| 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 | 02/13/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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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 IN00400400, IN00400634, and IN00401243.<br><br>Complaint IN00400400 - Unsubstantiated due to lack of evidence.<br><br>Complaint IN00400634 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686.<br><br>Complaint IN00401243 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684.<br><br>Survey dates: February 9, 10, and 13, 2023.<br><br>Facility number: 013635<br>Provider number: 155843<br>AIM number: 300026664<br><br>Census Bed Type:<br>SNF/NF: 7<br>SNF: 29<br>Total: 36<br><br>Census Payor Type:<br>Medicare: 29<br>Medicaid: 7<br>Total: 36<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on February 15, 2023 | F 0000 | | |
| F 0684<br>SS=D | 483.25<br>Quality of Care | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Crystal Alllen | Director of Nursing | 03/02/2023 |

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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| Bldg. 00 | § 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>Based on interview and record review the facility failed to provide an antibiotic as prescribed by the physician to treat a resident's urinary tract infection (UTI) for 1 of 3 residents reviewed for infections (Resident B).<br><br>Finding include:<br><br>Review of the record of Resident B on 2/9/23 at 12:30 p.m., indicated the resident's diagnoses included, but were not limited to, UTI, anxiety disorder, osteoarthritis, reduced mobility and acute/chronic respiratory failure.<br><br>The Admission Minimum Data Set (MDS) for Resident B, dated 12/26/22, indicated the resident required extensive assistance of one person for toileting needs and the resident was always incontinent of the bladder and bowels.<br><br>The urine culture for Resident B, collected on 1/6/23 and received by the facility on 1/9/23, indicated the resident had above 100,000 escherichia coli (e-coli) in the urine. The physician ordered macrobid (antibiotic) 100 milligrams (mg) twice a day for 7 days.<br><br>The event report for Resident B, dated 1/15/23, indicated the resident had urinary infection. The resident had symptoms of painful urination and | F 0684 | - Residents B was affected by the alleged deficient practice with no adverse effects.<br>- Resident B received medication as soon as order was entered into EHR and pharmacy delivered medication.<br>All residents have the potential to be affected by the alleged deficient practice.<br>- Nursing staff were reeducated on the Guidelines for Medication Orders policy and procedure with concentration on, but not limited to, receiving medication orders and entering them appropriately into the electronic health record (EHR) and administering medications as ordered.<br>- All inhouse residents were audited on 2.13.2023 by the DHS/RN/designee for appropriate medication orders, including entered in the EHR correctly. No residents qualified to have documentation amended.<br>Education provided:<br>o Guidelines for Medication Orders. | 03/24/2023 |

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| | burning during urination.<br><br>The Medication Administration Record (MAR) for Resident B, dated January 2023, indicated the resident did not receive the prescribed macrobid until 1/15/23. This indicated the resident missed 11 doses of the antibiotic.<br><br>During an interview with Resident B's family member on 2/10/23 at 12:50 p.m., indicated the resident had symptoms of UTI on 1/5/23 and the physician ordered a urine culture. The resident had itching and burring with urination and was confused. The family member indicated she talked with a nurse on 1/15/23 about the resident's symptoms and inquired if the resident was receiving an antibiotic. The nurse reported the resident did have a UTI and the antibiotic had not been started, but would be started on 1/15/23.<br><br>During an interview with the Director Of Health Services (DHS) on 2/10/23 at 1:20 p.m., indicated Resident B's family had expressed some concerns that the resident was showing signs of a UTI. The resident was "a little bit off", there was a urine culture obtained and it showed e-coli and the physician wrote an order for an antibiotic. The resident was having delusions and seeing dead people. The DHS indicated she agreed that something was going on with the resident but did not feel it was a UTI.<br><br>During an interview with the DHS on 2/10/23 at 1:45 p.m., when queried why Resident B had a delay in receiving the antibiotic ordered on 1/9/23 and did not receive it until 1/15/23, the DHS indicated someone scanned the physician order for macrobid into the computer and the order did not get transcribed. | | o Medication documentation and order entry into the EHR.<br>- DHS/Nurse/designee will ensure weekly monitoring for medication documentation in the clinical care meeting to ensure that residents with new antibiotic orders has appropriate documentation 5 days a week for 4 weeks, 3 days a week for 4 weeks, 1 day a week for 4 weeks, and monitored monthly in QAPI for 6 months.<br>- DHS/Nurse/Designee will be responsible for monitoring compliance of the weekly audit's procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. | |

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| | The change in condition policy provided by the DHS on 2/9/23 at 2:35 p.m., indicated the resident, physician and resident legal representative would be notified when there was a need to alter treatment significantly, clinical complications such as onset of delirium or recurrent UTI.<br><br>This Federal tag relates to Complaint IN00401243.<br><br>3.1-37(a) | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, interview and record review the facility failed to provide pressure ulcer reducing wheelchair cushion as ordered by the physician for a resident with an unstageable pressure ulcer (wound covered with slough or eschar) for 1 of 3 resident's reviewed for pressure ulcers (Resident E).<br><br>Finding include:<br><br>Review of the record of Resident E on 2/13/23 at | F 0686 | - Residents E was affected by the alleged deficient practice with no adverse effects noted.<br>- Resident E was offered and accepted a wheelchair cushion.<br>- Residents with pressure reducing interventions have the potential to be affected by the alleged deficient practice.<br>- Nursing staff were | 03/24/2023 |

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| | 10:35 a.m., indicated the resident's diagnoses included, but were not limited to, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, Urinary tract infection, site not specified, Hypertensive heart disease with heart failure, Chronic diastolic (congestive) heart failure, Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, Anxiety disorder, unspecified.<br><br>The Admission MDS assessment for Resident E, dated 1/17/23, indicated the resident was cognitively intact for daily decision making, was reasonable and consistent. The resident had no behaviors of refusing care. The resident was extensive assistance of two people for bed mobility and transfers. The resident did not ambulate and used a wheelchair as a mobility device. The resident was admitted with an unstageable pressure ulcer (Wound covered with slough and eschar). The resident was at risk for developing pressure ulcers.<br><br>The physician order for Resident E, dated 2/9/23, indicated the resident was to have a pressure ulcer relieving cushion in her wheelchair at all times.<br><br>The wound management report for Resident E, dated 1/13/23, the resident had a unstageable pressure ulcer on the coccyx, measuring 4 centimeters (cm) by 3 cm. The wound had seropurulent (yellow or tan, cloudy and thick). The tissue was necrotic.<br><br>The wound management report for Resident E, dated 2/7/23, the resident had a unstageable pressure ulcer on the coccyx, measuring 3 centimeters (cm) by 2.2 cm. The wound had heavy | | reeducated on the Guidelines for Pressure Prevention policy and procedure with concentration on, but not limited to, assessing and monitoring residents for appropriate interventions to maintain good skin integrity and avoid development of pressure ulcers.<br>- Inhouse residents were audited on 2.13.2023 by the DHS/WCC/designee for skin impairment and appropriate pressure reducing interventions. No residents qualified to be added to wound management or have additional pressure reducing modalities added.<br>Education provided:<br>o Guidelines for Pressure Prevention<br>o Weekly Skin Assessments<br>o Documentation of assessment, evaluation, diagnosis, and implementation of pressure reducing modalities.<br>- DHS/designee will ensure a weekly monitoring and review of a sample of 10% of census for pressure reducing interventions through the clinical care meeting to ensure that any residents with ordered pressure reducing modalities has appropriate documentation and implementation. Monitoring will take place 5 days a week for 4 weeks, 3 days a week for 4 weeks, and 1 day a week for 4 weeks, and monitored monthly in | |

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| | serosanguineous drainage (pale red to pink, thin and watery). The tissue had slough.<br><br>During an observation on 2/13/23 at 11:40 a.m., Resident E was sitting in her wheelchair, the resident had a towel on the wheelchair seat and there was no pressure ulcer reducing cushion in the wheelchair.<br><br>During an observation and interview on 2/13/23 at 12:10 p.m., LPN 1 verified Resident E did not have a pressure reducing cushion in her wheelchair. The resident indicated she never had one in her wheelchair. LPN 1 searched the resident's room and was unable to locate a pressure reducing cushion and indicated she would go get one to put in the resident's wheelchair. LPN 1 indicated it was her responsibility to ensure Resident E had a pressure reducing cushion in the wheelchair.<br><br>This Federal tag relates to Complaint IN00400634.<br><br>3.1-40(2) | | QAPI for 6 months.<br>- DHS/designee will be responsible for the wound management program, with focus on pressure reducing interventions and implementation monitoring. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. | |