STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155762	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/13/2022	
	ROVIDER OR SUPPLIER			2401 S	ADDRESS, CITY, STATE, ZIP COD OUTH L ST OND, IN 47374		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
F 0677	Licensure Survey. Residential Licensur Survey dates: Septe Facility number: 01 Provider number: 1 AIM number: 1008  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 is accordance with 410 Quality review com	mber 6, 7, 8, 9, 12, and 13, 2022  1387 55762 53180  reflect State Findings cited in 0 IAC 16.2-3.1.  pleted on September 19, 2022	F 00	000	The submission of this plan of correction does not indicate at admission by Forest Park Heat Campus that the findings and allegations contained herein at accurate, true representation the quality of care provided, a living environment provided to residents of Forest Park Healt Campus. The facility recognizits obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains in substantial compliance with requirements of participation f skilled health care facilities. To this end, the plan of corrections hall serve as the credible allegation of compliance with state and federal requirements governing the management of facility. It is thus submitted as matter of statute only. The fact respectfully requests from the department a desk review for substantial compliance.	n alth ire of nd othe th es or and othe fths fthis a	
SS=D Bldg. 00	ADL Care Provide §483.24(a)(2) A re carry out activities necessary service	d for Dependent Residents esident who is unable to of daily living receives the s to maintain good g, and personal and oral	F 06	577	F 677 – ADL Care Provided f	or	10/05/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155762	B. W	ING		09/13/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			OUTH L ST		
FOREST	PARK HEALTH CA	AMPUS	RICHMOND, IN 47374				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on, interview, and record			Dependent Residents		
		failed to assist a resident with a			1: What corrective action(s)	will	
	meal per their care plan (Resident 51) and failed to				be accomplished for those		
		esident with showering			residents found to have		
	activities (Resident 204) for 2 of 3 residents				affected by the deficient		
	reviewed for activities of daily living.				practice		
					Resident 51 was assisted wit		
	Findings include:				meal. Resident 204 was give	n a	
	<b>.</b> _, _,				shower per her preference.		
		rd for Resident 51 was reviewed			2: How other residents hav	_	
		p.m. The medical diagnoses			the potential to be affected	-	
	· · · · · · · · · · · · · · · · · · ·	not limited to, muscle			the same deficient practice	will	
	weakness and obstructive uropathy.				be identified and what		
					corrective action will be take	en	
		um Data Set Assessment dated		Care plans were reviewed to			
		d that Resident 51 was mildly		determine which residents need			
		d and needed extensive			assistance with meals. The		
	assistance of one sta	aff member for eating.			shower schedule was review		
					and residents who were ident		
		Resident 51 on 9/6/2022 at			as not receiving a shower, we	ere	
		was alone and laying in bed,			offered a shower.		
	_	vith her lunch tray in front of			3: What measures will be pu		
		table. She was attempting to			into place or what systemic		
	eat meat and vegeta	ıbles.			changes will be made to		
					ensure that the deficient		
		Resident 51 on 9/6/2022 at 1:02			practice does not recur?		
		was alone and laying in bed,					
	l ~	vith less than half of her meal			All nursing staff were educat		
	consumed.				providing assistance with me		
		\(\alpha\)			for dependent residents and		
	_	8/22/2022, indicated that			Guidelines for Bathing Prefer	ence	
		"Go to DR. [Dining Room] If			policy.		
	in bed need to assis	t with meals"			The Diverton of Normalian		
	An intom:	Clinical Decident Con-			The Director of Nursing or		
		Clinical Resident Care			Designee will observe all		
		2022 at 2:50 p.m. indicated that			dependent residents, who are		
		osed to go to the dining room			planned to receive assistance		
		e stays in bed then they are to		their meals, to ensure they're			
	help her with her m	eals.			receiving assistance during 5		
	Ī		1		I meals each week for four we	eks	1

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155762	B. W	ING		09/13/	/2022
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIEF	₹			OUTH L ST		
FOREST	PARK HEALTH CA	AMBUS			OND, IN 47374		
FUREST	PARK HEALTH CA	AWPUS		KICHIVI	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2. The clinical reco	rd for Resident 204 was			then 5 dependent residents w	ill be	
	reviewed on 9/6/20	22 at 3:17 p.m. The medical			reviewed every other week for	r 2	
	diagnoses included,	, but were not limited to,			months, then 5 dependent		
	muscle wasting and	l Alzheimer's' dementia.			residents monthly for 2 month	S.	
		imum Data Set Assessment			The Director of Nursing or		
	· · · · · · · · · · · · · · · · · · ·	icated that Resident 204			Designee will audit shower		
	admitted on 9/1/2022, was cognitively impaired,				documentation for all Residen	ts 3	
	and needed assistan	nce of one staff for bathing			times a week for 4 weeks, the	n 5	
	services.				Residents every other week for	or 2	
					months, then 5 Residents mor	nthly	
	-	9/6/2022, indicated the			for 2 months.		
	Resident 204 was to receive showers on Mondays						
	and Wednesdays.						
		bservation of Resident 204 on					
	-	m. indicated she reported not			4: How the corrective action		
	-	nce she admitted to the facility.			will be monitored to ensure t	-	
		dry, and her hair appeared			deficient practice will not rec	cur	
	unkempt and greasy	y.			i.e. what quality assurance		
					program will be put into plac		
		tion indicated that Resident			Audit findings will be submitted		
		ed a shower from 9/1/2022 until			the QAPI Committee monthly		
	9/7/2022.				two months, then quarterly for		
					quarters to ensure compliance	9	
		Guidelines for Bathing			goals. The QAPI Committee		
	-	rovided by the Executive			reserves the right to modify or		
		022 at 10:30 a.m. The policy			extend monitoring times accor	rding	
		ng shall occur at least twice a			to outcomes.		
	week unless resider	nt preference stated					
	otherwise."				5. Date of completion:		
	2.1.20(.)(2)(7)				10/5/2022		
	3.1-38(a)(2)(B)						
	3.1-38(a)(2)(D)						
F 0684	402 DE						
SS=D	483.25						
	Quality of Care	-f					
Bldg. 00	§ 483.25 Quality of	oi care					

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CE	NIERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039			
	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY			
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED			
			155762	B. WING		09/13/2022			
				CTREE	CADDREGG CITY CTATE ZID COD				
	NAME OF P	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP COD				
	FODEST		AMDUC	2401 SOUTH L ST					
	FUREST	PARK HEALTH CA	AMPUS	RICHMOND, IN 47374					
	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
		Quality of care is	a fundamental principle that						
		•	ment and care provided to						
		facility residents. I	-						
		•	ssessment of a resident, the						
		1	re that residents receive						
			e in accordance with						
		professional standards of practice, the comprehensive person-centered care plan,							
	and the residents' choices.		E 0694	E 694 Quality of Core	10/05/2022				
		Based on interview, observation, and record review the facility failed to complete preventative		F 0684	F 684 – Quality of Care	10/05/2022			
					1: What corrective action(s)	WIII			
					be accomplished for those				
			heels and the right fourth		residents found to have				
		_	37 for 1 of 6 reviewed for		affected by the deficient				
		non-pressure skin ii	mpairments.		practice				
					Resident 37's Self Determinat				
		Findings include:			Observations were reviewed f				
					4/26/21, 11/15/2020, 10/31/18				
			for Resident 37 was reviewed		1/18/18, 10/1/17. Resident 37	7			
			p.m. Diagnoses included, but		suffered no adverse effects from	om			
		were not limited to,	Parkinson's disease and		the deficient practice.				
		tremor.			2: How other residents havi	ng			
					the potential to be affected by	ру			
		A Quarterly Minim	um Data Set Assessment,		the same deficient practice v	will			
		dated 8/8/2022, ind	icated that Resident 37 was		be identified and what				
		cognitively intact.			corrective action will be take	en			
					All Residents with preventativ	e			
		A physician order,	dated 3/18/2021, indicated for		dressing changes were review	ved			
		Resident 37 to have	e heel protectors on while in		to ensure orders were in place	e.3:			
		bed as resident will	allow.		What measures will be put int	o			
					place or what systemic chang				
		A physician order,	dated 6/10/2021, indicated for		will be made to ensure that th				
			e a preventative foam dressing		deficient practice does not red				
			inger changed every week and		The Director of Nursing or				
		as needed.			Designee will audit all Reside	nt			
					with Preventative Dressing				
		An interview with I	Resident 37 on 9/6/2022 at 2:19		changes and appropriate				
			she did not ever wear heel		documentation 3 times a wee	k for			
		-	essing to her right hand		4 weeks, then 5 Residents ev				
		protectors of the dif	cooming to not right flamu	1	+ weeks, then a residents ev	⊂ıy			

because they were uncomfortable.

other week for 2 months, then 5

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

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155762		A. BUILDING 00 COMPLETE  B. WING 09/13/20				
	PROVIDER OR SUPPLIER		2401	r address, city, state, zip co SOUTH L ST MOND, IN 47374	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	An observation on 9 that Resident 37 wa on towels due to see heel protectors on or fourth finger.  An observation on 9 Resident 37 was lay towels due to seepir heel protector on or fourth finger. She st dressings at this tim  An observation on 9 Resident 37 was lay towels due to seepir heel protector on or fourth finger. She st dressings at this tim  The Administration 37 had heel protector 9/8/2022, and 9/9/20  The Administration Resident 37 had a for right fourth finger or place on 9/6/2022, 9  An interview with L	2/6/2022 at 2:19 p.m. indicated is laying in bed with her legs eping areas. She did not have in a foam dressing to the right 2/8/2022 at 2:51 p.m. indicated ing in bed with her legs on ing areas. She did not have a foam dressing to the right atted she did not want any e.  2/9/2022 at 1:31 p.m. indicated ing in bed with her legs on ing areas. She did not have a foam dressing to the right atted she did not have a foam dressing to the right atted she did not want any e.  2/9/2022 at 1:31 p.m. indicated ing in bed with her legs on ing areas. She did not have a foam dressing to the right atted she did not want any e.  2/9/2022 at 2:32 p.m. indicated that pam dressing changed to the hanged on 9/8/2022 and was in 2/8/2022, and 9/9/2022.  2/PN 1 on 9/9/2022 at 2:32 p.m. inent orders should be		Residents monthly for 2 4: How the corrective will be monitored to el deficient practice will i.e. what quality assurprogram will be put in Audit findings will be suthe QAPI Committee mitwo months, then quart quarters to ensure comigoals. The QAPI Committee mestres the right to me extend monitoring times to outcomes.  5. Date of completion 10/5/2022	action nsure the not recur ance to place? abmitted to conthly for erly for two pliance nittee odify or s according	
F 0685 SS=D Bldg. 00	§483.25(a) Vision	s to Maintain Hearing/Vision and hearing				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155762	B. W	ING		09/13/	2022
	PROVIDER OR SUPPLIER PARK HEALTH CA		STREET ADDRESS, CITY, STATE, ZIP COD 2401 SOUTH L ST RICHMOND, IN 47374				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	treatment and ass vision and hearing if necessary, assis §483.25(a)(1) In n §483.25(a)(2) By a to and from the of specializing in the hearing impairment professional specializing or hearing a Based on interview, review, the facility optometry services for visual impairment Findings include:  The clinical record on 9/6/2022 at 2:19 were not limited to, tremor.  A Quarterly Minimulated 8/8/2022, indicated 8/8/2022, indicated that stop in the p.m. indicated that stop is the saw the eyvision gets blurry.  The last optometry	distive devices to maintain abilities, the facility must, set the resident- making appointments, and arranging for transportation fice of a practitioner treatment of vision or not or the office of a dializing in the provision of assistive devices.  The observation, and record failed to assist Resident 37 with for 1 of 1 residents reviewed ents.  The observation of the obs	F 00		F 685 Treatment/Devices to Maintain Hearing/Vision 1: What corrective action(s) to 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 defipractice. 2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be take All residents and or Responsible Parties were interviewed to determine the need for Optom 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	cient ng y vill n ole etry	10/05/2022

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

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155762		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR         A. BUILDING       00       COMPLETE         B. WING       09/13/202			ETED		
	PROVIDER OR SUPPLIER		24	401 SC	DDRESS, CITY, STATE, ZIP COD DUTH L ST DND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	An eye care consent for Resident 37 was completed on 6/8/2021 for in house ancillary services.				determining need for Ancillary Services quarterly at Residen First Meetings.  DSS or designee will audit		
	3:16 p.m. indicated appointment for sch clinical staff would	Clinical Support on 9/12/2022 at that there was not a specific reduling ancillary services, but assist with scheduling and services, such as dental or			Resident charts for Ancillary service consents. Every day days a week times 4 weeks d CCM meetings, then weekly for weeks, then monthly for 2 mo Residents with new complaint vision impairment will be refer for Optometry appointments.	uring or 2 nths s of	
					4: How the corrective action will be monitored to ensure a deficient practice will not redice. what quality assurance program will be put into place Audit findings will be submitted the QAPI Committee monthly two months, then quarterly for 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	cur ee? d to for two	
F 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin Ir §483.25(b)(1) Pre						

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Event ID:

GG7Z11

Facility ID: 011387

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLE	
		155762	B. WI	NG		09/13/2	2022
NAME OF I	PROVIDER OR SUPPLIER	3	•		ADDRESS, CITY, STATE, ZIP COD		
					OUTH L ST		
FOREST	PARK HEALTH CA	AMPUS		RICHM	OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		ility must ensure that- ives care, consistent with					
	` '						
	professional standards of practice, to prevent pressure ulcers and does not develop						
		nless the individual's clinical					
		trates that they were					
	unavoidable; and	•					
		pressure ulcers receives					
	necessary treatme	ent and services, consistent					
		standards of practice, to					
	promote healing, prevent infection and prevent						
	new ulcers from developing.						
			F 06	86	F 686 – Treatment/Svcs to		10/05/2022
		on, interview and record			Prevent/Heal Pressure Ulcer		
	_	failed to implement pressure			1: What corrective action(s)	will	
	_	failed to float a resident's			be accomplished for those		
		who had an unstageable of 4 residents reviewed for			residents found to have		
	pressure ulcers (Res				affected by the deficient practice		
	pressure dicers (Res	sident 154).			The wounds for Resident 154	are	
	Finding include:				healed. Resident suffered no		
	Timumg meruuer				adverse effects from deficient		
	During an observati	ion on 9/07/22 at 11:40 a.m.,		practice. Resident 154 heel			
	_	aying in bed, no heel protectors		protectors were applied while in			
		ng flat on the resident's bed.			bed and heels were floated w		
					in recliner.		
	_	ion on 9/8/22 at 11:15 a.m.,			2: How other residents havi	_	
		aying in bed with eyes closed.			the potential to be affected b		
		t have heel protectors in place,			the same deficient practice v	will	
		the resident's bed. The			be identified and what		
		ectors observed to be up on			corrective action will be take		
	top of her closet.				All Residents with Pressure R		
	During an observation	ion on 9/9/22 at 3:00 p.m., the			Interventions were reviewed to	υ	
	_	_			ensure orders were in place.  3: What measures will be pu		
	Wound Nurse and LPN 7 provided the wound care treatment of derma blue and allevyn dressing				into place or what systemic	١	
	to the right heel of Resident 154. The right heel				changes will be made to		
	had a black open area with callous skin around				ensure that the deficient		
	•	ainage on the old dressing. The			practice does not recur?		
		se measured the wound .5					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G <u>00</u>	COMPLETED
		155762	B. WING		09/13/2022
		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP COD	1
NAME OF F	PROVIDER OR SUPPLIEF	8		1 SOUTH L ST	
FOREST	PARK HEALTH CA	AMPUS		HMOND, IN 47374	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPE	COMPLETION COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
		6 cm. The resident was sitting		All Nursing staff educated o	
		her heels flat on the recliner		Guidelines for Pressure Pres	ention
	_	iced a pillow under heels to		policy.	
		dent's heel protectors were			
		her closet. The resident		The Director of Nursing or	
		only placed the heel protectors		Designee will audit all Resid	
	boots on her one time when she was in bed since			with Preventative Intervention	
	she had been at the facility. The resident indicated it did not bother her to wear the heel protector			Pressure Ulcers to ensure the	,
	•			in place 3 times a week for 4	
	boots and she had never refused to wear them,			weeks, then 5 Residents eve	
	staff just did not put them on her.			other week for 2 months, the	
	During an observation on 9/12/22 at 10:05 a.m.,			Residents monthly for 2 mor	iths.
	Resident 154 was sitting in her recliner, heels were				
		e were laying flat on the			
		he resident indicated she did			
		at her heels while in the		4: How the corrective actio	_
		s unsure what happened to it.		will be monitored to ensure	
	recinier, but she wa	s unsure what happened to it.		deficient practice will not re	
	During an interview	with the Director Of Health		i.e. what quality assurance	Jour
	_	9/12/22 at 12:47 p.m., indicated		program will be put into pla	ace?
		onsible to ensure Resident 154		Audit findings will be submitt	
	_	poots on while in bed and		the QAPI Committee monthl	
	_	e floated while in the recliner.		two months, then quarterly for	₹
				quarters to ensure complian	
	Review of the recor	rd of Resident 154 on 9/12/22 at		goals. The QAPI Committee	
		ed the resident's diagnoses		reserves the right to modify	
		not limited to, Hypertensive		extend monitoring times acc	
	· · · · · · · · · · · · · · · · · · ·	idney disease with heart failure		to outcomes.	ĭ
		stage 4 chronic kidney			
		ned chronic kidney disease,		5. Date of completion:	
		ic kidney disease, stage 2		10/5/2022	
		piratory failure with hypoxia,			
		pulmonary disease, dementia			
	without behavioral disturbance, Major depressive				
	disorder, Repeated	falls and unstageable pressure			
	ulcer.	- <del>-</del>			
	The physician recap	pitulation for Resident 154,			
	dated September 20	22. indicated the resident was			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155762		A. BU	A. BUILDING <u>00</u> COM			survey leted /2022		
	PROVIDER OR SUPPLIES			2401 SC	DDRESS, CITY, STATE, ZIP COD			
FUREST	PARK HEALTH CA	AMPUS		RICHING	OND, IN 47374			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	while in bed as residual	tors or antipressure boots dent will allow.						
	The plan of care for Resident 154, dated 6/9/22, indicated the resident had a pressure ulcer on the right heel.							
	assessment for Resi indicated the reside daily decision maki consistent and reaso behaviors of rejective required extensive a mobility and transfe developing a pressurunstageable-deep tipressure reducing dated 9/9/22, indicated 9/9/22, indicated a pressure eschar on the right measured 0.6 cm by	nimum Data Set (MDS) ident 154, dated 6/10/22, int was cognitively intact for ing. The resident was conable. The resident had no ion of care. The resident assistance of two staff for bed iers. The resident was at risk of ire ulcer. The resident had one issue injury. The resident had ievice for the bed and chair.  assessment for Resident 154, ited the resident had an ive ulcer with slough and inheel. The pressure ulcer iy 0.5 cm. The resident had ior tan, cloudy and thick						
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Inc §483.25(e) Incont §483.25(e)(1) The resident who is co bowel on admissic assistance to main or her clinical cond that continence is	continence, Catheter, UTI inence.  Ine facility must ensure that continent of bladder and continence services and intain continence unless his dition is or becomes such not possible to maintain.  In resident with urinary						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155762		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/13/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2401 SOUTH L ST RICHMOND, IN 47374  ID (X5)				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  FACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE			
	incontinence, base comprehensive as ensure that- (i) A resident who an indwelling cath unless the resider demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possibility of catheterization is a	enters the facility without enters the facility without eter is not catheterized at's clinical condition catheterization was  enters the facility with an or or subsequently receives for removal of the catheter le unless the resident's elemonstrates that the encessary; and to is incontinent of bladder attended at the extent possible.  The resident with fecal end on the resident's essessment, the facility must dent who is incontinent of propriate treatment and encessary, and encessed ences	F 0690	F 690 – Bowel/Bladder Incontinence, Catheter, UTI 1: What corrective action(s) be accomplished for those residents found to have affected by the deficient practice Resident 51 catheter tubing w readjusted to be elevated fror floor. Resident suffered no adverse effects from deficient practice. 2: How other residents havi the potential to be affected by	vas n the ng		

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

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155762		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/13/2022	
	PROVIDER OR SUPPLIER		2401 S	ADDRESS, CITY, STATE, ZIP COD SOUTH L ST IOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Resident 51 had an obstructive uropathy.  An observation on 9 Resident 51 was sitt time with her urinar contacting the floor.  An observation on 9 Resident 51 was sitt time with her urinar contacting the floor.  An interview with 0 Associate 2 on 9/8/2 the urinary catheter kept free from the f wheelchair, it is har.  A policy entitled, "Uprovided by the Excellent provided by the	0/8/2022 at 2:35 p.m., indicated ring in her wheelchair at the y catheter bag and tubing 0/8/2022 at 2:50 p.m., indicated ring in her wheelchair at the y catheter bag and tubing		the same deficient practice be identified and what corrective action will be take All Residents with Catheters observed to ensure Foley Cadrainage systems were not in contact with the floor.  3: What measures will be puinto place or what systemic changes will be made to ensure that the deficient practice does not recur?  All nursing staff were educat Urinary Catheter Care standard operating procedure.  The Director of Nursing or designee will observe every Resident with a catheter to enthe system is not touching the floor 5 times a week for 4 weet then every other week for 2 months, then monthly for 2 months.	en were theter  et  ed on ard  nsure
				4: How the corrective action will be monitored to ensure deficient practice will not re i.e. what quality assurance program will be put into planal Audit findings will be submitted the QAPI Committee monthly two months, then quarterly for quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or	the cur  ce? ed to for r two e

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AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155762	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/13/2022	
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP COD	00, 10,	
FOREST	PARK HEALTH CA	MPUS			OUTH L ST OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
F 0695	483.25(i)	ESC IDENTIFY TING INFORMATION		IAG	extend monitoring times accor to outcomes  5. Date of completion: 10/5/	J	DAIL
SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must e needs respiratory tracheostomy care is provided such o professional stand comprehensive pe	e and tracheal suctioning, are, consistent with ards of practice, the erson-centered care plan, s and preferences, and	F 06	595	F 695 –		10/05/2022
	review, the facility tubing at least once failed to date the ox for 2 of 3 residents of the facility of the fa	on, interview, and record failed change the oxygen a month for Resident 51 and tygen tubing for Resident 37 reviewed for oxygen therapy.  In the diagnoses and limited to, muscle are respiratory failure.  The medical diagnoses and limited to, muscle are Data Set Assessment dated at that Resident 51 was mildly and utilized oxygen therapy.  The sesident 51 on 9/6/2022 at gen tubing dated for 7/10/2022.			Respiratory/Tracheostomy C and Suctioning 1: What corrective action(s) to be accomplished for those residents found to have affected by the deficient practice Resident 51 oxygen tubing wa changed. Resident has no adverse effects from deficient practice Resident 37 oxygen tubing wa dated. Resident has no advereffects from deficient practice 2: How other residents having the potential to be affected by the same deficient practice who identified and what corrective action will be take All Residents with Oxygen ord	will s s s se ng y vill	10,00,2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155762	B. W	'ING	_	09/13/2022	
	n a v v n n n a		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			OUTH L ST		
FOREST	PARK HEALTH CA	AMPUS			OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 2	dated 5/12/2021, indicated for			were reviewed to ensure that		
		her oxygen tubing changed			tubing is changed per order a	nd	
	the first of the mont	th every month.			dated per policy.		
		1 . 1 (///2021 : 1: . 1 . 1 . 1			3: What measures will be pu	t	
		dated 6/4/2021, indicated for			into place or what systemic		
		oxygen therapy at 3-4 liters			changes will be made to		
	per minute continuo	ousiy.			ensure that the deficient		
	2 The clinical recor	rd for Resident 37 was reviewed			practice does not recur?		
		p.m. Diagnoses included, but			All purging stoff wars advects	nd on	
		Parkinson's disease and			All nursing staff were educate the policy of Administration of		
	tremor.	1 arkinson s disease and			Oxygen.		
	tiemor.				Oxygen.		
	A Ouarterly Minim	um Data Set Assessment,			The Director of Nursing or		
		icated that Resident 37 was			designee will observe every		
	cognitively intact.				Resident with oxygen orders t	0	
					ensure the tubing has been		
	An interview with I	Resident 37 on 9/6/2022 at 2:19			changed per MD orders and d	ated	
	p.m. indicated that s	she did not believe they have			per policy 1 time a week for 4		
	changed her oxyger	tubing since it was started.			weeks, then 5 Residents ever	y	
					other week for 2 months, then	5	
	An observation on 9	9/6/2022 at 2:19 p.m., indicated			Residents monthly for 2 montl	ns.	
	Resident 37's oxyge	en tubing did not have an					
	initiation date.						
	A physician and	dated 7/17/2022 indicated for					
		dated 7/17/2022, indicated for her oxygen tubing changed			4: How the corrective action		
	monthly.	ner oxygen monig changed				ho	
	monuny.				will be monitored to ensure to deficient practice will not recommend.		
	Δ nhysician order	dated 7/18/2022, indicated for			i.e. what quality assurance	,ui	
		oxygen therapy at 2 liters per			program will be put into place	-02	
	minute continuously				Audit findings will be submitte		
	minute commuousi	, •			the QAPI Committee monthly		
	A policy entitled "	Administration of Oxygen",			two months, then quarterly for		
		Executive Director on			quarters to ensure compliance		
		.m. The policy indicated, "			goals. The QAPI Committee		
		or the date it was imitated a.			reserves the right to modify or		
	_	be changed monthly and PRN			extend monitoring times accor		
	[as needed]"	g-u monung unu i iti			to outcomes.	unig	
	[				15 54.0011100.		

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155762	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVE COMPLETED 09/13/2022	Y
	PROVIDER OR SUPPLIER PARK HEALTH CA		2401 8	ADDRESS, CITY, STATE, ZIP CO SOUTH L ST MOND, IN 47374	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE COM	(X5) PLETION DATE
F 0755	483.45(a)(b)(1)-(3	)		5. Date of completion: 10/5/2022		
SS=D Bldg. 00	Pharmacy Srvcs/Procedures. §483.45 Pharmac The facility must p emergency drugs residents, or obtai described in §483 permit unlicensed drugs if State law general supervisio §483.45(a) Procedures that as acquiring, receivin administering of a meet the needs of §483.45(b) Servic must employ or ob licensed pharmace §483.45(b)(1) Pro aspects of the pro in the facility. §483.45(b)(2) Esta records of receipt controlled drugs in an accurate recon	/Pharmacist/Records y Services provide routine and and biologicals to its n them under an agreement 1.70(g). The facility may personnel to administer permits, but only under the on of a licensed nurse.  dures. A facility must nutical services (including ssure the accurate ng, dispensing, and ll drugs and biologicals) to reach resident.  The facility rotain the services of a rist who-  vides consultation on all vision of pharmacy services  ablishes a system of and disposition of all n sufficient detail to enable ciliation; and  ermines that drug records				
	are in order and the controlled drugs is	nat an account of all s maintained and				

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		X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			
		155762	B. W	ING		09/13/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u>.                                    </u>	
NAME OF F	PROVIDER OR SUPPLIER	8			OUTH L ST		
FOREST	PARK HEALTH CA	AMPUS			OND, IN 47374		
	T		1		, - I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	BEITEERETT	DATE	
	periodically recond	cilea.	FO	755	5.755 Dhawaaa	10/05/2022	
	Dagad on observative	on, interview, and record	F 0'	/33	F 755 – Pharmacy Srvcs/Procedures/Pharmaci	10/05/2022	
		failed to ensure medications			ecords	SUR	
		armacy for 2 of 4 residents			1: What corrective action(s)	will	
	_	ed from the health center.			be accomplished for those	WIII	
	(Resident 20 and Re				residents found to have		
	(Acsident 20 and Re	Coldent 237)			affected by the deficient		
	Findings include:				practice		
	i manigo metade.				Medications for Resident 20 a	and	
	The medication roo	m was observed with Qualified			254 were returned to the	iii G	
		OMA) 8 on 9/9/22 at 10:00 a.m.			pharmacy. There were no ad	Verse	
	, ,	us medication cards located on			effects from deficient practice		
		dent 20 and Resident 254.			2: How other residents havi		
		ne night shift staff were			the potential to be affected by	-	
	1	ng out the paperwork for the			the same deficient practice v	-	
	_	avolving the residents who			be identified and what		
	were discharged.	ivorving the residents who			corrective action will be take	an	
	, were unserningen.				Discharged residents for the la		
	The medication roo	m was observed on 9/12/22 at			30 days have been reviewed		
		re 3 blue totes with numerous			ensure medications were retu		
	_	r different residents, including			to the pharmacy.3: What		
		sident 254. There were			measures will be put into place	e or	
		orms completed and dated for			what systemic changes will be		
	9/11/22.	•			made to ensure that the defici		
					practice does not recur?		
	The clinical records	for Resident 20 and Resident			4: How the corrective action		
	254 were reviewed	on 9/9/22 at 3:35 p.m. Resident			will be monitored to ensure	the	
		on 8/28/22 and Resident 254			deficient practice will not red		
	was discharged on 8	8/3/22.			i.e. what quality assurance		
					program will be put into place	e?	
	A policy titled Guid	lelines for Disposal of			Audit findings will be submitte	d to	
	Non-Controlled Dru	ugs, revised 12/1/21, was			the QAPI Committee monthly	for	
	provided by the Reg	gional Minimum Data Set			two months, then quarterly for	· two	
	(MDS) Staff on 9/1	2/22 at 3:08 p.m. The policy			quarters to ensure compliance	e	
	indicated the follow	ring, "To ensure medications			goals. The QAPI Committee		
	are destroyed in acc	cordance with appropriate			reserves the right to modify or		
	infection control, sa	afety and State Laws and			extend monitoring times acco	rding	
	Federal Regulations	s3. There may be some			to outcomes.		
	medications for resi	idents who have been			5. Date of completion:		

PRINTED: 10/05/2022

DEPARTMENT	FORM APPROVED						
CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		155762	B. WING			09/13/2022	
	PROVIDER OR SUPPLIER			2401 SC	DDRESS, CITY, STATE, ZIP COD DUTH L ST DND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID BROWDER'S BLANCE CORRECTION			(X5)

FOREST	FPARK HEALTH CAMPUS	RICHM	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	
	discharged or expire that may be returned to the pharmacy for credit"		10/5/2022		
	3.1-25(r)				
F 0791 SS=D	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs				
Bldg. 00	§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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155762 B. WING 09/13/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 SOUTH L ST FOREST PARK HEALTH CAMPUS RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of skin cancer and dementia. Services quarterly at Resident First Meetings. The electronic health record for Resident 27 had no documentation of the resident receiving dental DSS or designee will audit services or being offered dental services. Resident charts for Ancillary service consents. Audits will be The plan of care for Resident 27, dated 11/21/2019, conducted every day for 5 days a indicated the resident had the potential for mouth week times 4 weeks during CCM pain related to having his own teeth with obvious meetings, then weekly for 2 or likely cavity and/or broken teeth. The weeks, then monthly for 2 months. interventions included, but were not limited to. Residents with new complaints of dental evaluation and intervention as needed. tooth discomfort will be referred for **Dental appointments** The Annual Minimum Data (MDS) assessment for Resident 27, dated 3/8/22, indicated the resident had obvious or likely cavity or broken natural 4: How the corrective action teeth. will be monitored to ensure the deficient practice will not recur The Quarterly MDS assessment for Resident 27, i.e. what quality assurance dated 8/3/22, the resident was cognitively intact, program will be put into place? decisions reasonable and consistent. Audit findings will be submitted to the QAPI Committee monthly for During an interview with the Administrator on two months, then quarterly for two 9/12/22 at 10:40 a.m., indicated she filled out the quarters to ensure compliance request for ancillary services to see the dentist for goals. The QAPI Committee Resident 27 on 9/11/22. The Administrator reserves the right to modify or indicated she would look for further extend monitoring times according documentation that Resident 27 was offered to outcomes. ancillary services and if the resident had seen a dentist since being at the facility. 5. Date of completion: 10/5/2022 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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155762	(X2) MULTIF A. BUILDIN B. WING	PLE CONSTRUCTION NG 00	(X3) DATE COMPI 09/13	
	PROVIDER OR SUPPLIER		24	REET ADDRESS, CITY, STATE, ZIP CO 01 SOUTH L ST CHMOND, IN 47374	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	PROVIDER'S PLAN OF CORE FIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI	OULD BE	(X5) COMPLETION DATE
	services. The protoc	I not have a policy for ancillary col was staff would assist with and scheduling for the dentist.				
F 9999						
Bldg. 00	education and traini advance for all pers include, but not be a (1) Residents' rights (2) Prevention and a (3) Fire prevention. (4) Safety and accid (5) Needs of special (6) Care of cognitiv (1) The frequency are education and traini accordance with the facility personnel as personnel, this shall	lent prevention. lized populations served. lely impaired residents. and content of inservice ling programs shall be in le skills and knowledge of the le follows. The nursing linclude at least twelve (12)	F 9999	F 9999 – Personnel 1: What corrective act be accomplished for the residents found to have affected by the deficite practice Personnel Files for staff 12 were reviewed. 2: How other resident the potential to be affected and what corrective action will the Audit of all employee file conducted; all missing to obtained. 3: What measures will	hose ye int  f 10,11 and s having ected by ectice will ee taken les were items were be put	10/05/2022
	hours of inservice p hours of inservice p nonnursing personn required inservice h who have regular co have a minimum of dementia-specific tr initial employment, personnel assigned dementia special ca annually thereafter	er calendar year and six (6) er calendar year for el. (u) In addition to the ours in subsection (l), staff ontact with residents shall		into place or what sys changes will be made ensure that the deficie practice does not recu.  All Department heads educated on personnel list for new hires.  Business office Manag designee will audit all n staff personnel files mo	temic to ent ur? have been file check er or ewly hired	

	OF CORRECTION	IDENTIFICATION NUMBER  155762	A. BUILDING B. WING	00 00	COMPLETED 09/13/2022
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
FOREST	PARK HEALTH CA	MPUS		MOND, IN 47374	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		n understanding of the current		ensure all required document	s are
		r residents with dementia.		included.	
		ination shall be required for			
		facility within one (1) month			
		t. The examination shall			
		skin test, using the Mantoux		1	
	· ·	), administered by person		4: How the corrective action	
	-	on of training from a d course of instruction in		will be monitored to ensure	
		lin skin testing, reading, and		deficient practice will not re- i.e. what quality assurance	cur
		reviously positive reaction		program will be put into place	2
		The result shall be recorded		Audit findings will be submitte	
		luration with the date given,		the QAPI Committee monthly	
		nom administered. The		two months, then quarterly for	
		must be read prior to the		quarters to ensure compliance	
		ork. The facility must assure		goals. The QAPI Committee	
	the following:	·		reserves the right to modify or	r
	(1) At the time of er	nployment, or within one (1)		extend monitoring times acco	
	month prior to empl	oyment, and at least annually		to outcomes.	
		es and nonpaid personnel of		5. Date of completion:	
	facilities shall be sci	reened for tuberculosis. For		10/5/2022	
	health care workers				
		re tuberculin skin test result			
		g twelve (12) months, the			
		skin testing should employ the			
	•	f the first step is negative, a			
		be performed one (1) to three			
	(3) weeks after the f	Irst step.  I maintain a health record of			
	each employee that				
		reemployment physical			
	examination.	1 7 F/ 5.500			
		e required inservice hours in			
		who have regular contact with			
		minimum of six (6) hours of			
		aining within six (6) months of			
		or within thirty (30) days for			
		to the Alzheimer's and			
	-	re unit, and three (3) hours			
	annually thereafter t	to meet the needs or			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	A. BUILDING <u>00</u>			COMPLETED	
		155762	B. WIN	B. WING 0		09/13/	/2022	
			<del>-                                    </del>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R			OUTH L ST			
CODECT	DADK HEALTH C	AMDUC			OND, IN 47374			
FUREST	PARK HEALTH C	AMPUS		KICHIVI	JND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	preferences, or botl	h, of cognitively impaired						
	residents and to gai	in understanding of the current						
	standards of care for	or residents with dementia.						
	This state rule was	not met as evidenced by:						
	Based on interview	and record review, the facility						
	failed to provide sta							
	_	reening, physical exam,						
		eneral and specific, resident						
	_	or dementia training for 3 of 10						
	_	files reviewed. ((Dietary Staff						
		ent Care Assistant (CRCA) 11,						
		Assistant (RCA) 12)).						
		, , ,,						
	Findings include:							
	TI . CC 1	. 1 0/12/22						
	_	files were reviewed on 9/12/22						
	missing:	following was found to be						
	missing.							
	1. Dietary Staff 10'	s file did not contain						
	-	reening consisting of a criminal						
		and reference check, physical						
	_	or specific orientation, resident						
	rights and/or abuse							
	2. CRCA 11's file of	did not contain pre-employment						
	screening consistin	g of a criminal background						
	check and reference	e check, general and/or specific						
	orientation, residen	t rights, abuse, and/or						
	dementia in-services.							
		d not contain pre-employment						
	_	g of a reference check,						
		eral and/or specific orientation,						
	resident rights and/	or abuse in-services.						
	An interview as - 1-	ucted with the Executive						
	Director on 9/12/22	2 at 1:47 p.m., indicated they	I				I	

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

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155762	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/13/2022		
	ROVIDER OR SUPPLIER		_	2401 S	ADDRESS, CITY, STATE, ZIP COD OUTH L ST OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
R 0000 Bldg. 00	were unable to local employee files. The switching positions	te the missing items from the facility was in the process of and found out some items pleted pertaining to employee	R 00		The submission of this plan of		
	Survey.  Survey dates: Septe Facility number: 01 Residential Census: Forest Park Health Compliance with 41 State Residential Li	17 Campus was found to be in 0 IAC 16.2-5 in regard to the			correction does not indicate ar admission by Forest Park Hea Campus that the findings and allegations contained herein at accurate, true representation of the quality of care provided, ar living environment provided to residents of Forest Park Health Campus. The facility recognize its obligation to provide legally medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it in substantial compliance with requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with a state and federal requirements governing the management of facility. It is thus submitted as a matter of statute only. The faci respectfully requests from the department a desk review for substantial compliance.	n lth re of  nd the n es and r. is the or o this a	

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