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	06/30/2023

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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 26, 27, 28 29 and 30, 2023 Facility number: 000074 Provider number: 155154 AIM number: 100290050 Census Bed Type: SNF/NF: 69 SNF: 7 Total: 76 Census Payor Type: Medicare: 14 Medicaid: 47 Other: 15 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed July 10, 2023.	F 0000	Please accept State Form 2567, Plan of Correction for the Annual Recertification and State Licensure Survey completed on June 30, 2023. The facility also requests that the 2567 serve as our letter of credible allegation of compliance. The facility requests a desk review in lieu of a post survey revisit on or after August 1, 2023.	
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Based on observation, interview and record review, the facility failed to monitor daily weights as ordered for a resident with the diagnosis of congestive heart failure (CHF) for 1 of 1 resident reviewed for edema. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 06/28/23 at 11:03 a.m. The diagnoses included, but were not limited to, unspecified diastolic congestive heart failure. A care plan, dated 1/18/23, indicated the resident was at risk for fluid imbalance due to diastolic dysfunction, enteral feeding, and diuretic medications. Interventions included, but were not limited to, daily weights. A physician's order, dated 6/7/23, indicated to obtain a daily weight for CHF, and to notify the physician of a weight gain of 2 pounds day or 5 pounds in a week. A progress note, dated 6/12/23 at 4:26 p.m., indicated the reason for the NAR (nutrition at risk) review was a significant weight loss for 33 days of 20 pounds or 8%. The root cause of the weight change was progression of CHF with fluid retention as exhibited by non-pitting edema (swelling), needing Lasix (medication to reduce edema) to remove excess fluid. A physician's progress note, dated 6/14/23 at 4:00 p.m., indicated the resident had abnormal labs as well as a reported weight loss. The most recent weight showed a weight loss from 265- 239.2 and was reweighed at 237. Weight loss was likely attributed to Lasix and diuresis (removing fluid). Would monitor closely.	F 0684	**F684** It is the policy of this facility to monitor daily weights 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 7 has discharged. **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 daily weights have the potential to be affected by this alleged deficient practice. · DNS/designee completed a full house audit of daily weights of current residents. Physician notification was made if 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 M-F in clinical meeting to ensure daily weights are obtained and orders followed. · Nursing staff will be educated on the facility daily weight protocol by the DNS/designee by 7-27-23. **How the corrective action(s) will be monitored to ensure the**	08/01/2023

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	A review of the MAR (Medication Administration Record), dated 6/1/23 to 6/30/23, indicated there were no weights on 6/8, 6/12, 6/13, 6/15, 6/17, and 6/19 to 6/28/23. A review of vital signs indicated there were no weights documented on 6/8, 6/12, 6/13, 6/15, 6/17, and 6/19 to 6/28/23. During an interview, on 6/30/23 at 2:00 p.m., the Director of Nursing indicated there was no policy for CHF and physician's orders should be followed. A policy, titled "Resident Weight Monitoring," dated 12/22 and received from the Director of Nursing on 6/30/23 at 1:10 p.m., indicated "...It is the policy of this facility that residents will be weighed no less than monthly or per physician's orders...." 3.1-37(a)		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** · Annual POC QA tool will be 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**: 8-1-23	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure dependent residents were transferred as care planned using proper technique and transfer assist times two for	F 0689	**F 689** It is the policy of this facility to transfer residents as care planned using proper technique and transfer assist of	08/01/2023

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	2 of 10 residents reviewed for accidents. (Residents 46 and 49) Findings include: 1. The record for Resident 46 was reviewed on 06/29/2023 at 9:20 a.m. Diagnosis included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, abnormal posture, muscle weakness, and pain. A care plan, dated 05/01/2023 and last revised on 05/26/2023, indicated the resident was at risk for falls due to an impaired balance with right hemiparesis. Other factors included a new environment, high risk medications, the resident's age and debility, and a history of falls. The resident attempts self-transfers and was a two person assist with transfers. A Minimum Data Set (MDS) Assessment, dated 05/05/2023, indicated under sections G functional status the resident was an extensive assistance of two people. A Physical Therapy Discharge Summary, dated 05/19/2023, indicated the resident required assistance for safety. Point of care history charting related to staff support provided for transferring, dated 05/01/2023 to 05/30/2023, indicated the resident was transferred 52 times, only 12 transfers were 2 person assist transfers. Point of care history charting related to staff support provided for transferring, dated 06/01/2023 to 06/29/2023, indicated the resident was transferred 67 times, only 4 transfers were 2		two for those residents who are care planned. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident 46 and 49 are transferred with assist of 2 as care planned. Staff will be re-educated on accurate documentation for transfers. **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 require assist of 2 for transfers could be affected by the alleged deficient practice. · The facility IDT will audit and review all residents requiring 2 for assist to ensure plans of care are accurate. · Nurses and aides were educated by the DNS/designee by 7-27-23 on accurate documentation for transfers. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurses and aides were educated by the DNS/designee by 7-27-23 on the importance of accurately documenting transfers for residents. · MDS Coordinator will run a	

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	person assist transfers. During an interview, on 06/30/2023 at 9:24 a.m., CNA 5 (Certified Nursing Assistant) indicated the resident's profile, dated 05/01/2023, was posted on the back of the resident's door. The profile indicated the resident should be transferred with a two person assist. 2. The record for Resident 49 was reviewed on 6/28/23 at 11:16 a.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), repeated falls, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body), muscle weakness, Parkinson's disease, and repeated falls. A care plan, dated 6/4/22, indicated the resident was a fall risk and was a two-person transfer assist. During an observation, on 06/29/23 at 12:55 p.m., CNA 6 assisted the resident back to his room and closed the door. CNA 6 then attempted to transfer the resident unassisted. CNA 6 started to lift the resident up and was stopped. CNA 6 indicated they did not know the resident was a two-person transfer. A current policy, titled "IDT Comprehensive Care Plan Policy," dated as last revised 10/2019 and received from the DON on 06/30/2023 at 11:30 a.m., indicated "...it is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including, medical, nursing, mental,		report daily M-F for all transfers to review accuracy. · The facility IDT reviews all care plans at admission, quarterly, and with significant change for any updates that are needed. **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?** · Annual POC 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**: 8-1-23	

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	and psychosocial needs...." A policy was not received before the exit conference about transfers. 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to reweigh a resident after a significant weight loss to ensure a correct weight was obtained and to notify the physician of the weight loss for 1 of 3 residents reviewed for nutrition. (Resident 10) Finding includes:	F 0692	**F692** It is the policy of this facility to monitor resident weights when a significant change has been identified and notify the physician. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/01/2023

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	The record for Resident 10 was reviewed on 06/28/23 at 9:12 a.m. Diagnoses included, but were not limited to, dementia, protein-calorie malnutrition, dysphagia (difficulty swallowing), traumatic brain injury, pressure ulcer of right hip, and local infection of the skin and subcutaneous tissue- right hip infection. The resident's weights were as follows: a. On 3/3/23, the resident's weight was 123 pounds. b. On 3/12/23, the resident's weight was 98 pounds which was a significant weight loss of 20.33% in 9 days. The resident was not reweighed to ensure the weight was correct. The physician was not called when the weight was obtained and showed a significant weight loss. c. On 3/20/23, the resident's weight was 97 pounds after a reweigh. A care plan, dated 11/08/22, indicated to notify MD of any significant weight changes. A physician's order, dated 4/10/23, indicated to start mirtazapine 7.5 mg (milligrams) at bedtime for protein calorie malnutrition which was 29 days after the weight loss occurred. During an interview, on 06/30/23 at 9:40 a.m., the DON (Director of Nursing) indicated they were unsure of what caused the residents weight loss. The facility did not have a reweigh policy. During an interview, on 06/30/23 at 2:21 p.m., a weight care plan for Resident 10 was requested, and the DON indicated the resident did not have a weight care plan. A reweigh policy was not available before the exit conference.		**practice?** · Resident 10 has discharged. **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 significant changes in weights have the potential to be affected by this alleged deficient practice. · DNS/designee completed a full house audit of weights of current residents. Physician notification was made if needed. · All residents will be reviewed and assessed for which scale to be used by 8-1-23. **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/RD/designee will review weights daily M – F to ensure weights are obtained and are accurate. Re-weights will be obtained if needed per policy and physician notified. · Nursing staff will be educated on the facility weight protocol by the DNS/designee by 7-27-23. **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?**	

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	3.1-46(a)(1)		· Annual POC QA tool will be 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**: 8-1-23	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which			

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	the quantity stored is minimal and a missing dose can be readily detected. Based on observation and record review, the facility failed to label liquid narcotics stored in the narcotic box in the medication cart for 1 of 3 medication carts reviewed. (Cart 2) Findings include: During an observation, on 6/28/23 at 3:00 p.m., a narcotic count was conducted. a. A clear plastic bag contained a bottle of liquid morphine sulfate 20 mg (milligrams) per milliliter. The label on the plastic bag contained information regarding dosing. There was no label to identify the resident on the plastic bag or bottle. There were 28.25 milliliters remaining in the 30-milliliter bottle. b. A brown and white box contained lorazepam 2mg/ml had no label on the box or bottle. There were 27.75 milliliters of medication remaining in the 30-milliliter bottle. During an interview, on 6/28/23 at 3:26 p.m., the Director of Nursing indicated the medication (morphine and lorazepam) had been pulled from the emergency medication supply yesterday. The resident was a new admission. She indicated the medications should have been labeled. A current policy, titled "Omnicell: Best Practice for Medication Removal," dated 2018 and received from the Executive Director on 6/29/23 at 1:00 p.m., indicated "...any medication or product removed from the Omnicell (an automated emergency drug storage system) should always be assigned to a specific resident...." 3.1-25(k)(1)	F 0761	**F761** It is the policy of this facility to label liquid narcotics stored in the narcotic box, including those obtained from an emergency kit/Omnicell. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The medications identified were destroyed immediately. · All med carts were audited by pharmacy on 7-3-23 and 7-5-23. **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 require multi dose medications to be obtained from the Omnicell have the potential to be affected by the alleged deficient practice. · Nurses were educated by the DNS/designee by 7-27-23 on labeling medications pulled from the emergency kit/Omnicell. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Nurses were educated by the DNS/designee by 7-27-23 on the labeling policy related to the	08/01/2023

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			Omnicell. · A daily report is received by the ED/DNS regarding multi-dose items obtained from the Omnicell which will be audited daily. **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?** · Annual POC QA tool will be utilized, weekly x 4 weeks, 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**: 8-1-23	
F 9999 Bldg. 00	Sec. 1.4. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (A) aged;	F 9999	**F999** It is the policy of this facility to ensure all employees ensure appropriate screening items are maintained for prospective employees including references, first and second step ppd, specific job orientation information, and dementia training. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/01/2023

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	(B) developmentally disabled; (C) mentally ill; (D) children; or (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result		**practice?** · NA5 – references, TB tests, and job orientation information, were obtained. · NA7 – references were obtained. · Cook8 – completed 3 hours of dementia training. **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 reside at the facility could be affected by the potential deficient practice. · Office staff were educated by the Ed/designee by 7-27-23 on completing prospective hire files prior to the start of the job. · Home office completes monthly audits of random files. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Office staff were educated by the ED/designee by 7-27-23 on completing prospective hire files prior to the start of the job. · An employee file checklist will be used on each new hire. The ED will review the forms weekly after orientation. **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**	

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	during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure references were considered at the time of employment, to ensure new employees received a 1st and/or 2nd PPD (Purified Protein Derivative) (a skin test to determine if a person had been exposed to TB), to have specific job orientation information, and failed to provide documentation of dementia training for 3 of 10 employee records reviewed. (NA 5, NA 7 and Cook 8) Findings include: 1. Employee personnel files for NA 5, with a hire		**into place?** · Annual POC 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**: 8-1-23	

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	06/30/2023

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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	date of 12/14/2022, did not contain references, a 1st or 2nd step TB test and job orientation. 2. Employee personnel files for NA 7, with a hire date of 11/09/2022, did not contain references. 3. Employee personnel files for Cook 8, with a hire date of 11/17/2017, did not contain the required three hours of dementia training. During an interview, on 6/30/2023 at 2:31 p.m., the Executive Director (ED) indicated she had no additional information regarding the employee files. A policy was requested, however the ED indicated there was no policy and procedure regarding employee files.			