STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155843	A. BUILDING 00 B. WING	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS OF RICHMOND, THE	400 INDUSTRIES ROAD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00352230, IN00353324 and IN00353334, a Focused Infection Control Survey and for a Residential COVID-19 Quality Assurance Walk Through Survey. Complaint IN00352230 - Substantiated. Federal/state deficiency related to the allegations is cited at F580. Complaint IN00353324 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00353334 - Substantiated. Federal/state deficiency related to the allegations is cited at F880. Survey dates: May 17, 18, 19 and 20, 2021 Facility number: 013635 Provider number: 155843 AIM number: 300026664 Census Bed Type: SNF/NF: 8 SNF: 38 Residential: 9 Total: 55 Census Payor Type: Medicare: 35 Medicaid: 4 Other: 7 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaints and Focused COVID-19 Infection Control Survey conducted on May 17, 2021 through May 20,2021. Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 12, 2021. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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

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	Quality review completed on May 27, 2021			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.			

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	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure the former Social Services Director (SSD) directly communicated a resident's change in condition related to chest pain for over 18 hours to the facility's nursing staff. (Resident C) Findings include: In a telephone interview on 5-17-21 at 4:07 p.m., with the former SSD, she indicated she had a conversation with a family member of Resident C on 4-12-21 in which the family member mentioned she thought the resident might have pneumonia and was having chest pains. The former SSD indicated she put this information into a notation in Resident C's chart on 4-12-21. She clarified she did not personally relay this information to the nurse or other staff on duty. "The next morning [4-13-21], I got a text from [name of the Assistant Director of Health Services (ADHS)] wanting to know if I had told any of the nurses about this. I told her that I had put it in the note in the computer. After that, I called [name of LPN 5] to tell her to read my note in the chart and to go check on her [Resident C]. This was at 10:32	F 0580	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The resident affected is no longer residing in the facility. Social Service progress notes for all residents were audited to ensure appropriate notification was in place related to any documented changes of condition. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. The DHS or designee will audit Social Service progress notes for ten residents weekly x4 weeks, then 5 residents weekly x4 weeks identifying any documentation that would indicate	06/12/2021

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	a.m...I think [name of Resident C] died later the same afternoon, on 4-13-21." The clinical record of Resident C was reviewed on 5-18-21 at 12:02 p.m. It indicated Resident C was admitted to the facility on 4-8-21 after a hospitalization for a urinary tract infection (UTI) and altered mental status. Her diagnoses included, but were not limited to, UTI, altered mental status, lupus, history of myocardial infarction (heart attack), aortic valve stenosis, rheumatoid arthritis, polyosteoarthritis, unspecified thryrotoxicosis without crisis or storm, hypertension, depression, a history of basal cell cancer of the right leg, including the hip and advanced age (over 100 years old). A progress note, dated 4-13-21 at 10:52 a.m., indicated LPN 5 had conducted a physical assessment of Resident C with results of clear lungs bilaterally, oxygen saturation of 93 percent on oxygen at 3 liters via nasal cannula, and no complaints of the resident specific to cough or shortness of breath. A notation on 4-13-21 at noon indicated Resident C was complaining of her feet "feeling hot and cold and being painful," with a dark purple discoloration. The notation indicated a daughter was present. The physician was notified and a video appointment was arranged. The video appointment, began at 11:52 a.m. The notes reflected Resident C was able to speak with the physician. It indicated the resident had recently been hospitalized "for increasing confusion, decreased oral intake and pain," was treated for a UTI and also diagnosed with a NSTEMI type 2 (type of heart attack). It identified her past medical history included lupus, rheumatoid arthritis, hypertension, aortic stenosis,		a potential change in condition and ensuring appropriate nursing follow-up. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The DHS or designee will complete an in-service with all facility staff regarding proper notification procedures for resident change of condition, found in policy entitled “Notification of Change in Condition”. The DHS or designee will continue to review Social Services progress notes in Clinical Care Meeting to identify changes in resident condition and ensure proper notification and action were completed. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into place: The DHS or designee will report findings of these notification/documentation audits in monthly QAPI meetings for six (6) months. Any identified notification failures will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation.	

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	thyroid disorder and long-term use of prednisone. It identified two daughters were present during the video visit. The plans and assessment included obtaining serum labs of a complete blood count, basic metabolic panel, sed rate, c-reactive protein and a bilateral arterial ultrasound to evaluate for possible "vasculitis," or "possible vascular occlusion." Additionally, the prednisone was restarted at 5 milligrams daily until lab results were obtained and reviewed. Nursing progress notes indicated the video visit lasted approximately 45 minutes. Shortly after the video visit, at 1:19 p.m., the resident was found unresponsive and without pulse or respirations, and CPR (cardiopulmonary resuscitation) was initiated by facility staff, until the EMS (emergency medical staff) arrived and continued CPR. The code was called by EMS at 1:47 p.m. The family was updated on the resident's passing at that time. In an interview on 5-18-21 at 1:28 p.m., with the Executive Director, she indicated on the evening of 4-12-21, the former SSD apparently spoke with one of the daughters of Resident C, regarding the resident. She indicated the former SSD documented in the progress notes that the daughter was concerned Resident C might have pneumonia and was having chest pain. "We were not aware of any of this until the next morning." The SSD did not relay this information to the nurse on duty, merely put a note in the computer. So, we did some investigation and did ask all the staff that may have had any interaction with the resident if anything had been said or they had reason to consider respiratory problems or chest pain and they did not have any voiced concerns. In an interview with the Director of Health			

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	Services (DHS) on 5-19-21 at 12:03 p.m., she recalled on the morning of 4-13-21, reviewing the nursing progress notes for Resident C and finding the notation from the previous day regarding chest pain. "We immediately started talking with the staff and resident about this and there were no reports or complaints of chest pain." The DHS indicated she was unfamiliar with the past work history of the former SSD and was "not sure if she understood the importance of personally relaying the health information to the nurse to follow up on and not just putting it in a note in the computer." In an interview on 5-17-21 at 4:07 p.m., with the former SSD, she indicated on 4-14-21, she was terminated related to an issue "with not notifying staff about a resident's care, not sure exactly what that means." In review of the former SSD's personnel record, a written counseling document, dated 4-14-21, indicated, "Gross Misconduct-failure to notify appropriate staff to address resident health concern/failure to seek care." It indicated this employee was terminated, effective 4-14-21. On 5-20-21 at 12:35 p.m., the Executive Director provided a copy of a policy, revision dated of 5-23-2018, entitled, "Notification of Change in Condition." This policy indicated its purpose is, "To ensure appropriate individuals are notified of change in condition...when a significant change in the resident's physical, mental or psychosocial status [occurs]." This Federal tag relates to Complaint IN00352230. 3.1-5(a)((2)			

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to ensure visitors to the facility were routinely screened for signs and symptoms of Covid-19 and temperature prior to entry into the facility for 2 visitors in the last month. Findings include:	F 0880	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific resident was identified in the deficient practice. How other residents having the	06/12/2021

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	1. Upon the entrance of a visitor on 5-17-21 at 1:07 p.m., into the facility, the facility's Staff Development Coordinator (SDC) was observed seated at the front entrance desk to monitor visitor entrance and to ensure Covid-19 screening was routinely conducted. She was observed to greet the visitor, but failed to screen the visitor for temperature or screen for signs and symptoms of Covid-19 during the five minutes the visitor was in the lobby awaiting an escort into the building by the Executive Director. 2. In an interview on 5-19-21 at 3:05 p.m., with a family member of Resident E, she indicated when she arrived for visit on Sunday, 4-25-21, she found no one was at the front desk to check her for Covid screening. "I had no idea what their process was and no one to ask. I ended up walking past several staff people and residents, but no one stopped me...From working in long term care, I know how important the Covid screening is. The next day when I visited, there was someone at the desk and I told them the day before, I had no idea what to do and was not screened. They explained how their system works. Seems odd to me they would not have someone around to make sure it is being done." In an interview with the Director of Health Services on 5-19-21 at 12:10 p.m., she indicated she was unaware of any other family or visitor, mentioning any problems with the facility's electronic Covid-19 screening system, located at the entrance to the facility. "We normally have someone up at the front desk during normal business hours and signs to explain how to use the system or how to reach someone in case they have any questions or would have a Covid symptom."		potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. The Executive Director or designee will review the COVID visitor screening policy, entitled "Covid-19 Visitation Policy SOP" for visitors with all staff to ensure proper education and compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Executive Director or designee will ensure appropriate staffing of the screening station during visitation hours. The Executive Director or designee will audit the Care.ai screening system five (5) times per week for two (2) weeks then weekly for six (6) weeks to ensure visitor screening compliance. One random audit will be conducted monthly thereafter to maintain compliance. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director or designee will report findings of these audits in monthly QAPI meeting for six (6) months. Any	

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	On 5-20-21 at 12:35 p.m., the Executive Director provided a copy of policy dated 9-15-20, and entitled "Covid-19 Screening." This policy indicated, "In response to the Covid-19 global pandemic, Trilogy is enacting procedures to address employees and/or visitors that could cause risk to residents by having Covid-19 by screening each person as mandated by federal and state requirements. Care.ai system [an electronic screening system] will be used as a resource to assist with the screening process...can by access [sic] through myTrilogyVisit.com, Red E App [or] app on phone. The employee and/or visitor will use Care.ai system to answer the following Covid-19 symptoms with to [sic] (2) hours of entrance: temperature greater than 100.0, chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, congestion or runny nose, GI symptoms (nausea, diarrhea, vomiting), sore throat, new loss of taste or smell [or] repeated shaking with chills. The following steps will occur if any questions are answered "yes" to any of the above symptoms: Please contact the ED, DHS, or Leadership Designee at the campus to get approval for entry. Campus ED, DHS, or Leadership Designee will notify the screener of approval. Employee and/or visitor will bring in the verification from Care.ai, (screen with green check), name, date and/or QR code, [and] the screening table personnel will review for approval from the system. Screening table personnel will do the following: obtain temperature at entry and exiting, Have you ever had Covid-19 (positive test results)? Have you been to any hotspots in the past 14 days? Was anyone you live with Covid-19 positive in the last 14 days? Ask the person to complete a screening questionnaire when indicated. Comments as needed."		identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation.	

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	The Indiana Department of Health's "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure, updated 5-3-21, indicates, "Long-term care centers should take everyday preventive measures to help contain the spread of COVID-19. Actively screen all healthcare personnel (HCP), visitors, vendors entering the facility for symptoms of COVID 19 and any history of being a close contact or exposed to COVID 19 positive or symptomatic person. Post signs at the entrance instructing visitors not to visit if they have symptoms of COVID 19 infection. Ensure sick leave policies allow employees to stay home if they have symptoms of COVID 19 infection. Assess residents ' symptoms of COVID 19 infection upon admission to the facility, and daily during this pandemic and implement appropriate infection prevention practices for incoming symptomatic residents. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficult breathing, Fatigue, Muscle or body aches [or] Headache..." This Federal tag relates to Complaint IN00353334 and the Covid-19 Focused Infection Control Survey. 3.1-18(b)(1)			
R 0000 Bldg. 00	This visit was for a Residential COVID-19 Quality Assurance Walk Through Survey. This visit included a COVID-19 Focused Infection Control Survey and Investigation of Complaints IN00352230, IN00353324 and IN00353334.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on	

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	Complaint IN00352230 - Substantiated. Federal/state deficiency related to the allegations is cited at F580. Complaint IN00353324 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00353334 - Substantiated. Federal/state deficiency related to the allegations is cited at F880. Survey date: May 17, 18, 19 and 20, 2021 Facility number: 013635 Residential Census: 9 The Springs of Richmond was found to be in compliance with 410 IAC 16.2-3.5 in regard to the Residential COVID-19 Quality Assurance Walk Through Survey. Quality review completed on May 27, 2021		the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaints and Focused COVID-19 Infection Control Survey conducted on May 17, 2021 through May 20,2021. Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 12, 2021. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	