STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Mill Health Campus	101 W 87th Ave Merrillville, IN 46410

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. Based on record review and interview, the facility failed to ensure residents were administered insulin and accuchecks (blood sugar testing) were completed as ordered for 2 of 3 residents reviewed for medications and accuchecks. (Residents C and D)Findings include:1. Resident C's record was reviewed on 6/3/26 at 10:08 a.m. The diagnoses included, but were not limited to, diabetes mellitus.A Care Plan, dated 5/18/26, indicated a risk for complications related to diabetes mellitus. The interventions included, diabetic medication would be administered and blood sugars checked as ordered by the physician.A Physician's Order, dated 5/10/26 and discontinued on 5/24/26, indicated Glargine-yfgn (long acting insulin) 10 units was to be administered at bedtime.The Medication Administration Record (MAR), dated 5/2026, indicated the blood sugar on 5/12/26 at 9:00 p.m. was 124 and the insulin had not been given due to not required (marked with a code of 13). The blood sugar on 5/17/26 at 9:00 p.m. was 112 and the insulin had not been given (marked with a code of 9, see progress notes).There were no Nursing Progress Notes, dated 5/17/26, that indicated the reason the insulin was not administered.During an interview on 6/3/26, the RN Nurse Consultant indicated there had been no documented reasons for the insulin not being administered.A Physician's Order, dated 5/28/26, indicated 10 units of Glargine-yfgn insulin was to be administered every 12 hours for blood sugar levels of 150 and above.The blood sugar on 5/31/26 at 7:30 a.m. was 149 and the insulin had been administered.During an interview on 6/3/26 at 1:58 p.m., the Director of Nursing (DON) acknowledged the insulin had been given with a blood sugar result less than 150.A Physician's Order, dated 5/7/26, indicated an accucheck was to be completed before meals and at bedtime. The Physician was to be notified if the results were below 70 or above 350.The 9:00 p.m. blood sugar result on 5/21/26 was 362. There was was no documentation that indicated the Physician had been notified.The blood sugar result on 5/22/26 at 5:30 p.m. was 359.A Nurse's Progress Note, dated 5/22/26 at 8:25 p.m., indicated the Nurse Practitioner (NP) had been notified of the blood sugar of 359 and orders for Novolog insulin 10 units was to be given and Glargine-yfgn insulin was increased by five units at bedtime.The blood sugar at 8:30 p.m. on 5/22/26 was 379 and the insulin had been administered as ordered. There was no documentation that indicated the Physician/NP had been notified of the blood sugar of 379 at 8:30 p.m.The blood sugar result on 5/26/26 at 9:00 p.m. was 353. There was no documentation that indicated the Physician had been notified.During an interview on 6/3/26 at 2:10 p.m., the RN Nurse Consultant indicated there was no documentation that indicated the Physician had been notified of the blood sugars over 350. 2. Resident D's record was reviewed on 6/3/26 at 2:33 p.m. The diagnoses included, but were not limited to, diabetes mellitus.A Physician's Order, dated 3/9/26, indicated blood sugars were to be checked three times a day, before meals.The MARs, dated 5/2026 and 6/2026, lacked documentation the blood sugars had been checked as ordered.There was no documentation in the clinical record that indicated the blood sugars had been checked three times a day as ordered. During an interview on 6/3/26 at 2:49 a.m., the DON acknowledged the blood sugars were not checked as ordered.The undated facility guidelines for diabetes mellitus care, received from the DON as current on 6/3/26 at 2:47 p.m., indicated the Physician's Orders were to be followed.This citation relates to Intake 3011487.410 IAC (Indiana Administrative Code) 16.2-3.1-48(a)(6)

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
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 3 residents observed during medication pass. Two errors were observed during 33 opportunities for errors during medication administration. This resulted in a medication error rate of 6.06%. (Resident G)Finding includes:During a morning medication pass observation on 6/3/26 at 7:45 a.m., RN 2 prepared Resident G's morning medications, which consisted of 13 different oral medications.RN 2 pulled the medication cards out of the medications cart. The cards which contained meloxicam (anti-inflammatory) 15 mg and Senna (laxative) 8.6 mg were placed on the top of the medication cart with the other medications cards. The medications were not removed from the cards and placed in the plastic medication cup to be given. RN 2 indicated the medications were ready to be administered and counted 11 oral medications in the medication cup.The morning medications were reviewed again and RN 1 acknowledged there should have been 13 oral medications in the medication cup and indicated the meloxicam and senna had not been placed in the medication cup.Resident G's record was reviewed on 6/3/26 at 10:00 a.m. The diagnoses included, but were not limited to, soft tissue disorder.The Physician's Orders, dated 3/4/26, indicated meloxicam 15 mg, 1 tablet was to be given daily and the Senna 8.6 mg, 1 tablet was to be given twice a day.A facility medication administration policy, dated 12/2025 and received from the DON as current, indicated medications were to be administered in accordance with the Prescriber's Orders.This citation relates to Intake 3011487.410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(1)