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	11/13/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report Resident B received Resident D's morning medication in error to the local hospital that Resident B was being transferred, to ensure continuity of care 1 of 3 residents reviewed for Discharge Process. (Resident B). Findings include:Review of the clinical record of Resident B on 11/12/25 at 10:50 a.m., indicated the resident's diagnoses included, but were not limited to, chronic pain, diabetes, stage 5 chronic kidney disease, heart failure, dependence on renal dialysis and pulmonary edema.The progress note for Resident B, dated 10/26/25 at 10:37 a.m., indicated the wrong resident's medication, error occurred. Nursing supervisor made aware immediately. Director of Health Services (DHS) notified. The Nurse Practitioner (NP) made aware and completed an in person assessment. Orders were given to combat potential side effects include midodrine (medication used to treat low blood pressure) 5 milligrams (mg) by mouth every 8 hours as needed for systolic blood pressure below 100, a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) to be drawn today and repeat on 10/27/2025, and check vital signs every 4hours for 24 hours. Vitals completed at the time of incident and multiple times since then. No signs and symptoms of adverse effects noted at this time. Vitals would continue to be taken minimal every 4 hours for the next 24 hours. The resident was made aware and a message was left for his wife with no return communication at this time. The facility census for Resident B, dated 10/27/25, indicated he was discharged to the local hospital from the facility.The physician recapitulation for Resident B, dated October 2025, indicated the resident was ordered the following morning medications: carvedilol (treatment for hypertension) 12.5 milligrams (mg), cetirizine (treatment for allergies) 10 mg, gabapentin (anticonvulsant) 300 mg, monocal (calcium supplement) 22.75-625 mg, senna (laxative) 8.6 mg and sertraline (antidepressant) 25 mg. The physician recapitulation for Resident D, dated October 2025, indicated the resident was ordered the following morning medications: amlodipine (treatment for hypertension) 5 mg, atorvastin (treatment for high cholesterol) 20 mg, vitamin D3 25 micrograms (mcg), duloxetine (antidepressant) 60 mg, Eliquis (blood thinner) 5 mg, furosemide (diuretic) 30 mg, gabapentin 800 mg, multivitamin, potassium chloride 20 milliequivalent (meq), sotalol (antiarrhythmic agent) 120 mg and atenolol (treatment for hypertension) 50 mg.The local hospital note for Resident B, dated 10/27/25 to 11/2/25, indicated the facility had no documentation of the resident receiving the wrong medication at the facility provided with the resident, on 10/26/25, prior to admission to the hospital. During an interview with Resident B's family member, on 11/13/25 at 10:00 a.m., indicated when the resident was transferred to the local hospital from the facility on 10/27/25, the facility did not tell the hospital that he had received medications in error on 10/26/25. The family member went to the facility, on 10/28/25, and got a list of the medications that the resident received in error and provided it the resident's nurse at the hospital. The resident's nurse at the hospital then reported it to the physician that was caring for Resident B. During an interview with the NP, on 11/13/25 at 11:00 a.m., the NP indicated it was important for the facility to report to the local hospital that Resident B received the wrong medication, on 10/26/25, for his treatment and care at the hospital. During an interview with the Director of Health Services (DHS), on 11/13/25 at 11:18 a.m., indicated it was the facilities expectation that the nurse transferring Resident B to the local hospital should have reported to the hospital that the resident had received the wrong medications. During an interview with the DHS, on 11/13/25 at 12:50 p.m., verified Resident B did not receive his scheduled morning medications on 10/26/25 and verified the resident received Resident D's morning medications on 10/26/25. There was no documentation that the hospital was notified of the medication error when Resident B was transferred to the hospital on [DATE]. During an interview with Clinical Support, on 11/13/25 at 12:00 p.m., indicated the facility did not have a policy for continuity of care of what the nurse should report to the hospital on when a resident is transferred to the hospital. This citation relates to Intake 2658401. 3.1-12(a)25(A)3.1-12(a)25(B)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error when Resident B received Resident D's morning medication for 1 of 3 residents reviewed for medication error (Resident B). Finding include:Review of the clinical record of Resident B on 11/12/25 at 10:50 a.m., indicated the resident's diagnoses included, but were not limited to, chronic pain, diabetes, stage 5 chronic kidney disease, heart failure, dependence on renal dialysis and pulmonary edema.The facility baseline care plans, for admission, were in place for Resident B from 10/24/25 to 10/27/25. The plan of care for Resident B, dated 10/27/25, indicated the resident was at risk for dehydration/fluid imbalance. The interventions included, but were not limited to, administer medications as ordered. The plan of care for Resident B, dated 10/27/25, indicated the resident was at risk for pain related to pulmonary fibrosis, diabetes, congestive heart failure, neuropathy, tubular adenoma, colon cancer, intractable back pain, intervertebral disc aspiration, spinal stenosis, cardiomyopathy, lymphadenopathy and pulmonary edema. The interventions included, but were not limited to, administer medications as ordered. The resident was sent to the local hospital on [DATE].The laboratory values for Resident B were reviewed. The resident had the following laboratory values: dated 6/29/24, creatinine level was high at 5.5; dated 6/1/25, creatinine level was high at 6.1; dated 10/12/25, creatinine level was critical at 8.5; dated 10/13/25, the creatinine level was critical at 8.2; dated 10/17/25, the creatinine level was critical at 7.9; dated 10/22/25, the creatinine level was high at 6.4. The progress note, dated 10/26/25 at 10:37 a.m., indicated Resident B received the wrong resident's medication, a medication error occurred (Resident B had received Resident D's medication). Nursing supervisor made aware immediately. Director of Health Services (DHS) notified. The Nurse Practitioner (NP) made aware and completed an in-person assessment. Orders were given to combat potential side effects include midodrine (medication used to treat low blood pressure) 5 milligrams (mg) by mouth every 8 hours as needed for systolic blood pressure below 100, a Complete Blood Count (CBC) and Comprehensive Metabolic Panel (CMP) to be drawn today and repeat on 10/27/2025, and check vital signs every 4-hours for 24 hours. Vitals completed at the time of incident and multiple times since then. No signs and symptoms of adverse effects noted at this time. Vitals would continue to be taken minimal every 4 hours for the next 24 hours. The physician recapitulation for Resident B, dated October 2025, indicated the resident was ordered the following morning medications: carvedilol (treatment for hypertension) 12.5 milligrams (mg), cetirizine (treatment for allergies) 10 mg, gabapentin (anticonvulsant) 300 mg, monocal (calcium supplement) 22.75-625 mg, senna (laxative) 8.6 mg and sertraline (antidepressant) 25 mg. Resident D's medication record was reviewed on 11/13/25 at 10:15 a.m. The physician recapitulation for Resident D, dated October 2025, indicated the resident was ordered the following morning medications: amlodipine (treatment for hypertension) 5 mg, atorvastin (treatment for high cholesterol) 20 mg, vitamin D3 25 micrograms (mcg), duloxetine (antidepressant) 60 mg, Eliquis (blood thinner) 5 mg, furosemide (diuretic) 30 mg, gabapentin 800 mg, multivitamin, potassium chloride 20 milliequivalent (meq), sotalol (antiarrhythmic agent) 120 mg and atenolol (treatment for hypertension) 50 mg.The medications Resident B received had the following potential side effects: Amlodipine -swelling of the extremities, nausea, stomach pain, dizziness, drowsiness, excessive tiredness, flushing, and muscle stiffness or tremors.Atorvastin - diarrhea, heartburn, gas, joint pain, memory loss, and confusion.Duloxetine - nausea, vomiting, diarrhea, constipation, decreased appetite, dry mouth, sweating, and tiredness.Eliqis - bleeding gums, nosebleeds, coughing up or vomiting blood, swelling or joint pain, headache, vomiting, rash, chest paint, swelling of the face or tongue, trouble breathing, wheezing, and feeling dizzy or faint. Furosemide - frequent urination, blurred vision, headache, constipation, and diarrhea. Gabapentin - drowsiness, tiredness, dizziness, headache, uncontrollable shaking of a part of your body, blurred vision, unsteadiness, anxiety, memory problems, unwanted eye movements, nausea, vomiting, heartburn, diarrhea, and swelling of extremities.Potassium chloride - upset stomach, vomiting, and diarrhea. Sotalol - warning alert indicated the following: may cause QT prolongation (an irregular heart rhythm that can lead to fainting, loss of consciousness, seizures, or sudden death). For the first three days you take sotalol, you will have to be in a facility where your heart can be monitored. Tell your doctor if you or anyone in your family has or has ever had long QT syndrome (an inherited condition in which a person is more likely to have QT prolongation) or if you have or have ever had or you have or have ever had low levels of potassium in your blood, slow or irregular heartbeat, heart failure, or kidney disease. Your doctor may tell you not to take