| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155843 | A. BUILDING 00<br>B. WING | 05/17/2024 |

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| SPRINGS OF RICHMOND, THE | 400 INDUSTRIES ROAD<br>RICHMOND, IN 47374 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00425452, IN00431057, IN00433045 and IN00433665.<br><br>Complaint IN00425452 -- Federal/State deficiency related to the allegations is cited at F558.<br><br>Complaint IN00431057 -- No deficiencies related to the allegations are cited.<br><br>Complaint IN00433045 -- No deficiencies related to the allegations are cited.<br><br>Complaint IN00433665 -- Federal/State deficiency related to the allegations are cited at F656, F677 and F812.<br><br>Survey date: May 14, 15, 16 and 17, 2024<br><br>Facility number: 013635<br>Provider number: 155843<br>AIM number: 300026664<br><br>Census Bed Type:<br>SNF/NF: 7<br>SNF: 45<br>Residential: 12<br>Total: 64<br><br>Census Payor Type:<br>Medicare: 41<br>Medicaid: 7<br>Other: 4<br>Total: 52<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. | F 0000 | Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Investigation of Complaints: 425452, 433045, 431057, 433665.<br>Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 9, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. | |

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

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| | Quality review completed on May 22, 2024 | | | |
| F 0558 SS=D Bldg. 00 | 483.10(e)(3)<br>Reasonable Accommodations Needs/Preferences<br>Based on interview and record review, the facility failed to promptly respond to call light requests for assistance for 2 of 3 residents reviewed for timely response to call lights. (Resident B and M)<br><br>Findings include:<br><br>A. The clinical record of Resident B was reviewed on 5-15-24 at 10:29 a.m. Her diagnoses included, but were not limited to, falls, metabolic encephalopathy, recent urinary tract infection and Alzheimer's disease. Her most recent Minimum Data Set assessment, dated 12-15-23, indicated she was severely cognitively impaired, required substantial assistance with meals and was dependent for assistance with bathing, hygiene, toileting and the use of a wheelchair for mobility.<br><br>In an interview with a family member on 5-16-24 at 9:10 a.m., the family member indicated during a visit with Resident B, she observed Resident B was in need of toileting assistance and clean up. "One day, I turned on [name of Resident B]'s call light for help. A nurse was across the hall and said someone would be with me shortly. Still, no one came for over 30 minutes. Someone finally came in and brought in a meal for her and we were able to get her cleaned up then. She had to sit in a mess for some time because of this and that is not right."<br><br>B. The clinical record of Resident M was reviewed on 5-16-24 at 9:58 a.m. His diagnoses included, but were not limited to, pressure ulcers | F 0558 | **F 558 Reasonable Accommodations Needs/Preferences**<br>**1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Residents B and M were affected. No adverse effects noted. Rounding implemented to ensure call lights are answered timely.<br>**2. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected. Rounding completed on all residents to ensure staff are responding to call lights. DHS or designee to educate staff on the Guidelines for Answering Call Lights.<br>**3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** As a measure of ongoing compliance, the DHS or designee will perform call light audits on 5 residents weekly x4 weeks, then every other week x2 months, then monthly x3 months. | 06/09/2024 |

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| | and osteomyelitis. His most recent Minimum Data Set assessment, dated 3-1-24, indicated he was cognitively intact.<br><br>In an interview with Resident M on 5-15-24 at 9:34 a.m., he indicated he uses his call light frequently as he is bedbound. He indicated the response time can vary from a few minutes to an hour, depending on staffing availability. He added, for him, it negatively impacts him by causing him to have incontinence episodes when it takes a long time for the call light to be answered, which causes him to feel very uncomfortable and "can be embarrassing; it's bad enough having to wear a diaper."<br><br>In an interview with the Executive Director on 5-17-24 at 2:40 p.m., he indicated his goal for call light response time is under 20 minutes.<br><br>On 5-17-24 at 2:40 p.m., the Executive Director provided a copy of a policy entitled, "Guidelines for Answering Call Lights," with a review date of 12-31-23. This policy indicated, "To respond to the resident's request and needs... Answer the resident's call light as quickly as possible."<br><br>This Federal tag relates to Complaint IN00425452.<br><br>3.1-3(v)(1) | | **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. | |
| F 0656 SS=D Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br><br>Based on interview and record review, the facility failed to develop and implement a care plan for bathing preferences for 1 of 1 residents reviewed for bathing preferences. (Resident H)<br><br>Findings include: | F 0656 | **F 656 Develop/Implement Comprehensive Care Plan**<br>**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient** | 06/09/2024 |

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| | The clinical record of Resident H was reviewed on 5-17-24 at 10:07 a.m. It indicated her diagnoses included, but were not limited to atherosclerotic heart disease, cerebral ischemic, age-related physical debility, adult failure to thrive and unspecified dementia. Her most recent Minimum Data Set (MDS) assessment, dated 4-15-24, indicated she was moderately cognitively intact, had unclear speech, sometimes she understood what was said and sometimes could be understood, was nonambulatory and required a wheelchair for mobility and was dependent for hygiene care and services. It indicated she was frequently incontinent of bowel and bladder.<br><br>In an observation and interview with Resident H on 5-16-24 at 3:45 p.m., she was unable to recall how long she had been at the facility. She indicated she receives showers, but was unsure of the frequency of this and an occasional partial bed bath at unknown frequency. At the time of the interview, she appeared clean and without unpleasant odors.<br><br>In an interview on 5-17-24 at 1:10 p.m. with the Executive Director (ED), he indicated the facility "had received some feedback from family about [name of Resident H] not getting bathed as often as she should have been been. The ED indicated Resident H preferred to have a bed bath, not a shower because that is what her husband did at home for her.<br><br>A review of Resident H's care plans for bathing preferences was not located, specific to preferring a bed bath and not to receive a shower. A care plan, dated 1-26-24, indicated she was to receive a shower on Tuesdays, Thursdays and Saturdays. | | **practice?** Resident H has no adverse effects. Resident H's care plan for bathing was updated to reflect bathing preference.<br>**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected. MDS Coordinator educated to ensure care plans per the "Comprehensive Care Plan Guideline" policy. Whole house audit completed to ensure bathing preference present on care plans.<br>**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** As a measure of ongoing compliance, the Assessment Support Nurse or designee will conduct an audit of five residents (as available) for accurate bathing preference weekly x4 weeks, then twice per month x2 months, then monthly x3 months.<br><br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the | |

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| | In an interview on 5-17-24 at 1:40 p.m., with the Corporate MDS Staff, she indicated she was unable to locate a care plan referring to bathing preferences.<br><br>On 5-17-24 at 2:40 p.m., the ED provided a copy of a policy entitled, "Comprehensive Care Plan Guideline," with a revision date of 5-22-18. This policy indicated the purpose of the policy as, "To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines." It continued, "Pertinent care plan approaches are communicated to the nursing staff per the 24-hour CRCA [aide] assignment or the care tracker profile dependent on campus preference...Comprehensive care plans need to remain accurate and current."<br><br>This Federal tag relates to Complaint IN00433665.<br><br>3.1-35(a)<br>3.1-35(b)(1) | | campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation. | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br><br>Based on interview and record review, the facility failed to ensure a dependent resident received bathing and hygiene care and services on a routine basis, for 1 of 5 residents reviewed for activities of daily living (ADL), specific to hygiene care and services. (Resident H)<br><br>Findings include:<br><br>The clinical record of Resident H was reviewed on 5-17-24 at 10:07 a.m. It indicated her diagnoses included, but were not limited to atherosclerotic | F 0677 | **F 667 ADL Care Provided for Dependent Residents**<br>**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident H received bathing per her preference.<br>**2: How other residents having the potential to be affected by the same deficient practice will be identified and what** | 06/09/2024 |

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| | heart disease, cerebral ischemic, age-related physical debility, adult failure to thrive and unspecified dementia. Her most recent Minimum Data Set (MDS) assessment, dated 4-15-24, indicated she was moderately cognitively intact, had unclear speech, sometimes she understood what was said and sometimes could be understood, was nonambulatory and required a wheelchair for mobility and was dependent for hygiene care and services. It indicated she was frequently incontinent of bowel and bladder.<br><br>In an observation and interview with Resident H on 5-16-24 at 3:45 p.m., she was unable to recall how long she had been at the facility. She indicated she receives showers, but was unsure of the frequency of this and an occasional partial bed bath at unknown frequency. Her speech was of a halting nature and somewhat slurred while seeming to search for words. At the time of the interview, she appeared clean and without unpleasant odors.<br><br>A review of Resident H's care plans for ADL care, dated 1-26-24, indicated she was to receive a shower on Tuesdays, Thursdays and Saturdays.<br><br>A review of her bathing and hygiene records for 4-1-24 to 5-16-24, indicated she had received no showers during this time period and a total of 8 complete bed baths on an irregular basis for April and 3 complete bed baths for 16 days of May, 2024. A lack of documentation of any type of bathing or hygiene services was identified for April, 2024, on 5, 6, 7, 8, 9, 12, 14, 16, 20, 21, 24, 24, 27 and 30. A lack of documentation of any type of bathing was identified for May, 2024, on 1, 3, 6, 7 and 16.<br><br>In an interview on 5-17-24 at 1:10 p.m. with the | | **corrective action will be taken.**<br>All resident who are dependent or rely on staff to assist with bathing have the potential to be affected by the alleged deficient practice. DHS or designee will educate nursing staff related to the Guidelines for Bathing Preference.<br><br>**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>DHS or designee will be responsible for auditing 5 random residents to ensure bathing is occurring per their preference. Audits will be conducted weekly x4 weeks, every two weeks x 4 weeks, then monthly x 4 months.<br><br>**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?**<br>For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure | |

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| | Executive Director (ED), he indicated the facility "had received some feedback from family about [name of Resident H] not getting bathed as often as she should have been been. She preferred to have a bed bath, not a shower because that is what her husband did at home for her. It looks like we haven't done as good of a job as we should have recently from looking at the documentation."<br><br>This Federal tag relates to Complaint IN00433665.<br><br>3.1-38(a)(3)(A)<br>3.1-38(a)(3)(B)<br>3.1-38(b)(2) | | compliance with this regulation. | |
| F 0812 SS=F Bldg. 00 | 483.60(i)(1)(2)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>Based on observation, interview and record review, the facility failed to ensure:<br>1. 1. Food products held in the refrigerator for re-use were properly dated for date placed in the refrigerator and date to be used by.<br>2. The bin covers for the flour and sugar containers were closed.<br>3. Refrigerator and freezer temperatures were documented on facility forms routinely.<br>4. Manual ware washing logs were documented on facility forms routinely.<br>These deficient practices have the potential to adversely affect 64 of the 65 residents who receive foods from the dietary department.<br><br>Findings include:<br><br>1. During a tour of the walk-in cooler (refrigerator) with the Dietary Manager on 5-14-24 at 1:55 p.m., she indicated any leftovers are to be discarded after 3 days. The following observations were | F 0812 | **F 812 Food Procurement, Store/Prepare/Serve-Sanitary**<br>**1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were negatively affected. No adverse effects noted. We immidiately ensured all food in the kitchen was labeled, covered and dated properly with all expired items being discarded, flour containers were covered, fridge and freezer temps were taken within normal limits. 3 compartment sink was tested for correct sanitation PPM<br>**2. Identification of other residents having the potential to be affected by the same alleged deficient practice and** | 06/09/2024 |

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| | made:<br>-container of chicken, with preparation date of 5-10-24, with no discard date was present.<br>-container of chicken pot pie mixture with label of preparation on 5-1-24 and to discard 5-3-24 was present.<br>-cheese sauce with label of preparation on 5-2-24 and use by date of 5-5-24 was present.<br>-container of macaroni and cheese with preparation date of 5-9-24, with no discard date was present.<br>-container of meat sauce with a preparation date of 5-4-24 and discard date of 5-10-24 was present.<br>-container of tomato sauce with a preparation date of 5-4-24 and with no discard date was present.<br>-container of ham with a labeled date for use as 4-29-24 to 5-29-24 was present. The Dietary Manager indicated, "these dates are wrong."<br>-container of BBQ ribs with a label date of 5-9-24 was present. The label did not indicate if the date cited was the date of preparation or discard date.<br>-container of salmon patties that was unlabelled was present.<br>--container of brussell sprouts with a label of dates, "5-2-24 - 5-4-24," was present.<br>-container of sliced tomatoes with a date of 5-9-24 was present. The label did not indicate if the date cited was the date of preparation or discard date.<br>-A food cart was in the walk-in fridge with trays of bowls of fruit which were undated and uncovered. The Dietary Manager indicated the fruit was prepared for the evening meal and should have been covered.<br><br>In the stand up refrigerator, on 5-14-24 at 1:45 p.m., an opened block of 1 pound of butter with the cut end unwrapped/uncovered was present and a bowl of butter balls was observed partially uncovered with clear wrap | | **corrective actions taken**: All residents have the potential to be affected. Rounding completed by DFS in kitchen to ensure that fridge temperatures are logged twice daily and within normal limits, PPM in the 3 compartment sink concentration is within normal limits, and food is labeled, dated, and covered correctly. Staff education also provided on proper label and dating, fridge temperature logs, and PPM 3 compartment sink logs<br>**3. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** As a measure of ongoing compliance, the DFS or designee will audit food labeling and dating, fridge temperature logs, and PPM logs for the 3 compartment sink 5 times a week x 4 weeks. weekly x4 weeks, then every other week x2 months, then monthly x3 months. **4. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** For quality assurance, the ED or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure | |

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| | 2. On 5-14-24 at 1:50 p.m., a flour bin and a sugar bin had their lids open. No staff were observed in this area of the kitchen at that time.<br><br>3. 5-17-24 at 9:40 a.m., a record review for the dietary logs for 3-1-24 to 5-16-24 was conducted. The logs included documentation of the refrigerator and freezer temperatures. Various forms were used by dietary staff to record temperatures of refrigerators and freezers. Some of the forms listed only the temperatures for a singular freezer. Those dates were on 3-17-24, 4-7-24, 4-12-24, 4-17-24, 4-25-24, 4-27-24, 4-28-24, 4-29-24 and 4-30-24. In an interview with the the Dietary Manager on 5-17-24 at 12:50 p.m., she indicated the kitchen has two freezers. On 5-5-24, 5-6-24 and 5-7-24, there were no temperatures for refrigerators or freezers documented for evening time.<br><br>The only facility-provided thermometer for the refrigerators or freezers was observed to be located in the walk-in freezer. In an interview with the Dietary Manager on 5-14-24 at 1:55 p.m., she indicated the walk-in freezer has the only thermometer she has located.<br><br>4. The logs included documentation of the manual ware washing concentrations to ensure sanitation levels for hand-washed items used in the kitchen. There was a lack of documentation of the "manual ware washing concentration," from 3-1-24 through 4-30-24, with additional lack of documentation for this on 5-4-24, 5-5-24, 5-6-24 and 5-7-24<br><br>In an interview on 5-17-24 at p.m., with the Corporate Nurse, she indicated as of 5-17-24, the kitchen currently serves meals/food to 64 residents out of total of 65 residents. | | compliance with this regulation. | |

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| | In an interview on 5-14-24 at 2:05 p.m., with the Dietary Manager, she indicated she began position as Director of Food Service in January, 2024, but with trainings, did not begin working in the position until a month or so later. Indicated she has been actively working on getting more staff and training of staff. Issues she has identified have included, but not limited to, following recipes, maintaining general cleaning and time management. She indicated currently her dietary staff only has 2 or 3 staff members that have been working in the facility for more than 6 months. She indicated some of the temperature logs have not been maintained as well as she would prefer to have done. She indicated the cooks are responsible for checking the coolers for leftovers and to make sure the items are not outdated every day. "By looking at the number of outdated leftovers, that obviously has not been happening. I have to accept responsibility for this as well since I am the dietary manager."<br><br>On 5-14-24 at 4:08 p.m., the Corporate Nurse provided a copy of a policy entitled, "Food Labeling and Dating Policy, " with a review date of 3-18-19. This policy indicated, "Any food product removed from its original container, has a broken seal, has been processed in any way must have a label that contains the following: Item Name, Date and Time the food was labeled, Use by date, Initials of the person labeling the item, Securely cover the food item."<br><br>On 5-14-24 at 4:42 p.m., the Corporate Nurse provided a copy of a policy entitled, "Storage Procedures," with an effective date of 5-31-16. This policy indicated, "Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance...Dry bulk | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155843 | A. BUILDING 00<br>B. WING | 05/17/2024 |

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

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| | foods are stored in plastic containers with tight covers or bins...Thermometers are placed in every refrigeration unit so as to be easily visible for checking and in the upper third part of the front of the storage unit. Temperatures will be recorded on the Refrigerator Log at least twice a day...Food items are to be arranged so that older items will be used first. Frozen storage temperatures will be at 0 [degrees] F [Fahrenheit] or below. Thermometers are placed in every freezer unit to be easily visible for checking and in the upper third part of the front of the storage unit. Temperatures will be recorded on the Freezer Temperature Log twice a day."<br><br>The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004) indicates any food substances prepared or held for use for more than 24 hours "shall be clearly marked to indicate the date or day by which the food shall be consumed..." This information can be found at 410 IAC 7-24-191(a).<br><br>The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004) indicates, any food substances which have been removed from their original packaging, "shall be protected from contamination by storing the food..."in a clean, dry location. Where it is not exposed to splash, dust , or other contamination..." This information can be found at 410 IAC 7-24-177(a).<br><br>The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004) indicates foods that are to be cooled or refrigerated should be maintained at 41 degrees or less. This information can be found at 410 IAC 7-24-187(a)(2)(A). Foods that are to be frozen should be maintained at 0 (zero) degrees or less and can be | | | |

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| | found at at 410 IAC 7-24-197(a). Thermometers are indicated to be provided and readily accessible for use in ensuring , attaining and maintaining food temperatures. This information can be found at 410 IAC 7-24-257(a).<br><br>The current "Retail Food Establishment Sanitation Requirements" manual for Indiana (2004) indicates manual warewashing sanitizing should utilize a testing kit or device to accurately measure the concentration in parts per million (ppm) of the sanitizing solution. This information can be found at 410 IAC 7-24-29(a).<br><br>This Federal tag relates to Complaint IN00433665.<br><br>3.1-21(i)(2)<br>3.1-21(i)(3) | | | |