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	02/14/2025

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		F 0000		

This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00444990, IN00445166, IN00447250, and IN00452120. This visit included a State Residential Licensure Survey.

Complaint IN00444990 - Federal/State deficiencies related to the allegations are cited at F0755.

Complaint IN00445166 - No deficiencies related to the allegations are cited.

Complaint IN00447250 - No deficiencies related to the allegations are cited.

Complaint IN00452120 - No deficiencies related to the allegations are cited.

Survey dates: February 11, 12, 13, and 14, 2025

Facility number: 013635
Provider number: 155843
AIM number: 300026664

Census Bed Type:
SNF/NF: 6
SNF: 45
Residential: 15
Total: 66

Census Payor Type:
Medicare: 38
Medicaid: 6
Other: 7
Total: 51

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Benjamin Meier	Executive Director	02/27/2025

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 19, 2025.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure a resident was deemed appropriate to self-administer a nebulizer (a device that converts liquid medicine to mist to inhale it) medication for 1 of 5 residents reviewed for medication administration. (Resident 207) Findings include: An observation was conducted of medication administration for Resident 207 with Licensed Practical Nurse (LPN) 2 on 2/13/25 at 8:08 a.m. LPN 2 prepared Resident 207's morning medications and after the resident took the medications by mouth, she requested a nebulizer treatment. LPN 2 obtained a vial of a medication and dispensed such into the nebulizer medicine cap connected to the nebulizer machine. LPN 2 secured the medicine cup to the face mask and handed the face mask to Resident 207. Resident 207 proceeded to hold the face mask to administer the nebulizer medication at 8:28 a.m. LPN 2 proceeded to leave Resident 207's room to prepare medications for Resident 209. At 8:45 a.m., LPN 2 returned to the medication cart and the nebulizer machine was still on in Resident 207's room. LPN 2 indicated Resident 207 preferred to turn the nebulizer machine off herself. Resident 207 was observed to have a sling in place to her right arm and the nebulizer machine was located on the nightstand located on the right side of her bed.	F 0554	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. F 554 1. Resident 207 was affected. No adverse effects noted. Self-Administration observation was completed immediately upon finding. Medications were removed from the resident's room.	03/07/2025

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	The clinical record for Resident 207 was reviewed on 2/13/25 at 9:32 a.m. The diagnoses included, but were not limited to, humerus (long bone of the upper arm) fracture. A care plan for functional status, start date of 2/6/25, indicated Resident 207 had functional impairment related to a right humerus fracture. A progress note, dated 2/12/25 at 5:34 p.m., indicated Resident 207 returned from an orthopedic appointment and was non weight bearing to the right upper extremity with the utilization of a sling. A care plan, start date of 2/13/25, indicated Resident 207 desired to self-administer medications. The goal was for Resident 207 to self-administer medications safely. The approach listed assessing the safety and efficacy of self-administration of medications that included to assess and require return demonstration to ensure safety and provide support to the resident as needed. There was no care plan or assessment in the electronic health record (EHR) to deem Resident 207 could self-administer her nebulizer treatments prior to 2/13/25. A policy entitled "Guidelines for Self Administration of Medications", review date of 12/17/24, was provided by the Executive Director on 2/13/25 at 11:15 a.m. The policy indicated the following, "...1. Residents requesting to self-medicate or has self-administration as a part of their plan of care shall be assessed using the observation ...within the electronic health record...."		2. All residents have the potential to be affected. All nurses were educated on administration of medication and self-administration observation completion. All residents requesting self-administer medications were reviewed for completion of the self-administration observation. 3. As a measure of ongoing compliance, the DHS or designee will audit medication passes during rounding to ensure that medications are administered according to policy. Audit to consist of five residents, weekly x4 weeks, monthly x3 months, then as needed thereafter during rounding for appropriate medication administration. 4. 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. The plan will be revised and updated as warranted.	

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F 0584 SS=D Bldg. 00	3.1-11(a) 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to provide a homelike environment for 1 of 2 residents reviewed for homelike environment. (Resident 14). Findings include: The clinical record of Resident 14 was reviewed on 2/11/25 at 2:45 p.m. The diagnoses included, but were not limited to, acute respiratory disease, heart failure, and obesity. During an observation on 2/11/25 at 2:34 p.m., Resident 14's corner molding was off the wall exposing where the dry wall connected at the corner. The molding was leaning up against the opposite wall. There were areas where the paint was missing on the wall behind the head of the bed. Observations were conducted of Resident 14's room and the molding was observed to be off of the wall exposing the dry wall on 2/12/25 at 11:12 a.m. and 2/12/25 at 1:45 p.m. During a tour on 2/14/25 at 2:15 p.m., the Executive Director (ED) indicated he was not aware of the molding being off the wall and areas where the paint was missing behind the bed. He stated this had been an issue in the past due to Resident 14 being in a motorized wheelchair. An interview with the Executive Director, on 2/14/25 at 3:38 p.m., indicated the facility's	F 0584	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. F 584 1. Resident 14 was affected. No adverse effects noted. Resident room was repaired and painted immediately upon findings. 2. All residents have the potential to be affected. All maintenance personnel were educated on the homelike environment regulation.	03/07/2025

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	expectation was to promote a safe, clean, and homelike environment for all residents. 3.1-19(f)(5)		All residents rooms reviewed for homelike environment concerns and repaired if necessary 3. As a measure of ongoing compliance, the maintenance director or designee will audit resident rooms to ensure homelike environment is being maintained per regulation. Audit to consist of five residents, weekly x4 weeks, monthly x3 months then as needed thereafter. 4. As a quality measure, the maintenance director or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure a resident's bowel movements were documented and followed up when a resident went over three days without having a bowel movement for 1 of 1 resident reviewed for constipation. (Resident G) Findings include: The clinical record for Resident G was reviewed on 2/13/25 at 12:31 p.m. The diagnoses included, but were not limited to, constipation. An Admission Minimum Data Set (MDS)	F 0690	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	03/07/2025

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	assessment, dated 12/16/24, indicated Resident G was cognitively intact and always continent of bowel. A bowel and bladder care plan, start date of 12/11/24, indicated Resident G was continent of bowel. The approach was to notify the charge nurse of a change in bowel and bladder patterns as needed and report signs and symptoms of constipation. An interview conducted with Family Member (FM), on 2/12/25 at 11:00 a.m., indicated Resident G went 13 days without a bowel movement after her admission to the facility. The electronic health record, under the "Vitals" section, noted the following bowel movements documented for Resident G: - No bowel movements documented from 12/10/24 until 12/14/24, - No bowel movements documented from 12/19/24 until 12/23/24 as a "small", - No bowel movements documented from 12/26/24 until 12/29/24, - No bowel movements documented from 12/30/24 until 1/2/25 as a "small", - No bowel movements documented from 1/6/25 until 1/11/25, - No bowel movements documented from 1/12/25 until 1/16/25, - No bowel movements documented from 1/18/25 until 1/23/25, - No bowel movements documented from 1/29/25 until 1/31/25 as a "small", and - No bowel movements documented from 2/9/25 until 2/12/25 as a "small". On 2/14/25 at 8:50 a.m., the Executive Director		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. **F 690** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident G bowel monitoring protocol in place to prevent constipation. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will complete a ongoing review during daily clinical meeting (5 times per week) of all residents with no bowel movement in 72 hours to ensure bowel monitoring and bowel protocol orders are being followed to prevent constipation. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Nursing Team on the following campus guidelines: Guideline for Bowel Protocol.	

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	indicated there was no facility policy regarding monitoring of bowel movements. The National Library of Medicine at https://www.ncbi.nlm.nih.gov/books/NBK513291/, was retrieved on 2/14/25 at 4:30 p.m., updated 11/12/23, indicated the following, "... Constipation... Characterized by infrequent and often difficult bowel movements... Introduction... Constipation is a symptom or condition characterized by difficult and infrequent bowel movements, typically 3 or fewer times a week...." 3.1-38(a)(2)(C)		**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits for 5 residents will be conducted by the DHS or designee 5 times per week times 4 weeks, monthly x 3 months, then as needed thereafter to ensure compliance: Residents with no bowel movement in 72 hours to ensure bowel monitoring and bowel protocol orders are being followed to prevent constipation. 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. The plan will be revised and updated as warranted.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure a gastric tube (g-tube) feeding and water flushes were administered as ordered by the physician for 1 of 4 residents reviewed for nutrition. (Resident 299) Findings include: The clinical record for Resident 299 was reviewed on 2/11/25 at 2:45 p.m. The diagnoses included, but were not limited to, encounter for orthopedic aftercare following surgical amputation, severe	F 0693	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	03/07/2025

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	sepsis with septic shock, and dysphagia. A care plan for tube feeding, initiated on 2/5/25 and revised on 2/11/25, indicated Resident 299 required tube feeding related to dysphagia. The approaches indicated providing a diet as ordered, providing water flushes as ordered, and provide tube feedings as ordered. A review of the physician orders indicated, effective on 02/11/25 09:50 a.m., Resident 299 was to receive Jevity 1.5 (brand of tube feed) at 60 mL/hr (milliliters per hour) and flush with 180 mL of water every four hours. The previous order for the g-tube was for Jevity 2.0 at 50mL/hr with 150 mL every four hours of water flushes and the order was discontinued on 2/11/25. Observations of Resident 299's feeding pump (device to monitor the infusion of the feeding), on 2/11/25 at 2:25 p.m. and 2/12/25 at 11:20 a.m., was observed running at 50ml/hour of Jevity 2.0 with 150 mL of water flushes every four hours. An interview conducted with the Director of Health Services (DHS), on 2/14/25 at 2:40 p.m., indicated the Assistant Director of Health Services (ADHS) entered the order change regarding the g-tube feedings and flushes after the Registered Dietitian gave the order. The ADHS should have followed up with the nursing staff to ensure communication the g-tube feeding order was changed. A policy entitled "Tube Feedings", revised on 5/10/24, was provided by the Executive Director on 2/13/25 at 11:15 a.m. The policy indicated the following, " ...1. Residents requiring tube feeding		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. F 693 1. Resident 299 was assessed with no adverse effects noted. Resident was weighed with no significant weight change. 2. One like resident had the potential to be affected. The like resident was assessed with no adverse effects noted. 3. The DHS/Designee provided training to nurses on administering tube feed orders as ordered including correct formula and correct rate. 3. To ensure ongoing compliance the Director of Health Services will conduct weekly audits in which the DHS/Designee will visually observe tube feed administration to ensure the rate and formula are administered as ordered. These audits will be completed weekly for 4 weeks then monthly for 3 months then as needed thereafter.	

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	are assessed by Registered Dietitian (RD) or the Nutrition & Dietetics Technician, Registered (NDTR) per MDS [Minimum Data Set] guidelines and suggested monthly monitoring. The assessment includes the estimated calorie, protein, and fluid needs for resident...." 3.1-44(a)(2)		4. 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. The plan will be reviewed and updated as warranted.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to date oxygen tubing for 1 of 1 resident reviewed for respiratory care needs. (Resident 253) Findings include: The clinical record for Resident 253 was reviewed on 2/13/25 at 9:14 a.m. Diagnoses included, but were not limited to, acute kidney failure and falls. A physician's order, dated 2/9/25, indicated Resident 253 was to be on continuous oxygen of two to three liters per minute. During an observation on 2/11/25 at 12:42 p.m., Resident 253 had oxygen tubing at the bedside not dated when it was initiated. During an observation on 2/12/25 at 11:38 a.m., Resident 253 had oxygen tubing on that was not dated. During an observation on 2/13/25 at 9:41 a.m., Resident 253 had oxygen tubing on that was not dated.	F 0695	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. F695 1. Resident 253 was affected. No adverse effects were noted.	03/07/2025

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	During an interview on 2/13/25 at 12:29 p.m. with the Assistant Director of Health Services (ADHS), she indicated oxygen tubing was dated but it kept rubbing off, so we ordered labels to date and time the oxygen tubing. The ADHS indicated they date and time the tubing, then a couple hours later it would be rubbed off. The ADHS indicated the policy was to date the tubing when it was initially placed on a resident. An Administration of Oxygen Policy provided by the Executive Director (ED), on 2/13/25 at 11:18 a.m., indicated,"...14. Date the tubing for the date it was initiated...a. Tubing should be changed monthly and PRN [as needed] ..." 3.1-47(a)(6)		Resident's oxygen tubing was immediately replaced and dated appropriately. 2. All residents receiving oxygen treatment have the potential to be affected. All residents receiving oxygen have been reviewed to ensure that oxygen tubing is dated properly. The DHS or designee educated nursing staff on proper labeling and dating of oxygen tubing. 3. As a measure of ongoing compliance, The DHS or designee will complete rounding audit on 5 residents receiving oxygen weekly x 4 weeks, monthly x 3 months, and then as needed thereafter to ensure tubing is properly dated. 4. 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. The plan will be revised and updated as warranted.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, interview, and record review, the facility failed to ensure effective pain management was provided for a resident who voiced concerns of pain for 1 of 3 residents reviewed for pain medication. (Resident 251)	F 0697	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	03/07/2025

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	Findings include: The clinical record for Resident 251 was reviewed on 2/13/25 at 10:11 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, chronic back pain, and chronic vertebral fractures due to osteoporosis. A physician's order, with a start date of 2/10/25 and an end date of 2/13/25, indicated to monitor pain, three times a day, for seventy-two hours. A pain medication order, dated 2/10/25, indicated morphine concentrate solution could be given every four hours as needed for pain or shortness of breath. Resident 251's medication administration record (MAR) was reviewed on 2/13/25 at 12:15 p.m. The MAR indicated resident 251 rated her pain a 5 out of 10 on the pain scale. Per the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 published by the Centers for Medicaid and Medicare Services, the numeric pain scale indicated 0 being no pain and 10 as the worst pain one could imagine. This indicated a 5 out of 10 rating would have been moderate pain. Review of the MAR on 2/12/25 at 12:15 p.m., indicated no pain medication was given and no follow up was charted in the EHR. During an interview with Licensed Practical Nurse (LPN) 2 on 2/13/25 at 12:57 p.m., she indicated she did not do anything non-pharmacologically or give pain medication to Resident 251 after voicing her pain was a 5 out of 10 on the pain scale. LPN 2 indicated Resident 251 reported to her that, "she		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. F 697 1. Resident 251 was affected. Resident was immediately assessed with no adverse effects noted. Resident was sleeping peacefully and did not required pain medication at the time. 2. All residents have the potential to be affected. All residents have been audited for signs, symptoms of increased pain. Pain assessments have been implemented as indicated. Licensed clinical staff educated on pain management and appropriate interventions for pain. 3. As a measure of ongoing compliance, the DHS or designee will monitor 5 residents to ensure pain is managed weekly x4	

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	hurt all over". LPN 2 indicated it was around 9:00 a.m. when Resident 251 voiced her pain as a 5 out of 10. LPN 2 indicated, she did not offer anything for pain at the time and was going to look and see if Resident 251 had anything for pain ordered but forgot to look. During an interview with Resident 251's daughter on 2/13/25 at 1:23 p.m., they indicated Resident 251 gets uncomfortable when they (staff) clean her up or turn her in bed. A progress note, dated 2/13/25 at 2:55 p.m., indicated Resident 251 had stated she had some pain earlier in the day and upon re-assessment she was resting in bed with eyes closed, as though sleeping, with no outward signs of pain such as moaning or grimacing. An Admission Observation and Data Collection Report was provided by the Executive Director (ED) on 2/14/25 at 8:50 a.m. The report recorded, on 2/10/25 at 5:47 p.m., and indicated Resident 251 answered, "yes", to the interview question of, "Have you had pain or hurting at anytime in the last 5 days?". A baseline care plan goal for pain was to be controlled at a tolerable level, with resident's desired approaches: assess or observe for signs and/or symptoms of pain, reposition for comfort, administer analgesics per MD (Medical Doctor) order, and assess or observe for effectiveness of pain management approaches. A Guidelines for Pain Observation and Management Policy provided by the ED, on 2/14/25 at 8:50 a.m., indicated, "... To ensure each resident's pain including it's origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be observed and documented according to the		weeks, monthly x 3 months then as needed thereafter. 4. 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. The plan will be revised and updated as warranted.	

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	needs of each individual... c. The observation should include self-report of pain... 7. Evaluate the effectiveness of pain management interventions and modify as indicated..." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure an antibiotic was administered according to physician orders, a resident received their medication, as ordered, during their respite stay at the facility, and ensure administration of a sedative/hypnotic medication as ordered by the physician for 1 of 1 resident reviewed for hospitalization, 1 of 1 resident reviewed for antibiotic use, and 1 of 3 closed records reviewed. (Resident G, Resident C, and Resident 40) Findings include: 1. The clinical record for Resident G was reviewed on 2/13/25 at 1:24 p.m. The diagnoses included, but were not limited to, sepsis and urinary tract infection (UTI). A care plan, dated 12/11/24, indicated Resident G was at risk for bladder incontinence related to a UTI. The approach included, but was not limited to, monitor for signs and symptoms of a UTI and administer medications as ordered. A physician order, dated 12/20/24, was noted for cefdinir (antibiotic) 300 milligrams (mg) twice a day for seven days related to a UTI. The medication administration record (MAR),	F 0755	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. F755 1. Residents G, C and 40 were affected. Resident C has discharged. Residents G and 40 medications have been reviewed, and all orders are up to date with	03/07/2025

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	dated December of 2024, indicated the cefdinir 300 mg tablets was signed off, twice a day, for eight days. A physician order, dated 1/28/25, was noted for cefdinir 300 mg twice a day for seven days related to a UTI. The MAR, dated January of 2025, indicated the cefdinir 300 mg tablets were signed off, twice a day, for eight days. 2. The clinical record for Resident C was reviewed on 2/13/25 at 2:38 p.m. The diagnoses included, but were not limited to, dementia, senile degeneration of the brain, pain, and Parkinson's disease. Resident C was admitted to the facility, on 10/4/24 at 10:09 a.m., for a respite stay and discharged home on 10/6/24 at 10:01 a.m. The MAR, dated October of 2024, indicated the following medications were listed as "unavailable": Depakote 125 mg on 10/4/24 in the evening and 10/5/24 in the morning and evening, ropinirole 2 mg on 10/5/24 at 11:00 a.m. to 1:30 p.m. and 10/5/24 at 6:00 p.m. to 10:00 p.m., Rytary (carbidopa-levodopa) 61.25-245 mg; three capsules; on 10/5/24 in the morning, afternoon, and evening, and trazodone 100 mg on 10/5/24 in the evening. There was no documentation in the electronic health record (EHR) to reflect that the physician was notified of the missed medication doses nor any attempt made to notify the pharmacy to follow up with medication delivery for Resident C. An interview was conducted with Licensed		all medications available for administration. No adverse effects noted. 2. All residents have the potential to be affected. EMAR compliance reviewed to ensure that all medications are available at this time. Staff nurses educated on appropriate methods to reorder medications. Education includes notification to provider and responsible party of any medications that are unavailable. Staff nurses educated on accurately transcribing orders to reflect the appropriate duration of administration. 3. As a measure of ongoing compliance, the DHS or designee will audit the EMAR compliance report on 5 residents 5 days a week x4 weeks, monthly x 3 months, then as needed thereafter. All antibiotic orders will be reviewed and confirmed by the DHS or designee for 4 weeks then as needed thereafter. 4. 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. The plan will be reviewed and updated as warranted.	

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	Practical Nurse (LPN) 2 on 2/13/25 at 8:30 a.m. She indicated that any physician orders inputted prior to 3:30 p.m. would be delivered by pharmacy the same day. The Director of Health Services was interviewed on 2/14/25 at 8:50 a.m. She indicated there was no policy regarding medication administration. 3. The clinical record for Resident 40 was reviewed on 2/14/25 at 1:05 p.m. The diagnoses included, but were not limited to, anxiety disorder, insomnia, and acute respiratory failure with hypoxia. A physician's order, dated 1/29/25, was noted for Ambien (zolpidem) (sedative/hypnotic medication) 10 milligrams (mg) once a day as needed (PRN) and was discontinued on 2/6/25. A physician's order, dated 2/6/25, was noted for Ambien (zolpidem) 5 mg PRN at bedtime for insomnia. Resident 40's EMAR (electronic medication administration record), dated February of 2025, showed, on 2/6/25 and 2/9/25, Ambien 5 mg was not administered. On 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, and 2/13/25, the documentation showed 5 mg of Ambien was administered. The Controlled drug use record was received by the Director of Health Services (DHS) on 2/14/25 at 2:50 p.m. The document indicated, on 2/10/25 through 2/13/25, Resident 40 was given 10 mg of Ambien instead of 5 mg as prescribed. During an interview on 2/14/25 at 2:50 p.m., the DHS indicated medication should be administered as ordered.			

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	This citation is related to Complaint IN00444990. 3.1-25(a) 3.1-25(b)(3) 3.1-25(b)(9) 3.1-25(e)(3)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to ensure a clinical rationale was provided for a decline of a gradual dose reduction of an antidepressant and antianxiety medication for 2 of 5 residents reviewed for unnecessary medications. (Resident 26 and Resident 30) Findings include: 1. The clinical record for Resident 30 was reviewed on 02/13/25 at 9:50 a.m. The diagnoses included, but were not limited to, other generalized epilepsy and epileptic syndromes (seizure disorder), major depressive disorder, agoraphobia with panic disorder (anxiety disorder characterized by fear of places or situations), and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 12/30/24, indicated Resident 30 showed no abnormal behaviors, and showed no abnormal depression or anxiety symptoms. A physician's order, dated 02/29/24, indicated clonazepam (a narcotic antianxiety medication) 1 mg (milligrams) three times a day scheduled, for agoraphobia with panic disorder. A physician's order, dated 11/10/24, indicated "Order Set Target Behavior- sweating, SOB	F 0756	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. F756 1. The Director of Health Services (DHS)or designee addressed pharmacy recommendations for residents 26 and 30 by reviewing with the Medical Director/NP and	03/07/2025

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	[shortness of breath], chest pain, trouble sleeping, irritability. At the end of each shift mark Frequency-how often behavior occurred & Intensity-how resident responded to redirection. Intensity Code: 0=Did Not Occur; 1=Easily Altered; 2=Difficult to Redirect." It had a frequency to be assessed three times per day on the eMAR (electronic medication administration record). A review of an eMAR behavior report, covering the dates 01/21/2025 - 02/13/2025, showed that a code of "0" was documented for every entry on every date, indicating that resident exhibited no anxious behaviors during that time period. A care plan for Psychotropic Drug Use, initiated 03/11/24, indicated "the resident was at risk for adverse consequences R/T [related to] receiving antianxiety medication for anxiety". It indicated "Attempt Gradual Dose Reduction [GDR] in two separate quarters (with at least one month between the attempts) during the first year the resident receives an anxiolytic [antianxiety] medication, then yearly, unless clinically contraindicated...Observe for drug use effectiveness and adverse consequences...." In an interview conducted with Certified Resident Care Associate (CRCA) 4, on 02/13/25 at 9:31 a.m., she indicated she had not noticed any symptoms of anxiety from Resident 30. A document titled "Pharmacist Drug Regimen Review", dated 08/29/24, indicated the following, " ...resident has an order for CLONAZEPAM 1MG TID [three times a day] FOR AGORAPHOBIA WITH PANIC DISORDER which is due for dosage reduction evaluation. Please evaluate s/sx [signs/symptoms] related to treatment and		executing any indicated orders. 2. To assess like residents, the DHS/Designee reviewed all pharmacy recommendations received in the last 30 days to ensure they were addressed by the physician in a timely manner. Any deficiencies noted were corrected at the time of the discovery. The provider provided a clinical rationale for any declined recommended gradual dose reductions. 3. To prevent recurrence, the Regional Clinical Support Nurse re-educated the DHS on the importance of ensuring the physician addresses pharmacy recommendations in a timely manner. 4. To ensure ongoing compliance, the DHS/Designee will audit 5 random pharmacy recommendations weekly to ensure the physician has addressed them timely, ensuring the provider has provided clinical rationale for any declined recommendations. This audit will occur for four weeks, monthly x 3 months, then randomly thereafter. 5. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance	

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	determine if GDR would be appropriate at this time. If GDR is clinically contraindicated, please document that the risks vs. benefits have been considered. Documentation related to clinically contraindicating a gradual dose reduction should include specific and individualized rationale for why the medication is medically necessary at the current dose..." The response from the physician indicated "Deny" and "Md - no changes at this time". A document titled "Pharmacist Drug Regimen Review", dated 09/25/24, indicated the following, "Response to pharmacy recommendation regarding GDR of CLONAZEPAM 1MG TID states 'no changes'. Please provide documentation to support rationale as to why a GDR is clinically contraindicated at this time. Thank you." No rationale or documentation was provided. A document titled "Pharmacist Drug Regimen Review", dated 02/03/25, indicated the following, "The resident had a recent fall. Please consider the following: Resident is due for a dose evaluation of Clonazepam 1mg TID. If this medication is continued as written, please document that the risk vs. benefits have been considered. Documentation related to clinically contraindicating a gradual dose reduction should include specific and individualized rationale for why the medication is medically necessary at the current dose." Response from physician indicated "Deny" and "Md - no changes at this time". In a review of physician progress notes, dated from 2/29/24 to 2/12/25, there was no rationale for continuance of clonazepam and/or contraindication to gradual dose reduction was documented or provided.		Improvement meetings. The plan will be reviewed and updated as warranted.	

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	In a progress note, created on 02/13/2025 at 2:28 p.m., the physician indicated, "pharmacy recs [recommendations] reviewed. i do not recommend decreasing clonazepam at this time due to his underlying seizure disorder. with his recent infections he is at high risk for break through seizure [sic]." In an interview with the Director of Health Services (DHS), on 02/13/25 at 1:20 p.m., she indicated that the resident had initially denied a psychiatry consultation. So, the facility physician had been managing his psychotropic medications. She indicated that they recently started working with a new psychiatric provider, and that "once [name of psychiatric provider] gets on board, the GDRs will start getting done." She indicated she and other nurse unit managers "take ownership" and print the GDR requests out, they do not put it in the physician communication binder, instead they sit down with him and discuss when he comes in to round. If he gives any new orders, she will put a progress note into the resident's chart then scan it to the medical record. She was unable to provide the physician's rationale for not doing a GDR. 2. The clinical record for Resident 26 was reviewed on 2/13/25 at 10:44 a.m. The diagnoses included, but were not limited to, chronic gout, anemia, diabetes mellitus, and dysphagia. A Quarterly MDS assessment, dated 12/5/24, indicated Resident 26 was cognitively intact, exhibited no behaviors, and received an antidepressant and antianxiety medication. A care plan for anti-depressant medication, revised 1/21/25, indicated Resident 26 was at risk of developing adverse effects from the use of anti-depressant medication. The approach			

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	included, but were not limited to, attempt a GDR in two separate quarters at least one month between the attempt(s) during the first year and then yearly, unless clinically contraindicated. A physician order, dated 8/10/23, indicated the use of venlafaxine capsule extended-release (ER) 75 milligrams (mg) daily. A physician order, dated 1/6/23, indicated the use of Wellbutrin 150 mg extended-release (ER) tablet daily. A resident progress note, dated 11/11/24, indicated the following, "...discussed resident for psych [psychiatric] medications. Reviewed medications and recent progress notes. Resident takes venlafaxine 75 mg, Wellbutrin XL 150 mg and diazepam 5 mg PRN for Meniere's disease. Resident diagnoses with depression... No behaviors charted for October and November...." A resident progress note, dated 12/20/24, indicated the following, "...discussed resident for psych medications... Resident diagnosed with depression. Nursing staff monitors side effects...." A pharmacy review, dated 1/28/25, indicated Resident 26 was receiving two anti-depressants: venlafaxine extended release (ER) 75 mg daily and Wellbutrin ER 150 mg daily. Resident 26 was due for dose reduction evaluations of the anti-depressant medication. If the anti-depressants were to be continued, as written, please document that the risk vs. benefits have been considered. Documentation to clinically contraindicate a GDR should include specific and individualized rationale for why the medication was medically necessary at the current dose. The form indicated the response to the			

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	recommendation was "deny" and the clinical contraindication was "No change per MD [medical doctor]". A resident progress note, dated 2/13/25 at 3:30 p.m., indicated the following, "...patient is evaluated on 1/28/25 fore [sic] pharmacy recs [recommendations]. i do not recommend decreasing Effexor and Wellbutrin at this time due to severe depression related to recent illness and overall decline." A facility policy entitled "Psychotropic Medication Usage and Gradual Dose Reductions", effective 10/09/17 and revised 12/17/24, was provided by the Executive Director on 2/13/25 at 12:00 p.m. The policy indicated the following, "1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record...3. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate. 4. A gradual dose reduction (GDR) will be attempted for two (2) separate quarters (with at least one month between attempts) per the physician's recommendation. Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated...6. Reviews of medication use will be conducted by the consultant pharmacist and will...notify the physician and the nursing staff whenever a psychotropic medication is due for review." 3.1-25(i)			
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to maintain infection control practices by not donning personal protective equipment (PPE) while providing activities of daily living (ADL) care for 1 of 1 randomly observed resident. (Resident 299). Findings include: The clinical record for Resident 299 was reviewed on 2/13/25 at 9:15 a.m. The diagnoses included, but were not limited to, encounter for orthopedic aftercare following surgical amputation, severe sepsis with septic shock, and dysphagia. A care plan for tube feeding, initiated on 2/5/25 and revised on 2/11/25, indicated Resident 299 required tube feeding related to dysphagia. The approaches indicated providing a diet as ordered, providing water flushes as ordered, and provide tube feedings as ordered. An observation was conducted of Resident 299's room on 2/11/25 at 11:30 a.m. On the outside of Resident 299's door was a sign stating Resident 299 was in Enhanced Barrier Precautions (EBP). The sign stated everyone must clean their hands before entering and when leaving the room. Providers and staff were to wear gloves and a gown for the following high contact resident care activities: - Providing hygiene, - Toileting assistance, and - Device care or use: central line, urinary catheter, feeding tube, and/or tracheostomy. An observation was conducted of Resident 299's	F 0880	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. F880 1. All residents were assessed by the DHS/designee for adverse effects related to employees not properly donning appropriate PPE upon entering a room with EBP. No adverse effects were noted. 2. The DHS/Designee provided training to staff providing high contact direct care to residents. The training included Enhanced Barrier Precautions and the appropriate use of PPE while caring for residents placed in	03/07/2025

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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	room on 02/13/25 at 08:50 a.m. A Certified Resident Care Associate (CRCA) came to the door and stated patient care was being performed. Resident 299 was lying on his left side. Both CRCAs were in the room and were providing care that consisted of perineal care after an episode of incontinence. The resident was incontinent of bowel and bladder and the CRCAs were assisting with perineal care. Each of the CRCAs were wearing gloves but no gowns. There was a cart with personal protective equipment (PPE) inside the door, to the left, and it was stocked with the appropriate PPE. An interview was conducted, on 2/14/25 at 3:30 p.m., with the Director of Health Services (DHS). She indicated the CRCA's should have been wearing the proper PPE. A policy entitled "Enhanced Barrier Precautions (EBP) Standard Operating Procedure (SOP)" was received by the Executive Director (ED) on 2/13/25 at 11:15 am. The policy indicated the following, " ... 1. Enhanced Barrier Precautions (EBP) will be in place during high-contact care activities for residents with the following conditions ... ii. All residents with chronic wounds, including but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous statis ulcers ... ii. All residents with indwelling medical devices ... Includes but not limited to: catheters, central lines, feeding tubes, tracheostomy tubes. A peripheral intravenous line is not considered an indwelling medical device for the purpose of EBP ... At Minimum, staff shall wear gloves and gown during high-contact care activities. May include face protection if splashes or sprays are anticipated during care ... High-contact care activities include but are not limited to: morning and evening ADL care, toileting, and showers.		EBP. 3. To ensure ongoing compliance the Director of Health Services will conduct weekly audits in which the DHS/Designee will visually observe staff members providing care in rooms on EBP to ensure they are donning and doffing PPE appropriately. These audits will be completed weekly for 4 weeks, monthly x 3 months, then as needed thereafter. 4. 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. The plan will be reviewed and updated as warranted.	

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	Includes transfers when bundled together with other high-contact activity which does not typically include transfers in common areas such as dining or activity rooms but would be included in therapy gym/treatment ...." 3.1-18(b)(2)			
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 Complaints IN00444990, IN00445166, IN00447250, and IN00452120. Survey dates: February 11, 12, 13, and 14, 2025 Facility number: 013635 Residential Census: 15 The 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 February 19, 2025.	R 0000		