STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Nursing Center	650 Fairway Dr Evansville, IN 47710

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent falls for 2 of 3 residents reviewed for accidents. Following a significant decline, a dependent resident was encouraged to participate in dressing which resulted in a fall, and a resident's care plan intervention was not in place to prevent an additional fall. (Resident C, Resident D)Findings include: 1. A record review on 12/22/25 at 1:40 P.M. indicated Resident C's diagnoses included, but were not limited to, vascular dementia with agitation, anxiety disorder, muscle weakness, and unsteadiness on feet.Resident C's Significant Change Minimum Data Set (MDS) assessment, dated 8/20/25, indicated the resident required set-up assistance with the Activity of Daily Living (ADL) of upper and lower body dressing. Resident C's most recent Significant Change MDS, dated [DATE], indicated the resident had significant cognitive impairment, was dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with the ADL of upper and lower body dressing, and had 2 or more falls and 1 fall with injury since the previous assessment. A fall risk assessment dated [DATE] indicated Resident C was at a high risk for falls. Resident C's care plan specific to ADL assistance was last reviewed or revised on 12/3/25. A focus of Resident required assistance with ADLs, including bed mobility, transfers, eating, and toileting, related to decreased mobility and weakness, and impaired cognition due to dementia (started 7/10/23). An intervention included assist with dressing, grooming, and hygiene as needed. Encourage the resident to do as much for self as possible (started 7/10/23). Resident C's nurse's progress notes included, but were not limited to:11/23/25 at 8:05 P.M. - Resident stood from the wheelchair and fell backward onto the floor.11/24/25 at 7:00 P.M. - CNA on duty alerted the LPN to witnessed fall of resident in his room. CNA was performing bedtime care with the resident and allowing for as much independence as possible with the resident as the resident was standing upright, near the bed, and lost his balance. 11/25/25 at 9:23 A.M. (Intra-disciplinary team) IDT note - Determined root cause of fall: resident immediately became unsteady when assisted by one staff member with PM care. Intervention put in place to address the root cause of fall: Dress the resident while lying in bed or sitting at the bedside.During an observation on 12/23/25 at 11:40 A.M. , Resident C was observed in the dining room sitting in a high-back wheelchair. During an interview on 12/23/25 at 11:45 A.M., LPN 2 indicated Resident C had several falls recently following a general decline in health and functional abilities. Resident C would, at times, stand without assistance, which resulted in falls. During an interview on 12/23/25 at 12:30 P.M., the MDS nurse indicated Resident C's plan of care should have been updated following the significant change to reflect the assessments that indicated the resident was dependent for ADL care, which included upper and lower body dressing. 2. A record review on 12/23 at 10:40 A.M., Resident D's diagnoses included but were not limited to vascular dementia with mood disturbance, abnormalities in gait and mobility, and repeated falls. dA fall risk assessment dated [DATE] indicated Resident D was at a high risk for falls.Resident D's most recent Significant Change MDS assessment dated [DATE], indicated the resident had moderate cognitive impairment, used a wheelchair for mobility, was dependent for mobility and transfers, and had two or more falls with one with injury since the previous assessment. Resident D's care plan included, but was not limited to, the resident at risk for falls due to a history of one ormore falls within the previous 6 months, age greater than or equal to 80, incontinence, oxygen use, takes one or more high fall risk drugs, requires assistance or supervision for mobility, transfer, has altered awareness of immediate physical environment, lack of understanding of one's physical and cognitive limitations and she is impulsive. The resident often refuses to lie down after dinner (started 5/21/23 and last reviewed/revised 12/22/25). Interventions included but were not limited to, if the resident declines to go to bed after dinner, provide a sensory activity or a busy box within staff's eyesight (started 11/26/25). Resident D's nurse progress notes included, but were not limited to:11/25/25 at 8:45 P.M. - Staff heard the resident yelling out from the activity area. Upon arrival, the resident was observed to be lying on the right side in front of the wheelchair. The resident could not explain how fall occurred. 11/26/25 at 8:33 P.M. - IDT note - Determined root cause of fall: Resident initially refused to be placed into bed after dinner, then attempted to transfer self. Intervention put in place to address root cause of fall: If the resident declines to go to bed after dinner, provide a sensory activity or a busy box within staff eyesight.11/28/25 at 7:24 P.M. - CNA reported to the nurse that resident was found seated on the floor in another resident's room.Resident C Fall Event for the fall that occurred on 11/28/25 at 7:24 P.M., indicated the fall was unwitnessed. On 12/23/25 at