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	09/10/2024

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48383 Based on observation, record review, and interview, the facility failed to ensure a resident's preferences were honored related to allowing the resident to leave their room while in contact isolation for 1 of 1 resident reviewed for choices. (Resident 261) Finding includes: During a random observation on 9/3/24 at 10:31 a.m., Resident 261 indicated she had been confined to her room due to an infection on her back. On 9/4/24 at 3:12 p.m., the resident was observed in her room sitting in her wheelchair. She indicated to LPN 3, who was also in the room, that she was unable to leave her room due to her isolation status. During an interview at the time, LPN 3 indicated she was unsure if the resident could leave her room. LPN 3 was told in shift report that the resident was in contact isolation, but she was a new nurse and was unsure if that meant the resident could not leave her room. The record for Resident 261 was reviewed on 9/4/24 at 11:15 a.m. The diagnoses included, but were not limited to, lymphedema (swelling in arms or legs), hypoxia (inadequate oxygen), difficulty walking, kidney failure, anemia (decrease in red blood cells), and cellulitis (bacterial infection). The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. Eating, personal hygiene, and oral hygiene required set up and clean up assistance. Partial/moderate assistance was required for toileting and shower/bathing, and lower body dressing. A Physician's Order, dated 9/1/24, indicated to place the resident in Contact Isolation related to Methicillin-resistant Staphylococcus aureus (MRSA) in the wound. During an interview on 9/4/24 at 3:16 p.m., CNA 1 indicated the resident used to leave her room all the time, and she had noticed the resident had not left her room in a couple days. She was unaware what contact isolation required and did not know why the resident was not allowed to leave her room. (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
	155764	A. Building B. Wing	09/10/2024

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 3:19 p.m., the ADON indicated as long as the resident's wound was covered, she could leave her room. She was not aware a staff member told the resident otherwise, but she would in-service the staff immediately. During an interview on 9/4/24 at 3:40 p.m., the ADON indicated the wound nurse had told the resident she did not have to leave her room to go to activities. The resident was feeling embarrassed by how much her legs were weeping when they were wrapped. The wound nurse indicated activities could come to her room for a 1:1. The resident had probably misunderstood and thought she had to stay in her room. During an interview on 9/6/24 at 1:59 p.m., the DON and Nurse Consultant indicated they understood the concern with staff not understanding contact isolation and they had no additional information to provide. 3.1-3(u)(1)

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	155764	A. Building B. Wing	09/10/2024

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure staff were knowledgeable regarding the residents' code status for 3 of 5 residents reviewed for advanced directives. (Residents 160, 50, and 261) Findings include: 1. The record for Resident 160 was reviewed on 9/4/24 at 3:28 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, non traumatic subarachnoid hemorrhage, type 2 diabetes, asthma, stroke, depressive disorder, and cognitive communication deficit. The Admission Minimum Data Set (MDS) assessment, completed on 8/28/24, indicated the resident was moderately impaired for daily decision making. During an interview on 9/4/24 at 11:08 a.m., the Assistant Director of Nursing indicated she was not aware of the resident's code status because there was no documentation in the clinical record or in the advance directive binder located at the nursing station. During an interview on 9/4/24 at 11:11 a.m., the Social Service Director (SSD) indicated he would go look on his desk to see if the resident had completed a POST (Physician's Orders for Scope of Treatment) form. During an interview on 9/4/24 at 11:18 a.m., the SSD indicated he had the POST form on his desk which was signed by the resident and signed by the Director of Nursing and another nurse, it was not signed by a Physician or a Nurse Practitioner. The POST form indicated the resident was a full code. When asked why the information had not been passed onto nursing staff, the SSD had no additional information to provide. 48055 2. Resident 50's record was reviewed on 9/3/24 at 3:28 p.m. Diagnoses included, but were not limited to, communication deficit, end stage renal disease, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease. The Admissions Minimum Data Set (MDS) assessment, dated 7/26/24, indicated the resident was cognitively intact. Resident 50 was admitted on [DATE]. There was no code status order and no advanced directives documentation in Resident 50's electronic record or in the advanced directives binder. During an interview on 9/4/24 at 1:35 p.m., RN 1 indicated she could not locate a code status for Resident 50. She was not aware that she did not have access to the code status for this resident. (continued on next page)

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	155764	A. Building B. Wing	09/10/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/24 at 1:45 p.m., the Social Service Director (SSD) indicated the resident had a POST form in his office, signed by the resident on 7/23/24 and by the physician on 8/1/24, which indicated their code status wishes. He was not able to provide any information on why the POST form was not in the resident's chart or why nursing staff were not made aware of their code status. 48383 3. The record for Resident 261 was reviewed on 9/4/24 at 11:15 a.m. The diagnoses included, but were not limited to, lymphedema (swelling in arms or legs), hypoxia (inadequate oxygen), difficulty walking, kidney failure, anemia (decrease in red blood cells), and cellulitis (bacterial infection). The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact for daily decision making. There was no code status order and no POST form found in the electronic medical record (EMR) for Resident 261. During an interview on 9/4/24 at 1:35 p.m., RN 1 indicated she could not locate a code status for Resident 261. She was not aware that she did not have access to the code status for this resident. During an interview on 9/4/24 at 1:45 p.m., the SSD indicated all 3 residents had POST forms signed by the resident and the Physician indicating their code status wishes. He was not able to provide any information on why the POST forms were not in the resident's chart or why nursing staff were not made aware of their code statuses. A facility policy, titled, Advance Directives, provided by the Director of Nursing as current, indicated the resident, the legal representative, or the individual who has been authorized as the resident's health care representative will be asked if an Advance Directive, as recognized under the state law, has been executed. Documentation concerning this inquiry and the individual response shall include the date the entry was made and the individual making the inquiry. This information shall then be included in the resident's medical record 3.1-4(f)(5)

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	155764	A. Building B. Wing	09/10/2024

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Spring Mill Health Campus	101 W 87th Ave Merrillville, IN 46410

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 10770 Based on observation, record review, and interview, the facility failed to ensure the comprehensive assessment was accurate related to dental status for 1 of 17 residents whose comprehensive assessments were reviewed. (Resident 6) Finding includes: During an observation on 9/3/24 at 11:02 a.m. Resident 6's teeth were observed to be caried and broken off. The resident indicated at that time that he was supposed to get new dentures. The record for Resident 6 was reviewed on 9/5/24 at 8:20 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance, type 2 diabetes, epilepsy, paranoid schizophrenia, depressive disorders, anxiety disorder, high blood pressure, and PTSD (post traumatic stress disorder) The 3/11/24 Annual Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making and had no oral or dental problems. The Modification of the Quarterly MDS assessment, dated 7/25/24, indicated the resident was cognitively intact for daily decision making and had no dental issues. There was no care plan for dental care. During an interview on 9/6/24 at 2:30 p.m., the MDS Coordinator indicated she was unaware the resident's teeth were broken off, discolored, and caried. During an interview on 9/9/24 at 3:00 p.m., the MDS Nurse Consultant indicated she had no additional information to provide. 3.1-31(i)

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	155764	A. Building B. Wing	09/10/2024

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Spring Mill Health Campus	101 W 87th Ave Merrillville, IN 46410

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure dependent residents received at least 2 baths a week and had their hair washed at least weekly for 2 of 4 residents reviewed for activities of daily living. (Residents 41 and 158) Findings include: 1. During an interview on 9/3/24 at 11:20 a.m., Resident 41 indicated he sometimes did not get a bed bath 2 times a week and did not get his hair washed at least weekly. The resident's hair was observed to be greasy. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. The Care Plan, dated 7/19/24, indicated the resident required assistance with activities of daily living for bathing. The approaches were to assist with personal hygiene and grooming as needed. The Shower Book indicated the resident was to receive a shower or complete bed bath on Mondays and Thursdays. The resident did not have a complete bed bath on 8/5 and 8/22/24. During an interview on 9/5/24 at 2:45 p.m., the Assistant Director of Nursing indicated she had just brought up shower caps for the residents to get their hair washed. The resident should be bathed at least 2 times a week and be offered to have their hair washed. During an interview on 9/9/24 at 10:30 a.m. , the Director of Nursing indicated the resident was to have at least 2 complete bed baths weekly and be offered to have his hair washed. 2. During an interview on 9/3/24 at 2:03 p.m., Resident 158 indicated she had not had her hair washed since she had been at the facility. The record for Resident 158 was reviewed on 9/5/24 at 1:55 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, type 2 diabetes, obesity, heart failure, chronic kidney disease, anemia, cardiac pacemaker, osteoarthritis, and high blood pressure. The 8/18/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making was dependent on staff for bathing. (continued on next page)

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	155764	A. Building B. Wing	09/10/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, dated 8/13/24, indicated the resident required assistance with activities of daily living including bathing. The Shower Book indicated the resident was to receive a bath on Wednesdays and Saturday. The resident did not receive a complete bed bath on 8/14 and 8/17/24 During an interview on 9/5/24 at 2:30 p.m., the Assistant Director of Nursing indicated she was not aware the resident had not had her hair washed since admission and should have received a completed bed bath at least 2 times a week. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B)

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	155764	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** 10770 Based on observation, record review, and interview, the facility failed to ensure surgical bandages were changed as ordered by the physician for 1 of 2 resident reviewed for skin conditions non-pressure. (Resident 41) Finding includes: On 9/3/24 at 11:25 a.m., Resident 41 was observed lying in bed wearing a hospital gown. At that time, a surgical bandage was observed to his abdomen with a date of 8/30/24. At 11:35 a.m., the Assistant Director of Nursing (ADON) was asked to come to the room and observe the date on the bandage. During an interview at that time, the ADON indicated the bandage was supposed to be changed three times a week on Monday, Wednesday, and Friday. On 9/6/24 at 12:49 p.m., the Wound Nurse was observed changing the bandage to the surgical wound. The wound was pink and was healing. During an interview at that time, the Wound Nurse indicated the bandage should have been changed on 9/2/24 and she was off that day. Nursing staff were to change the bandages when she was not in the facility. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. The Care Plan, revised on 9/5/24, indicated the resident had a mid abdomen surgical wound. Physician's Orders, dated 8/28/24, indicated to cleanse the surgical incision to the mid abdomen with normal saline or wound cleanser and pat dry. Cut wound sized pieces of Hydrofera Blue and moisten with normal saline, apply to wound bed and cover with dry dressing every Monday, Wednesday, and Friday. The Treatment Administration Record for 9/2024 indicated the treatment was signed out as being completed on 9/2/24. The surgical wound was last measured by the Wound Nurse Practitioner on 9/4/24. The wound was 9 centimeters (cm) by 0.8 cm and was pink. The wound had decreased in size and was improving. (continued on next page)

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	155764	A. Building B. Wing	09/10/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/6/24 at 2:15 p.m., the Director of Nursing indicated the bandage to the surgical wound should have been changed as ordered by the physician. 3.1-37(a)

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	09/10/2024

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48383 Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer had interventions in place related to not floating their heels when in bed for 1 of 3 residents reviewed for pressure ulcers. (Resident 31) Finding includes: On 9/4/24 at 10:10 a.m. and 3:07 p.m., Resident 31 was observed awake lying in bed. The resident's heels were not floated off the bed. On 9/05/24 at 10:07 a.m., the resident was observed in bed. CNA 1 lifted the resident's blanket by his feet and the resident did not have his heels floated off the bed. The record for Resident 31 was reviewed on 9/04/24 at 9:35 p.m. The diagnoses included, but were not limited to, diabetes, hemiplegia (paralysis on one side), encephalopathy (swelling in the brain), dementia, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of his lower extremities and used a wheelchair. The resident had a stage 2 pressure ulcer. A Care Plan, dated 4/18/24, indicated the resident had impaired skin integrity. A Physician's Order, dated 1/27/24, indicated to suspend or offload heels when in bed every shift. A Physician's Order, dated 1/27/24, indicated to administer [NAME]-[NAME] Oil External Ointment ([NAME]-[NAME] Oil) to right and left heels topically one time a day for supplement. The undated Wound Rounds summary tab in the EMR (electronic medical record) indicated the resident had a deep tissue pressure injury to the left heel that was resolved on 3/7/24. During an interview on 9/6/24 at 1:58 p.m., the Director of Nursing (DON) indicated Resident 31 should have had his heels floated. No additional information was provided. 3.1-40(a)(2)

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	09/10/2024

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Spring Mill Health Campus	101 W 87th Ave Merrillville, IN 46410

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure a peg tube (a tube inserted into the stomach for nutrition) was cleaned on a daily basis and according to facility policy for 1 of 2 residents reviewed for peg tubes. (Resident 41) Finding includes: On 9/3/24 at 11:22 a.m., Resident 41 was observed lying in bed wearing a hospital gown. At that time, there was a tube observed near a bandage on his abdomen. The area under the flange had dried crusty blood noted. During an interview at that time, the resident indicated the wound nurse cleaned around the tube when she changed his bandages. On 9/6/24 at 12:49 p.m., the Wound Nurse was observed changing the resident's surgical bandage on his abdomen. During an interview at that time, the Wound Nurse indicated the peg tube was solely placed for decompression and was not used for feeding or flushes. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. There was no care plan for the care of the peg tube. There were no physician's orders for the care of or to monitor the peg tube. During an interview on 9/6/24 at 1:00 p.m., the Wound Nurse indicated she cleaned around the peg tube and stoma site when she changed his bandages. On the days she worked, which was Monday through Friday, she saw the resident just to make sure the bandage was clean and in place. During those visits, she did look at the peg tube, however, if there was no drainage and it looked okay, she would not clean around it. When she did clean around the peg tube, there was no place in the clinical record to document she had completed the care. During an interview on 9/6/24 at 1:04 p.m., LPN 1 indicated she was aware the resident had a peg tube, however, she had never cleaned around the stoma site because she had always thought the wound nurse completed the task. (continued on next page)

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	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/6/24 at 1:06 p.m., the Assistant Director of Nursing indicated there were no orders to monitor, assess or clean the peg tube site on a daily basis. During an interview on 9/6/24 at 2:15 p.m., the Director of Nursing (DON) indicated the peg tube was to be cleaned at least daily. The current 2/15/21 Gastrostomy/Jejunostomy Site Care policy, provided by the DON on 9/9/24 at 10:30 a.m. , indicated it was the policy of the facility to provide gastrostomy and jejunostomy site care to decrease the risk of infection. The procedure was to obtain a physician order to include the following information resident room and number, type of solution for cleansing and frequency of treatment. 3.1.44(a)(2)

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	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48383 Based on observation, record review, and interview, the facility failed to ensure a resident's PICC (peripherally inserted central catheter) line had Physician's Orders for the care and monitoring of a PICC line for 1 of 1 residents reviewed for PICC lines. (Resident 31) Finding includes: During an observation on 9/3/24 at 11:21 a.m., Resident 31's PICC line bandage was dated 8/29/24 and was peeling off on the top of the dressing. During an observation on 9/4/24 at 10:11 a.m., the PICC line bandage was dated 8/29/24 and was peeling off on the top of the dressing. The record for Resident 31 was reviewed on 9/4/24 at 9:35 p.m. The diagnoses included, but were not limited to, diabetes, hemiplegia (paralysis on one side), encephalopathy (swelling in the brain), dementia, and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 8/1/24, indicated the resident was severely impaired for daily decision making. The resident had impairment on both sides of his lower extremities and used a wheelchair. There was no Care Plan for a PICC line or Intravenous therapy. There were no active orders for PICC line care or intravenous therapy. During an interview on 9/6/24 at 1:58 p.m., the DON indicated there should have been PICC line orders for Resident 31. No additional information was provided. 3.1-47(a)(2)

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	155764	A. Building B. Wing	09/10/2024

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 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. 10770 Based on record review and interview, the failed to ensure a PRN (as needed) psychotropic medication was not ordered longer than 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 25) Finding includes: The record for Resident 25 was reviewed on 9/5/24 at 10:35 a.m. Diagnoses included, but were not limited to, left lung cancer, type 2 diabetes, stroke, osteoarthritis, heart disease, depressive disorder, repeated falls, high blood pressure, paranoid schizophrenia, and atrial fibrillation. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 7/16/24, indicated the resident was cognitively intact for daily decision making and received insulin, an antipsychotic, an anxiolytic, an antidepressant, an anticoagulant, and hypoglycemic medications. Physician's Orders, dated 7/17/24, indicated Alprazolam (Xanax, an anti-anxiety medication) 0.5 milligrams (mg), give 1 tablet by mouth every 8 hours as needed for anxiety. The Medication Administration Record (MAR) for the month of 8/2024 indicated the Alprazolam was administered five times and on the 9/2024 MAR, the medication was administered two times. During an interview on 9/6/24 at 2:42 p.m., the Assistant Director of Nursing indicated the scheduled dose of Xanax was discontinued in July and was then ordered as prn. The resident did ask for the medication and the daughter would call to make sure she had received it. The current 9/2/20 Psychotropic Medication-Gradual Dosage Reduction policy, provided by the Director of Nursing on 9/9/24 at 10:30 a.m., indicated . PRN hypnotic, antianxiety, or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and extended duration . 3.1-48(a)(2)

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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** 10770 Based on observation, record review, and interview, the facility failed to store medicated creams and loose pills properly for 1 of 1 resident and 1 of 2 medication carts observed during medication storage. (Resident 41 and Health Care 2 medication cart) Findings include: 1. During random observations on 9/3/24 at 11:26 a.m. and 3:04 p.m., Resident 41 was observed lying in bed. The resident was severely contracted for both his upper and lower extremities and was unable to use them. At that time, there was a tube of Diclofenac cream (a cream used to reduce swelling in joints and muscles) on the over bed table. During an interview on 9/3/24 at 11:26 a.m., the resident indicated he used the cream for his severe rheumatoid arthritis. During random observations on 9/4/24 at 11:18 a.m. and 2:50 p.m., and on 9/5/24 at 8:09 a.m., 10:20 a.m., and 11:45 a.m., the medicated cream was observed inside the night stand drawer. The record for Resident 41 was reviewed on 9/5/24 at 2:50 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, post surgical procedure to the digestive system, osteoarthritis of both knees and hips, disc degeneration, kidney disease, rheumatoid arthritis, and type 2 diabetes. The 7/24/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and was dependent on staff all activities of daily living (ADLs) including eating, toileting, repositioning, bathing and personal hygiene. The resident had range of motion impairment to both upper and lower extremities. He had 1 surgical wound upon admission. There was no care plan for the medicated cream to be kept at the bedside. Physician's Orders, dated 7/19/24, indicated Diclofenac Sodium External Gel 1 % (medicated cream), apply to both lower legs topically every 6 hours as needed for pain. There were no physician's order to keep the medication at the bedside. During an interview on 9/6/24 at 1:06 p.m., the Assistant Director of Nursing indicated the family would bring in creams for him and did not tell the nursing staff. During an interview on 9/6/24 at 2:15 p.m., the Director of Nursing (DON) indicated the resident was not able to self-administer the medicated cream due to his contractures. The family brought in the creams and the nursing staff were unaware. There was no order to keep the medicated cream at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current 9/1/20 Medication Storage policy, provided by the DON on 9/9/24 at 10:30 a.m., indicated the facility should ensure that all medications and biologicials, including treatment items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents and visitors. 48055 2. On 9/5/24 at 9:58 a.m., LPN 2 was observed at the HC 2 medication cart preparing to pass medications. The cart was observed to have 10 loose pills, varying in size, shape, and color. The pills were located in the bottom 3 drawers of the medication cart. LPN 2 removed the pills from the cart and disposed of them in the drug buster container. During an interview at that time, LPN 2 indicated she knew the pills should not be loose in her cart and she cleaned her cart daily. A current facility policy, titled Medication Storage, 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 3.1-25(m)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure the resident's environment was clean and sanitary related to an uncontained bed pan for 1 of 3 units. (Health Care Center 2) Finding includes: During random observations on 9/5/24 at 8:09 a.m.,10:20 a.m., and 11:45 a.m., an uncontained bed pan was observed lying on a cloth chair in room [ROOM NUMBER]. During an interview on 9/5/24 at 8:09 a.m., the resident who resided in the room indicated he had diarrhea 8 times yesterday and during the nigh,t and had used the bed pan. During an interview on 9/6/24 at 2:30 p.m., the Director of Nursing (DON) indicated the bed pan was to be contained and put away after each use. The current 3/21/21 Space and Equipment policy, provided by the DON on 9/10/24 at 2:58 p.m., indicated the facility will provide areas of space for storing devices and supplies used for continence. 3.1-19(f)