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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure care plan meetings were held quarterly, the residents and the residents' representatives were invited to participate, and to develop a comprehensive care plan related to a PICC line (peripherally inserted central catheter) and enhanced barrier precautions for 4 of 20 residents reviewed for care plans. (Resident 40, 57, 5 and 2)Findings include: 1. During an interview, on 7/30/25 at 10:51 a.m., Resident 40 indicated he had not been to a care plan meeting to discuss his care at the facility. The clinical record for Resident 40 was reviewed on 8/5/25 at 1:40 p.m. The diagnoses included, but were not limited to, hypertension, major depressive disorder, and hemiparesis and hemiplegia following unspecified cerebrovascular disease. There was no documentation in the clinical record to indicate Resident 40 had a care plan meeting in 2025. During an interview, on 8/1/25 at 2:21 p.m., Social Service Worker 6 indicated it had been a while since the resident had a care plan meeting. Care plan meetings were supposed to be held every 90 days. The last care meeting for Resident 40 was on 12/26/24. 2. During an interview, on 7/31/25 at 10:48 a.m., Resident 57 indicated she had not been invited to care planning meetings quarterly to discuss her care at the facility. The clinical record for Resident 57 was reviewed on 7/31/25 at 1:39 p.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease. There was no documentation in the clinical record to indicate Resident 57 had a care plan meeting from 7/2/24 to 3/27/25. A progress note, dated 3/18/25, indicated a care plan meeting would be scheduled for 4/2/25 at 1:30 p.m., in the resident's room. The documented care plan meeting, on 4/2/25 at 1:30 p.m., was not located in the clinical record. During an interview, on 8/1/25 at 2:51 p.m., Social Service Worker 7 indicated care plan meetings would be documented in an observation or progress note. Social Service Worker 7 reviewed the observations and progress notes and indicated the care plan meeting for Resident 57 had not been completed. She completed a care plan meeting with Resident 57 in April (2025) but did not take notes during the meeting or document the care plan meeting in the record. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation, on 7/30/25 at 10:57 a.m., Resident 5 had a Foley catheter and a PICC line. The clinical record for Resident 5 was reviewed on 8/4/25 at 2:39 p.m. The diagnoses included, but were not limited to, necrotizing fasciitis, obstructive and reflux uropathy, and urinary retention. A care plan history report, dated 6/24/25 to 7/8/25, indicated Resident 5 had an infection and was currently on IV (intravenous) antibiotics which was discontinued on 7/7/25. A nursing progress note, dated 7/8/25 at 4:12 p.m., indicated Resident 5's PICC line was in place in his right upper arm and without signs of infection. The comprehensive care plans for Resident 5 did not indicate the care plan had been updated since his baseline care plan and did not include his PICC line or enhanced barrier precautions for his Foley catheter. During an interview, on 8/4/25 at 3:31 p.m., the Director of Nursing (DON) indicated she was not sure why the PICC line was discontinued in the comprehensive care plan. The Minimum Data Set (MDS) Coordinator reviewed and managed residents' care plans. During an interview, on 8/5/25 at 10:37 a.m., the MDS Coordinator indicated the PICC line was discontinued from Resident 5's care plan because the resident's antibiotic treatment via the PICC line had ended on 7/5/25 or 7/6/25. When treatments were completed, the care plans would be standardized. There must have been a communication error regarding Resident 5's PICC line. 4. During an observation, on 7/30/25 at 12:30 p.m., Resident 2 had a Foley catheter drainage bad attached to the bed frame and a PICC line in his right upper arm. The clinical record for Resident 2 was reviewed on 8/1/25 at 11:15 a.m. The diagnoses included, but were not limited to, obstructive and reflux uropathy, urethral discharge, and pain. The clinical record indicated Resident 2 was readmitted to the facility, on 6/5/25, from the hospital with a Foley catheter. A physician's order, dated 6/6/25, indicated a Foley catheter was in place. A care plan, dated 6/6/25 and last revised 7/24/25 at 9:21 a.m., indicated Resident 2 required an indwelling urinary catheter related to obstructive uropathy. The care plan did not include enhanced barrier precautions which were required for residents with an indwelling device. During an interview, on 8/4/25 at 3:31 p.m., the DON indicated she was not sure why the care plan did not include enhanced barrier precautions for the Foley catheter. During an interview, on 8/5/25 at 12:26 p.m., the Executive Director indicated the policy titled Comprehensive Care Plan Policy covered care plan meetings. A current facility policy, titled Comprehensive Care Plan Policy, dated as last reviewed in 10/2019 and provided by the Director of Nursing on 8/4/25 at 1:44 p.m., indicated .It is the policy of this (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and psychosocial needs. The policy did not cover when care plan meetings were to be held. 3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(c)(2)(A) 3.1-35(c)(2)(C) 3.1-35(c)(2)(C) 3.1-35(d)(2)(B) 3.1-35(e)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure Personal Protection Equipment (PPE) was used during care for residents on Enhanced Barrier Precautions (EBP), staff removed soiled gloves after cleaning a catheter line and prior to touching items in a resident's environment, to ensure EBP signage was posted, and to properly store a bed pan for 5 of 5 residents reviewed for infection control. (Resident 67, 81, 6, 2 and 5)Findings include:1. During an observation, on 7/31/25 at 8:10 a.m., a sign was posted outside Resident 67's door to indicate the resident was on EBP precautions. During the observation, LPN 1 was observed to perform hand hygiene and put on clean gloves. She was not observed to put on a gown. LPN 1 attached a piston syringe to the gastrostomy tube, flushed the line with water, administered liquid gabapentin (a medication for neuropathy and/or seizures), flushed the line again, and then reconnected the nutrition line. LPN 1 was not observed to use a gown throughout the procedure. During an interview, on 7/31/25 at 8:22 a.m., LPN 1 indicated EBP required the use of a gown, and she did not use one. The clinical record for Resident 67 was reviewed on 7/31/2025 at 9:42 a.m. Diagnoses included, but were not limited to, gastronomy status, hemiplegia and hemiparalysis following cerebral infraction (stroke), and dysphagia (difficulty swallowing) following a cerebral infraction. A current care plan, dated 8/15/24, indicated Resident 67 was at risk of transferring or becoming colonized with multidrug resistant bacteria (MDRO) due to the use of a gastronomy tube and a history of MDRO. An intervention was to identify through signage and the medical record the use of enhanced barrier precautions. 2. During an observation of catheter care, on 8/4/25 at 11:28 a.m., with CNA 5 and the Infection Preventionist, CNA 5 performed catheter care using the appropriate enhanced barriers. Once CNA 5 had completed cleaning the catheter line, she placed the soiled linen into a bag, placed a brief on the resident, dressed him, and covered the resident up. CNA 5 handled the resident's call light and used the resident's bed controls to adjust the bed. She was not observed to remove her gloves or wash her hands after performing catheter care or prior to handling the call light or the bed controls. During an interview, on 8/4/25 following the observation, the Infection Preventionist indicated CNA 5 should not have handled the resident's call light with the gloves she used to perform catheter care. The clinical record for Resident 81 was reviewed on 8/4/25 at 10:44 a.m. The diagnoses included, but were not limited to, muscle weakness, cognitive communication deficient, and difficulty walking. A care plan intervention, dated 5/15/25, indicated .Use standard precautions including hand hygiene. 3. During an observation, on 8/1/25 at 1:45 p.m., the door to Resident 6's room was closed, a green EBP sign was posted to the left of the door, above Resident 6's room number. The surveyor knocked on the door and Qualified Medication Aide (QMA) 12 opened the door and indicated she was providing patient care. QMA 12 was observed to be wearing blue gloves but was not observed wearing a gown (PPE). During an interview, on 8/1/25 at 1:55 p.m., QMA 12 indicated she was providing incontinent care for Resident 6. She indicated she knew Resident 6 was in EBP but forgot to put the proper PPE on (gown) (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and was only wearing gloves. The clinical record for Resident 6 was reviewed on 8/1/25 at 1:29 p.m. The diagnoses included, but were not limited to, respiratory failure, tracheostomy status, and gastrostomy status. A care plan, dated as last revised on 7/31/25 at 9:54 a.m., indicated Resident 6 was at risk of transferring or becoming colonized with an MDRO (multidrug resistant organism) and required enhanced barrier precautions due to an indwelling medical device with an approach to wear gown and gloves prior to high contact resident care activities. A physician's order for EBP could not be found in the record. 4. During an observation, on 7/30/25 at12:30 p.m., Resident 2 had a Foley catheter drainage bag attached to the bed frame and a PICC (peripherally inserted central catheter) in his right upper arm. EBP/PPE signage was not observed outside or inside Resident 2's room. During an observation and interview, on 7/31/25 at 8:54 a.m., EBP signage was not found outside or inside Resident 2's room. Resident 2 indicated staff did not wear gowns while providing personal care to him. During an interview, on 7/31/25 at 9:02 a.m., Social Service Worker 7 indicated Resident 2 was in enhanced barrier precautions and would have a green sign outside his room labeled EBP as well as a sign located inside the room which demonstrated the proper PPE equipment needed with instructions on when the PPE would need to be utilized. She indicated she did not see any EBP signage. During an interview, on 7/31/25 at 9:04 a.m., CNA 8 indicated EBP would be used for a resident with wounds, a urinary catheter, and/or an IV (intravenous catheter). The clinical record for Resident 2 was reviewed on 8/1/25 at 11:15 a.m. The diagnoses included, but were not limited to, acute cystitis (microscopic blood in the urine), obstructive and reflux uropathy, and urethral discharge. A care plan, dated as last revised 7/24/25 at 9:21 a.m., did not include the need of EBP related to his Foley catheter and PICC line. A physician's order for EBP was not located in the record. 5. During an observation and interview, on 7/30/25 at 11:10 a.m., Resident 5 indicated staff did not wear gowns while providing care for him. EBP/PPE signage was not observed outside or inside Resident 5's room. During an observation and interview, on 8/4/25 at 10:13 a.m., Resident 5 had an unbagged bed pan sitting on his bedside table next to a box of cookies. Resident 5 indicated his call light was on because he wanted someone to clean his bedside table off and wipe it down with a rag. He last used the bed pan the night before, during 3rd shift, and was not sure why the bed pan was on his bedside table. During an interview, on 8/5/25 at 10:14 a.m., Unit Manager 9 indicated he was not sure why the bed pan was on the bedside table, and it should not be there. (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record for Resident 5 was reviewed on 8/4/25 at 2:39 p.m. The diagnoses included, but were not limited to, necrotizing fasciitis, obstructive and reflux uropathy, and retention of urine. A care plan, dated as last revised 7/7/25 at 9:47 a.m., did not include the need of EBP related to his Foley catheter and PICC line. During an interview, on 8/4/25 at 3:31 p.m., the Director of Nursing (DON) indicated Resident 5 was admitted with the Foley catheter and PICC line in place, both which required the resident to be placed in EBP. A current facility policy, titled Enhanced Barrier Precautions (EBP) Education, undated and received from the DON on 8/1/25 at 10:40 a.m., indicated .Before providing care to a resident with Enhanced Barrier Precautions (EBP) .Correctly put on gown and gloves .Gown before gloves A current facility skill competency, titled Catheter Care (Urinary), dated as last revised 6/25 and received from the Infection Preventionist on 8/4/25 at 11:50 a.m., indicated .Remove gloves .Perform hand hygiene A current facility policy, titled Nursing Department Infection Control, dated as last revised 12/2024 and received from the DON on 8/4/25 at 9:01 a.m., indicated .To ensure that resident(s) are is provided in a safe and sanitary manner to prevent the spread of infection.The nursing staff shall follow infection control guidelines to prevent the spread of infection.Bedside personal equipment, such as.bedpan, shall be maintained in a sanitary condition. This shall include.storing equipment in a way that prevents cross contamination.place clean/disinfected equipment in a clean plastic bag. 3.1-18(b) 3.1-18(l)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team (IDT) determined that a resident was safe to self-administer medications and to obtain a physician's order for self-administration for 1 of 1 resident reviewed for self-administration of medication. (Resident 57)Findings include:During an observation and interview, on 7/31/25 at 2:59 p.m., Resident 57 had 2 respiratory inhalers on her bed. Resident 57 indicated her inhalers had been at bedside with her for a long time and she kept the inhalers within arm's reach, either on her bed or in her bedside table drawer.During an observation and interview, on 8/1/25 at 8:55 a.m., Resident 57 had 3 respiratory inhalers with her at bedside. Resident 57 indicated she self-administered the medications, and the nurse would bring her replacements when the medications were empty.At bedside the 3 respiratory inhalers were:1. Spiriva 1.25 mcg (microgram), dated 5/20/25, with instructions to discard by 8/9/25.2. Albuterol rescue inhaler with 15 doses remaining.3. Breo Ellipta, dated 5/21/25, with 18 out of 30 doses remaining. The clinical record for Resident 57 was reviewed on 7/31/25 at 1:39 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, shortness of breath, and anxiety disorder.A care plan, dated 3/24/25, indicated Resident 57 self-administered her medications although she had no order to self-administer, would seek outside sources for medication, and administer the medication herself.A care plan, dated 7/29/25, indicated Resident 57 exhibited cognitive impairment in which her cognition shifted between intact and moderately impaired.A care plan, dated 7/31/25, indicated Resident 57 chose to self-administer medications. The resident preferred to take her oral medication at her leisure with a preference of the nurse to leave her medication at the bedside table. The approach to this care plan was for the facility to complete a medication self-administration request/evaluation.A nursing progress note, dated 5/21/25, indicated that while cleaning Resident 57's room multiple inhalers and breathing treatment vials were found. Some of the medications found contained labels different than the facility's pharmacy label.The physician's orders included, but were not limited to,1. Spiriva Respimat 1.25 mcg, with instructions to inhale 2 puffs, once a day.2. A physician's order for the Albuterol inhaler was not located in the medical record.3. Breo Ellipta 200-25 mcg/dose, with instructions to inhale 1 puff daily, rinse mouth with water after, and spit out. A physician's order for Resident 57 to self-administer medication was not located in the medical record.An IDT evaluation which included the medications appropriate and safe for self-administration, the resident's physical capacity, the resident's cognitive status, the resident's capability to follow directions and know when medications needed to be taken, the resident's comprehension of instructions for the medications including the dose, timing, and signs of side effects, and the ability to ensure medication was stored safely and securely for Resident 57 to self-administer medication was not located in the medical record.During an interview, on 7/31/25 at 2:50 p.m., the Director of Nursing (DON) indicated in the past Resident 57 used to self-administer her respiratory medications and had a self-administration evaluation. Resident 57 had experienced a change in cognition, and the self-administration was removed.A current facility policy, titled Self-Administration of Medications, dated as last revised 1/2015 and received from the DON on 8/4/25 at 9:01 a.m., indicated .It is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medications, as allowable under state regulations. The facility will provide instruction for all residents choosing to and capable of self-administration.If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the [Self-Administration of Medication Assessment] observation.A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan.The licensed nurse will instruct the resident regarding proper administration of medication.Storage of self-administrated medications will comply with state and federal regulations. All bedside medications will be maintained in a secured (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	location in the resident's room.The resident's care plan will be updated to include self-administration.3.1-11(a)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure a Notice of Medicare Non-Coverage (NOMNC) was signed by the resident or resident's representative for 1 of 3 residents reviewed for beneficiary notices. (Resident 68)Findings include:The beneficiary notices were reviewed on 8/4/25 at 3:00 p.m.A NOMNC document indicated the skilled services for Resident 68 would end on 6/16/25. The document indicated to sign to show you received, understood the notice, and was notified the service coverage would end on the date of the notice. The decision could be appealed by contacting the Quality Improvement Organization (QIO).The signature section was dated 6/13/25 and the signature of the patient or representative was blank and indicated Resident 68 was unable to sign due to their cognition.There was no documentation to indicate anyone had signed on behalf of Resident 68 to show they received and understood the notice of non-coverage.During an interview, on 8/4/25 at 3:35 p.m., the Executive Director (ED) indicated Resident 68 could not sign the NOMNC due to their cognition. She was not sure why it was not signed and if the resident could not sign it, then the representative would sign it. During an interview, on 8/04/25 at 4:05 p.m., the ED indicated the NOMNC was not signed by the resident or representative.The facility did not provide a beneficiary notices policy by the time of exit.3.1-4(f)(3)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was updated when new diagnoses or psychotropic medications were added for 2 of 2 residents reviewed for PASARR. (Residents 3 and 79)Findings include:1. The clinical record for Resident 3 was reviewed on 7/31/25 at 2:51 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, anxiety disorder, and major depressive disorder.A PASARR level I screen, dated 10/30/23, indicated Resident 3 did not have a diagnosis of dementia or neurocognitive disorder and was not taking donepezil or memantine. It indicated if changes occurred, a new screen must be submitted.A neurobehavior status exam note, dated 11/27/24, indicated Resident 3 displayed severe cognitive impairment on the brief cognitive assessment with impaired memory performance. Resident 3's history, symptoms, and current presentation appeared consistent with dementia with an etiology likely related to Alzheimer's disease. The established diagnosis list included late onset Alzheimer's disease and moderate dementia with mood disturbance.A physician's order, dated 12/5/24, indicated to give donepezil (a medication used to treat cognitive symptoms associated with Alzheimer's disease) 5 milligrams (mg) at bedtime.A behavioral health progress note, dated 12/11/24, indicated to increase donepezil from 5 mg to 10 mg for the diagnosis of Alzheimer's disease.A physician's order, dated 12/19/24, indicated to increase donepezil from 5 mg to 10 mg at bedtime.A current physician's order, dated 12/23/24, indicated to give donepezil 10 mg at bedtime.A psychiatry progress note, dated 1/2/25, indicated to start memantine (a medication used to treat moderate to severe Alzheimer's disease) 5 mg for diagnosis of Alzheimer's disease.A physician's order, dated 1/3/25, indicated to give memantine 5 mg once a day.A psychiatry progress note, dated 2/7/25, indicated the resident had no history of dementia on the PASARR and had current medications of donepezil and memantine.A physician's order, dated 2/7/25, indicated to increase the memantine to 5 mg twice a day.A significant change in status minimum data set assessment, dated 2/12/25, indicated the resident had a new diagnosis of Alzheimer's disease.A current physician's order, dated 3/7/25, indicated to give memantine 10 mg twice a day.A current physician's order, dated 5/1/25, indicated to increase sertraline (an antidepressant medication) from 50 mg to 75 mg per day.A care plan, dated 5/16/25, indicated Resident 3 required a dressing and grooming program related to Alzheimer's disease which started on 2/24/25.A psychiatry consult note, dated 6/17/25, indicated the resident's PASARR showed no history of dementia and late onset Alzheimer's disease and moderate dementia with mood disturbance was on her current diagnosis list.During an interview, on 8/5/25 at 10:16 a.m., Social Services 7 indicated a PASARR update should have been completed after the new diagnosis of Alzheimer's disease was determined and with any new medications or increased doses. 2. The clinical record for Resident 79 was reviewed on 8/1/25 at 9:15 a.m. The diagnoses included, but were not limited to, anxiety disorder, major depressive disorder without psychotic features, insomnia, depression, and adult failure to thrive.A PASARR level I, dated 6/30/25, indicated the resident had taken alprazolam (a medication used to treat anxiety) within the past six months but it had been discontinued. It did not indicate the resident was currently taking any psychotropic medications. It indicated if changes occurred or new information refuted these findings, a new screen must be submitted.A hospital Discharge summary, dated [DATE], indicated the resident was to continue to take alprazolam 1 milligram (mg) as needed and duloxetine (an antidepressant medication) 60 mg once a day.A physician's order, dated 7/3/25, indicated to give duloxetine 60 mg once a day and alprazolam 1 mg at bedtime as needed.A social service progress note, dated 7/8/25, indicated Resident 79's PASARR Level I was checked for accuracy.A physician's order, dated 7/11/25, indicated to give alprazolam 1 mg three times a day.A social services progress note, dated 7/12/25, indicated the resident expressed signs of suicidal ideation with thoughts of harming herself and a plan (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of action.A physician's order, dated 7/14/25, indicated to give bupropion (an antianxiety medication) 150 mg twice a day.A physician's progress note, dated 7/15/25, indicated Resident 79 had continued duloxetine and alprazolam as needed on 7/7/25, but then on 7/15/25 alprazolam had changed from as needed to routinely three times a day and Resident 79 was started on bupropion for worsening depression and anxiety.During an interview, on 8/5/25 at 10:28 a.m., Social Services 6 and 7 indicated they thought Resident 79 was admitted on only 1 psychotropic medication and the admission PASARR had been accurate. Social Services 7 indicated all admission medications should have been on the PASARR, or a new one should have been completed immediately. Resident 79's depression and anxiety had increased during her stay, so medications had been increased and added. The resident had expressed the intent to stab herself with a knife at breakfast on 7/12/25.A current facility policy, titled PASRR Policy, dated 11/17 and provided by the Director of Nursing on 8/1/25 at 2:30 p.m., indicated .PASRR assessments are updated with significant changes in mental and physical status.3.1-16(d)(1)(A)3.1-16(d)(1)(B)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and record review, the facility failed to ensure baseline care plans were developed within 48 hours of admission and included enhanced barrier precautions for 2 of 4 residents reviewed for baseline care plans. (Resident 5 and 79) Findings include: 1. During an observation, on 7/30/25 at 10:57 a.m., Resident 5 was lying in bed with a Foley catheter drainage bag attached to the bed frame and a PICC line (peripherally inserted central catheter used for medication administration and blood draws) was in his right arm. The clinical record for Resident 5 was reviewed on 8/4/25 at 2:39 p.m. The diagnoses included, but were not limited to, necrotizing fasciitis, obstructive and reflux uropathy, and urinary retention. A nursing progress note, dated 6/24/25, indicated Resident 5 was admitted to the facility by ambulance. An assessment was obtained by the staff, which included, but were not limited to, a PICC line in the right upper extremity and a Foley catheter in place. A physician's order, dated 6/24/25, indicated to monitor the PICC line site daily for warmth, redness or swelling. A physician's order, dated 7/18/25, indicated Resident 5 had a Foley catheter. A baseline care plan history report, dated 6/24/25 to 7/8/25, indicated Resident 5 had an infection and was currently on IV (intravenous) antibiotic therapy. A baseline care plan history report, dated 6/24/25 to 7/8/25, indicated Resident 5 required assistance with his ADLs (activities of daily living), which included, but were not limited to, Resident 5 had a Foley catheter. The baseline care plan did not include enhanced barrier precautions, which were required for a resident with an indwelling device. During an interview, on 8/4/25 at 3:31 p.m., the Director of Nursing (DON) indicated Resident 5 was admitted to the facility from the hospital with the PICC line and Foley catheter in place. She was not sure why the baseline care plan did not include enhanced barrier precautions. 2. The clinical record for Resident 79 was reviewed on 8/1/25 at 9:15 a.m. The diagnoses included, but were not limited to, anemia, anxiety disorder, major depressive disorder without psychotic features, chronic obstructive pulmonary disease, emphysema, insomnia, weakness, adult failure to thrive, age-related osteoporosis, and pain. A nursing progress note, dated 7/3/25 at 3:12 p.m., indicated the resident was admitted to the facility from the hospital. A physician's order, dated 7/3/25, indicated to give duloxetine (an antidepressant medication) 60 milligrams (mg) once a day. A care plan history report, dated 7/3/25 to 8/4/25, indicated the baseline care plan was started on 7/7/25. (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/5/25 at 10:47 a.m., the Clinical Support Nurse indicated the baseline care plan should have been completed within 48 hours by 7/5/25. During an interview, on 8/5/25 at 10:50 a.m., Social Services 6 and 7 indicated the Minimum Data Set (MDS) Coordinator typically created the baseline care plan. Since Resident 79 admitted after the MDS Coordinator was gone for the day 3-day holiday weekend, it did not get completed until she returned on Monday, 7/7/25. A current facility policy, titled IDT Baseline Care Plan, dated 4/2023 and received from the Director of Nursing (DON) on 8/5/25 at 12:20 p.m., indicated .Baseline Care Plan will be . initiated within 48 hours of admission to the facility .Baseline Care Plan will include, but not limited to the following.The instructions needed to provide effective and person-centered care that meets professional standards of quality care; The resident's immediate health and safety needs; Physician's orders .Baseline Care Plan interventions/changes impacting care provided by CNAs will be available to CNAs via resident profile 3.1-35(g)(1)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician's orders were followed related to obtaining and documenting weekly weights following an admission and to notify the physician when a bladder scan showed greater than 400 milliliters for 2 of 2 residents reviewed for quality of care. (Resident 5 and 11)Findings include:1. During an interview, on 7/30/25 at 11:05 a.m., Resident 5 indicated he did not eat every meal and believed he had lost weight but was not sure how much weight he had lost. The clinical record for Resident 5 was reviewed on 8/4/25 at 2:39 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, depression, and morbid obesity due to excess calories. A physician's order, with a start date of 6/24/25 and an end date of 7/22/25, indicated Resident 5 was to be weighed weekly for 4 weeks. A care plan, dated 6/30/25, indicated Resident 5 presented with nutritional concerns, which included, but were not limited to, weight fluctuations related to diuretic therapy. The goal was to maintain the current weight without significant weight changes in the next 30 days. The documented weights recorded by the facility for Resident 5 in the vitals tab of the electronic health record indicated Resident 5 had only been weighed twice since his admission on [DATE]. The Treatment Administration Record (TAR), from 6/24/25 to 7/22/25, did not contain documented weights for the 4 weeks on admission according to the physician's order. During an interview, on 8/5/25 at 1:35 p.m., the Director of Nursing (DON) indicated weights would be documented in the vitals tab. She reviewed the electronic health record (EHR) and indicated the weights were not obtained. The staff should have obtained and documented the weights according to the physician's order. 2. The clinical record for Resident 11 was reviewed on 8/1/25 at 9:25 a.m. The diagnoses included, but were not limited to, complete paraplegia (complete loss of movement to the lower limbs), hemiplegia (complete paralysis on one side of the body), and hemiparesis (weakness on one side of the body). A physician's order, with a start date of 5/16/25, indicated to complete bladder scans every 6 hours on each shift and to call the physician if there was greater than 400 milliliters (ml). A Treatment Administration Record (TAR) indicated the following bladder scans were above 400 ml with no notification to the physician: a. On 7/4/25, at 6:00 a.m., the scan was 600 ml. b. On 7/9/25, at 12:00 a.m., the scan was 600 ml. c. On 7/9/25, at 12:00 p.m., the scan was 500 ml. d. On 7/13/25, at 12:00 p.m., the scan was 500 ml. (continued on next page)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 7/17/25, at 6:00 p.m., the scan was 451 ml. f. On 7/23/25, at 12:00 a.m., the scan was 600 ml. g. On 7/23/25, at 6:00 a.m., the scan was 600 ml. h. On 7/25/25, at 12:00 a.m., the scan was 500 ml. i. On 7/25/25, at 6:00 a.m., the scan was 500 ml. j. On 7/27/25, at 12:00 a.m., the scan was 500 ml. k. On 7/27/25, at 6:00 a.m., the scan was 500 ml. l. On 7/28/25, at 12:00 a.m., the scan was 500 ml. m. On 7/28/25, at 6:00 a.m., the scan was 500 ml. n. On 7/28/25, at 6:00 p.m., the scan was 500 ml. During an interview, on 8/1/25 at 10:30 a.m., Registered Nurse 16 indicated notification to the physician would be documented in the progress notes. During an interview, on 8/1/25 at 3:50 p.m., the Director of Nursing (DON) indicated she was unsure about the physician's order and would need check on it. During an interview, on 8/5/25 at 10:29 a.m., the DON indicated the order was discontinued. The physician wanted the order discontinued and the order should have been discontinued after 72 hours. A current facility policy, titled Resident Change of Condition, dated as last revised on 4/2023 and received from the Clinical Support Nurse on 8/5/25 at 1:50 p.m., indicated .The nurse in charge is responsible for notification of the physician.prior to the end of assigned shift when a significant change in the resident's condition is noted.Document resident change of condition and response on the Progress Notes and continue in the nursing progress notes if necessary. Documentation will include time and family/physician response. The facility did not provide a following physician's orders policy by the time of exit. 3.1-37(a)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to ensure a physician's order for the use of oxygen was prescribed for 1 of 3 residents reviewed for respiratory care. (Resident 16)Findings include:During an observation, on 7/30/25 at 12:35 p.m., Resident 16 was wearing oxygen which was set on 4.5 L (liters per minute).During an observation, on 7/31/25 at 10:34 a.m., Resident 16 was wearing oxygen which was set on 5 L.The clinical record for Resident 16 was reviewed on 7/31/25 at 2:25 p.m. The diagnoses included, but were not limited to, edema, moderate persistent asthma, and shortness of breath.A care plan, dated 6/19/25, indicated the resident had the potential for impaired gas exchange related to asthma. Interventions included, but were not limited to, administer oxygen as ordered.There was no physician's order for the use of oxygen, the type of oxygen delivery system, when to administer (such as continuous or intermittent and/or when to discontinue), the prescribed flow rates, or when to monitor SpO2 levels and vital signs located in the medical record.During an interview, on 7/31/25 at 2:30 p.m., Registered Nurse (RN) 16 indicated she could not locate a physician's order for oxygen and there should be an order.During an interview, on 8/05/25 at 1:53 p.m., the Clinical Support Nurse indicated the medication administration policy was what they used for the oxygen order policy. The facility treated oxygen like a medication. A current facility policy, titled Medication Administration (Medication Pass Procedure), dated as last revised on 4/2025 and received from the Director of Nursing on 8/1/25 at 10:40 a.m., indicated .The 5 rights of medication performed: Right Resident, Right Medication, Right Dose, Right Route, Right Time. 3.1-47(a)(6)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the attending physician documented in the resident's medical record the rationale for not acting upon a pharmacist's recommendations for 1 of 5 residents reviewed for drug regimen review. (Resident 57) Findings include:The clinical record for Resident 57 was reviewed on 7/31/25 at 1:39 p.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, and chronic pain syndrome.The monthly drug regimen reviews, for Resident 57, indicated the following:1. A recommendation, dated 8/27/24, indicated discontinue the lispro (insulin) sliding scale and relax A1C range. Closely monitor glucose levels with any change in diabetic therapy to guide further adjustments. The recommendation was declined by the physician without a rationale.2. a. A recommendation, dated 10/30/24, indicated to attempt a gradual dose reduction to hydroxyzine (an antihistamine sometimes used to treat anxiety) times 14 days and then discontinue. The facility did not provide the section of the document with the physician's signature to indicate whether the recommendation was accepted or declined.b. A recommendation, dated 2/21/25, indicate to discontinue hydroxyzine. The resident had an order for duloxetine (an antidepressant and antianxiety medication). If anxiety persists, consider buspirone (an antianxiety). The physician signed the recommendation but did not indicate whether the recommendation was accepted or declined.3. a. A recommendation, dated 10/30/24, indicated to discontinue meloxicam (a non-steroidal anti-inflammatory medication for pain) and initiate acetaminophen 500 mg, 2 tabs two times a day. The resident also received morphine immediate release 7.5 mg tabs, two times a day. The recommendation was declined by the physician without a rationale.b. A recommendation, dated 1/28/25, indicated to discontinue meloxicam and initiate acetaminophen 500 mg, 2 tabs two times a day. The resident also received morphine immediate release 7.5 mg tabs, two times a day. The recommendation was declined by the physician without a rationale.c. A recommendation, dated 4/29/25, indicated to discontinue meloxicam and initiate acetaminophen 500 mg (milligram), 2 tabs two times a day. The resident also received morphine immediate release 7.5 mg tabs, two times a day. The recommendation was declined by the physician without a rationale.4. a. A recommendation, dated 2/21/25, indicated to consider discontinuing docusate (for constipation) for insufficient quality evidence to support the effectiveness of docusate. If a routine laxative was deemed necessary, to initiate Miralax. The recommendation was declined by the physician without a rationale.b. A recommendation, dated 4/29/25, indicated consider discontinuing docusate for insufficient quality evidence to support the effectiveness of docusate, if a routine laxative was deemed necessary, to initiate Miralax. The recommendation was declined by the physician without a rationale.During an interview, on 8/4/25 at 10:08 a.m., the Director of Nursing (DON) indicated not all the facility's physicians included a rationale on the drug regimen reviews when they were declined.The facility did not provide any rationales for the declined drug regimen reviews prior to the survey exit date.The current facility policy, titled Medication Regimen Reviews and Pharmacy Recommendations, dated as last revised on 10/2018 and received from the DON, did not include the need for physicians to include a rationale when a recommendation made by the pharmacist was declined.3.1-25(i)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation, interview and record review, the facility failed to ensure two tuberculin bottles, containing solution, had been labeled with an open date and a medication had a legible label for 1 of 3 medication storage refrigerators reviewed for medication storage. (PACU medication refrigerator)Findings include: During an observation with the Director of Nursing, on 8/1/25 at 11:20 a.m., the PACU medication storage refrigerator was found to contain a liquid medication with a dried crusty substance on the bottle and label. The label was not legible. Also found in the refrigerator were two open bottles of tuberculin which contained solution and did not have an open date.During an interview, on 8/1/25 at 11:22 a.m., the Director of Nursing indicated the bottles should have been labeled when open and then the solution was good for 30 days. A current facility policy, titled Medication Storage and Expiration Policy, dated 11/24 and received from the Director of Nursing on 8/4/25 at 2:35 p.m., indicated .Facility staff should record the date opened on the primary medication container .when the medication has a shortened expiration date once opened .Facility should destroy and reorder medications with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions 3.1-25(k)(6)

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	08/05/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observation and interview, the facility failed to ensure refrigerator temperatures were monitored and documented to maintain proper temperatures and to discard food before the expiration date for 1 of 2 refrigerators reviewed for food storage. (the reach-in cooler)Findings include:1. During an observation, on 7/30/25 at 9:55 a.m., a foul odor was noted inside the reach-in cooler, upon opening the door. There were 2 thermometers located inside the reach-in cooler, both read 54 degrees.2. During a second observation, on 7/30/25 at 9:59 a.m., both thermometers in the reach-in cooler again read 54 degrees.The reach-in cooler temperature document, titled Equipment Temperature Monitoring, located on the front of the reach in cooler lacked recorded temperatures on 7/29/25 and 7/30/25. It was observed to have a documented time of 2:00 p.m. but lacked documentation of the temperature inside the reach-in cooler. It was also missing a time and temperature on 7/30/25.Items observed inside the reach-in cooler included, but were not limited to, milk, juice, prepped side salads, and a stick of butter with a discard date of 7/27/25.During an interview, on 7/30/25 at 9:55 a.m., [NAME] 14 indicated an odor was present when the door was opened and the door had been opened recently while staff put items inside the cooler.During an interview, on 8/1/25 at 12:35 p.m., the Kitchen Manager indicated the cooler must have stopped working sometime during the night of 7/29/25 because during the previous shift, the temperature inside the cooler was normal.A current facility policy, titled Food Storage, dated as last revised 5/24 and received from the Executive Director on 7/30/25 at 10:19 a.m., indicated .Food is stored at an appropriate temperature and by methods designed to prevent contamination .Food items that are not considered potentially hazardous.will be labeled when opened and, to ensure quality, used or disposed of within 90 days of opening or per the use-by-date, whichever comes first.Temperatures for refrigerators should be <41 degrees Fahrenheit.Thermometers should be checked utilizing an internal thermometer at least two times each day. Temperatures should be recorded prior to breakfast preparation and again prior to dinner service.If temperature of refrigerator is above 40 degrees F, take food temperatures of item(s) stored within.3.1-21(i)(3)