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	02/04/2025

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: January 29, 30, 31, and February 3 and 4, 2025 Facility number: 011387 Provider number: 155762 AIM number: 200853180 Census Bed Type: SNF/NF: 44 SNF: 11 Residential: 26 Total: 81 Census Payor Type: Medicare: 11 Medicaid: 32 Other: 12 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 7, 2025.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document that self-administration of medications	F 0554	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on	02/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeremy Sparks	Clinical Support	02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	was clinically appropriate for 1 of 1 resident randomly observed with medications at the bedside. (Resident 39) Findings include: The clinical record for Resident 39 was reviewed 1/31/25 at 9:46 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertensive heart disease with heart failure, and obesity. During an observation and interview with Resident 39 on 1/30/25 at 10:28 a.m., a full cup of open pills and a clear vial of fluid used for breathing treatments was located beside Resident 39. He indicated the cup of pills were all his morning medications and the vial was his medicine for his breathing treatments that he administered himself. An Annual Minimum Data Set assessment, completed 12/12/24, indicated he was cognitively intact for daily decision making. Resident 39's clinical record, reviewed on 1/31/25 at 11:00 a.m., did not have a physician's order for self-administration of medication and/or self-administration of medication assessment completed. The medication administration record (MAR) was provided by Clinical Support 3 on 2/3/25 at 12:52 p.m. It indicated Resident 39 had orders for the following oral medications to be administered between the hours of 6:00 a.m. to 10:00 a.m.: aspirin, bisoprolol fumarate, cetirizine, citalopram, furosemide, gabapentin, guaifenesin, isosorbide mononitrate, mirtazapine, pantoprazole, potassium chloride, ranolazine, spironolactone, tamsulosin,		the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on February 4, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 21, 2025 . The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. F554 1. Resident #39 had no adverse effects noted. Self-Administration observation completed on 1/31/25 and resident deemed appropriate to self administer hydrocortisone cream. All other medications were removed from the resident's room immediately. 2. All residents have the potential to be affected. All nurses will be educated by the DHS/Designee on administration of medication and self-administration observation. All residents requesting self-administer medications will be reviewed for completion of the self-administration observation. An order will be received by the provider for any residents that qualify for self-administration.	

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	and ropinirole. An ipratropium-albuterol solution for nebulization was to be given every four hours and the MAR indicated it was given at 8:00 a.m., on 1/30/25. During an interview with the Director of Nursing (DON) on 2/3/25 at 12:09 p.m., indicated Resident 39 should not have medications left at the bedside. The DON indicated it was the IDT's responsibility to ensure a self-medication administration assessment was completed on any resident who self-administers medications. The DON also indicated it was nursing's responsibility to ensure there was a physician's order for anyone who self-administers medications. A Guidelines for Self-Administration of Medications Policy was provided by Clinical Support 2 on 1/31/25 at 1:30 p.m. The policy indicated the following, "... 1. Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation [name of corporation] Self Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication..." 3.1-11(a)		3. As a measure of ongoing compliance, the DHS or designee will audit medication passes during rounding to ensure that medications are administered according to policy. Audit to consist of five residents, weekly x4 weeks, then monthly x3 months during rounding for appropriate medication administration. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be revised and updated as warranted.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure residents received assistance with bathing as preferred for 3 of 3 residents reviewed for activities of daily living. (Resident 7, Resident 41, and Resident 31)	F 0677	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and	02/21/2025

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	Findings include: 1. The clinical record for Resident 7 was reviewed on 1/30/2025 at 1:10 p.m. The medical diagnoses included pulmonary disease and osteoarthritis. A Quarterly Minimum Data Set assessment, dated 11/15/2024, indicated Resident 7 was cognitively intact and needed substantial/maximal assistance with bathing. An activities of daily living care plan, revised 11/25/2024, indicated Resident 7's preference for showers were on Mondays, Wednesdays, and Saturdays. During an observation and interview on 1/29/2025 at 1:31 p.m., Resident 7 indicated she was "lucky to get one [shower] a month". Resident 7's hair was noted to be greasy at that time. Resident 7 indicated she did not "feel clean" and she had not had a shower in "about a week." Review of the shower documentation indicated Resident 7 only received two showers for the month of January 2025 and two "other baths". During an interview on 1/31/2025 at 1:05 p.m., Resident 7 indicated she did not receive her last scheduled shower because the Certified Nurse Aide (CNA) told her they did not have enough help. Per Resident 7, her hair remained greasy at that time. 2. The clinical record for Resident 41 was reviewed on 1/31/2025 at 11:30 a.m. The medical diagnoses included respiratory failure and anxiety. A Quarterly Minimum Data Set assessment, dated 1/8/2025, indicated Resident 41 was cognitively		executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on February 4, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 21, 2025 . The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. F677 1.Residents #7 #41 & #31 had showers completed. All resident preferences for shower days reviewed with residents with no changes needed. 2.All residents have the potential to be affected. DHS/Designee reviewed all resident records for completion of showers, shower schedule preferences, and shower documentation accuracy. All nursing staff educated by DHS/Designee on following resident preferences for showers and completion of shower documentation in the HER. 3.As a measure of ongoing compliance, the Director of Health Services or designee will perform audits to ensure showers were given and documented on 5 residents weekly x4 weeks, then	

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	intact and needed substantial/maximal assistance with bathing. An activities of daily living care plan, dated 1/30/2025, indicated Resident 41 was scheduled for showers on Tuesdays and Fridays. During an observation and interview on 1/29/2025 at 12:55 p.m., Resident 41 indicated she did not get showers as often as she would like them. She indicated in the last month, she had less than four showers in total and would like them at least a "couple" times a week. When asked to clarify, she said two to three times a week would be her preference. Review of shower documentation, for January of 2025, indicated Resident 41 received four showers and one "other" bath for the whole month. 3. During an observation and interview with Resident 31 on 1/30/25 at 11:16 a.m., he indicated he was supposed to have showers on Monday and Thursday, and he did not receive his showers for weeks at a time. Resident 31 indicated his preference was to have three showers a week, but he could not get two showers a week, so there was no way he would get three. The staff were "wetting him down a little" in bed and he does not feel clean without a shower. The resident indicated when they do provide a bed bath, they do not always wash his hair. Observation of the resident's hair was greasy and uncombed. During an observation on 1/31/25 at 1:40 p.m., Resident 31's hair was greasy and uncombed. During an interview with the Director of Nursing (DON) on 2/3/25 at 12:32 p.m., she indicated it was all of nursing staff's responsibility to ensure resident's receive showers twice a week.		monthly x3 months. 4.As a quality measure, the Director of Health Services and/or designee will forward results of the audits to the Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance achieved.	

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	Review of the record of Resident 31 on 2/3/25 at 12:24 p.m., indicated the diagnoses included, but were not limited to, hemiplegia/hemiparesis, atherosclerotic heart disease, atrial fibrillation, contracture of the left hand, head injury, cerebral vascular accident (stroke), abnormal gait, peripheral vascular disease, major depression, anxiety, muscle weakness and osteoarthritis. The Quarterly Minimum Data Set assessment for Resident 31, dated 11/6/24, indicated the resident was cognitively intact for daily decision making. The resident had no behaviors of rejecting care. The resident was dependent on staff for showers and required substantial/maximal assistance for personal hygiene (including combing his hair). The care plan profile for Resident 31, dated 3/16/23, indicated the resident was to have two showers a week on Monday and Thursday. The shower documentation for Resident 31, dated from 11/1/24 to 1/30/25, indicated the resident had two showers and nine complete bed baths. The bathing preference policy provided by the DON, on 2/3/25 at 1:40 p.m., indicated the resident shall determine their preference for bathing, the day of the week, time of day, and type of bathing (tub bath, bed bath or shower). 3.1-38(a)(3)(A) 3.1-38(a)(3)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record	F 0684	Preparation or execution of this plan of correction does not	02/21/2025

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	review, the facility failed to identify a skin alternation for 1 of 2 residents reviewed for general skin impairments. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 2/3/2025 at 2:03 p.m. The medical diagnoses included edema and dysphagia. An admission assessment, dated 12/12/2024, indicated Resident 45 did not have any skin impairments. A physician order, dated 12/12/2024, indicated "Weekly skin assessment completed. New treatments and notifications completed for any new areas noted." Review of the Medication Administration Record for Resident 45's weekly skin assessments were completed each week. The MAR reflected only then the initials of the staff completing the assessment, but no other results were recorded. During an observation and interview on 1/29/2025 at 1:21 p.m., Resident 45 indicated he had an abrasion on his right ankle. Resident 45 stated this area had been present for over a year and he was treating it with over-the-counter cortisone spray he bought from a local store then covered the area with a paper towel from the bathroom. During an observation and interview on 1/31/2025 at 2:44 p.m., Registered Nurse (RN) 1 indicated Resident 45 had abrasions on his right ankle. RN 1 indicated they had never seen Resident 45's ankle before. RN 1 was not aware of Resident 45 being able to self-administer cortisone spray on the bedside table.		constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on February 4, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 21, 2025 . The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. F684 1. Resident #45 had skin assessment completed immediately. Resident had no adverse outcome related to alleged deficient practice. 2. All residents with non-pressure skin alterations have the potential to be affected. Skin sweep completed on all residents with any non pressure skin alterations assessed and added to the EHR by the DHS/Designee. All nurses educated by DHS/Designee regarding appropriate assessment and monitoring of non pressure skin alterations. 3. As a measure of ongoing	

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	A policy, entitled "Guidelines for Weekly Skin Observations", was provided by Clinical Support 3 on 2/3/2025 at 1:00 p.m. The policy indicated, "Upon admission the admitting nurse shall include as part of the admission orders a weekly skin observation. The order shall read: Weekly skin observation on (day of the week). 0= no areas on skin impairment ...1= new area of skin impairments (see wound event) ...2= existing area of impairment (see wound management tool and/or event)". 3.1-37(a)		compliance, the Director of Health Services (DHS), or designee, will complete audits of 3 resident to ensure that non-pressure skin alterations are transcribed to EMAR system accurately 3x weekly x4 weeks, then monthly x3 months 4. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of 6 months to ensure substantial compliance is maintained.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 29, 30, 31, and February 3 and 4, 2025 Facility number: 011387 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 7, 2025.	R 0000		
R 0240	410 IAC 16.2-5-4(d) Health Services - Deficiency			

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Bldg. 00	Based on interview and record review, the facility failed to ensure a resident, who was identified with significant weight loss, received follow-up for 1 of 5 residents reviewed for weight loss. (Resident R3) Findings include: The clinical record for Resident R3 was reviewed on 2/3/25 at 11:30 a.m. The diagnoses included, but were not limited to, pain and anxiety. A resident progress note, dated 4/15/24, indicated Resident R3 was seen by the Registered Dietitian. Resident R3 exhibited weight gain that was desired, and the diet/intake met her estimated nutrition needs. A Service Plan document, dated 11/8/24, indicated Resident R3 required physical assistance with eating along with an altered diet. A physician order, dated 11/8/24, indicated Resident R3 was to receive a regular diet with a mechanical soft texture. Resident R3's weights were reviewed, from 5/1/24 to 2/3/25, and the following results were noted: - 5/1/24 of 117.4 pounds (lbs.), - 6/1/24 of 108.6 lbs., - 7/1/24 of 116 lbs., - 8/1/24 of 116.8 lbs., - 9/1/24 of 115.5 lbs., - 10/1/24 of 113.2 lbs., - 11/8/24 of 113.9 lbs., - 12/1/24 of 105.2 lbs., - 1/1/25 of 98.5 lbs.,	R 0240	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on February 4, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 21, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. **1. All residents have the potential to be affected by the alleged deficient practice. Resident R3 was affected by the alleged deficient practice. Resident R3 weight has stabilized and was reviewed by the provider with a supplement added to the resident's orders.2. Nursing staff were educated on the Assisted Living Weights Guidelines Policy.3. As a measure of ongoing compliance DHS/designee will conduct random audits on 5 like**	02/21/2025

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	- 2/1/25 of 97.5 lbs., and - 2/3/25 of 97.5 lbs. The review of Resident R3's weights indicated a 7% weight loss from 11/8/24 to 12/1/24 and a 14% weight loss from 11/8/24 to 2/1/25. The clinical record did not reflect Resident R3 being seen by a Registered Dietitian, initiation of supplements, or any follow up regarding the approach to the identified weight loss for Resident R3. An interview conducted with Clinical Support 3, on 2/3/25 at 2:12 p.m., indicated Resident R3's clinical record did not reflect she was seen by a Registered Dietitian and Resident R3 had weight loss. A policy titled "Nutrition Recommendation Guideline", revised 5/13/24, was provided by Clinical Support 3 on 2/3/25 at 1:24 p.m. The policy indicated the following, "...PROCEDURES... 1. The Registered Dietitian (RD) or the Nutrition & Dietetics Technician (NDTR) will complete a Nutrition Event with resident - directed nutrition recommendation upon completed visit... 2. The Registered Dietitian (RD) or the Nutrition & Dietetics Technician, Registered (NDTR) reviews recommendations with resident or resident representative and/or clinical and culinary leaders, if possible. If not available, a copy of the recommendations are to be provided to campus leaders to review... 3. Suggested discipline follows up on recommendation(s) in a timely manner... 4. Dietitian follows up on recommendations, if indicated ..."		**residents to ensure significant weight losses are reviewed by the provider and any provider orders are added as directed. Audits will be completed x5 days a week for 4 weeks, then as needed thereafter.4. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.**	
R 0247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency			

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Bldg. 00	Based on interview and record review, the facility failed to ensure an as needed (PRN) medication was not administered as scheduled for two administrations for 1 of 5 residents reviewed for medication administration. (Resident R2) Findings include: The clinical record for Resident R2 was conducted on 2/3/25 at 11:08 a.m. The diagnoses included, but were not limited to, hypertension. A Service Plan document, dated 12/6/24, indicated Resident R2 was cognitively intact and needed staff assistance with medication administration. A resident progress note, dated 1/17/25 at 6:00 p.m., indicated Resident R2 was complaining of chest pain. The physician was notified and a new order for nitroglycerin (medication used to treat chest pain) as needed was given. The nitroglycerin was obtained from the emergency drug kit, and one dose was administered. A physician order, dated 1/17/25, indicated to administer nitroglycerin 0.4 milligrams (mg) tablet; sublingual (applied under the tongue) three times a day. The administration time(s) were the following: 6:00 a.m. to 10:00 a.m., 11:00 a.m. to 1:30 p.m., and 6:00 p.m. to 10:00 p.m. The electronic medication administration record (EMAR) for January of 2025 was reviewed. The EMAR indicated Resident R2 received nitroglycerin 0.4 mg on 1/18/25 between 6:00 a.m.	R 0247	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during Recertification visit with exit on February 4, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 21, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. 1. All residents that receive PRN medications have the potential to be affected by the alleged deficient practice. No residents were found to have been affected by the alleged deficient practice. 2. Skilled nursing staff were educated on the PRN medication administration policy. 3. As a measure of ongoing compliance DHS/designee will conduct random audits on 3 like residents to ensure PRN medications are ordered as written by the provider. Audits will be	02/21/2025

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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
	to 10:00 a.m., and 1/18/25 between 11:00 a.m. to 1:30 p.m. A resident progress note, dated 1/18/25 at 2:30 p.m., indicated the following, "...This nurse received report over resident and noticed while looking at resident orders, resident had an order placed for routine nitroglycerin 0.4 TID [three times a day] yesterday on 01/17 [1/17/25] d/t [due to] chest pain by a previous nurse. This nurse educated QMA [qualified medication aide] on shift today on nitroglycerin and how we do not give routinely and is for emergencies only. [Name of Nurse Practitioner] notified and made aware. VS [vital signs] within normal limits. Resident does not have any complaints at this time. Order corrected by this nurse." A physician order, dated 1/18/25, indicated to administer nitroglycerin 0.4 mg sublingual once every five minutes for up to three doses for chest pain. The order indicated to administer three times a day as needed. A resident progress note, dated 1/20/25, indicated the following, "...IDT [interdisciplinary team] review of medication error. Resident had a medication error that was caused by a transcription error. Error was caught and corrected by nurse. NP [Nurse Practitioner] was notified and resident was monitored with no adverse effects. Staff education provided...." An interview conducted with Resident R2, on 2/4/25 at 11:10 a.m., indicated the nursing staff administered his medications. A policy titled "PREPARATION AND GENERAL GUIDELINES", revised 11/18, was provided by Clinical Support 3 on 2/3/25 at 2:01 p.m. The policy		completed x5 days a week for 4 weeks, then as needed thereafter. 4. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months	

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	02/04/2025

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	indicated the following, "...B. Administration... 2) Medications are administered in accordance with written orders of the prescriber...."			