

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155842	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Springs of Mooresville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 302 North Johnson Road Mooresville, IN 46158	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a Braden Scale (an assessment to evaluate a resident's risk of developing pressure ulcer) was completed on a resident who had developed two pressure ulcers while in the facility for 1 of 3 residents reviewed for pressure ulcer. (Resident 42) Findings include: On 6/25/26 at 1:31 p.m., Resident 42 was observed to be resting on his back on a low loss air mattress (specialized mattress to treat or prevent pressure ulcers). On 6/29/26 at 10:05 a.m., Resident 42 was observed to be resting on his back on a low air mattress eating breakfast. On 6/30/26 at 9:38 a.m., Resident 42's clinical record was reviewed. The diagnoses included, but were not limited to, diabetes mellitus, dementia, and Parkinson's disease. A care plan, dated 6/26/24, indicated Resident 42 was at risk for skin breakdown. An admission Observation and Data Collection, dated 12/29/25 at 3:13 p.m., indicated the Braden Scale score was 11 which indicated Resident 42 was a high risk for pressure ulcers. The clinical record lacked any additional Braden Scale assessments. A Wound Management Detail Report indicated the following: On 5/28/26 at 6:59 p.m., Resident 42 had an unstageable-slough and/or eschar pressure ulcer to the right gluteal (under the buttock) fold. The measurements were 4 cm (centimeters) by 3 cm. On 6/24/26 at 3:24 p.m., Resident 42 had an unstageable pressure ulcer to the sacrum (bone at the base of the spine). The measurements were 3.5 cm x 4 cm. On 6/29/26 at 1:45 p.m., the Nurse Consultant indicated Braden Scale Assessments were completed on admission and quarterly. On 7/1/26 at 2:50 p.m., the Director of Health Services (DHS) indicated Resident 42's clinical record lacked any Braden Scale Assessments since 12/29/25. On 7/1/26 at 3:05 p.m., the DHS provided the facility policy, Guideline for Wound Risk Observation, dated 11/18/25 and indicated it was the policy currently being used by the facility. A review of the policy indicated, .2. A Braden Scale will be completed a minimum of quarterly to identify any changes to risk factors that may predispose them to skin impairment . 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(1)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure the urinary catheter tubing (flexible tube which passed through the urethra and into the bladder to drain urine) and drainage bag was not touching the floor for a resident with a urinary tract infection for 1 of 1 residents reviewed for urinary catheters. (Resident 66) Findings include: On 6/26/26 at 11:35 a.m., Resident 66 was observed to be sitting in her wheelchair in her room. A urinary drainage bag was observed to be resting on the floor. On 6/26/26 at 11:55 a.m., Resident 66 was observed to be sitting in the dining room eating lunch. A urinary catheter drainage bag was observed to be resting on the floor. On 6/26/26 at 1:46 p.m., Resident 66 was to be resting in a low bed, and the urinary catheter drainage bag was resting on the floor. On 6/30/26 at 1:47 p.m., Resident 66's clinical record was reviewed. The diagnoses included, but were not limited to, sacrum (bone in the lower back) fracture, urinary tract infection (UTI), and neuromuscular dysfunction of the bladder (lacks bladder control due to brain or nerve condition). The admission Observation and Data Collection, dated 6/16/26 at 11:53 p.m., indicated Resident 66 had an indwelling catheter. Her baseline care plan indicated to observe for signs and symptoms of a UTI. The care plan, dated 6/23/26, indicated Resident 66 had a catheter due to neurogenic bladder. Her interventions were to observe the tubing, avoid any obstructions, and to observe for any signs of a UTI. The Physician Order Report indicated the following: Catheter care every shift (start date 6/22/26). Change catheter as needed (start date 6/22/26). Indwelling urinary catheter (start date 6/23/26). Ciprofloxacin (antibiotic) 250 milligrams (mg) twice a day for UTI (start date 6/26/26). The Infection Control Event, dated 6/26/26 at 11:24 a.m., indicated Resident 66 had a UTI. She had a new onset of suprapubic (lower abdomen) pain. The IDT (interdisciplinary team) note, dated 6/26/26 at 11:28 a.m., indicated Resident 66 had increased confusion. Her urine was sent and the culture was indicated. The culture indicated Pseudomonas aeruginosa (bacteria). Resident 66 was started on ciprofloxacin 250 mg twice a day for UTI. On 7/1/26 at 10:22 a.m., Resident 66 was observed to be sitting by the nursing station in her wheelchair. The urinary catheter tubing was observed to be resting on the floor. On 7/1/26 at 11:35 a.m., Resident 66 was observed to be up in her wheelchair in the dining room. The urinary catheter tubing was observed to rest on the floor. During an interview on 7/1/26 at 2:34 p.m., CNA 1 indicated Resident 66 required assistance with all activities of daily living (ADL). The urinary tubing and drainage bag should not touch the floor. On 7/2/26 at 9:14 a.m., Resident 66 was observed to be sitting in her wheelchair at the table beside the nursing station. The urinary catheter tubing was observed to be resting on the floor. At that time, CNA 1 indicated the urinary catheter tubing was on the floor. The urinary catheter tubing needed to be off the floor. On 7/2/26 at 10:05 a.m., the Director of Health Services (DHS) provided the facility policy, Urinary Catheter Care, dated 12/16/24, and indicated it was the policy currently being used by the facility. A review of the policy indicated, .11. Be sure the catheter tubing and drainage bag are kept off the floor . 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)		