STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155843	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs of Richmond, The	400 Industries Road Richmond, IN 47374

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28309 Based on interview and record review, the facility failed to routinely document meal intakes for 3 of 3 residents reviewed for nutritional concerns. (Residents B, C and D) Findings include: 1. The clinical record of Resident B was reviewed on 6-25-24 at 11:25 a.m. Her diagnoses included, but were not limited to, non-ST elevation MI (heart attack), Covid-19 at admission, hypertensive chronic kidney disease (stage 3), diabetes, esophageal obstruction, cerebral ischemia, hyperlipidemia, depression, obesity and generalized muscle weakness. Her admission Minimal Data Set assessment, dated 5-15-24, indicated she was cognitively intact, required substantial assistance with bed mobility (turning and repositioning), bathing, toileting, was dependent for transfers, was non-ambulatory and required supervision assistance, after initial meal set up, with eating. It indicated she had concerns regarding her appetite. In an interview, on 6-25-24 at 1:14 p.m., with a family member, she indicated Resident B had difficulty chewing as does not like to wear her dentures. The family member indicated she requested for a nutritionist and was told they would see what they could do and to my knowledge, nothing was done. She added around this time Resident B was declining in her health, in her opinion. I don't think they documented her meal intake. In an interview, on 6-26-24 at 2:10 p.m., with the Wound Nurse, she indicated Resident B was admitted to the facility with Covid-19 and was placed in isolation. She added an entry was made into the resident's record concerning her skin. By the time I did my skin rounds several days later, I identified the skin area not as pressure [ulcer], but MASD (moisture associated skin damage), and it was actively healing. So I didn't make any notations or any changes, because the staff were already providing the care she needed. A progress note, dated 5-24-24, by the facility's Registered Dietitian (RD), indicated the resident's meal intake for her physician-ordered diet of a regular diet with regular texture was averaging 70% (percent). It indicated she consumed meals independently with supervision following set up assistance. It indicated she was edentulous (no teeth) and did not wear dentures. It indicated she had no known chewing or swallowing difficulties. The RD's recommendations included, but were not limited to, adding a dietary supplement for two weeks, due to the recent identification of skin issues to promote wound healing and collagen production, as well as monitoring her weight and meal intakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident B's meal intake documentation for her time at the facility, 24 days and approximately 70 meals, revealed no meal documentation on the following dates and times: -5-9-24: dinner. -5-11-24: dinner. -5-12-24: dinner. -5-13-24: dinner. -5-15-24: breakfast and lunch. -5-17-24: breakfast, lunch and dinner. -5-26-24: dinner. 2. The clinical record of Resident C was reviewed on 6-25-24 at 10:15 a.m. Her diagnoses included, but were not limited to, rhabdomyolysis (muscle tissue breakdown that may release a damaging protein into the blood), history of sepsis, pneumonia, Covid-19, previous heart attack and urinary tract infection, congestive heart failure and COPD (chronic obstructive pulmonary disease). Her most recent Minimum Data Set assessment, dated 4-27-24, indicated she was cognitively intact, required substantial assistance with bed mobility (turning and repositioning), was dependent for bathing, toileting and transfers, was non-ambulatory and required meal set up with eating. A quarterly nutrition note, dated 6-3-24, by the facility's Registered Dietitian (RD), indicated Resident C is over [AGE] years old, was on a physician's ordered diet of a regular mechanical soft diet with ice cream at dinner daily. Her average meal intake was 80%. Current concerns identified were bilateral lower extremity edema (swelling). The RD noted the resident had a significant weight gain of approximately 10% in the last 6 months and a non-significant weight gain 5.8% in the last 3 months, followed by a non-significant weight gain of 3.2% in the last 30 days, with her BMI (body mass index) in the overweight range, though within ideal range for age. She indicated Resident B's trending weight gain is beneficial for overall QOL (quality of life). The RD's plan of care was identified as Will follow weights and intakes. A review of Resident C's meal intake documentation for June, 2024, or 25 days and approximately 74 meals, revealed no meal documentation on the following dates and times: -6-1-24: breakfast and lunch. -6-9-24: breakfast. -6-14-24: breakfast and lunch. -6-16-24: breakfast and lunch. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The clinical record of Resident D was reviewed on 6-26-24 at 10:34 a.m. His diagnoses included, but were not limited to, left hip fracture, malnutrition, pneumonia, enlarged heart, hypertensive heart and kidney disease, diabetes and pressure ulcers. His admission Minimum Data Set assessment, dated 4-12-24, indicated he was moderately cognitively impaired, required supervision with bed mobility (turning and repositioning), eating and hygiene, required moderate assistance with toileting and was non-ambulatory. Resident D had been followed closely by the Registered Dietitian (RD), due to weight loss. In a visit note dated, 5-21-24, the RD identified a significant weight loss of [sign for about] 21% since 4-9-24. At time of admission Resident did have severe edema r/t [related to congestive heart failure] CHF, though edema is under control at this time. The RD indicated Resident D's appetite was poor, with meal intakes at 73% recently. The RD's recommendations included, but were not limited to, liberalizing his diet to a regular, fortified diet to allow for higher caloric options and foods at each meal and additional nutritional supplements three times daily and a prescription appetite stimulant, dependent on the agreement of his physician, the resident and family. An RD visit note on 5-31-24, indicated Resident D had newly acquired pressure wounds. Her documented concerns were listed as poor appetite and poor intakes resulting in weight loss and decreased skin integrity. Recent interventions in place to increase appetite through stimulant (mirtazapine), nutritional supplements three times daily and a liberalized diet from the previous limited diabetic diet. Further RD recommendations included additional dietary supplements twice daily for additional calorie and protein support to aid wound healing. The most recent RD note, dated 6-14-24, indicated Resident D continued to demonstrate significant weight loss compared to his admission weight. However, he was now demonstrating a significant weight gain in the last 2 weeks of 10%, related to medication changes and nutrition interventions put in place. This weight gain is warranted and beneficial for overall QOL [quality of life]. A review of Resident D's meal intake documentation for June, 2024, or 25 days and approximately 74 meals, revealed no meal documentation on the following dates and times: -6-9-24: dinner. -6-10-24: lunch. -6-13-24: lunch. -6-14-24: breakfast, lunch and dinner. On 6-26-24 at 4:12 p.m., the Corporate Nurse provided a copy of a policy entitled, Guidelines for Meal Service, with a revision date of 12-31-23. This policy indicated, Meal intakes should be recorded in the electronic health record. This citation relates to Complaint IN00436445. 3.1-46(a)(1) 3.1-46(a)(2)