STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155843	A. BUILDING -- B. WING	12/14/2023

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/14/23 Facility Number: 013635 Provider Number: 155853 AIM Number: None At this Emergency Preparedness survey, The Springs of Richmond was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey, the census was 57. Quality Review completed on 12/18/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/14/23 Facility Number: 013635 Provider Number: 155853 AIM Number: None At this Life Safety Code survey, The Springs of Richmond was found not in compliance with	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 12/18/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 3 of 3 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:	K 0211	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	01/01/2024

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	(a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 28 residents in the facility. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Management Support on 12/14/23 between 12:40 p.m. and 2:30 p.m., Personal Protective Equipment (PPE) carts were in use but were not equipped with wheels allowing the carts to be moved out of the halls during an emergency. This condition existed outside Resident Rooms 205, 227 and 207. Based on an interview at the time of observations, the Director of Plant Operations stated the PPE carts are not equipped with wheels and would need to be replaced with a PPE cart with wheels. The finding was acknowledged by the Director of Plant Operations at the time of discovery and again with the Director of Plant Operations and Facilities Management Support during the exit conference. 3.1-19(b)		executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on December 14th 2023. Upon Submission of this Plan of Correction and supporting documentation and or photographic evidence we respectfully request a desk review. **K 211 Means of Egress** **Immediate Intervention** The wheeled carts that were being stored in the hallway were immediately removed to a location in the campus as not to impede the path of egress in the hallway. Which could affect approximately 28 residents to meet deficiency K211. **Exhibit A – Photo** **Compliance Date 1-1-2024** The Director of Plant Operations was educated by regional support on NFPA 101 Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11 and 18.2.1,19.2.1, 7.1.10.1 and in accordance with	

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			19.2.3.4(4) **Exhibit B – Inservice Documentation** The Director of Plant Operations will audit hallways for means of egress Daily for 6 weeks then weekly for 6 weeks **Exhibit C – Audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 delayed egress locking arrangements in the 600 hall was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 10. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Management Support on 12/14/23 between 12:40 p.m. and 2:30 p.m., the Therapy Exit door to the outside was equipped with a 15 second delayed egress. When the exit	K 0222	**K222 – Egress Doors.** **Immediate Intervention** The delayed egress has been adjusted to activate after three seconds as stated in code to satisfy deficiency K222 this practice could affect 10 residents. **Exhibit D – Photo** **Compliance Date** **1-1-24** The Director of plant operations was educated by regional support on egress doors NFPA101 stating that doors in a required means of egress is in accordance with delayed egress locking arrangements or Access controlled egress locking arrangement. This is in accordance with 7.2.1.6.2, 18.2.2.2.4, 19.2.2.2.4 **Exhibit B – Inservice Documentation** The Director of plant operations will complete a visual inspection on the building for locking devices once a week x3 months then	01/01/2024

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	door was tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Surveyor and DOPO tried 3 times to activate the delay egress. The DOPO stated the delayed egress was not working and will need to be repaired. The finding was acknowledged by the Director of Plant Operations at the time of discovery and again with the Director of Plant Operations and Facilities Management Support during the exit conference. 3.1-19(b)		monthly x 3 months. **Exhibit E – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Management Support on 12/14/23 between 12:40 p.m. and 2:30 p.m., the corridor door to Resident Room #234 failed to close and latch positively into the door frame. Based on interview at the time of the observations, the DOPO agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. The finding was acknowledged by the Director of Plant Operations at the time of discovery and	K 0363	**K363 – Corridor – Doors** **Immediate intervention** Realigned the door frame that would have prevented keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke that could affect 2 staff to meet K363 deficiency. **Exhibit F - Photo** **Compliance date** **1/1/24** The Director of Plant Operations was educated by Regional Support on K363 corridor – doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas to resist the passage of smoke as it pertains NFPA 101 in compliance with	01/01/2024

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	again with the Director of Plant Operations and Facilities Management Support during the exit conference. 3.1-19(b)		7.2.1.9, 19.3.6.3.6, 8.3, 19.3.6.3, 42 CFR parts 403,418,460,482,483 and 485. **Exhibit B – Inservice Documentation** The Director of Plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit G - Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. NFPA 101, Section 19.5.2.2(2) requires any fuel-fired heating device, other than a central	K 0522	**0522 HVAC – any Heating Device** **Immediate Intervention** A contractor was called to replace the motor for the fresh air louvers for the dryer area to allow	01/01/2024

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	heating plant, shall be designed and installed so they shall take air for combustion directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observations and interview during a tour of the facility with the Director of Plant Operations and Facilities Management Support on 12/14/23 between 12:40 p.m. and 2:30 p.m., the laundry room had fuel fired dryers with an automatic louver system that would open when the dryers are running to provide air from the outside. When a dryer was turned on the louvers would not open. Based on interview, this was acknowledged by the DOPO at the time of observation. The finding was acknowledged by the Director of Plant Operations at the time of discovery and again with the Director of Plant Operations and Facilities Management Support during the exit conference. 3.1-19(b)		air movement from the outside. To meet deficiency of K522 This could affect all staff in the laundry area. **Exhibit H – Photo** **Compliance date 1/1/24** The Director of plant operations was educated by Regional Facilities Support on K522 in accordance with NFPA 101, Section 19.5.2.2(2) requiring that any fuel fired device other than heating plant shall be designed and installed so they take air for combustion directly from the outside. **Exhibit B – Inservice** The Director of plant operations will visually inspect weekly for correct operation of fresh air intake x 3 months then monthly after that. **Exhibit I – audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	