STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 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** Based on observation, record review and interview, the facility failed to ensure the necessary treatment and services were provided for dependent residents related to showers for 3 of 5 residents reviewed for activities of daily living (ADL's). (Residents B, H and G) Findings Include: 1. The closed record for Resident B was reviewed on 8/11/20 at 10:49 a.m. The resident was admitted on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment was unavailable for review. A Nurses' Note, dated 1/3/20 at 6:10 p.m., indicated the resident alert and oriented times 2 and followed commands. There was excoriation noted to the peri area. A Social Service Progress Note, dated 1/4/20 at 4:48 p.m., indicated the resident was cognitively intact. A Nurses' Note, dated 1/6/20 at 9:45 a.m., indicated the resident was a 1 person assist with all care with weakness to her right upper extremity. The Care Plan, dated 1/6/20, indicated the resident was limited in functional status in regards to the ability to transfer self related to decreased mobility, [MEDICAL CONDITION], arthritis and [MEDICAL CONDITION]. The Care Plan, dated 1/7/20, indicated the resident's preferences were assessed and the resident stated she preferred to have a shower in the evening. The shower schedule indicated the resident was to receive a shower on Wednesdays and Saturdays. There were no shower/bath sheets available for review. Interview with the Director of Nursing (DON) on 8/12/20 at 11:15 a.m., indicated there was no documentation the resident had received a shower during her stay. The resident should have been bathed/ showered at least 2 times a week. 2. The record for Resident H was reviewed on 8/12/20 at 2:45 p.m. The resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The 6/2/20 Admission Minimum Data Set (MDS) assessment, indicated the resident was not alert and oriented. She was totally dependent with 1 person physical assist for bathing and needed extensive assist with 1 person physical assist for transfers. There was no Care Plan indicating the resident refused care. A Care Plan, updated 6/3/20, indicated the resident preferred to have a shower in the morning. The resident was scheduled for showers on Mondays and Thursdays evenings. The shower/bath sheets for the months of 5/2020, 6/2020 and 7/2020 indicated showers were not completed on 5/28, 6/8, 6/11, 6/15, 6/18, 6/25, 6/29, 7/9, 7/20, 7/23, 7/27, and 7/30/20. Interview with the Director of Nursing (DON) on 8/13/20 at 12:00 p.m., indicated the resident should have received a shower at least 2 times per week. 3. The record for Resident G was reviewed on 8/11/20 at 1:30 p.m. The resident was admitted on [DATE]. [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 7/2/20, indicated the resident was moderately impaired for decision making. She needed extensive assistance with a 2 person physical assist for bed mobility and was totally dependent on staff for bathing. The resident was to receive showers on Wednesdays and Saturdays. The shower/bath sheets for the months of 6/2020, 7/2020, and 8/2020 indicated the resident did not receive a shower on 6/17, 6/20, 6/24, 6/27, 7/4, 7/11, 7/15, 7/22, 7/25, 7/29, and 8/1/20. Interview with the DON on 8/12/20 at 11:15 a.m., indicated the showers were to be completed at least 2 times a week and there was no documentation of the resident refusing showers. This Federal tag relates to Complaints IN 529 and IN 955. 3.1-38(a)(2)(A)
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 observation, record review, and interview, the facility failed to ensure bruises were assessed and monitored for 1 of 3 residents reviewed for skin conditions non-pressure related. (Resident M) Finding includes: On 8/11/20 at 3:02 p.m., Resident M was observed lying in her bed in her room. At that time, RN 1 was asked to check the resident's skin and there was a yellow/dark purple bruise noted to the back of the right hand/wrist area. Interview with RN 1 at that time indicated the bruise was present on admission from a previous peripheral intravenous site from the hospital and the bruise was not being currently monitored. The record for Resident M was reviewed on 8/11/20 at 10:55 a.m. The resident was re-admitted on [DATE] from the hospital. [DIAGNOSES REDACTED]. The Scheduled 5-Day Minimum Data Set (MDS) assessment, dated 8/06/20, indicated the resident rarely or never understood others or made self understood. A physician's orders [REDACTED]. The admission Progress Note, dated 7/10/20, did not indicate any bruising. Nursing Notes, dated 7/10-8/12/20, had no documentation regarding any bruises to the right hand. A Bath and Skin Report sheet, dated August 2020 indicated no documentation of any bruising. A Care Plan, dated 12/27/18 and revised on 7/12/20, indicated the resident had potential for abnormal bleeding and bruising related to use of medication with anticoagulant properties. The interventions included, but were not limited to, observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, epistaxis). The current Measurement of Alterations in Skin Integrity policy, dated January 2017 and provided by the Director of Nursing (DON) on 8/12/20 at 1:34 p.m., indicated bruises should be described upon initial observation and documented in the clinical record. An interview with the DON on 8/12/2020 at 2:48 p.m., indicated bruising was monitored weekly and with showers. It was the facility's policy when a bruise was identified, the nurses were to initiate an event, document the bruise, and monitor it. This Federal tag relates to Complaints IN 932. 3.1-37(a)
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** Based on record review and interview, the facility failed to ensure new onset pressure sores were assessed timely and monitored for 1 of 3 residents reviewed for pressure sores. (Resident C) Finding includes: The closed record for Resident C was reviewed on 8/12/20 at 9:02 a.m. The resident was admitted on [DATE] and discharged home on[DATE]. [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 1/15/20, indicated the resident was not alert and oriented. She was an extensive assist with a 1 person physical assist for bed mobility and transfers. The resident had 1 unstageable pressure that was not present on admission. There was no Care Plan for pressure ulcers. A Full Clinical Observation Assessment, dated 1/9/20, indicated the resident had a skin tear to the inner buttock measuring 1 centimeter (cm) by 1 (cm). No other open areas were observed. A Nurse Practitioner (NP) Progress Note, dated 1/10/20 at 8:31 p.m. indicated the resident's daughter had been at her bedside nearly her entire stay thus far. A skin check was performed in her presence and noted Stage 2 open areas to the gluteal cleft, 2 blister like [MEDICAL CONDITION] in the area as well, and skin tears to the bilateral shins that she sustained prior to her stay. There was no further assessment, description of the Stage 2 pressure ulcers or measurements available for review. physician's orders [REDACTED]. A NP Progress Note, dated 1/14/20 indicated she was able to view the wounds on the gluteus and bilateral lower extremities and all were healing. A Nurses' Note, dated 1/16/20 at 1:45 p.m., indicated the resident had an open blister on the right buttock. The area was

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

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) assessed by the wound Physician and a [MEDICATION NAME] bandage was recommended for the area. A physician's orders [REDACTED]. A Wound Assessment, dated 1/16/20, indicated an unstageable pressure ulcer to the right buttock (coccyx) area. The ulcer measured 3 cm by 3 cm with dark purple tissue noted. The Treatment Administration Record (TAR), dated 1/2020, indicated the Zinc ointment was not available on 1/11/20 for the evening and midnight shifts. An interview with the Director of Nursing (DON) on 8/12/20 at 1:15 p.m., indicated there was no wound assessment or measurements taken on 1/11/20 after the NP had observed the resident's skin and identified open areas to her gluteal cleft and the blisters to the buttocks. She indicated it was the facility's policy to assess and measure open areas after observed and the nurses were to start an event note. An interview with the Wound Nurse on 8/12/20 at 1:45 p.m., indicated she was not made aware of the open areas the NP found on 1/11/20. There was a wound book on each unit and the nurses were to document any new wounds in the book when they were first observed, and on her working wound days she looked in the book to see what new wounds were documented and then assessed them at that time. The resident's pressure ulcers were not documented in the wound book, and she had found out about them by reviewing the treatment books prior to wound rounds. The resident's skin was assessed by her on 1/16/20 and that was first time she had seen them and a new treatment was obtained. The current 1/2017 Measurement of Altercations in Skin Integrity policy, provided by the DON, indicated at the first observation of any skin condition, the charge or treatment nurse was responsible to measure and/or describe the skin condition in the clinical record. This Federal tag relates to Complaint IN 343. 3.1-40(a)(2)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents who were at risk for falls received adequate supervision related to leaving a resident alone on the toilet and not having a bed in the lowest position for residents with a history of falls for 2 of 3 residents reviewed for falls. (Residents H and G) Findings includes: 1. The record for Resident H was reviewed on 8/12/20 at 2:45 p.m. The resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The 6/2/20 Admission Minimum Data Set (MDS) assessment, indicated the resident was not alert and oriented. She was totally dependent with a 1 person physical assist needed for bathing and an extensive assist with 1 person physical assist for transfers. The Care Plan, updated 6/3/20, indicated the resident was at risk for falling related to decreased mobility and use of [MEDICAL CONDITION] and cardiovascular medication. The approaches were to give the resident verbal reminders not to ambulate/transfer without assistance. A Fall Risk Assessment, dated 5/27/20, indicated the resident had intermittent confusion, required use of assistive devices and was confined to a chair. The resident was totally unable to ambulate without assist and used a wheelchair for locomotion. The resident needed assistance to and from and on and off the toilet. The resident was determined a high fall risk based on the assessment. Nurses' Notes, dated 6/19/20 at 3:48 p.m., indicated a CNA notified the staff the resident was found on the floor in the bathroom. The resident indicated someone transferred her to the toilet and she tried to transfer herself back to the wheelchair without pulling the emergency call light in the bathroom for assistance. A Fall Investigation, dated 6/19/20, indicated the resident was assisted to the toilet by the CNA. The resident required peri care and requested a change in pants. The CNA went to get a change in pants, and instructed the resident to use the call light, she voiced understanding. An interview with the Director of Nursing (DON) on 8/13/20 at 12:00 p.m. indicated, after the investigation was completed, the staff were educated again on making sure they stayed with the resident while in the bathroom. 2. On 8/11/20 at 9:10 a.m., 1:15 p.m., and 2:10 p.m., Resident G was observed in bed. Her bed was observed in a very high position and was not low to the ground. On 8/12/20 at 7:30 a.m., the resident was observed in bed. Her bed was observed in a very high position and was not low to the ground. The record for Resident G was reviewed on 8/11/20 at 1:30 p.m. The resident was admitted on [DATE]. [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) assessment, dated 7/2/20, indicated the resident was moderately impaired for decision making. She needed extensive assistance with a 2 person physical assist for bed mobility and was totally dependent on staff for bathing. She had no falls since the last assessment. A Care Plan, dated 6/11/20, indicated the resident was at risk for falling related to decreased mobility and use of cardiovascular and diabetic medication. The approaches were to keep the bed in the lowest position with brakes locked. An Event, dated 7/16/20, indicated the resident rolled out of bed and fell on to the floor. The fall was witnessed by the CNA. The CNA was finishing peri-care and the resident attempted to turn herself, moved her leg too far over and gravity rolled her from the bed. A Nurses' Note, dated 7/15/20 at 8:58 a.m., indicated the Nurse Practitioner was notified of the resident slipping out of bed. The resident stated she fell on to her left knee and had increased pain. A new order for an X-ray was obtained. A Nurses' Note, dated 7/16/20 at 2:15 p.m., indicated the X-ray results indicated a fracture to the left femur. The resident was sent to hospital. An interview with the Director of Nursing (DON) on 8/12/20 at 1:15 p.m., indicated the resident's bed should be in the lowest position as per the Care Plan. This Federal tag relates to Complaint IN 529. 3.1-45(a)(2)