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	05/15/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to assist a resident timely with incontinence care for 1 of 3 residents reviewed for Activities of Daily Living. (Resident B) Findings include:The clinical record for Resident B was reviewed on 5/14/26 at 12:06 p.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety, and chronic obstructive pulmonary disease (progressive lung disease that blocks air-flow and causes severe breathing difficulty). A Quarterly Minimum Data Set (MDS) assessment, dated 2/5/26, indicated Resident B was cognitively intact, had no behaviors for rejection of care, was dependent with toileting and hygiene (the ability to maintain perineal hygiene, adjust cloths before and after voiding or having a bowel movement), was non-ambulatory, and was always incontinent of bowel and bladder. During an interview with Resident B and her family member on 5/14/26 at 11:35 a.m., indicated Resident B had an incontinent episode of stool while doing activities. Per family member, when they found her, she had stool coming through her brief and pants, and coming out of her front and backside. The family member indicated she had several meetings with staff to tell them Resident B needed to be checked for incontinence between meals because she does not know when she goes and will just sit in it. Resident B indicated it made them feel terrible to have to wait for help and they cry often because they do not know when they need to be changed due to the incontinence and makes them uncomfortable. During an observation and interview with Resident B on 5/15/26 at 11:15 a.m., they were sitting up in their wheelchair. Resident B indicated they had not been toileted since before breakfast time and they did not know if they were soiled or not. A progress note, dated 5/15/26 at 12:39 p.m., indicated Resident B was toileted before breakfast and was offered again at that time (12:39 p.m.). A plan of care, dated 7/12/22, indicated Resident B had potential for decline in Activities of Daily Living (ADLs) due to decreased mobility. The interventions included, but were not limited to, if incontinence occurs, provide incontinent care after each incontinent episode. A plan of care, dated 5/14/26, indicated Resident B had MASD (Moisture Associated Skin Damage) to a gluteal tear skin fold. The interventions included, but were not limited to, keeping resident's skin clean and dry. A Resident Right's policy was provided by the Executive Director (ED) on 5/15/26 at 9:39 a.m. It indicated .Each resident has the right to be treated with dignity and respect. This citation relates to intake 2972144 410 IAC (Indiana Administrative Code) 3.1-38(a)(2)(C)

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