication and no new orders received. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with medication orders have the potential to be affected. Residents with medication orders including parameters have the potential to be affected.	

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	The MAR, for August 2024, indicated on 8/11/24 the residents blood sugar was above 350. There was no documentation in the clinical record to indicate the physician was notified at the time the blood sugars were found to be outside the ordered parameters. During an interview, on 8/27/24 at 11:29 a.m., the Director of Nursing (DON) indicated she could not provide documentation the physician was notified at the time the blood sugars were found outside of the ordered parameter. 2. The clinical record for Resident H was reviewed on 8/23/24 at 10:58 a.m. The diagnosis included, but were not limited to, chronic systolic congestive heart failure and blood pressure with abnormal findings. A physician's order, with a start date of 7/25/24, indicated to give Hydralazine (a medication to treat high blood pressure) 10 mg (milligrams) two times a day (BID) and to hold the medication for a systolic blood pressure (SBP) above 130. The MAR indicated Hydralazine 10 mg was administered when the systolic blood pressure was below the ordered hold parameter: a. On 7/28/24, for the a.m. and p.m. dose. b. On 8/1/24, for the a.m. dose. c. On 8/2/24, for the a.m. dose. d. On 8/3/24, for the a.m. and p.m. dose. During an interview, on 8/26/24 at 2:37 p.m., an anonymous staff member indicated if the medication was held there would be parentheses around the initials of the nurse and a comment would have been documented on the MAR.		DNS/designee completed a full house audit of missing medications of current residents and residents who have orders including parameters. Physician notification was made if/when needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The DNS/designee will review the EMAR administration records daily to ensure medications are not missed and parameter orders followed. Licensed Nursing staff will be educated on documentation of medication administration and physician notification by the DNS/designee by 9-25-24. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Medication Compliance QA tool will be utilized daily x 4 weeks, weekly x 4 weeks, monthly thereafter for one year with results	

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	During an interview, on 8/26/24 at 4:04 p.m., the DON indicated according to the MAR, Resident H was administered the medication when the systolic blood pressure was outside of the hold parameter.3. The clinical record for Resident K was reviewed on 8/22/24 at 3:58 p.m. The diagnoses included, but were not limited to, acute systolic heart failure, stage 3 chronic kidney disease, peripheral vascular disease, and essential hypertension. A physician's order, dated 7/2/24, indicated to give Metoprolol succinate (a medication used to lower blood pressure) extended release 100 mg at bedtime and to hold the medication if the systolic blood pressure was below 120 or the heart rate was below 60. The MAR indicated Metoprolol 100 mg was administered when the systolic blood pressure was below the ordered hold parameter: a. On 6/10/24, the systolic blood pressure was 118 and the medication was given. b. On 6/28/24, the systolic blood pressure was 118 and the medication was given. c. On 7/14/24, the systolic blood pressure was 118 and the medication was given. d. On 7/27/24, the systolic blood pressure was 118 and the medication was given. e. On 8/4/24, the systolic blood pressure was 103 and the medication was given. f. On 8/8/24, the systolic blood pressure was 118 and the medication was given. A physician's order, dated 2/7/24, indicated to give furosemide (a diuretic medication) 40 mg every day and to hold if the systolic blood pressure was below 120. The MAR indicated Furosemide 40 mg was		reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of correction: 9-25-24	

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	administered when the systolic blood pressure was below the ordered hold parameter: a. On 6/10/24, the systolic blood pressure was 118 and the medication was given. b. On 7/11/24, the systolic blood pressure was 114 and the medication was given. c. On 7/12/24, the systolic blood pressure was 111 and the medication was given. d. On 7/28/24, the systolic blood pressure was 118 and the medication was given. e. On 8/9/24, the systolic blood pressure was 112 and the medication was given. f. On 8/16/24, the systolic blood pressure was 116 and the medication was given. g. On 8/20/24, the systolic blood pressure was 108 and the medication was given. During an interview, on 8/28/24 at 9:30 a.m., the DON indicated it appeared according to the MAR, the medications were administered outside of the physician ordered hold parameters. During an interview, on 8/28/24 at 4:47 p.m., the DON indicated they did not have a policy on holding medications.4. During an interview, on 8/22/24 at 9:47 a.m., Resident B indicated there were several days she missed some of her medications. The clinical record for Resident B was reviewed on 8/22/24 at 3:55 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, sickle-cell trait, diabetes mellitus, chronic kidney disease, rheumatoid arthritis, anxiety disorder, major depressive disorder, and hypertension. A physician's order, dated 7/2/24, indicated to give 1 puff of fluticasone propionate-salmeterol (used for asthma and chronic obstructive			

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	pulmonary disease) 500-50 micrograms (mcg) twice a day. The MAR indicated the resident missed the fluticasone propionate-salmeterol dose on 7/3/24, 7/4/24, 7/5/24 and 7/6/24 between 7:00 a.m. and 11:00 a.m. A physician's order, dated 7/2/24, indicated to give 1 puff of tiotropium bromide (to prevent bronchospasms caused by chronic obstructive pulmonary disease) 500-50 micrograms (mcg) twice a day. The MAR indicated the resident missed the tiotropium bromide dose on 7/3/24, 7/5/24 and 7/6/24 between 7:00 a.m. and 11:00 a.m. A physician's order, dated 7/3/24, indicated to give 2 grams of cefazolin reconstitute (an antibiotic every eight hours. The MAR indicated the resident missed the cefazolin reconstitute dose on 7/5/24 at 6:00 a.m. A physician's order, dated 7/5/24, indicated to give 5 milliliters (ml) of nystatin suspension (used for a fungal infection) twice a day. The MAR indicated the resident missed the nystatin suspension dose on 7/5/24, 7/6/24, and 7/7/24 between 7:00 a.m. and 11:00 a.m. A care plan, dated 3/25/24, indicated the resident had the potential for impaired gas exchange and chronic respiratory failure. The interventions included, but were not limited to, administer medication per order and nebulizer treatments as ordered.			

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	There was no documentation to indicate the physician was notified of the missing doses of the antibiotics, mouthwash and the inhalers. During an interview, on 8/28/24 at 10:29 a.m., the DON indicated she would have to assume the antibiotic, mouthwash, and inhalers were not given according to the physician's order if the nurses did not sign the MAR and there was no documentation the physician was notified of the missed medication. 5. The clinical record for Resident 37 was reviewed on 8/22/24 at 3:57 p.m. The diagnoses included, but were not limited to, acute on chronic combined systolic and diastolic heart failure, end stage renal disease, peripheral vascular disease, hypertensive emergency and hypertension. A care plan, with a start date of 4/11/22, indicated the resident had ineffective tissue perfusion related to hypertension. The resident had fluctuating blood pressures and a most recent hospitalization for hypertensive emergency. Interventions included, but were not limited to, observe for and document: pallor, cyanosis, dizziness, syncope, shortness of breath, bounding/thready pulse, and headache. A physician's order, dated 7/25/24, indicated to notify the physician if the resident's systolic blood pressure was over 180 or the heart rate was over 110. A vitals log indicated the following: a. On 8/2/24, the resident's systolic blood pressure was 194 on the morning shift and 186 on the night shift. b. On 8/3/24, the resident's systolic blood pressure was 186 on the morning shift.			

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	c. On 8/9/24, the resident's systolic blood pressure was 184 on the morning shift and 186 on the night shift. d. On 8/10/24, the resident's systolic blood pressure was 187 on the morning shift. The Electronic Health Record (EHR) did not indicate the physician was notified of the blood pressure readings. During an interview, on 8/27/24 at 12:10 p.m., the DON indicated they would call the physician when blood pressures with call orders were out of the parameters, but the readings were "pretty normal" for Resident 37, so they put it on an acute (non-urgent) needs list for the physician instead. A current facility policy, titled "Resident's Rights," dated 11/2015 and received from the DON on 8/28/24 at 3:51 p.m., indicated "...The Resident has a right to be fully informed in advanced about care and treatment and any changes in that care of treatment that may affect the Resident's wellbeing...." A current facility policy, titled "Medication Administration (Medication Pass Procedure)," dated as revised 07/2023 and received from the Executive Director on 8/27/24 at 4:20 p.m., indicated "...Medication administration will be recorded on the MAR/EMAR or TAR after given...." The facility did not provide a policy for notification to the physician. This citation relates to Complaint IN00439059. 3.1-37(a)			

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	155154	A. BUILDING 00 B. WING	08/28/2024

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure the physical therapy recommended method to transfer a resident was used for 1 of 5 residents reviewed for accidents. (Resident E) The deficient practice was corrected on 3/17/24, prior to the start of the survey, and therefore was past noncompliance. Findings include: The clinical record for Resident E was reviewed, on 8/23/24 at 3:03 p.m. The diagnosis included, but were not limited to, morbid obesity, anemia, weakness, and encounter for surgical aftercare following surgery on the digestive system. An event note, dated 3/4/24, indicated Resident E was being transferred by two staff members from her bed to her wheelchair, when her legs "gave out" and she was lowered to the floor. A written statement by CNA 6, dated 3/4/24, indicated he and another staff member were transferring Resident E by lifting her under both arms from her bed to her wheelchair. When her leg gave out, she was lowered to the floor. A physical therapy (PT) baseline evaluation, dated 1/12/24, indicated a stand and pivot transfer was not attempted due to medical reasons and safety. A PT discharge summary, dated 1/12/24 to 3/1/24, indicated for chair/bed-to-chair transfers staff should use a Hoyer or a sit-to-stand lift. A PT recertification summary, dated 2/23/24 to	F 0689	The facility achieved past non-compliance and no plan of correction is required.	08/28/2024

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	3/23/24, indicated for chair/bed-to-chair transfers staff should use a Hoyer or a sit-to-stand lift. A care plan, dated 1/15/24, indicated the resident required assistance with activities of daily living which included bed mobility, transfers, eating, and toileting. An intervention, dated 1/31/24, indicated to use a sit-to-stand lift for transfers. A physician's order for a Hoyer lift or a sit-to-stand lift was not found in the clinical record. An interdisciplinary team (IDT) progress note, on 3/5/24, indicated staff education about transfers was completed. During an interview, on 8/28/24 at 10:39 a.m., the Director of Therapy indicated during a baseline evaluation, if it was unsafe to transfer a resident, the PT would recommend the use of a mechanical lift for transfers. PT would communicate to the nursing staff the recommendation and the nursing staff would place the order. He indicated the nursing staff did put in an order for the use of a Hoyer lift but did not click the box to keep the order open ended and it was immediately discontinued. During an interview, on 8/28/24 at 2:35 p.m., the Director of Therapy indicated he was able to find the documentation and notes from the sit-to-stand evaluation. The sit-to-stand lift was probably added to the care plan by word of mouth. The nursing staff should not attempt to transfer the resident in any way, other than what PT had recommended. The recommendation was to continue to use the Hoyer lift, and the staff should not attempt an "under the arm" transfer.			

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	A current facility policy, titled "Fall Management Policy," dated as last revised 8/2022, indicated "...A "fall" refers to unintentionally coming to a rest on the ground, floor, or other lower level...Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls...A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factor...." The deficient practice was corrected by 3/17/24, after the facility implemented a systemic plan which included a thorough audit of resident transfers, skills validation, and all staff members were educated on gait belt, mechanical lifts, and transfers. This citation relates to Complaint IN00429846. 3.1-45(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to complete an abnormal involuntary movement scale (AIMS) assessment on a resident who started on an antipsychotic for over a month and did not educate about the black box warnings associated with taking an antipsychotic medication while having dementia for 1 of 5 residents reviewed for unnecessary medications. (Resident 37) Findings include: The clinical record for Resident 37 was reviewed on 8/22/24 at 3:57 p.m. The diagnoses included, but were not limited to, generalized anxiety	F 0758	F758 It is the policy of this facility to complete an AIMS assessment on a resident who starts an antipsychotic medication and provides black box warning education when the antipsychotic medication is started. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 37's AIMS assessments was completed on 8-27-24 and the black box warning education completed on 9-24-24. How will	09/25/2024

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	disorder, major depressive disorder, dementia, unspecified psychosis, altered mental status, and insomnia. A physician's order, dated 7/5/24, indicated to administer Risperidone (an antipsychotic medication) 0.25 mg once a day. A physician's order, dated 7/5/24, indicated to administer Risperidone 0.5 mg at bedtime. A care plan, dated 7/25/24, indicated the resident was at risk for adverse effects related to psychotropic medication use. An approach was to complete an AIMS assessment two times per year. An AIMS assessment was completed on 8/27/24 at 8:18 p.m. There were no AIMS assessment completed until over a month after the resident was started on Risperidone. During an interview, on 8/28/24 at 9:30 a.m., the Director of Nursing (DON) indicated the AIMS assessment on 8/27/24 was the first one completed since starting the antipsychotic. During an interview, on 8/28/24 at 11:46 a.m., the DON indicated she was not sure if they completed education on the black box warning of the medication. During an interview, on 8/28/24 at 4:01 p.m., the Executive Director (ED) indicated there was no education on the black box warning after the resident was started on the antipsychotic in July. A study from the National Institute of Health (NIH) indicated typical and atypical		you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who are ordered an antipsychotic medication could be affected by the alleged deficient practice. An audit was completed by the SSA/designee of all antipsychotic medications for current residents to ensure AIMS assessments completed and black box warning education was received. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Social Service Department was educated by the ED/designee by 9-25-24 on the importance of completing the AIMS assessment and black box warning education for residents. DNS/designee and SS will review all medications upon admission or when a resident experiences a significant change to ensure residents who receive antipsychotics are educated regarding the black box warnings and the education is documented in the clinical record. The facility IDT reviews all residents care plans at admission, quarterly, and with significant change for any updates that are needed to the resident record. (is this on cp pathway form as reminder?) How the corrective action(s) will be monitored to	

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	antipsychotics carry a black box warning for increased risk of death and cerebrovascular events in patients with dementia. There was no policy provided about education on black box warnings for medications by the time of exit A current policy, titled "Psychotropic Management," dated as last reviewed 10/22 and received from the DON on 8/28/24 at 9:50 a.m., indicated "...An AIMS assessment will be completed for residents who are taking antipsychotic medication as a tool to monitor for adverse side effects. The assessment should be completed within 72 hours of a new order to initiate an antipsychotic, within 72 hours of an increase in antipsychotic medication and then every 6 months while taking antipsychotic medication...." 3.1-48(a)(3)		ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The daily antipsychotic QA tool will be utilized weekly x 4, and monthly thereafter for 6 months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Date of correction: 9-25-24	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medication carts were free of loose medications, label an inhaler, keep narcotic cards free of compromise, and ensure the narcotic count log was correct for 3 of 3 medication carts reviewed for medication storage (medication cart 1, 4 and 3) Findings include: 1. During an observation of medication cart 1, on 8/27/24 at 2:38 pm, a large round white pill and an orange oval capsule were found lying in the second drawer. A round brown spotted pill, a	F 0761	F761 It is the policy of this facility to ensure medication carts are free of loose medications, inhalers are labeled, narcotic cards free of compromise and ensure the narcotic count log . p paraid="4288155" paraeid="{d51fd78d-fa66-4fc8-adf6-63417fd1b638}{20}" >What corrective action(s) will be accomplished for those residents	09/25/2024

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	long white capsule and a long yellow capsule were lying in the bottom of the third drawer. During a narcotic reconciliation, on 8/27/24 at 2:40 p.m., a card of Tramadol (a pain medication) 25 milligrams (mg) tablets for Resident 20 had white tape on the back of slot 7, holding the tablet in place. 2. During an observation of medication cart 4, on 8/27/24 at 3:17 p.m., two individual dosages of hydralazine (a blood pressure medication) 25 mg without a pharmacy label were lying in the top drawer of the cart. An individual dose package of sodium chloride 1 gram (gm) without a pharmacy label was lying in the second drawer. A Lupihaler (inhaler for breathing issues) had a handwritten name on the outside without a pharmacy label. During an interview, on 8/27/24 at 3:20 p.m., LPN 2 indicated she was not sure if the inhaler was being used or not. 3. During an observation of medication cart 3, on 8/27/24 at 3:49 p.m., a small blue capsule and a larger light and dark green capsules were found in the second drawer. During a narcotic reconciliation with LPN 2, on 8/27/24 at 3:20 p.m., the medication card for Resident 78 contained 16 Tramadol (a pain medication) 50 milligram (mg) tablets. The narcotic record log indicated the card should have had 15 tablets. A tablet had been signed out at 8:50 a.m. on 8/27/24 which would have made the count 15. The documentation of the dosage given at 8:50 a.m. was crossed out by LPN 2 at the time of the reconciliation, and she indicated the 8:50 a.m. dose was not given.		found to have been affected by the deficient practice? Cart 1 medication lying in the bottom of the cart was destroyed. The identified Tramadol was destroyed. In cart 4, the blood pressure and sodium chloride medications and inhaler without pharmacy label were destroyed. Cart 3 capsules on bottom of drawer were destroyed. Resident 78 pain medication was reconciled. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with medications have the potential to be affected by the alleged deficient practice. DNS/designee completed a full house audit of medication carts by 9-25-24. Corrections were made as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Nursing staff will be educated on medication storage and labeling by the DNS/designee by 9-25-24.	

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	During an interview, on 8/27/24 at 2:22 pm, LPN 5 indicated the Tramadol tablet should not be taped. He would destroy the loose pills from the drawer by putting them in the biohazard sharps container. He did not use a Drug Buster. During an interview, on 8/27/24 at 2:30 p.m., the Unit Manager indicated the narcotic cards should not be taped on the back because she had no idea what the medication was. Medications needed to be destroyed by two nurses. During an interview, on 8/27/24 at 2:50 p.m., the Director of Nursing (DON) indicated the procedure for medication destruction was for two nurses to place the medication in a Drug Buster. During an interview, on 8/27/24 at 3:20 p.m., LPN 2 indicated the narcotic reconciliation was not correct. A current facility policy, titled "Storage and Expiration Dating of Medications and Biologicals," dated as revised 8/1/24 and received from the DON on 8/28/24 at 4:51p.m., indicated "...controlled medications must be counted with another designated staff member when there is an exchange of keys...." A current facility procedure, titled "Medication Administration (Medication Pass Procedure)," last dated as revised 7/2023 and received from the Executive Director on 8/27/24 at 4:20 p.m., indicated "...administration and inventory of controlled substances were documented according to facility policy...." A current facility policy, titled "Storage and Expiration Dating of Medications and Biologicals," dated as revised 8/1/24 and received		Nurse managers/designees will audit the carts daily and make corrections as needed with assigned nurses. One on one education up to and including disciplinary action will be completed as needed. (audit tool) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A medication storage QA tool will be utilized daily x 4 weeks, weekly x 4 weeks, monthly thereafter for 6 months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of 9-25-24	

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	from the DON on 8/28/24 at 4:51p.m., indicated "...facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding...facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions...facility should ensure that medications and biologicals are stored in the container in which they were originally received...." A current facility policy, titled "Disposal/Destruction of Expired or Discontinued Medication," received from the DON on 8/28/24 at 11:38 a.m., indicated "...facility should destroy non-controlled medications in the presence of a registered nurse and witnessed by one other staff member, in accordance with facility policy or applicable law...facility should destroy discontinued or outdated medications by one of three methods...pour medications into a container or plastic bag...an authorized facility staff member may add a substance that renders the medications unusable to the plastic container or bag...place medication containers in a container or box...seal box with strong tape a label the box as medication for destruction...secured in a locked cabinet or room until it disposed or picked up by licensed waste disposal company...facility - approved commercially available drug disposal kit...facility should destroy controlled substances in the presence of a registered nurse and a licensed professional or in accordance with facility policy or applicable law...." 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(j)			

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F 0791 SS=D Bldg. 00	3.1-25(o) 483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, interview and record review, the facility failed to assist a resident to obtain dentures as recommended during a dental exam for 1 of 3 residents reviewed for dental services. (Resident 20) Finding includes: During an observation, on 8/21/24 at 1:12 p.m., Resident 20 was eating soft foods and was edentulous (had no teeth). During an observation, on 8/22/24 at 9:35 a.m., the resident was eating soft foods for breakfast. The clinical record for Resident 20 was reviewed on 8/23/24 at 9:39 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, bipolar disorder, schizophrenia, dementia with agitation, dysphagia oral phase, and mild intellectual disabilities. A dental examination note, dated 2/8/24, indicated the resident was edentulous, would like dentures, and was a good candidate for dentures. The recommended follow-up was to obtain impressions for complete upper and lower dentures. A facility social services note, entered on 2/28/24, indicated the resident had been seen by the dentist and no new recommendations were made. A care plan, revised on 6/13/24, indicated the	F 0791	p paraid="204842956" paraeid="{d51fd78d-fa66-4fc8-adf6-63417fd1b638}{200}" >F is the policy of this facility to ensure those residents who have a recommendation for dentures, obtain them. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 20 was seen by dental services on 9-9-24 with confirmation that she is not appropriate for dentures. p paraid="1731029101" paraeid="{d51fd78d-fa66-4fc8-adf6-63417fd1b638}{236}" >How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who request dental services have the potential to be affected by the alleged deficient practice.	09/25/2024

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	resident was edentulous and did not have dentures. During an interview, on 8/28/24 at 11:35 a.m., Resident 20 indicated she would like to have dentures. During an interview, on 8/26/24 at 3:02 p.m., the Social Services Assistant indicated the resident was seen and followed by dental services. The dental service provider was responsible for obtaining the molds for dentures. She would make sure the resident was on the list to be seen. During an interview, on 8/27/24 at 4:15 p.m., the Social Services Assistant indicated there had been no further action to obtain dentures for the resident since the recommendation in February. A current policy, titled "Dental Services/Missing Dentures," dated as revised on 9/17 and received from the Executive Director on 8/27/24 at 11:25 a.m., indicated "...The facility obtains needed dental services...assists in providing these services and makes prompt referrals for dental services as needed...." 3.1-24(a)(1)		An audit of all residents wanting dental services was completed by the SSA/designee on 9-25, and referrals made as needed. SSA/designee was educated by the ED/designee by 9-25-24 on the dental services policy and procedure. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? SSA/designee was educated by the ED/designee by 9-25-24 on the dental services policy and procedure. The SSA will review the provider notes and copy the ED/DNS with recommendations made per facility follow up procedure. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? An Ancillary QA tool will be utilized weekly x 4, and monthly thereafter for 6 months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director.	

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			If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Date of 9-25-24	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to ensure frozen foods were sealed and to ensure food was free of moisture in 1 of 1 freezer reviewed for food safety. (the walk-in freezer) Finding includes: During a kitchen observation, beginning on 8/21/24 at 12:08 p.m., the walk-in freezer had the following: a. Garlic toast was stored in an unsealed bag inside an opened box. b. Ten pounds of pork sausage links were stored in an unsealed bag inside a wet box. c. Two 5-pound bags of egg omelets were stored in unsealed bag inside an ice-covered box. d. 13.5 pounds of egg rolls were stored in an unsealed wet box. e. 18.9 pounds of Colby cheese omelets were stored in an ice-covered box. f. Two 5-pound bags of marinated diced white chicken were stored in an ice-covered box. g. Two boxes of diced ham were stored in an ice-covered box. During an interview, on 8/21/24 at 12:15 p.m., the	F 0812	p="" paraid="1444446030" paraeid="{19b76b49-33ab-4aa5-af67-76664ed9660e}{143}">F812 It is the policy of this facility to ensure frozen foods are sealed and to remain free of moisture in the facility freezer. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The following items were destroyed – garlic toast, pork sausage, egg omelets, egg rolls, cheese omelets, chicken and ham. The freezer was repaired on 9-4-24. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ul="" role="list" Residents who reside at the facility could be affected by the potential deficient practice. Culinary staff were educated on the food storage/freezer storage policy by the Corporate	09/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING 00 B. WING	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(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
	Dietary Manager indicated he had noticed the ice-covered and wet boxes and questioned the food service delivery person, who indicated it was from condensation. During an interview, on 8/21/24 at 1:36 p.m., Resident 59 indicated the chicken tasted as if it had been frozen, thawed, and then frozen again. During an interview, on 8/21/24 at 3:53 p.m., the Maintenance Supervisor indicated moisture and condensation would form while the staff were stocking supplies. He did not usually manually defrost the freezer, but when he did, he would shut the power off and leave the door open for 10-15 minutes to allow the ice accumulation on the ceiling to thaw. He did this a couple days ago. He did not place anything up to catch the ice as it melted. During an interview, on 8/22/24 at 12:30 p.m., the Administrator indicated the freezer was an auto defrost and should not need to be defrosted. A current policy, titled "Food Storage," dated as last revised 5/24 and received from the Director of Nursing on 8/22/24 at 3:49 p.m., indicated "...Frozen Foods...Food items should remain frozen solid...Foods should be covered or wrapped tightly...Food items should not be refrozen after being thawed...." 3.1-21(i)(3)		RD/designee by 9-25-24. The facility freezer will be monitored daily for items not stored correctly by the culinary manager/designee. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Culinary staff were educated on the food storage/freezer storage policy by the Culinary manager/designee by 9-25-24. The culinary manager/designee will check the facility freezer daily for items not stored correctly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Food storage QA tool will be utilized daily x 4, weekly x 4, and monthly thereafter for 6 months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Date of correction: 9-25-24 -	