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	02/04/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 50436 Based on observation, interview, and record review, the facility failed to have the interdisciplinary team (IDT) determine and document that self-administration of medications 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, 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. (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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Park Health Campus	2401 South L St Richmond, IN 47374

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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

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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 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. 45291 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) 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 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. 25054 (continued on next page)

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45291 Based on observation, interview, and record 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. 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)