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	12/09/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, the facility failed to develop and implement a care plan related to the use of a Continuous Passive Motion (CPM) machine for 1 of 2 residents reviewed for rehab and restorative. (Resident 64) Finding includes:On 12/2/25 at 10:00 a.m., Resident 64 was observed seated in her room. There was a CPM machine on the floor next to her bed. The resident indicated she had a recent knee replacement and the machine was supposed to be used twice daily, but only therapy staff put the machine on her once a day when they were present. The resident's record was reviewed on 12/3/25 at 9:23 a.m. Diagnoses included, but were not limited to, encounter following orthopedic aftercare and presence of right artificial knee joint.The admission Minimum Data Set assessment, dated 11/25/25, indicated the resident was cognitively intact and needed set up assistance for toileting and bed mobility. There were no nursing care plans related to the CMP machine. The Physical Therapy (PT) Evaluation and Plan of Treatment, dated 11/20/25, indicated treatment approaches were therapeutic exercises, neuromuscular reeducation, gait training therapy, PT evaluation moderate complexity and therapeutic activities. There was no approaches or interventions related to the CPM machine. During an interview on 12/3/25 at 10:06 a.m., the Director of Nursing indicated the CPM machine was the responsibility of the therapy department and nursing had nothing to do with it. During an interview on 12/3/25 at 11:26 a.m., the PT Director indicated the CPM should be included on the Plan of Treatment. 3.1-35(b)(1)

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

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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. Based on record review and interview, the facility failed to ensure a compression glove was in place per the physician's order, there was adequate monitoring of use of the compression glove and medications were available and administered as ordered for 1 of 1 resident reviewed for edema and for 1 of 21 records reviewed. (Resident 58)Finding includes:a. During an observation on 12/1/25 at 12:25 p.m., Resident 58 was observed sitting up in her wheelchair. Her right hand was observed with no compression glove on at the time.Resident 58's record was reviewed on 12/3/25 at 9:07 a.m. Diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage (brain bleed) and multiple sclerosis.A Physician's Order, dated 11/26/25, indicated compression glove for right hand and try to maintain a degree of elevation as well to reduce edema.The record lacked documentation of how often the compression glove was supposed to be on or when the compression glove was on or off.There was no care plan related to the compression glove.During an interview on 12/8/25 at 9:22 a.m., the Director of Nursing indicated she believed the resident's daughter had brought in the compression glove as they had not ordered it. There was no other documentation of when the compression glove was on or off.b. A Physician's Order, dated 11/20/25, indicated theophylline extended-release oral tablet 100 milligrams, 1 tablet twice daily.The November 2025 Medication Administration Record indicated the theophylline was not administered at 8:00 p.m. on 11/20/25, 11/21/25, 11/22/25, and 11/23/25 and at 8:00 a.m. on 11/21/25, 11/22/25, 11/23/25, and 11/24/25.During an interview on 12/9/25 at 11:54 p.m., the Director of Nursing indicated all of the doses were marked 9 - See Progress Notes and had no further information to provide.3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review and interview, the facility failed to obtain Physician Orders and coordinate care between departments related to the use of a Continuous Passive Motion (CPM) machine for 1 of 2 residents reviewed for rehab and restorative care. (Resident 64)Finding includes: On 12/2/25 at 10:00 a.m., Resident 64 was observed seated in her room. There was a CPM machine on the floor next to her bed. The resident indicated she had a recent knee replacement, and the machine was supposed to be used twice daily, but only therapy staff put the machine on her once a day when they were present. The resident's record was reviewed on 12/3/25 at 9:23 a.m. Diagnoses included, but were not limited to, encounter following orthopedic aftercare and presence of right artificial knee joint.The admission Minimum Data Set assessment, dated 11/25/25, indicated the resident was cognitively intact and needed set up assistance for toileting and bed mobility. There was no Physician's Order for the CPM machine or frequency of use. During an interview on 12/3/25 at 9:55 a.m., LPN 2 indicated the resident put the CPM machine on herself, she believed after therapy. The LPN indicated she was unable to find a Physician's Order related to the CPM machine. During an interview on 12/3/25 at 10:06 a.m., the Director of Nursing indicated the CPM machine was the responsibility of the therapy department and nursing had nothing to do with it. During an interview on 12/3/25 at 10:45 a.m., the Administrator indicated they did not have a Physician's Order for the CPM machine. During an interview on 12/3/25 at 11:26 a.m., the Physical Therapy Director indicated when therapy wasn't available, nursing staff should be putting the CPM machine on. She indicated PT put the machine on the resident twice daily when they were present. She was unable to locate documentation when the CPM machine was applied by therapy. 3.1-42(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, record review and interview, the facility failed to ensure a resident was assessed and treated for pain prior to wound care for 1 of 2 residents reviewed for pressure ulcers. (Resident 71)Finding includes: On 12/8/25 at 11:30 a.m., Resident 71's wound care was observed with the Wound Nurse and CNA 1. The resident was in bed, positioned on her left side and held in place by the CNA. The Wound Nurse removed the old dressing from her sacrum. Then she used normal saline and gauze to clean the wound bed. The resident said, ow, ow, the Wound Nurse apologized to her and continued to clean the wound. The resident again said, ow, ow, the CNA said she was sorry. The Wound Nurse completed the treatment with no additional complaint of pain from the resident. During an interview following the wound treatment observation, the Wound Nurse indicated the resident had prn (as needed) pain medication she could take if she started moaning. She indicated the resident wasn't complaining of pain and had not received anything. The resident's record was reviewed on 12/8/25 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, adult failure to thrive and spinal stenosis. The resident had a stage 3 pressure ulcer on her sacrum. The Brief Interview for Mental Status, dated 12/7/25, indicated the resident had moderate cognitive impairment. There were no Physician's Orders for any type of analgesic. A Care Plan, dated 12/4/25, indicated the resident was at risk for pain related to (blank). Intervention was to administer analgesia as per orders. During another interview on 12/8/25 at 2:13 p.m., the Wound Nurse indicated she did not recall the resident verbalizing signs of pain during the wound treatment or apologizing to her. She also indicated she had obtained an order for a prn pain medication. 3.1-37(a)

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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** Based on observation, interview, and record review, the facility failed to ensure medication was labeled correctly, a bag of normal saline (NS) 0.9% was not expired, and a tube of zinc paste was stored to prevent cross-contamination for 1 of 4 medication carts and 1 of 2 medication rooms. (Healthcare 1)Finding includes:On [DATE] at 2:13 p.m. the Healthcare 1 Medication Cart and Medication Room was observed with QMA 1 and the Director of Nursing (DON). Inside the top drawer of the Medication Cart there was a used tube of zinc paste, stored openly with boxes of eye drops and other medications in the drawer. The tube of zinc was not labeled with a resident's name. QMA 1 indicated she was unsure who the zinc was used for.In the Medication Room refrigerator there was a 100 milliliter bag of NS 0.9% with an expiration date of [DATE] and a box of cath flo activase (blood clot busting agent for occluded central lines) without a label or resident's name. In the cabinet in the Medication Room, there was an opened box of Gas-X with no label and two mediplanners (Monday through Friday medication set ups), that contained medication, stored in a plastic bag without a resident's name.The DON at the time of the observation indicated it the Gas-X was probably medication someone had at the bedside and the mediplanner was someone's medications from home.A facility policy titled, Medication Storage, indicated .4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels.14.5 Facility should ensure that infusion therapy labels include the medication name, volume, infusion rate, name and quantity of each additive, date of preparation, initials of compounder, date and time of administration, ancillary labeling and expiration date.3.1-25(j)3.1-25(o)3.1-25(r)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review and interview, the facility failed to ensure resident records were accurate related to documentation of an air mattress in place and intravenous (IV) flushes for 2 of 21 records reviewed. (Residents 71 and 61)Findings include: 1. On 12/8/25 at 11:30 a.m., Resident 71's wound care was observed with the Wound Nurse and CNA 1. The resident was positioned in her bed, and she was on a standard mattress. The resident's record was reviewed on 12/8/25 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, adult failure to thrive and spinal stenosis. The resident had a stage 3 pressure ulcer on her sacrum. The Brief Interview for Mental Status, dated 12/7/25, indicated the resident had moderate cognitive impairment. A Physician's Order, dated 12/5/25, indicated an air mattress for the resident. The Treatment Administration Record for December 2025 indicated the air mattress was signed out as in place every shift from 12/5-12/8/25. During an interview on 12/8/25 at 2:13 p.m., the Administrator and Nurse Consultant indicated the resident had refused to get out of bed during the weekend to have the air mattress placed on the bed, it was being changed at that time. They were aware staff had been documenting the air mattress was in place incorrectly. 2. On 12/4/25 at 1:56 p.m., LPN 1 was observed passing medication to Resident 61. She prepared meropenem (an antibiotic medication) 1 gram (g) intravenous (IV). She primed the intravenous (IV) tubing, cleaned the right upper arm PICC lumen with an alcohol swab, flushed the PICC with 5 milliliters (ml) of normal saline, attached the IV tubing containing the meropenem, and started the IV infusion. On 12/4/25 at 2:45 p.m., LPN 1 was observed disconnecting the IV tubing after the medication had completed infusing. She flushed the PICC with 5 ml of normal saline and applied a cap to the lumen. Resident 61's record was reviewed on 12/4/25 at 3:25 p.m. Diagnoses included, but were not limited to, osteomyelitis, type two diabetes mellitus, and hypertension. A Physician's Order, dated 11/27/25, indicated meropenem 1 g three times a day intravenously for 31 days. A Physician's Order, dated 11/26/25, indicated sodium chloride 0.9% (normal saline) flush 10 milliliters (ml) intravenously every shift. There were no Physician's Orders to indicate the PICC was to be flushed with saline before and after the administration of the antibiotic medication. The Medication Administration Record (MAR), dated 11/2025 and 12/2025, indicated the meropenem had been administered as ordered. The normal saline 10 ml flushes were documented as given once on the day shift, once on the evening shift, and once on the night shift. There was lack of documentation to indicate the PICC was flushed with saline before and after the administration of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotic medication. During an interview on 12/4/25 at 3:05 p.m., the Director of Nursing indicated LPN 1 had administered the medication and flushes correctly. The PICC was to be flushed before and after the IV antibiotic medication administration. 3.1-50(a)(2)