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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Mill Meadows	2140 W 86th St Indianapolis, IN 46260

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50901 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 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. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48525 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 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 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 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46961 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 [DATE] 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 long white capsule and a long yellow capsule were lying in the bottom of the third drawer. During a narcotic reconciliation, on [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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. During an interview, on [DATE] 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 [DATE] 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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] 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 [DATE] 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 [DATE] and received from the DON on [DATE] 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 ,d+[DATE] and received from the Executive Director on [DATE] 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 [DATE] and received from the DON on [DATE] 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 [DATE] 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 3XXX,d+[DATE](e)(2) 3XXX,d+[DATE](e)(3) 3XXX,d+[DATE](j) 3XXX,d+[DATE](o)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 49891 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 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)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50956 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 [NAME] 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 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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-21(i)(3)