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	09/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 6, 7, 8, 9, 12, and 13, 2022 Facility number: 011387 Provider number: 155762 AIM number: 100853180 Census Bed Type: SNF/NF: 40 SNF: 12 Residential: 17 Total: 69 Census Payor Type: Medicare: 15 Medicaid: 27 Other: 10 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 19, 2022	F 0000	The submission of this plan of correction does not indicate an admission by Forest Park Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Forest Park Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 0677	**F 677 – ADL Care Provided for**	10/05/2022

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

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	Based on observation, interview, and record review, the facility failed to assist a resident with a meal per their care plan (Resident 51) and failed to assist a dependent resident with showering activities (Resident 204) for 2 of 3 residents reviewed for activities of daily living. Findings include: 1. The clinical record for Resident 51 was reviewed on 9/8/2022 at 2:35 p.m. The medical diagnoses included, but were not limited to, muscle weakness and obstructive uropathy. A Quarterly Minimum Data Set Assessment dated 6/12/2022, indicated that Resident 51 was mildly cognitively impaired and needed extensive assistance of one staff member for eating. An observation of Resident 51 on 9/6/2022 at 12:43 indicated she was alone and laying in bed, leaning to the left with her lunch tray in front of her on the over bed table. She was attempting to eat meat and vegetables. An observation of Resident 51 on 9/6/2022 at 1:02 p.m. indicated she was alone and laying in bed, leaning to the left with less than half of her meal consumed. A care plan, dated 3/22/2022, indicated that Resident 51 was to " ...Go to DR. [Dining Room] If in bed need to assist with meals ..." An interview with Clinical Resident Care Associate 2 on 9/8/2022 at 2:50 p.m. indicated that Resident 51 is supposed to go to the dining room for meals, but if she stays in bed then they are to help her with her meals.		**Dependent Residents** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident 51 was assisted with her meal. Resident 204 was given a shower per her preference. **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** Care plans were reviewed to determine which residents need assistance with meals. The shower schedule was reviewed and residents who were identified as not receiving a shower, were offered a shower. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff were educated on providing assistance with meals for dependent residents and the Guidelines for Bathing Preference policy. The Director of Nursing or Designee will observe all dependent residents, who are care planned to receive assistance with their meals, to ensure they're receiving assistance during 5 meals each week for four weeks,	

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	2. The clinical record for Resident 204 was reviewed on 9/6/2022 at 3:17 p.m. The medical diagnoses included, but were not limited to, muscle wasting and Alzheimer's' dementia. An Admission Minimum Data Set Assessment dated 9/6/2022, indicated that Resident 204 admitted on 9/1/2022, was cognitively impaired, and needed assistance of one staff for bathing services. A care plant dated 9/6/2022, indicated the Resident 204 was to receive showers on Mondays and Wednesdays. An interview and observation of Resident 204 on 9/6/2022 at 3:14 p.m. indicated she reported not having a shower since she admitted to the facility. Her skin appeared dry, and her hair appeared unkempt and greasy. Shower documentation indicated that Resident 204 had not received a shower from 9/1/2022 until 9/7/2022. A policy entitled, "Guidelines for Bathing Preference", was provided by the Executive Director on 9/12/2022 at 10:30 a.m. The policy indicated, " ...Bathing shall occur at least twice a week unless resident preference stated otherwise." 3.1-38(a)(2)(B) 3.1-38(a)(2)(D)		then 5 dependent residents will be reviewed every other week for 2 months, then 5 dependent residents monthly for 2 months. The Director of Nursing or Designee will audit shower documentation for all Residents 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: 10/5/2022**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, observation, and record review the facility failed to complete preventative dressing changes to heels and the right fourth finger for Resident 37 for 1 of 6 reviewed for non-pressure skin impairments. Findings include: The clinical record for Resident 37 was reviewed on 9/6/2022 at 2:19 p.m. Diagnoses included, but were not limited to, Parkinson's disease and tremor. A Quarterly Minimum Data Set Assessment, dated 8/8/2022, indicated that Resident 37 was cognitively intact. A physician order, dated 3/18/2021, indicated for Resident 37 to have heel protectors on while in bed as resident will allow. A physician order, dated 6/10/2021, indicated for Resident 37 to have a preventative foam dressing to the right fourth finger changed every week and as needed. An interview with Resident 37 on 9/6/2022 at 2:19 p.m. indicated that she did not ever wear heel protectors or the dressing to her right hand because they were uncomfortable.	F 0684	**F 684 – Quality of Care** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident 37's Self Determination Observations were reviewed from 4/26/21, 11/15/2020, 10/31/18, 1/18/18, 10/1/17. Resident 37 suffered no adverse effects from the deficient practice. **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 preventative dressing changes were reviewed to ensure orders were 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? The Director of Nursing or Designee will audit all Resident with Preventative Dressing changes and appropriate documentation 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5	10/05/2022

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	An observation on 9/6/2022 at 2:19 p.m. indicated that Resident 37 was laying in bed with her legs on towels due to seeping areas. She did not have heel protectors on or a foam dressing to the right fourth finger. An observation on 9/8/2022 at 2:51 p.m. indicated Resident 37 was laying in bed with her legs on towels due to seeping areas. She did not have heel protector on or a foam dressing to the right fourth finger. She stated she did not want any dressings at this time. An observation on 9/9/2022 at 1:31 p.m. indicated Resident 37 was laying in bed with her legs on towels due to seeping areas. She did not have heel protector on or a foam dressing to the right fourth finger. She stated she did not want any dressings at this time. The Administration Record indicated the Resident 37 had heel protectors in place on 9/6/2022, 9/8/2022, and 9/9/2022. The Administration Record indicated that Resident 37 had a foam dressing changed to the right fourth finger changed on 9/8/2022 and was in place on 9/6/2022, 9/8/2022, and 9/9/2022. An interview with LPN 1 on 9/9/2022 at 2:32 p.m. indicated that treatment orders should be completed per physician order. 3.1-37(1)		Residents monthly for 2 months. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: 10/5/2022**	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper			

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	treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview, observation, and record review, the facility failed to assist Resident 37 with optometry services for 1 of 1 residents reviewed for visual impairments. Findings include: The clinical record for Resident 37 was reviewed on 9/6/2022 at 2:19 p.m. Diagnoses included, but were not limited to, Parkinson's disease and tremor. A Quarterly Minimum Data Set Assessment, dated 8/8/2022, indicated that Resident 37 was cognitively intact, does not wear glasses and had adequate vision. An observation with Resident 37 on 9/66/2022 at 2:19 p.m. indicated she wears glasses. An interview with Resident 37 on 9/6/2022 at 2:19 p.m. indicated that she cannot remember the last time she saw the eye doctor, and she reported her vision gets blurry. The last optometry visit for Resident 37 was on 9/4/2019 and recommended new glasses.	F 0685	**F 685 Treatment/Devices to Maintain Hearing/Vision** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** An Optometry appointment was made for Resident 37, with no adverse effects due to the deficient practice. **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 and or Responsible Parties were interviewed to determine the need for Optometry services. Appointments were made as needed. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DSS was educated on	10/05/2022

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	An eye care consent for Resident 37 was completed on 6/8/2021 for in house ancillary services. An interview with Clinical Support on 9/12/2022 at 3:16 p.m. indicated that there was not a specific appointment for scheduling ancillary services, but clinical staff would assist with scheduling and obtaining ancillary services, such as dental or vision services. 3.1-39(a)(1)		determining need for Ancillary Services quarterly at Resident First Meetings. DSS or designee will audit Resident charts for Ancillary service consents. Every day for 5 days a week times 4 weeks during CCM meetings, then weekly for 2 weeks, then monthly for 2 months Residents with new complaints of vision impairment will be referred for Optometry appointments. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: 10/5/2022**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of			

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	a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to implement pressure relieving boots and failed to float a resident's heels for a resident who had an unstageable pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident 154). Finding include: During an observation on 9/07/22 at 11:40 a.m., Resident 154 was laying in bed, no heel protectors in place, heels laying flat on the resident's bed. During an observation on 9/8/22 at 11:15 a.m., Resident 154 was laying in bed with eyes closed. The resident did not have heel protectors in place, heels laying flat on the resident's bed. The resident's heel protectors observed to be up on top of her closet. During an observation on 9/9/22 at 3:00 p.m., the Wound Nurse and LPN 7 provided the wound care treatment of derma blue and allevyn dressing to the right heel of Resident 154. The right heel had a black open area with callous skin around with some black drainage on the old dressing. The resident wound nurse measured the wound .5	F 0686	**F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** The wounds for Resident 154 are healed. Resident suffered no adverse effects from deficient practice. Resident 154 heel protectors were applied while in bed and heels were floated while in recliner. **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 Pressure Relief Interventions were reviewed to ensure orders were 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?**	10/05/2022

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	centimeters cm by .6 cm. The resident was sitting in her recliner with her heels flat on the recliner foot rest. LPN 7 placed a pillow under heels to float them. The resident's heel protectors were observed on top of her closet. The resident indicated staff had only placed the heel protectors boots on her one time when she was in bed since she had been at the facility. The resident indicated it did not bother her to wear the heel protector boots and she had never refused to wear them, staff just did not put them on her. During an observation on 9/12/22 at 10:05 a.m., Resident 154 was sitting in her recliner, heels were not floated and were were laying flat on the recliner foot rest. The resident indicated she did have a pillow to float her heels while in the recliner, but she was unsure what happened to it. During an interview with the Director Of Health Services (DHS) on 9/12/22 at 12:47 p.m., indicated the nurse was responsible to ensure Resident 154 had heel protector boots on while in bed and ensure her heel were floated while in the recliner. Review of the record of Resident 154 on 9/12/22 at 12:56 p.m., indicated the resident's diagnoses included, but were not limited to, Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, heart failure, Chronic kidney disease, stage 2 (mild), Chronic respiratory failure with hypoxia, Chronic obstructive pulmonary disease, dementia without behavioral disturbance, Major depressive disorder, Repeated falls and unstageable pressure ulcer. The physician recapitulation for Resident 154, dated September 2022, indicated the resident was		All Nursing staff educated on Guidelines for Pressure Prevention policy. The Director of Nursing or Designee will audit all Residents with Preventative Interventions for Pressure Ulcers to ensure they're in place 3 times a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: 10/5/2022**	

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	ordered heel protectors or antipressure boots while in bed as resident will allow. The plan of care for Resident 154, dated 6/9/22, indicated the resident had a pressure ulcer on the right heel. The Admission Minimum Data Set (MDS) assessment for Resident 154, dated 6/10/22, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident had no behaviors of rejection of care. The resident required extensive assistance of two staff for bed mobility and transfers. The resident was at risk of developing a pressure ulcer. The resident had one unstageable-deep tissue injury. The resident had pressure reducing device for the bed and chair. The pressure ulcer assessment for Resident 154, dated 9/9/22, indicated the resident had an unstageable pressure ulcer with slough and eschar on the right heel. The pressure ulcer measured 0.6 cm by 0.5 cm. The resident had serpurulent (yellow or tan, cloudy and thick drainage). 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary			

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	incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to keep a urinary catheter bag free from contact with the floor for 1 of 3 residents reviewed for indwelling catheter management. Findings include: The clinical record for Resident 51 was reviewed on 9/8/2022 at 2:35 p.m. The medical diagnoses included, but were not limited to, muscle weakness and obstructive uropathy.	F 0690	**F 690 – Bowel/Bladder Incontinence, Catheter, UTI** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident 51 catheter tubing was readjusted to be elevated from the floor. Resident suffered no adverse effects from deficient practice. **2: How other residents having the potential to be affected by**	10/05/2022

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	A physician order dated 5/16/2021 indicated that Resident 51 had an indwelling urinary catheter for obstructive uropathy. An observation on 9/8/2022 at 2:35 p.m., indicated Resident 51 was sitting in her wheelchair at the time with her urinary catheter bag and tubing contacting the floor. An observation on 9/8/2022 at 2:50 p.m., indicated Resident 51 was sitting in her wheelchair at the time with her urinary catheter bag and tubing contacting the floor. An interview with Clinical Resident Care Associate 2 on 9/8/2022 at 2:50 p.m. indicated that the urinary catheter bag and tubing should be kept free from the floor and due to Resident 51's wheelchair, it is hard to keep it off the floor. A policy entitled, "Urinary Catheter Care", was provided by the Executive Director on 9/9/2022 at 1:07 p.m. The policy indicated, " ...Be sure the catheter tubing and drainage bag are kept off the floor ..." 3.1-41(b)		**the same deficient practice will be identified and what corrective action will be taken** All Residents with Catheters were observed to ensure Foley Catheter drainage systems were not in contact with the floor. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff were educated on Urinary Catheter Care standard operating procedure. The Director of Nursing or designee will observe every Resident with a catheter to ensure the system is not touching the floor 5 times a week for 4 weeks, then every other week for 2 months, then monthly for 2 months. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or	

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	155762	A. BUILDING 00 B. WING	09/13/2022

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			extend monitoring times according to outcomes **5. Date of completion: 10/5/22**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed change the oxygen tubing at least once a month for Resident 51 and failed to date the oxygen tubing for Resident 37 for 2 of 3 residents reviewed for oxygen therapy. Findings include: 1. The clinical record for Resident 51 was reviewed on 9/8/2022 at 2:35 p.m. The medical diagnoses included, but were not limited to, muscle weakness and chronic respiratory failure. A Quarterly Minimum Data Set Assessment dated 6/12/2022, indicated that Resident 51 was mildly cognitively impaired and utilized oxygen therapy. An observation of Resident 51 on 9/6/2022 at 12:43 indicated oxygen tubing dated for 7/10/2022.	F 0695	**F 695 – Respiratory/Tracheostomy Care and Suctioning** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Resident 51 oxygen tubing was changed. Resident has no adverse effects from deficient practice Resident 37 oxygen tubing was dated. Resident has no adverse effects from deficient practice **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 Oxygen orders	10/05/2022

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	A physician order, dated 5/12/2021, indicated for Resident 51 to have her oxygen tubing changed the first of the month every month. A physician order, dated 6/4/2021, indicated for Resident 51 to have oxygen therapy at 3-4 liters per minute continuously. 2. The clinical record for Resident 37 was reviewed on 9/6/2022 at 2:19 p.m. Diagnoses included, but were not limited to, Parkinson's disease and tremor. A Quarterly Minimum Data Set Assessment, dated 8/8/2022, indicated that Resident 37 was cognitively intact. An interview with Resident 37 on 9/6/2022 at 2:19 p.m. indicated that she did not believe they have changed her oxygen tubing since it was started. An observation on 9/6/2022 at 2:19 p.m., indicated Resident 37's oxygen tubing did not have an initiation date. A physician order, dated 7/17/2022, indicated for Resident 37 to have her oxygen tubing changed monthly. A physician order, dated 7/18/2022, indicated for Resident 37 to have oxygen therapy at 2 liters per minute continuously. A policy entitled, "Administration of Oxygen", was provided by the Executive Director on 9/8/2022 at 10:30 a.m. The policy indicated, " ...Date the tubing for the date it was imitated a. The tubing should be changed monthly and PRN [as needed] ..."		were reviewed to ensure that tubing is changed per order and dated per policy. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff were educated on the policy of Administration of Oxygen. The Director of Nursing or designee will observe every Resident with oxygen orders to ensure the tubing has been changed per MD orders and dated per policy 1 time a week for 4 weeks, then 5 Residents every other week for 2 months, then 5 Residents monthly for 2 months. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.	

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	3.1-47(a)(6)		**5. Date of completion: 10/5/2022**	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure medications were returned to pharmacy for 2 of 4 residents who were discharged from the health center. (Resident 20 and Resident 254) Findings include: The medication room was observed with Qualified Medication Aide (QMA) 8 on 9/9/22 at 10:00 a.m. There were numerous medication cards located on the counter for Resident 20 and Resident 254. QMA 8 indicated the night shift staff were responsible for filling out the paperwork for the medication return involving the residents who were discharged. The medication room was observed on 9/12/22 at 1:28 p.m. There were 3 blue totes with numerous medication cards for different residents, including Resident 20 and Resident 254. There were medication return forms completed and dated for 9/11/22. The clinical records for Resident 20 and Resident 254 were reviewed on 9/9/22 at 3:35 p.m. Resident 20 was discharged on 8/28/22 and Resident 254 was discharged on 8/3/22. A policy titled Guidelines for Disposal of Non-Controlled Drugs, revised 12/1/21, was provided by the Regional Minimum Data Set (MDS) Staff on 9/12/22 at 3:08 p.m. The policy indicated the following, "...To ensure medications are destroyed in accordance with appropriate infection control, safety and State Laws and Federal Regulations...3. There may be some medications for residents who have been	F 0755	**F 755 – Pharmacy Srvcs/Procedures/Pharmacist/Records** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Medications for Resident 20 and 254 were returned to the pharmacy. There were no adverse effects from deficient practice. **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** Discharged residents for the last 30 days have been reviewed to ensure medications were returned to the pharmacy.3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion:**	10/05/2022

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	discharged or expire that may be returned to the pharmacy for credit...." 3.1-25(r)		**10/5/2022**	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or			

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	damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview and record review the facility failed to offer dental services and failed to obtain a dental appointment for a resident with poor dental health for 1 of 1 resident reviewed for dental services (Resident 27). Finding include: During an observation and interview on 9/06/22 at 2:47 p.m., Resident 27 indicated he had been requesting to be seen by the dentist for awhile now. The resident had talked with the Social Service Director about needing to see the dentist, but he was unsure why he still had not been seen by the dentist. The resident indicated he had missing teeth and teeth splitting off. The resident indicated sometimes his teeth hurt. The resident indicated he had not been seen by a dentist since admission to the facility. The resident was observed to have missing teeth, split teeth and in poor shape. Review of the record of Resident 27 on 9/9/22 at 1:40 p.m., indicated the resident's diagnoses included, but were not limited to, hypertensive heart disease with heart failure, peripheral vascular disease, primary generalized (osteo)arthritis, major depressive disorder, history	F 0791	**F 791 – Routine/emergency Dental Srvcs in NFs** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** A Dental appointment was made for Resident 27, with no adverse effects due to the deficient practice. **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 and or Responsible Parties were interviewed to determine the need for Dental services. Appointments were made as needed. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DSS was educated on determining need for Ancillary	10/05/2022

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	of skin cancer and dementia. The electronic health record for Resident 27 had no documentation of the resident receiving dental services or being offered dental services. The plan of care for Resident 27, dated 11/21/2019, indicated the resident had the potential for mouth pain related to having his own teeth with obvious or likely cavity and/or broken teeth. The interventions included, but were not limited to, dental evaluation and intervention as needed. The Annual Minimum Data (MDS) assessment for Resident 27, dated 3/8/22, indicated the resident had obvious or likely cavity or broken natural teeth. The Quarterly MDS assessment for Resident 27, dated 8/3/22, the resident was cognitively intact, decisions reasonable and consistent. During an interview with the Administrator on 9/12/22 at 10:40 a.m., indicated she filled out the request for ancillary services to see the dentist for Resident 27 on 9/11/22. The Administrator indicated she would look for further documentation that Resident 27 was offered ancillary services and if the resident had seen a dentist since being at the facility. During an interview with LPN 1 on 9/12/22 at 2:04 p.m., indicated the facility was unable to find documentation that Resident 27 had been offered dental services or that the resident had been seen by a dentist since his admission to the facility. The resident would be seen by a dentist within the next two weeks. During an interview with LPN 13 on 9/12/22 at 3:16		Services quarterly at Resident First Meetings. DSS or designee will audit Resident charts for Ancillary service consents. Audits will be conducted every day for 5 days a week times 4 weeks during CCM meetings, then weekly for 2 weeks, then monthly for 2 months. Residents with new complaints of tooth discomfort will be referred for Dental appointments **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: 10/5/2022**	

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	p.m., the facility did not have a policy for ancillary services. The protocol was staff would assist with obtaining services and scheduling for the residents to see the dentist. 3.1-24(a)(1)			
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired	F 9999	**F 9999 – Personnel** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice** Personnel Files for staff 10,11 and 12 were reviewed. **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** Audit of all employee files were conducted; all missing items were obtained. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Department heads have been educated on personnel file check list for new hires. Business office Manager or designee will audit all newly hired staff personnel files monthly to	10/05/2022

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	residents and to gain understanding of the current standards of care for residents with dementia. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method, (5 TU PPD), administered by person having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or		ensure all required documents are included. **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?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: 10/5/2022**	

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	preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide staff members with pre-employment screening, physical exam, orientation that's general and specific, resident rights, abuse, and/or dementia training for 3 of 10 employee personal files reviewed. ((Dietary Staff 10, Certified Resident Care Assistant (CRCA) 11, and Resident Care Assistant (RCA) 12)). Findings include: The staff personnel files were reviewed on 9/12/22 at 11:50 a.m. The following was found to be missing: 1. Dietary Staff 10's file did not contain pre-employment screening consisting of a criminal background check and reference check, physical exam, general and/or specific orientation, resident rights and/or abuse in-services. 2. CRCA 11's file did not contain pre-employment screening consisting of a criminal background check and reference check, general and/or specific orientation, resident rights, abuse, and/or dementia in-services. 3. RCA 12's file did not contain pre-employment screening consisting of a reference check, physical exam, general and/or specific orientation, resident rights and/or abuse in-services. An interview conducted with the Executive Director on 9/12/22 at 1:47 p.m., indicated they			

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	were unable to locate the missing items from the employee files. The facility was in the process of switching positions and found out some items were not being completed pertaining to employee files.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 6, 7, 8, 9, 12, and 13, 2022 Facility number: 011387 Residential Census: 17 Forest Park Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on September 19, 2022	R 0000	The submission of this plan of correction does not indicate an admission by Forest Park Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Forest Park Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	