DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155762	A. BUILDING 00 B. WING	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST PARK HEALTH CAMPUS	2401 SOUTH L ST RICHMOND, IN 47374

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00365382. Complaint IN00365382 - Substantiated. Federal/state deficiencies related to the allegations are cited at F- 558 & F-689. Survey dates: October 25, 26, & 27, 2021 Facility number: 011387 Provider number: 155762 AIM number: 200853180 Census Bed Type: SNF/NF: 45 SNF: 10 Total: 55 Census Payor Type: Medicare: 11 Medicaid: 35 Other: 9 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 29, 2021	F 0000	**Plan of Correction FOR Forest Park Health Campus** **F000 INITIAL COMMENTS** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted Oct 25, 26, & 27, 2021. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 13th, 2021. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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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	or other residents. Based on observation, interview and record review the facility failed to ensure fresh water was available daily for 3 of 4 residents reviewed for hydration (Resident G, Resident J and Resident D). Finding include: During an observation on 10/25/21 at 10:00 a.m., Resident G and Resident J were in their room, neither resident had water or a cup for water on their bedside table. During an observation on 10/25/21 at 2:55 p.m., Resident G and Resident J were in their room, neither resident had water or a cup for water on their bedside table. During an observation on 10/26/21 at 10:00 a.m., Resident G and Resident J did not have water or a cup for water on their bedside table. During an observation and interview with Resident D, on 10/26/21 at 11:10 a.m., was sitting in his room doing a crossword puzzle. When queried if he had fresh ice water, the resident indicated the water on his bedside table was from 10/25/21. The Styrofoam cup of water was half full and warm. Resident D indicated he was not provided with fresh water unless he request it and it happened "all the time". During an observation on 10/26/21 at 1:35 p.m., Resident G and Resident J were in their room, neither resident had water or a cup for water on their bedside table. During an observation on 10/26/21 at 1:45 p.m., Resident D was sitting in his room and indicated	F 0558	**F 558 Reasonable Accommodations Needs/Preferences** "The facility failed to ensure fresh water was available daily for 3 of 4 residents reviewed for hydration." It is the practice of this provider that each resident will have fresh water at bedside unless contraindicated. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident D– had no ill effects related to hydration · Resident #22 – had no ill effects related to hydration · Resident #38 - had no ill effects related to hydration **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** · Residents who are dependent or rely on staff to provide fresh water have the potential to be affected, unless clinically or medically contraindicated to have at bedside. · 100% audit of residents receiving ice water at bedside will be conducted to ensure residents have fresh water in their rooms. **3: What measures will be put into place or what systemic**	11/13/2021

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	he had not been provided fresh ice water. The resident indicated he had not requested any fresh ice water yet. During an observation on 10/27/21 at 9:40 a.m., Resident G had a medicine cup that was half full of water on his bedside table and Resident J did not have a cup for water or water on his bedside table. During an observation on 10/27/21 at 12:20 p.m., Resident G and Resident J were in the dining room, both residents were drinking fluids independently. During an observation on 10/27/21 at 12:30 p.m., Resident D was eating lunch in his room and was drinking independently. During an interview with the Assistant Director of Health Services (ADHS) on 10/27/21 at 2:31 p.m., indicated the expectation of the facility providing fresh ice water to residents was it was to be provided every shift and there was no set time that ice water was passed to residents. The ADHS indicated it was the responsibility of the night shift staff to switch out the old Styrofoam cups and provide new ones. Review of the record of Resident D on 10/27/21 at 3:15 p.m., indicated the resident's diagnoses included, but were not limited to, Pulmonary fibrosis, Chronic atrial fibrillation, Major depressive disorder, Venous insufficiency, hypertension, Peripheral vascular disease and Chronic obstructive pulmonary disease. The plan of care for Resident D, dated 9/28/21, indicated the resident was risk for dehydration/fluid imbalance.		**changes will be made to ensure that the deficient practice does not recur?** · DHS or designee will in-service all nursing staff on the facilities practice of passing ice water every shift · DHS or designee will be responsible to conduct random audits of 5 residents to ensure that the resident have fresh ice water 3x's a week for 4 weeks, then weekly for 4 weeks, then monthly for 4 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · For quality assurance, the DHS or designee will review any findings and subsequent corrective action at least quarterly for at least two quarters (six months) in the campus quality assurance meetings. Any identified issues will be reviewed in detail by the QAPI committee and new processes put in place to ensure compliance with this regulation.	

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	The Quarterly Minimum Data Set (MDS) assessment for Resident D, dated 9/7/21, indicated the resident was cognitively intact. The resident's decisions were consistent and reasonable. The physician recapitulation for Resident D, dated October 2021, indicated the resident was ordered thin liquids. Review of the record of Resident G on 10/27/21 at 3:26 p.m., indicated the resident's diagnoses included, but were not limited to, dehydration (1/26/21), Hypertensive heart disease with heart failure, Weakness and Hypothyroidism. The plan of care for Resident G, dated 1/26/21, indicated the resident was at risk for dehydration and fluid imbalance. The physician recapitulation for Resident G, dated October 2021, was ordered thin liquids with no straws. Review of the record of Resident J on 10/27/21 at 3:36 p.m., indicated the resident's diagnoses included, but were not limited to, dementia, chronic kidney disease, cardiomegaly, constipation and osteoarthritis. The resident was admitted to the facility on 10/21/2021. The physician recapitulation for Resident J, dated October 2021, thin liquids. This Federal tag relates to Complaint IN00365382. 3.1-3(V)(1)		**5. Date of completion:** 11/13/21	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to provide supervision and assistance for a resident during toileting resulting in the resident falling off the toilet and acquiring an acute subdural hemorrhage (brain bleed) for 1 of 3 residents reviewed for accidents (Resident B). Finding include: Review of the record of Resident B on 10/25/21 at 1:00 p.m., indicated the resident's diagnoses included, but were not limited to, emphysema, Alzheimer's disease, dementia, dysphagia, major depressive disorder, anxiety, hypertension, muscle weakness, difficulty walking, unsteadiness on feet, history of falling, Parkinson disease and traumatic brain injury. The fall care plan for Resident B, dated 5/19/21, indicated the resident was at risk for falling related to Alzheimer's disease, traumatic brain injury, muscle weakness, cerebral disease, chronic pulmonary disease, hypertension, anxiety, osteoarthritis, convulsions, tremors and sepsis. The interventions included, but were not limited to, do not leave the resident alone on the toilet (7/24/21). The fall risk re-assessment for Resident B, dated 6/27/21, indicated the resident's risk factors for	F 0689	**F 689 Free of Accidents Hazards/Supervision/Devices** " The facility failed to provide supervision and assistance for a resident during toileting resulting in the resident falling off the toilet and acquiring an acute subdural hemorrhage for 1 of 3 residents reviewed for accidents." It is the practice of this provider that each resident will be assessed for fall risk upon admission and routinely thereafter, and interventions implemented accordingly. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident B– returned to the campus and has fall interventions in place **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** · All residents with falls have the potential to be affected. All residents were assessed for fall	11/13/2021

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	falls were as follows- the resident had cognitive or memory impairment that effects safety and judgement, had difficulty understanding and following directions, required assistance with transfers, refused to comply with safety measures such as call light use and had a neurological disorder. The Quarterly Minimum Data Set (MDS) assessment for Resident B, dated 7/16/21, indicated the resident severely cognitively impaired for daily decision making. The resident required extensive assistance of two people to transfer and did not ambulate. The resident utilized a wheelchair for mobility. The fall event report for Resident B, dated 7/23/21 at 1:43 p.m., indicated the resident had a fall in her bathroom that was unwitnessed. The resident complained of pain in her buttocks. The resident had no injury. The immediate intervention implemented was "do not leave resident alone on the toilet". The nurse was called to the resident's room due to the resident was found on the floor beside her toilet. The resident had tried to get herself off the toilet. The fall event report for Resident B, dated 7/25/21 at 7:16 p.m., indicated the resident had an unwitnessed fall in her bathroom, the resident was attempting to get herself off the toilet. The resident complained her head was hurting. The physician was notified and an order was received to send the resident to the emergency room. The local hospital emergency room report for Resident B, dated 7/25/21 at 9:49 p.m., indicated the resident Computed Tomography (CT) scan of the head due to a fall with resulting in head trauma and pain. The resident had an acute subdural		risk upon admission and routinely thereafter, and interventions implemented accordingly. · 100% audit of residents with falls in the last 30 days were reviewed to ensure fall interventions are in place. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · DHS or designee will in-service all nursing staff on the Falls Management Guidelines · The DHS or designee will complete an audit at varied times on varied shifts to ensure fall interventions are in place as care planned. Said audit will include 5 residents weekly X 4 weeks, then monthly X 5 months, then quarterly, ongoing. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The DHS or designee will complete an audit at varied times on varied shifts to ensure fall interventions are in place as care planned. Said audit will include 5 residents weekly X 4 weeks, then monthly X 5 months, then quarterly, ongoing.	

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	hemorrhage in the left parietal region measuring 3 millimeters in thickness. The finding was discussed with the Major Medical hospital neurosurgeon and it was decided to transfer the resident to the Major Medical Hospital. The "Careflight note" for Resident B, dated 7/26/21 at 1:40 a.m., indicated the resident had been at an extended care facility, slid off the toilet striking her head. The resident was loaded into the aircraft and took to the Major Medical Hospital in serious condition. The Major Medical Hospital note for Resident B, dated 7/26/21, indicated the resident presented with a head injury, the resident was found to have a subdural hemorrhage from falling from the toilet and striking her head. The resident had a nonfocal neurological exam. The resident was alert and conversive. The trauma team was contacted and the resident would be hospitalized for further work-up and management. The recommendations for Resident B included, but were not limited to "do not leave unattended" while toileting. The resident was discharged back to the facility on 7/27/21. During an observation and interview on 10/26/21 at 1:09 p.m., QMA 1 and CNA 2 transferred Resident B from the wheelchair to the toilet using a sit to stand mechanical lift. QMA 1 and CNA 2 indicated they never left Resident B unattended on the toilet, because other staff had before and the resident fell off the toilet. During an interview with RN 3 on 10/27/21 at 12:49 p.m., indicated Resident B fell off the toilet on 7/23/21. The resident had been left unattended by staff. RN 3 was unsure who the CNA was that left the resident unattended on 7/23/21. RN 3		**5. Date of completion:** 11/13/21	

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	indicated on 7/25/21 Resident B was left unattended on the toilet by CNA 4 who no longer works at the facility and fell requiring hospitalization. CNA 4 should not left a cognitively impaired resident unattended on the toilet. During an interview with the Assistant Director of Health Services on 10/27/21 at 2:00 p.m., indicated when Resident B fell on 7/23/21 she should have been transferred by two CNA's and a gait belt and when she fell on 7/25/21 the resident should have been transferred with a sit to stand mechanical lift and one staff. The fall management program provided by Clinical Support on 10/26/21 at 11:55 a.m., indicated the facility strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. This Federal tag relates to Complaint IN00365382. 3.1-45(a)			