

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

PRINTED: 10/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 09/16/2024	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/16/24 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Emergency Preparedness survey, Spring Mill Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 84. Quality Review completed on 09/18/24			E 0000			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/16/24 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Life Safety Code survey, Spring Mill Meadows was found not in compliance with			K 0000	Please accept the submission of the Plan of Correction responses noted on state form 2567 for the alleged deficiency cited during the annual Life Safety Code survey. The facility is requesting desk review in lieu of a PSR after 10-7-24. Thank you for considering this request.		

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

TITLE

(X6) DATE

Cynthia Kump-Tarbutton

Executive Director

09/27/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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

PRINTED: 10/03/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 09/16/2024	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 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
K 0374 SS=E Bldg. 01	<p>Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two-story facility with a partial basement was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 84 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 09/18/24</p> <p>NFPA 101 Subdivision of Building Spaces - Smoke Barrie</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 12 residents, 4 staff and 2 visitors within the facility.</p> <p>Findings include:</p>			K 0374	<p>K374 It is the policy of this facility to ensure smoke barrier doors will restrict the movement of smoke for at least 20 minutes.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The smoke barrier doors closest to the environmental services</p>		10/07/2024

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

PRINTED: 10/03/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 09/16/2024	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 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
	<p>Based on observations made during a tour of the facility on 09/16/24 at 1:10 p.m. with the Director of Maintenance and the Field Maintenance Supervisor, the set of smoke barrier doors nearest to the Environmental Services office did not close completely or latch when tested on three separate occasions. There was a one-inch gap between the doors when closed to their fullest. Based on an interview at the time of observation, the Director of Maintenance acknowledged these smoke barrier doors did not close completely or latch stating that he would have them adjusted as soon as possible.</p> <p>This finding was reviewed with the Administrator, the Director of Maintenance and the Field Maintenance Supervisor at the exit conference.</p> <p>3.1-19(b)</p>				<p>office, were adjusted on 9-19-24.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents at the facility have the potential to be affected by this alleged deficient practice.</p> <p>The smoke barrier doors closest to the environmental services office were adjusted on 9-19-24.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Maintenance Director/designee will monitor the all smoke barrier doors in the facility, Mon-Fri on daily rounds.</p> <p>The Maintenance Director was re-educated by the ED by 10-7-24 on the smoke barrier door requirement.</p> <p>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?</p> <p>Weekly LSC QA tool will be</p>		

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

PRINTED: 10/03/2024
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155154		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 09/16/2024	
NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 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
					utilized 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 correction: 2 10-7-2024		