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	01/29/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review the facility failed to ensure residents had fluids available at bedside for 3 of 3 residents reviewed for hydration. (Resident B, Resident D and Resident E) Findings include:1. During an interview, on 1/28/26 at 12:48 p.m., Resident B's family member indicated she visited her family member daily and the resident never had fluids in the room. The resident reported that the only fluids they received were with meal trays. The family member indicated ever day they had to provide fluids for Resident B. Review of the clinical record of Resident B on 1/28/26 at 10:28 a.m., indicated the resident's diagnoses included, but were not limited to, stroke (sudden disruption of blood flow to the brain causes brain cells die leading to permanent neurological damage), chronic kidney disease (long term progressive loss of kidney function), and urinary tract infection. The plan of care for Resident B, dated 9/18/25, indicated the resident was at risk for dehydration. The interventions included, but were not limited to, staff were to offer fluids with meals, medication pass and activities. The plan of care for Resident B, dated 9/18/25, indicated the resident received a high risk medication diuretic. The intervention included, but were not limited to, staff were to encourage fluids if not contraindicated. The plan of care for Resident B, dated 12/4/25, indicated the resident was at risk for constipation. The intervention included, but were not limited to, staff were to encourage fluids. The admission Minimum Data Set (MDS) assessment for Resident B, dated 9/24/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. 2. The clinical record for Resident D was reviewed on 1/29/26 at 9:47 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure (heart muscle is too weak or stiff to pump blood efficiently) and iron deficiency anemia (body lacks sufficient iron to produce adequate hemoglobin). The admission Minimum Data Set (MDS) assessment, dated 1/22/26, indicated Resident D was cognitively intact for daily decision making. During an interview and observation, on 1/28/26 at 10:45 a.m., Resident D had a Styrofoam cup with a small amount of water in it. He indicated they had not brought him any water today, but he had not asked yet. Sometimes he had to ask and sometimes they brought it. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with Resident D, on 1/28/26 at 1:30 p.m., Resident D had a cup of water sitting in front of him. He indicated he just got fresh water about twenty minutes ago for the first time that day. A plan of care, dated 1/19/26, indicated Resident D was at risk for dehydration. The interventions included, but were not limited to, staff were to offer fluids. 3. The clinical record for Resident E was reviewed on 1/29/26 at 1:58 p.m. The resident's diagnoses included, but were not limited to, severe sepsis with septic shock (body's overwhelming response to infection causes organ dysfunction) and acute respiratory failure with hypoxia (inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function). The admission Minimum Data Set (MDS) assessment, dated 1/15/26, indicated Resident E was moderately cognitively impaired and was on a controlled carbohydrate diet with a 2 gram sodium restriction. During an interview and observation with Resident E, on 1/28/26 at 10:55 a.m., the resident had an empty Styrofoam cup with no date on it. The resident indicated she always had to ask for water. During an interview and observation with Resident E, on 1/28/26 at 1:45 p.m., the resident had a Styrofoam cup with no date on it, it was empty and had ice in it. The resident indicated that was what came on her lunch tray and the facility still had not passed water. A plan of care, dated 1/12/26, indicated Resident E was at risk for dehydration. The interventions included, but were not limited to, staff were to offer fluids. During an interview with the Administrator, on 1/29/26 at 3:03 p.m., the Administrator indicated the facility does not have a policy in regards to hydration and his expectation was to keep residents hydrated and the resident's water cups were passed once per shift. This Federal citation relates to intake 2707905. 3.1-3(v)(1)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify a resident's family of a large bruised area to the resident's back for 1 of 3 residents reviewed notification of injury. (Resident B) Finding include: During an interview, on 1/28/26 at 12:48 p.m., Resident B's family member indicated they were not notified of a large bruise on the resident's back. The family member indicated when the resident was admitted to the hospital, on 12/21/25, the bruise was observed. The resident reported to the family member that a week before she went to the hospital she had a fall during a transfer with staff. The family member was not aware the resident had a fall or had the bruising. Review of the clinical record of Resident B on 1/28/26 at 10:28 a.m., indicated the resident's diagnosis included, but was not limited to, stroke (lack of oxygen causing brain cells to die, potentially leading cause of long-term disability and death). The resident's record did not indicate the resident had a fall. The admission Minimum Data Set (MDS) assessment for Resident B, dated 9/24/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable.The progress note for Resident B, dated 12/21/25 at 2:23 p.m., indicated the dark areas to the resident's back had worsened and was getting darker. The area increased in size. An event was opened to ensure the wound nurse was aware. The Nurse Practitioner was notified. The documentation did not indicate the resident's family had been notified. During an interview with the Director Of Nursing Services (DNS) on 1/28/26 at 2:06 p.m., the DNS indicated when an event was created in the computer they were turned into incident reports that were an internal document. No further information or documentation was provided by the DNS. The notification policy provided by the DNS on 1/28/26 at 2:25 p.m., indicated the purpose was to ensure the resident's responsible party was notified of a change in condition timely. The responsible party would be notified immediately of a change in condition. This citation relates to Intake 2707905. 3.1-5(a)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review the facility failed to complete a thorough and accurate assessment of a large bruised area to a resident's back for 1 of 3 residents reviewed for Quality of Care. (Resident B) Findings include: The hospital note for Resident B, dated 1/21/26 (no time), indicated the resident had a traumatic wound on admission to the right side of her back measuring 22 centimeters (cm) by 9 cm. The area was purple and red with erythema (superficial reddening of the skin as result of an injury or irritation causing dilation of the blood capillaries). Review of the clinical record of Resident B on 1/28/26 at 10:28 a.m., indicated the resident's diagnosis included, but was not limited to, stroke (lack of oxygen causing brain cells to die, potentially leading to lasting damage, paralysis, or speech impairment, leading cause of long-term disability). The resident's record did not indicated the resident had a fall. The progress note for Resident B, dated 12/21/25 at 2:23 p.m., indicated the dark areas to the resident's back worsened, was getting darker, and increasing in size. An event was opened to ensure wound nurse aware. The Nurse Practitioner was notified. The documentation had no further assessments of the area to the resident's back. Review of the wound management for Resident B on 1/28/26 at 10:28 a.m., indicated the resident had no bruising assessment for the resident's back or any other assessment of the resident's back. During an interview with the Director Of Nursing Services (DNS) on 1/28/26 at 2:06 p.m., indicated the when an event was created in the computer they were turned into incident reports that were an internal document. No further documentation or assessments were provided by the DNS during the survey process. During an interview, on 1/28/26 at 12:48 p.m., Resident B's family member indicated they were not notified of a large bruise on the resident's back. The resident indicated she had a fall during a transfer with staff at the facility and hit the side of her bed. The family member was not aware the resident had a fall or had the bruising. The bruising policy provided by the DNS on 1/28/26 at 2:25 p.m., indicated the procedure was to complete an bruise incident in the electronic health record along with a template/assessment progress note. This citation relates to Intake 2707905.3.1-37(a)