STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155829	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 3, 4, 5, 6, 9 and 10, 2024. Facility number: 013499 Provider number: 155829 AIM number: 201285490 Census Bed Type: SNF/NF: 21 SNF: 18 Residential: 35 Total: 74 Census Payor Type: Medicare: 15 Medicaid: 21 Other: 3 Total: 39 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 16, 2024.	F 0000	The Springs of Lafayette Health Campus Plan of Correction 2024 The submission of this plan of correction does not indicate an admission by The Springs of Lafayette Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Springs of Lafayette Health Campus. 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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to contact the resident's representative regarding a fall for 1 of 1 resident reviewed for notification. (Resident 25) The deficient practice was corrected on 2/21/24, prior to the start of the survey, and therefore was past noncompliance.	F 0580	PNC was granted- No POC required.	09/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Thompson		09/26/2024

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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	Finding includes: During an interview, on 9/4/24 at 12:24 p.m., Resident 25's representative indicated she was not aware of a fall on 2/1/24. The clinical record for Resident 25 was reviewed on 9/6/24 at 2:58 p.m. The diagnoses included, but were not limited to, Parkinson's disease, Alzheimer's disease, dementia, and cognitive communications. A nursing progress note, dated 2/1/24 at 8:55 p.m., indicated the resident had a fall during a transfer to bed and hit her head on the dresser. A fall event, dated 2/1/24 at 8:42 p.m., indicated the resident had a fall on 2/1/24. The resident's representative was notified on 2/6/24. An IDT (interdisciplinary team) fall note, dated 2/2/24 at 4:36 p.m., indicated the resident's responsible party was not notified at the time of the fall. The progress notes did not include any notification to the resident representative to indicate the resident had a fall. During an interview, on 9/10/24 at 11:41 a.m., the Clinical Support Nurse indicated nurses should notify the family and physician of incidents the day of the event. A current policy, titled "Notification of Change in Condition," dated 12/31/23 and received from the Clinical Support nurse on 9/10/24 at 3:00 p.m., indicated "...To ensure appropriate individuals are notified of change of condition. The facility must			

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	inform the resident, consult with the resident's physician and if known notify the resident's legal representative when: An accident involving the resident which results in an injury and has the potential for requiring physician interventions...The resident representative/provider should be notified of change in condition or diagnostic testing results in a timely manner...." The deficient practice was corrected by 2/21/24, after the facility implemented a systemic plan which included audits, education, ensuring fall events were completed at the time of event, and proper documentation of physician and family notifications were completed. 3.1-5(a)(1)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure a cognitively impaired resident was safe from elopement for 1 of 3 residents reviewed for wandering. (Resident 27) The deficient practice was corrected on 8/24/24, prior to the start of the survey, and therefore was past noncompliance. Finding includes: The clinical record for Resident 27 was reviewed on 9/5/24 at 11:22 a.m. The diagnoses included, but were not limited to, dementia, schizoaffective disorder, bipolar disorder, major depressive disorder, and anxiety disorder. A care plan, dated 3/25/24, indicated the resident demonstrated exit seeking behaviors. The	F 0689	PNC was granted- No POC required.	09/26/2024

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	interventions included, but were not limited to, assess the need for a roam alert band and apply as appropriate and to re-direct the resident away from doors and exits as needed. An incident report, dated 8/4/24 at 7:33 p.m., indicated the resident was found outside the building unattended. The resident was wearing a roam alert band. The alarm did not sound when the resident exited the building. A checklist for suspected elopement and missing resident document indicated the resident was found by the dumpster approximately 200 feet from the main entrance of the facility. A statement of witness form, dated 8/4/24, indicated QMA 2 was leaving the facility and witnessed Resident 27 sitting in front of a white fence located by the trash dumpster. The resident was barefoot and wearing pajamas. QMA 2 told the resident she was not safe to be outside. A statement of witness form, dated 8/4/24, indicated RN 3 was flagged down by QMA 2 when she brought Resident 27 back to the 300-hallway. QMA 2 reported she was driving in the front parking lot when she noticed the resident in her wheelchair on the sidewalk by the loading dock. A physician's order, dated 8/19/24, indicated to check the function of the roam alert band daily. A physician's order, dated 8/19/24, indicated to check the placement of the roam alert band on every shift. During an interview, on 9/9/24 at 2:48 p.m., the Clinical Support Nurse indicated a resident			

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	noticed Resident 27 outside in her wheelchair sitting on the sidewalk. The roam alert alarm did not go off when the resident exited the building. A staff member was going out to her car and noticed the resident. During an interview, on 9/9/24 at 4:21 p.m., QMA 2 indicated she was leaving for the evening and witnessed the resident sitting in front of a white fence located by the trash dumpster. The resident was barefoot and wearing pajamas. During an interview, on 9/10/24 at 9:38 a.m., the Clinical Support Nurse indicated the code to the roam alert alarm was posted by the keypad. A current policy, titled "Guideline for Elopement/Missing Resident," dated as revised 12/31/23 and received from the Clinical Support nurse on 9/10/24, indicated "...Disoriented Resident (already deemed an elopement risk) observed exiting the campus door: Attempt to prevent the departure and re-direct. Obtain assistance from other staff members in the immediate vicinity...Instruct another staff member to inform the charge nurse or Director of Health Services that a resident has left/is leaving the campus...Notify the provider and responsible party for the resident. Complete an exit seeking event form. Attach progress note to an open exit seeking event...Upon return of the Resident to the facility (unwitnessed exit events) Examine resident for injuries. Contact the attending physician, report the findings and condition of the resident. Notify the responsible party for the resident...." The deficient practice was corrected by 8/24/24, after the facility implemented a systemic plan which included audits, staff education, elopement drills were conducted, the elopement binder was			

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	audited to ensure accuracy, daily audits on wander guard system was completed, a tech from wander guard system was scheduled to inspect the system, and the wander guard alarm system code was changed. 3.1-45(a)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were secured for residents who self-administer medications for 2 of 2 residents reviewed for self-medication administration. (Resident 23 and 6) Finding includes: 1. During a medication administration observation, on 9/6/24 at 9:35 a.m., Resident 23 had Flonase nasal spray (an allergy nasal spray) sitting on her over the bed table. The resident was asleep upon entry to the room. A physician's order, dated 6/1/24, indicated Flonase Allergy Relief spray suspension 2 puffs in each nostril. Special Instructions: May keep at bedside (MKAB) once daily. 2. During an interview, on 9/6/24 at 11:30 a.m., Resident 6 indicated she had her eye drops stored in the basket of her walker. They were not secured in a locked container. During a medication administration observation, on 9/6/24 at 9:51 a.m., Resident 6 had an order for eye drops to be kept at bedside. A physician's order, dated 1/24/24, indicated	F 0761	The Springs of Lafayette Health Campus Plan of Correction 2024 The submission of this plan of correction does not indicate an admission by The Springs of Lafayette Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Springs of Lafayette Health Campus. 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. **Date of Compliance: 10/01/24**	10/01/2024

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	Brimonidine 0.2% ophthalmic (eye) 1 drop in both eyes three times (TID) daily MKAB. A physician's order, dated 1/24/24, indicated Dorzolamide drops 2% 1 drop in both eyes twice daily (BID) MKAB. A physician's order, dated 1/24/24, indicated Restasis 0.05% 1 drop in both eyes BID MAB. A physician's order, dated 1/24/24, Timolol Maleate gel forming solution 0.05% 1 drop in both eyes MKAB. During an interview, on 9/6/24 at 11:15 a.m., the Clinical Support nurse indicated the medications for self-administration should be secured. A current policy, titled "Medication Storage in the Facility-Bedside Medication Storage," dated as revised November 2018 and received from the Clinical Support nurse on 9/10/24 at 3:00 p.m., indicated "...bedside storage of medication is indicated on the resident administration record (MAR) and in the care plan for the appropriate medication...for residents who self-administer medications...the following conditions are met for bedside storage to occur...the manner of storage prevents access by other residents...lockable drawers or cabinets are required only if unlocked storage is deemed inappropriate...bedside medication storage is routinely monitored by facility designee...." A current policy, titled "Guidelines for Self-Administration of Medications," dated as reviewed on 12/31/23 and received from the Clinical Support nurse on 9/6/24 at 11:30 a.m., indicated "...the medication will be kept in a locked drawer in the residents' room...the resident will		**F761 Label/Store Drugs and Biologicals** **1 Immediate actions taken for those residents identified:** Residents 6 and 23 were affected with no adverse reactions noted. Ensured all Residents medication were labeled and stored properly. **2 How the facility identified other residents:** All residents have the potential to be affected. **3 Measures put into place/System changes** All Nurses and QMA's will be re-educated on Medication Storage/Proper Labeling Policy and Procedure. DHS/designee will audit 3 Residents who self-administer medication weekly for proper medication storage of all medication x 8 weeks then every other week x 12 weeks. **4 How the corrective actions will be monitored:** As a Quality measure, the results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained or 100% compliance is met	

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	maintain a key, as well as a key will be maintained by the licensed nurse or QMA.... " 3.1-25(m)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 3, 4, 5, 6, 9 and 10, 2024. Facility number: 013499 Residential Census: 35 The Springs at Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on September 16, 2024.	R 0000	The Springs of Lafayette Health Campus Plan of Correction 2024 The submission of this plan of correction does not indicate an admission by The Springs of Lafayette Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of The Springs of Lafayette Health Campus. 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.	