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	12/04/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00422649. This visit included a State Residential Licensure Survey. Complaint IN00422649. No deficiencies related to the allegations are cited. Survey dates: November 27, 28, 29, 30, and December 1 and 4, 2023. Facility number: 013635 Provider number: 155843 AIM number: 300026664 Census Bed Type: SNF/NF: 7 SNF: 37 Residential: 12 Total: 56 Census Payor Type: Medicare: 31 Medicaid: 7 Other: 6 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 6, 2023	F 0000		
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol Lyons	HFA	12/15/2023

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	agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances			

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	may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the			

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	grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on interview and record review the facility failed to complete a grievance for Resident 30 that verbalized concerns with his care and failed to have a process for residents and/or families to file a grievances anonymously for 1 of 3 residents reviewed for grievance process (Resident 30). Finding include: During an interview with Resident 30 and his family member on 11/27/23 at 2:16 p.m., indicated they did not feel the facility had adequate staffing. The resident had to wait up to 40 minutes to go to the bathroom. The resident had become incontinent of urine due to waiting. The resident had frequently called the Executive Director and the Scheduler on their person phones to report waiting and they would have staff come in and assist him. During an interview with Resident 30 and his family member on 11/28/23 at 1:22 p.m., indicated he was not always provided with fresh water unless he request it. When queried if the resident/and or family had filed a grievance about	F 0585	The submission of this plan of correction does not indicate an admission by The Springs of Richmond that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs of Richmond. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. F585 D: Resident 30 was found to	12/29/2023

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	inadequate staffing and not being provided water, the resident and his wife indicated they had not been offered to file a grievance and did not know anything about filing a grievance. During an interview with the Minimum Data Set (MDS) Coordinator and the Social Service Director on 11/28/23 at 1:29 p.m., indicated the process for residents and families to file a grievance was on the facility computer and any nursing staff had access to it and could fill one out on the computer for the resident or their family. The grievance then would automatically be brought to morning meeting for review and weekend supervisor can also review them. During an interview with Resident 30 and his family member on 11/29/23 at 10:00 a.m., indicated they felt it was intimidating to have staff fill out a grievance and it was uncomfortable for them due to the resident requiring assistance from the staff that he would have to have fill out the grievance. The resident indicated he did not feel it was private enough and it was intimidating to him to have staff fill it out the grievance on the facility computer. The resident indicated he was dependent for his care from the staff so he did not feel comfortable to ask them to file a grievance. The resident indicated he was afraid they would retaliate or get mad at him. Review of the record of Resident 30 on 12/4/23 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, hemiparesis, dysphagia, hypertension, insomnia, muscle weakness, calculus of kidney, malaise, acquired absence of the kidney, reduces mobility and acquired absence of the kidney. The Quarterly Minimum Data Set (MDS)		have been affected by the alleged deficient practice. Paper forms for anonymous completion have been placed at the front desk for resident retrieval. All residents have the potential to be affected by the alleged deficient practice. Residents/POA and staff have been educated on the location of paper forms and the continued availability of our electronic log and the compliance hotline. The Social Services or designee will conduct a random audit by asking residents if they are aware of the location of the paper form of the grievances available to them. Auditing will occur 5 times a week x4 weeks, then every other week x 2 months then monthly for 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings or until 100% compliance is achieved. The plan will be revised and updated as warranted.	

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	assessment for Resident 30, dated 10/29/23, indicated the resident was moderately impaired for daily decision making. Review of the grievances provided by the Executive Director on 11/28/23 at 1:00 p.m., there were no grievances filed for Resident 30. The progress note for Resident 30 dated, 11/28/2023 at 9:20 a.m., indicated the resident had called the Scheduler and the Executive Director cell phone through out the day to report he needed help. Review of the record of Resident 30 on 12/4/23 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, hemiparesis, dysphagia, hypertension, insomnia, muscle weakness, calculus of kidney, malaise, acquired absence of the kidney, reduces mobility and acquired absence of the kidney. The Quarterly Minimum Data Set (MDS) assessment for Resident 30, dated 10/29/23, indicated the resident was moderately impaired for daily decision making. Review of the grievances on 12/4/23 at 11:15 a.m., provided by the Executive Director, there were no grievances filed for Resident 30. During an interview with Clinical Support on 12/01/23 at 11:41 a.m., indicated the facilities previous Social Service Director had implemented grievance being on the computer only. The resident concern policy provided by Clinical Support on 12/1/23 at 12:23 p.m., indicated the residents and/or their representatives have the right to voice grievances/concerns or			

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	recommendations without discrimination or reprisal. The campus will investigate reported concerns to resolve those concerns. Grievances or concerns can be filed verbally, in writing or anonymously. 3.1-7(a)(1) 3.1-7(a)(2) 3.1-7(a)(3)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide nail care for a dependent resident for 1 of 3 residents reviewed for Activities Of Daily Living (ADL) (Resident 3). Finding include: During an observation on 11/28/23 10:17 a.m., Resident 3's fingernails on both hands were long and jagged with chipped fingernail polish. During an observation on 11/29/23 at 10:22 a.m., Resident 3's fingernails on both hands were long and jagged with chipped fingernail polish. During an observation on 11/29/23 at 2:23 p.m., Resident 3's fingernails on both hands were long and jagged with chipped fingernail polish. During an observation on 11/30/23 at 12:45 p.m., Resident 3's fingernails on both hands were long, jagged with chipped fingernail polish.	F 0677	F677 D: Resident 3 was affected by the alleged deficient practice. Resident was immediately provided with nail care at time of alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. ADL education specific to attention to nail care performance has been provided to the appropriate team members providing this care. DHS/ADHS or designee will conduct an audit on 3 residents care planned for nail care x 3 days a week for 4 weeks, then 2 days a week x 8 weeks then weekly times x months to ensure the residents ADL nail care needs are met. —— As a quality measure, the DHS or designee will review any	12/29/2023

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	During an observation on 12/1/23 at 11:33 a.m., Resident 3 nails were long, jagged with chipped fingernail polish. During an interview with the Director Of Health Services (DHS) on 12/1/23 at 11:40 a.m., indicated if Resident 3 was a diabetic the nurses were responsible to provide nail care if the resident was not a diabetes the CNA's were responsible. Review of the record of Resident 3 on 12/1/23 at 1:08 p.m., indicated the resident's diagnosis included, but were not limited to, diabetes mellitus. The plan of care for Resident 3, dated 9/20/23, indicated the resident required staff assistance to complete ADL task completely and safely. The Quarterly Minimum Data Set (MDS) for Resident 3, dated 9/29/23, indicated the resident was severely cognitively impaired. The had no behaviors of rejection of care. The resident was totally dependent of one person for personal hygiene. 3.1-38(a)(3)(E)		findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings or until 100% compliance is achieved. The plan will be revised and updated as warranted.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and			

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	483.65 of this subpart. Based on observation, interview and record review the facility failed to store a nebulizer mask in a sanitary manner for good infection control practices for 1 of 3 residents reviewed for respiratory care (Resident 17). Finding include: During an observation on 11/28/23 at 1:43 p.m., Resident 17's nebulizer machine and mask were laying on the resident's bed, there was no storage bag visible in the resident's room for the nebulizer mask. During an observation on 11/29/23 at 11:18 a.m., Resident 17's nebulizer mask was laying on bedside table, there was no storage bag visible in the resident's room for the nebulizer mask. During an interview with the Director Of Health Services (DHS) on 12/1/23 at 11:36 a.m., indicated Resident 17's nebulizer mask should be in a bag have been stored in a bag for infection control purposes. Review of the record of Resident 17 on 12/1/23 at 1:50 p.m., indicated the resident's diagnoses included, but were not limited to, pneumonia, arteriosclerotic heart disease, cardiomyopathy, chronic obstructive pulmonary disease with acute exacerbation, chronic heart failure and respiratory disease. The physician order for Resident 17, dated November 2023, indicated the resident was ordered Albuterol sulfate 2.5 milligram (mg)/ 3 milliliter (ml) 0.083% nebulization solution give one dose every six hours while awake.	F 0695	F695 D: Resident 17 was found to have been affected by the alleged deficient practice. The nebulizer mask was placed immediately into a bag with date upon notification of the alleged deficient practice. All residents requiring humidified oxygen and nebulizer treatments have the potential to be affected by the alleged deficient practice. An audit on each resident with O2 and nebulizers will be conducted to ensure proper storage and humidification is in place if indicated and education will be provided to clinical team members on the processes that the residents have humidification if appropriate and nebulizer bags are placed in resident's rooms to place masks in when not in use. The DHS or designee will Audit for proper storage and placement 3 residents weekly for 4 weeks, 3 residents every other week for 2 months and 3 residents a month for 3 months. —— As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings or until 100% compliance is achieved. The plan will be revised and updated as warranted.	12/29/2023

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	3.1-47(a)(6)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review the facility failed to provide outdoor activities on a regular basis per the resident's preference for 1 of 1 resident reviewed for dementia care (Resident 8). Finding include: During an observation on 11/29/23 at 10:20 a.m., Resident 8 was sitting in the dining room with another resident. Resident 8 was wheeling himself around the dining room without purpose. During an observation on 11/29/23 at 11:18 a.m., Resident 8 was wandering in other resident's room in his wheelchair. During an interview with LPN 1 on 11/29/23 at 11:10 a.m., indicated Resident 8 started having behaviors of wanting to go outside in the Spring and Summer of 2023. The resident would see other residents sitting outside on the porch and he wanted to go outside too. During an interview with CNA 2 on 11/29/23 at 11:21 a.m., indicated yes the resident had behaviors of going outside unsupervised. The resident started having these behaviors in the Summer of 2023. The resident liked to be outside	F 0744	F744 D: Resident 8 was found to have been affected by the alleged deficient practice. Education was immediately provided to Activities and Clinical team on meeting the needs of the residents with dementia. All residents with dementia have the potential to be affected by the alleged deficient practice. Each resident with dementia will have their careplans reviewed to ensure we are continuing to meet their needs/preferences documented in their initial life enrichment assessment. Activities Director or Life Enrichment will audit careplans and engagement logs for 3 residents with dementia weekly x 4 weeks, then every other week x 2 months, then monthly x 3 weeks. As a quality measure, the DHS, Activities Director or designee will review any findings and corrective action at least quarterly in the campus Quality	12/29/2023

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	with the other residents. During an interview with the Activity assistant on 11/29/23 at 2:06 p.m., there was an incident where I was decorating outside and Resident 8 came out and his wander guard went off and beeped. I have witnessed him trying to leave the building before and I would redirect him. The Activity assistant tried to take the resident out at least once a week when the weather was nice. Review of the record of Resident 8 on 11/28/23 at 2:02 p.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, hemiparesis and vascular dementia. The activity plan of care for Resident 8, dated 7/12/22, indicated it was important for the resident to engage in activities and opportunities that were meaningful to him. The interventions included, but were not limited to, it was important for the resident to be able to go outside and get fresh air when the weather was warm and he would like to go outside when there were outside activities. The Annual Minimum Data Set (MDS) assessment for Resident 8, dated 6/14/23, the resident was severely cognitively impaired for daily decision making. The resident was independent with locomotion on the unit with set up. The resident utilized a wheelchair for locomotion. The resident's preference for activities included, but were not limited to, spending time outdoors. The progress note dated, 6/27/2023 at 2:48 p.m., the Activity staff report the resident didn't want to play cards in activity room. Staff report he kept pointing to front door and wheeling self in that direction wanting to go sit outside. Discussed		Assurance Performance Improvement meetings or 100% compliance achieved. The plan will be revised and updated as warranted.	

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	with activity director taking resident outside several days a week for a stroll or sit out side with staff. Activities to incorporate outside activity in to resident's plan of care. Review of Resident 8's activities from June 2023 to July 2023 indicated in two months the resident was taken outside 3 times. During an interview with Corporate Support on 11/30/23 at 10:27 a.m., verified Resident 8 had not been taken outside between 6/27/23 and 7/22/23. The Dementia Bill of Rights provided by Corporate Support on 12/4/23 at 10:30 a.m., indicated every person diagnosed with dementia deserves: to be outdoors on a regular basis. 3.1-37(a)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview and record review the facility failed to complete an elopement assessment for a resident who had behaviors of going outside the facility without supervision for 1 of 1 resident reviewed for elopement (Resident 8). Finding include: During an observation and interview on 11/29/23 at 10:25 a.m., LPN 1 took Resident 8 by the door in the dining room and the wander guard alarmed, the nurse indicated the wander guard was	F 0745	F745 D: Resident 8 was found to have been affected by the alleged deficient practice. Assessment was immediately completed upon the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. Education has been provided on residents that present an elopement risk and elopement risk interventions in the care planning	12/29/2023

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	underneath the wheelchair per families request out of the resident's sight. LPN 1 indicated the resident often tried to leave the facility was why he had a wander guard. During an interview with LPN 1 on 11/29/23 at 11:10 a.m., indicated yes she had known of times the resident had gotten out of the facility that is why he has a wander guard on now because he was unsafe to be outside without staff. The resident started this behavior in the late spring 2023 and the summer 2023. The resident would see other residents outside and would want to go. During an interview with LPN 1 on 11/29/23 at 1:50 p.m., indicated on 7/22/23 another resident's family member reported Resident 8 was in the parking lot of the facility with no staff supervision. LPN 1 indicated she did not want the resident outside alone and she called the physician and place a wander guard on the resident's wheelchair. Review of the record of Resident 8 on 11/28/23 at 2:02 p.m., left hip fracture, laceration without foreign body of the head, hyponatremia, hemiplegia, hemiparesis, dysphagia, hypertension, vascular dementia, psychotic disturbance, hypertension, cerebrovascular disease, unsteadiness on feet and muscle weakness. The Annual Minimum Data Set (MDS) assessment for Resident 8, dated 6/14/23, the resident was severely cognitively impaired for daily decision making. The resident was independent with locomotion on the unit with set up. The resident utilized a wheelchair for locomotion. The progress note for Resident 8, dated 7/22/23 at 4:51 p.m., indicated the nurse was approached by		process. —— Social Services/ DHS or designee will audit 3 residents a week for 4 weeks for elopement risk, care plan and interventions in place, then 3 residents every other week for 8 weeks, then 3 residents a month for 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings or until 100% compliance is achieved. The plan will be revised and updated as warranted.	

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	12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	a family member by another resident, stating this resident was out in the middle of the parking lot without supervision. The nurse went and got the resident and explained to him that if he would like to go outside that the nurse would take him out and that it was not safe for him to be in the middle of the parking lot. Resident stated "I do not get help when I ask". The resident's family was notified and the family requested a wander guard be placed on the resident's wheelchair so he would not know. The weekend supervisor indicated it was fine since the resident was always in a wheelchair and did not walk. The event report for Resident 8, dated 7/22/23 at 4:53 p.m., indicated the resident was found alone in the parking lot. The resident was not seen leaving the building and was found on the property. The resident did not have a wandering alert device on at the time of the exit. The resident did not sustain any injury. The resident was cognitively impaired and had impairments that effects his safety and judgement. The intervention was to apply a wandering device. The physician and the resident's family notified. During an interview with Clinical Support on 11/30/23 at 10:09 a.m., there was no elopement assessment completed for Resident 8 since 7/13/22. The Social Service Director was responsible to complete an elopement assessment quarterly. The elopement policy provided by Clinical Support on 11/29/23 at 2:15 p.m., indicated the facility strived to promote resident safety and protect the residents and dignity of the residents. Each resident would have an elopement risk assessment quarterly and with a change in condition.			

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	The Social Service Director job description provided by the Executive Director on 12/1/23 at 9:30 a.m., indicated the responsibilities included, but were not limited to, revise assessments as necessary, but at a minimum quarterly. 3.1-34(a)(1)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00422649. Survey dates: November 27, 28, 29, 30, and December 1 and 4, 2023. Facility number: 013635 Residential Census: 12 Th Springs of Richmond was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on December 6, 2023	R 0000		