STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155762	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Health Campus	2401 South L St Richmond, IN 47374

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 28309 Based on interview and record review, the facility failed to ensure the documentation of meal intakes were recorded by facility staff for 3 of 3 residents reviewed for pressure ulcers and nutrition. (Residents B, C and D) Findings include: 1. The clinical record of Resident B was reviewed on 3-21-24 at 11:45 a.m. Her diagnoses included, but were not limited to, Lewy body dementia with parkinsonism features, dysphagia (difficulty with swallowing), recurrent coccyx ulcer and osteomyelitis (bone infection). This resident was identified by the facility as having at least one pressure ulcer, weight loss and required assistance with meals for intake. A review of Resident B's recent weights indicated she has had significant weight loss since her admission to the facility. Her admission weight on 11-22-23, was 122.8 pounds (#). Her weight on 2-21-24, was 107.2# and the most recent weight on 3-20-24, was 101.8#. Resident B's clinical record indicated she was monitored by the facility's interdisciplinary team for concerns related to weight, nutrition and pressure ulcers. A review of Resident B's care plans indicated multiple care plans under the general categories of Nutrition and ADL [activities of daily living] with interventions that included, but are not limited to, not rushing the resident with tasks, observing the resident for any decline in functional abilities and reporting any decline and provision of eating assistance and/or supervision with meals. A review of Resident B's meal intakes from 2-1-24 to 3-20-24 indicated of 146 potential meals, consisting of breakfast, lunch and dinner, she had 11 meals, or 7.5 percent without documentation of the meal intakes, as follows: -2-18-24, no documentation of breakfast or lunch consumption. -2-20-24, no documentation of breakfast or lunch consumption. -3-3-24, no documentation of breakfast or lunch consumption. -3-4-24, no documentation of dinner consumption. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3-14-24, no documentation of breakfast or lunch consumption. -3-19-24, no documentation of breakfast or lunch consumption. In an interview on 3-22-24 at 2:05 p.m., with the Administrator, she indicated all resident meal intakes are to be documented and placed in the resident's electronic clinical record. She indicated the facility staff are trained on this. In a second interview on 3-22-24 at 2:30 p.m., the Administrator indicated she could not locate a specific policy, related to nutrition, that addresses that dietary intakes are to be documented for each resident at each meal, but we are to make sure that happens. 2. The clinical record of Resident C was reviewed on 3-21-24 at 3:05 p.m. His diagnoses included, but were not limited to, pressure wound to the left buttocks, gallstones with sludge of gallbladder, cognitive developmental delay and a speech impediment. This resident was identified by the facility as having at least one pressure ulcer, has had weight loss and requires meal assistance. A review of Resident C's recent weights indicated he has had weight loss in the recent past. Resident C's clinical record indicated he was monitored by the facility's interdisciplinary team for concerns related to weight, nutrition and pressure ulcers. A review of Resident C's meal intakes from 2-1-24 to 3-20-24 indicated of 119 potential meals, consisting of breakfast, lunch and dinner, he had 9 meals, or 7.6 percent without documentation of the meal intakes, as follows: -2-25-24, no documentation of breakfast or lunch consumption. -2-25-24, no documentation of lunch consumption. -3-1-24, no documentation of breakfast or lunch consumption. -3-4-24, no documentation of breakfast or lunch consumption. -3-7-24, no documentation of dinner consumption. In an interview on 3-22-24 at 2:05 p.m., with the Administrator, she indicated all resident meal intakes are to be documented and placed in the resident's electronic clinical record. She indicated the facility staff are trained on this. In a second interview on 3-22-24 at 2:30 p.m., the Administrator indicated she could not locate a specific policy, related to nutrition, that addresses that dietary intakes are to be documented for each resident at each meal, but we are to make sure that happens. 3. The clinical record of Resident D was reviewed on 3-22-24 at 10:30 a.m. His diagnoses included, but were not limited to, dementia, severe protein-calorie malnutrition and sacral area pressure ulcer. This resident was identified by the facility as having at least one pressure ulcer and has had recent weight fluctuations. (continued on next page)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident D's recent weights indicated he has had recent weight fluctuations. Resident D's clinical record indicated he was monitored by the facility's interdisciplinary team for concerns related to weight, nutrition and pressure ulcers. A review of Resident D's meal intakes from 2-1-24 to 3-20-24 indicated of 138 potential meals, consisting of breakfast, lunch and dinner, he had 19 meals, or 13.7 percent without documentation of the meal intakes, as follows: -2-11-24, no documentation of breakfast or lunch consumption. -2-24-24, no documentation of breakfast or lunch consumption. -2-25-24, no documentation of lunch or dinner consumption. -2-28-24, no documentation of breakfast or lunch consumption. -3-1-24, no documentation of breakfast or lunch consumption. -3-3-24, no documentation of dinner consumption. -3-4-24, no documentation of breakfast or lunch consumption. -3-7-24, no documentation of dinner consumption. -3-15-24, no documentation of dinner consumption. -3-18-24, no documentation of breakfast or lunch consumption. -3-19-24, no documentation of lunch consumption. -3-20-24, no documentation of lunch consumption. In an interview on 3-22-24 at 2:05 p.m., with the Administrator, she indicated all resident meal intakes are to be documented and placed in the resident's electronic clinical record. She indicated the facility staff are trained on this. In a second interview on 3-22-24 at 2:30 p.m., the Administrator indicated she could not locate a specific policy, related to nutrition, that addresses that dietary intakes are to be documented for each resident at each meal, but we are to make sure that happens. This Federal tag relates to Complaint IN00430792. 3.1-46(a)(1) 3.1-46(a)(2)