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	06/04/2025

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	This visit was for the Investigation of Complaints IN00459458, IN00459544, IN00460139, IN00460166, and IN00460478. Complaint IN00459458 -- Federal/State deficiencies related to the allegations are cited at F550, F684 and F755. Complaint IN00459544 -- Federal/State deficiencies related to the allegations are cited at F550, F554, F755 and F842. Complaint IN00460139 -- Federal/State deficiency related to the allegations is cited at F684. Complaint IN00460166 -- Federal/State deficiency related to the allegations is cited at F550. Complaint IN00460478 -- No deficiencies related to the allegations are cited. Survey date: June 2, 3 and 4, 2025 Facility number: 013635 Provider number: 155843 AIM number: 300026664 Census Bed Type: SNF/NF: 7 SNF: 45 Residential: 15 Total: 67 Census Payor Type: Medicare: 41 Medicaid: 7 Other: 4	F 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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	Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 10, 2025.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to promote the dignity of 2 of 3 residents reviewed for the need of assistance. (Resident B and Resident C) Findings include: 1. The clinical record for Resident C was reviewed on 6/3/2025 at 11:40 a.m. Medical diagnosis included infection to the left knee related to internal prosthetic. A nursing admission assessment, dated 5/12/2025, indicated Resident C was alert and oriented to person, place, time, and situation. During an interview on 6/2/2025 at 12:45 p.m., Resident C indicated he was unable to get assistance while he was at the facility. Resident C stated, "I hit my call light one time and told the CNA [Certified Nurse Aide] what I needed, but it was over two hours before someone came back. I ended up hitting my call light again and waited 45 minutes before someone answered it. I am used to not needing anyone to help me. I felt helpless having to ask multiple times, and having to wait so long made it even worse ..." During an interview on 6/3/2025 at 11:30 p.m.,	F 0550	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #B and C have been discharged. **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 interviews or assessments of all residents to assess if any residents were affected. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will educate staff on call light policy and response times. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 3 residents will be conducted by the DHS or designee 3 times per	06/13/2025

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	CRCA (Certified Resident Care Associate) 17 indicated staffing in the building was "bad". She routinely had 37 patients to herself, and she cannot get things done. When asked if she was able to get routine care done, like passing ice water and providing showers, she indicated, " ...that is the least of my worries. No, I cannot get them done all the time, but I am also not able to get my call lights answered as quickly as I like. There have been times that residents tell me their lights are on for thirty minutes or more, and these are long term care residents, they know when it is just me over there, but I am only one person. There are some residents which I need the nurse to help me with, leaving no one to answer lights or help with other residents ..." 2. The clinical record of Resident B was reviewed on 6-2-25 at 10:30 a.m. Her diagnoses included, but were not limited to, aftercare following joint replacement surgery, cerebral ischemia and hypertensive heart disease. Her admission Minimum Data Set assessment, dated 3-26-25, indicated she was cognitively intact. In an interview with Resident B, on 6-2-25 at 4:04 p.m., she indicated the response time for her call light to be responded to "varied from a few minutes up to 45 minutes; usually well over 15 minutes. I had nothing to do other than watch the clock to see how long it took. I am at an age that when I need to use the bathroom, it is immediate. Having to wait for someone to come and help can be very uncomfortable." In an interview with the Corporate Nurse, on 6-4-25 at 2:25 p.m., he indicated it was hard to put a numeric value on call light response time, as there are multiple variables, such as the volume of call lights, the circumstances of what each resident's care needs were and the situation of the		week for 4 weeks, then twice weekly for 4 weeks then once weekly for 4 weeks to ensure compliance: 1). Call light response The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	floor in general. "If I were to put a numeric value, the goal would be to respond in under 15 or 20 minutes." On 6-4-25 at 2:11 p.m., the Corporate Nurse provided a copy of policy with a review date of 12-17-24, and entitled, "Guidelines for Answering Call Lights." This policy indicated its purpose as, "To respond to the resident's request and needs." It indicated, "Answer the call light as quickly as possible." This citation relates to Complaints IN00459458, IN00459544, and IN00460166. 3.1-3(t)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on interview and record review, the facility failed to assess a resident for safe self-administration of medication for 1 of 3 residents reviewed for medication compliance. (Resident C) Findings include: The clinical record for Resident C was reviewed on 6/3/2025 at 11:40 a.m. Medical diagnosis included infection to the left knee related to internal prosthetic. A nursing admission assessment, dated 5/12/2025, indicated Resident C was alert and oriented to person, place, time, and situation. A nursing progress note, dated 5/12/2025, indicated Resident C's son brought in his home	F 0554	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #C have been discharged. **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 an audit of all residents that self administer medications. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will educate nurses on	06/13/2025

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	medications for tonight's dosage and his intravenous antibiotic. Resident C and his son " ...administered dose ..." and Resident C " ...took all medications including narcotics from home ..." Review of the clinical record did not indicate a Self-Administration of Medication assessment was completed or a physician order to reflect such. During an interview on 6/2/2025 at 12:45 p.m., Resident C indicated while he was at the facility, the facility did not have his medication when he admitted so he had to have his son bring in his medication the night of admission. He stated his pain was, "out of control, a 10/10 ... I had my son bring in my medications and took my oxys [oxycodone] ...I take three [oxycodone]..." During an interview on 6/2/2025 at 10:52 p.m., Licensed Practical Nurse (LPN) 19 indicated she took care of Resident C while he was here. Resident C was a " ...very frustrated person ...and he was agitated ..." The night Resident C was admitted, he had his son bring in his medication, and LPN 19 went to the bedside, where she witnessed Resident C remove pills from a "vial". When asked to elaborate, she indicated a container with multiple unlabeled medications. She then had Resident C verify the medications, and she checked them against the physician orders. When asked how she was able to verify what the medications were, she stated she couldn't, but just " ...had the resident verbally tell me since he [Resident C] knew his medications ..." When asked if she completed a self-administration of medication assessment, she stated she had not and she was unsure of the self-administration of medication policy within the building because she was " ...new ..."		medication self administration policy **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 3 residents will be conducted by the DHS or designee 3 times per week for 4 weeks, then twice weekly for 4 weeks then once weekly for 4 weeks to ensure compliance: 1). Self administration of medication. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	During an interview on 6/4/2025 at 1:55 p.m., LPN 20 indicated when a resident brings in medications from home, they were to be in the original pill bottles from the outside pharmacy with "...the correct name, label, and cannot be expired..." The nursing staff will then verify the medication by what was on the bottle. Medications were to be counted, and a medication slip filled out in front of the resident to verify the number of medications. LPN 20 admitted Resident C and stated she "...did not complete a Self-Administration assessment..." A policy entitled, "Guidelines for Safe Self-Administration of Medications," was provided by the Corporate Nurse on 6/3/2025 at 2:45 p.m. The policy indicated, "...Residents requesting to self-medicate or has self-medication as a part of their place of care shall be assessed using the observation Trilogy- Self Administration of Medication within the electronic health record..." This citation relates to Complaint IN00459544. 3.1-11(a)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to timely follow up on hemolyzed lab results for a resident at risk for complications related to a cancer diagnosis for 1 of 3 residents reviewed for laboratory services. This deficient practice resulted in hospitalization for treatment of acute on chronic anemia with the need for multiple transfusions of blood products. (Resident D) Findings include:	F 0684	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #D have been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and**	06/05/2025

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	The clinical record for Resident D was reviewed on 6/3/2025 at 1:43 p.m. The medical diagnoses included malignant melanoma and encephalopathy. An Admission Minimum Data Set assessment, dated 4/24/2025, indicated Resident D was cognitively impaired. A care plan for Resident D addressing his cancer diagnosis, revised 4/21/2025, included providing interventions as ordered and to include Resident D in care decisions. A care plan for Resident D addressing his potential for bleeding, revised 4/28/2025, indicated Resident D was at risk for bleeding and to monitor laboratory results as ordered. A physician order, dated 4/21/2025, indicated Resident D to have weekly laboratory tests, including a complete blood count, completed and faxed to his oncologist [Oncologist 13]. Per the National Health Institute in a June 8, 2024, publication entitled, "Normal and Abnormal Complete Blood Count with Differential", a complete blood count (CBC) is a laboratory blood test which monitors red blood cells, including hematocrit and hemoglobin, white blood cells, and platelets. A laboratory result, dated 4/28/2025, indicated Resident D had a hemoglobin of 7.2, which was indicated as "low." The Administration Record for Resident D indicated a CBC was completed on 5/5/2025.		**corrective actions taken**: DHS or Designee will complete an audit of all lab orders for prior 7 days to ensure all lab orders were addressed appropriately. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will educate nurses on lab procedures and appropriate notifications. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 3 residents will be conducted by the DHS or designee 3 times per week for 4 weeks, then twice weekly for 4 weeks then once weekly for 4 weeks to ensure compliance: 1). Labs ordered and results. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. Facility request IDR on this citation due to the labs originally being rejected and then reobtained in a timely manner according to	

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	A laboratory report, entitled "Rejected Labs", was ran on 6/4/2025 at 1:09 p.m. The report indicated Resident D's labs from 5/5/2025 were appraised on 5/6/2025. The labs were noted to be hemolyzed with text to, "... please enter a new order and recollect." Per the Center for Disease Control in an April 24, 2024, publication entitled, "Reference Tool to Determine Hemolysis Status", hemolyzed samples are samples which have hemolyzed, or red blood cells have been observed to be broken down, which may lead to inaccurate lab results. Review of progress notes did not address the 5/5/205 hemolyzed laboratory results. A nursing progress note, dated 5/9/2025, indicated obtaining a CBC for Resident D related to confusion. A laboratory result, dated 5/9/2025, indicated Resident D had a hemoglobin of 5.5, indicated as "critical", with the results called into the Nurse Practitioner. A nursing progress note, dated 5/9/2025, indicated Resident D was transferred to the emergency room for a critical hemoglobin result. Hospital documentation, dated for a day of 5/9/2025 through 5/21/2025, indicated Resident D was admitted through the emergency department with a critically low hemoglobin on 5/9/2025. During Resident D's hospital stay, Resident D received transfusions to treat acute on chronic anemia. During an interview with Family Member 12, on 6/2/2025 at 11:35 a.m., Family Member 12 indicated		the physician. The physician also states that the hospitalization was not a result of the lab itself.	

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	Resident D was at the facility for care, including management of his cancer diagnosis. Family Member 12 stated the facility, "...did not monitor [Resident D's] labs. A few days before Resident D went to the hospital, he was so out of it, and we [Resident D's family] kept telling the nurses, but no one seemed to care. One of the nurses told [Family Member 14] that Resident D's body was just shutting down. Come to find out, they were not even doing his labs, his oncologist [Oncologist 13] told me they had not received any labs for a week prior to his hospitalization..." During an interview with Oncologist 13's office manager on 6/5/2025 at 1:55 p.m., Office Manager 15 indicated they had not received any CBC results from the facility regarding Resident D between May 5th and May 9th, 2025, nor did they give the order to not redraw lab results. During an interview with Corporate Nurse on 6/4/2025 at 2:10 p.m., he indicated they did not have a specific policy for hemolyzed samples. Routine labs were usually sent through their facility's laboratory results, such as Resident D's labs that were drawn on 5/5/2025, and those results were then integrated into the system. It was the responsibility of the interdisciplinary team to review the results; the nursing staff would redraw the lab and/or reach out to the provider. During an interview with the Director of Nursing on 6/4/2025 at 2:27 p.m., she indicated she was unsure why the labs were not redrawn or if a provider was notified about the laboratory results. This citation relates to Complaint IN00459458 and IN00460139. 3.1-37(a)			

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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 1 of 4 residents reviewed for accurate and timely receipt of medications, received their medications as ordered by their physician. (Resident B) Findings include: In an interview with Resident B on 6-2-25 at 4:04 p.m., she indicated she kept track of the medications received while she was a resident of the facility. She indicated several days before she discharged from the facility, "I got to feeling real dizzy in the afternoon, and realized no one had given me my morning meds, which included several BP [blood pressure] pills." She did not indicate she had made the facility aware of this at the time of occurrence. In an interview with the Executive Director (ED) on 6-4-25 at 11:05 a.m., he indicated on the date of Resident B's discharge from the facility, 5-6-25, the facility learned of a medication error in which Registered Nurse (RN) 3 had not administered Resident B's morning medications on 5-1-25. In a second interview on 6-4-25 at 1:02 p.m., with the ED, he reiterated the facility did not learn of this until 5-6-25. He added the resident, nor her family member, mentioned any negative impacts the lack of medications caused. A review of the medication administration record (MAR), for 5-1-25, for Resident B indicated the following medications were designated as "Not Administered: Resident Unavailable": -amlodipine 5 mg (milligrams) once daily (for high	F 0755	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #B have been discharged. **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 an audit of all medications not administered for the prior 14 days to ensure no other residents were affected. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will educate nurses on appropriate medication administration **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 3 residents will be conducted by the DHS or designee 3 times per week for 4 weeks, then twice weekly for 4 weeks then once weekly for 4 weeks to ensure compliance: 1). Medication administration.	06/13/2025

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	blood pressure), -aspirin 81 mg once daily (a nonsteroidal anti-inflammatory medication which also has an anti-platelet effect, sometimes used for prevention of blood clots and reducing the risk of heart attacks or strokes), -biotin 1 mg once daily (supplement), -citalopram 20 mg once daily (for depression), -isosorbide extended release 60 mg once daily (for angina), -metformin 500 mg twice daily (for diabetes), and -metoprolol tartrate 25 mg twice daily (for high blood pressure). In an interview with the ED on 6-4-25 at 1:02 p.m., he indicated RN 3 was a relatively new staff member and that he, the Director of Nursing, the Assistant Director of Nursing had each checked in with RN 3 at least twice on 5-1-25, to see if she had any questions, concerns or needed assistance. He indicated RN 3 did not indicate she was encountering any problems or concerns at that time. The ED indicated he could see where it might have been difficult to locate this resident at that point in her stay, as she was involved in therapy services and very involved in the activities of the building. "But we could have helped her locate the resident." The clinical record of Resident B was reviewed on 6-2-25 at 10:30 a.m. Her diagnoses included, but were not limited to, aftercare following joint replacement surgery, cerebral ischemia and hypertensive heart disease. Her admission Minimum Data Set assessment, dated 3-26-25, indicated she was cognitively intact. A review of the progress notes indicated a late entry dated, 5-6-25, for 5-2-25 (sic), indicated Resident B had a "missed am [morning] med		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	administration," due to the resident was unavailable, and the nurse practitioner had been informed of this with no new orders received. In an interview with the Corporate Nurse on 6-4-25 at 2:25 p.m., he indicated if a resident does not receive their medications, ideally the nursing staff should let their supervisor know what was going on to see if the supervisor can offer any help. Additionally, the staff member should let the medical provider know the resident did not receive their medications, as well as notification to the resident if they were able to comprehend or that resident's responsible party. This citation relates to Complaints IN00459458 and IN00459544. 3.1-25(a) 3.1-25(b)(9)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to accurately reflect the behaviors, including refusal of care and verbal aggression, for 1 of 5 residents reviewed for abuse. (Resident C) Findings include: The clinical record for Resident C was reviewed on 6/3/2025 at 11:40 a.m. Medical diagnosis included infection to the left knee related to internal prosthetic. A nursing admission assessment, dated 5/12/2025, indicated Resident C was alert and oriented to	F 0842	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #C have been discharged. **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 an audit of all residents with behaviors to ensure accurate documentation. **Measures put in place and**	06/13/2025

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	06/04/2025

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
	person, place, time, and situation. During an interview on 6/2/2025 at 12:45 p.m., Resident C indicated while he was at the facility, two staff came into his room before he left. One of them, he believes was a nurse, kept trying to change the wound dressing on his leg. He had to tell her twice to leave him alone before he kicked her out of his room. He had his son pick him up and he left against medical advice. During an interview on 6/2/2025 at 10:52 p.m., Licensed Practical Nurse (LPN) 19 indicated she took care of Resident C while he was here. Resident C was a " ...very frustrated person ...and he was agitated ..." During an interview on 6/2/2025 at 11:12 p.m., Certified Resident Care Associate (CRCA) 18 indicated she went into Resident C's room one time during his stay with the QMA (Qualified Medication Aide) on duty. When the staff were in the room, Resident C " ...cussed them out ... and refused to let me empty his full urinal because he said he was leaving and going to pour it on the floor when he was going ..." During an interview on 6/4/2025 at 1:55 p.m., LPN 20 indicated Resident C was resistive to assistance, cussed at her, "fought everything we tried", and "kicked" her out of his room. Review of the medical record did not indicate documentation of these refusals of care or verbally aggressive behaviors. During an interview on 6/4/2025 at 2:35 p.m., Corporate Nurse indicated they did not have a specific policy for documenting behaviors, but it would be the expectation refusals of care would		**systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will educate nurses on appropriate documentation of resident behaviors. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 3 residents will be conducted by the DHS or designee 3 times per week for 4 weeks, then twice weekly for 4 weeks then once weekly for 4 weeks to ensure compliance: 1). Resident behaviors The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	be documented in the chart. This citation relates to Complaint IN00459544. 3.1-50(a)(1) 3.1-50(a)(2)			