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	02/25/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to maintain residents' dignity regarding timely answering call lights for provision of activities of daily living care for 12 of 56 residents in the facility. (Residents 5, 6, 8, 10, 12, 13, 24, 30, 38, 39, 42, and 44) Findings include:1. The clinical record for Resident 6 was reviewed on 2/23/2026 at 2:05 p.m. The resident's diagnoses included, but were not limited to, emphysema (a chronic, progress lung disease) and heart failure (a chronic, serious condition where the heart cannot pump enough blood and oxygen to support the body's needs). A Quarterly Minimum Data Set Assessment, dated 12/11/2025, indicated Resident 6 was cognitively intact, did not exhibit behaviors, occasionally incontinent of bladder, always continent of bowel, needed partial to moderate assistance from staff for transferring and toilet hygiene. An activity of daily living care plan, last revised on 12/26/2025, indicated Resident 6 had fluctuating activities of daily living (ADL) status, but needed supervision with transfers and toileting tasks. An incontinence care plan, last revised on 12/26/2025, indicated staff were to assist Resident 6 with toileting as needed and/or per request. During an interview, on 2/20/2026 at 11:12 a.m., Resident 6 indicated call light wait times were bad. He had nights that he had to wait hours to get assistance. He needed assistance with toileting and was supposed to have someone with him when he transferred, but he could not always wait for someone to help him. There were times he had to wait for someone to help him with toilet hygiene and transferring off of the commode that took every bit of two to three hours and his legs will go to sleep waiting. During an interview, on 2/23/2026 at 11:15 a.m., Resident 6 indicated last night he couldn't get assistance on the call light for over an hour. When he had to wait to get help, it made him feel like a pee-on. 2. The clinical record for Resident 24 was reviewed on 2/25/2026 at 9:59 a.m. The resident's diagnoses included, but were not limited to, heart failure, kidney failure, and muscle wasting. A Quarterly Minimum Data Set Assessment, dated 12/17/2025, indicated Resident 24 was cognitively intact, did not exhibit behaviors of refusal of care, did not have hallucinations or delusions, needed partial to moderate assistance with transferring, and substantial to maximum assistance with toileting hygiene. An activity of daily living care plan, revised 12/31/2025, indicated Resident 24 needed supervision with transferring and partial assistance with toileting. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incontinence care plan, last revised 12/31/2025, indicated staff were to assist Resident 24 with toileting as needed and/or per request. During an interview, on 2/20/2026 at 11:36 a.m., Resident 24 indicated she needs some help, but her spouse (Resident 6) needed a lot more. If it was a good day, they only had to wait 10 to 15 minutes to get their call lights answered. On average it was 30 to 45 minutes and can take up to hours. She did not trust staff to come when the call light was on because she has had to wait so long, so when they really need something like when Resident 6 fell, she will just go out into the hallway and raise a fuss. Resident 24 indicated she didn't want to be that way but it is the only way to get help. When this happened, it was upsetting and frustrating to Resident 24. 3. The clinical record for Resident 42 was reviewed on 2/19/26 at 1:00 p.m. Her diagnoses included, but were not limited to: chronic obstructive pulmonary disease, arthritis, and anxiety. The ADL care plan, revised on 12/9/25, indicated she required staffs' assistance to complete ADL tasks completely and safely. The potential for decline in ADL ability care plan, revised 12/9/25, indicated if incontinence occurred, staff were to provide incontinent care after each incontinence episode. An interview was conducted with Resident 42 on 2/19/26 at 1:10 p.m. She indicated staff did not assist her to use the restroom often enough. They did not routinely assist her to use the restroom between breakfast and lunch, so she would remain in a soiled brief until they assisted her. She preferred to use the bed pan, as opposed to soiling in her brief. 4. The clinical record for Resident 39 was reviewed on 2/20/26 at 12:15 p.m. Her diagnoses included, but were not limited to: dysphagia, chronic kidney disease, chronic obstructive pulmonary disease, and diabetes. The physician's orders indicated she was on a regular diet, pureed consistency, starting 2/11/26. She had episodes of the following swallowing issues: Severe oropharyngeal dysphagia such as coughing or choking during meals or medication pass, loss of liquids/solids from the mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, complaints of difficulty swallowing, continuous throat clearing, etc. Continue to monitor for additional or increased frequencies and if noted refer to speech therapy services. Diet as ordered with follow-up to the registered dietician if continued swallowing issues or poor intakes were noted. Monitor for any negative outcomes such as new or worsening swallowing issues and notify the physician, starting 2/11/26. The impaired swallowing care plan, revised on 2/11/26, indicated an intervention was to provide adequate time for Resident 39 to feed herself, and staff were to assist her as needed. An interview was conducted with Family Member 5 on 2/20/26 at 12:24 p.m. She indicated Resident 39 normally ate meals in the assisted dining room. On 2/16/26 for the dinner meal, when Resident 39's backside was hurting and she didn't want to go down and eat in the assisted dining room, the facility refused to allow Resident 39 to stay in her room for dinner, so the staff gave her a nutritional supplement instead and assisted her to bed. An interview was conducted with the Director of Health Services (DHS) on 2/23/26 at 1:01 p.m. She (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated residents were allowed to eat meals in their room if they preferred, even if they required staff assistance to eat. 5. The clinical record for Resident 5 was reviewed on 2/20/26 at 11:05 a.m. Her diagnosis included, but was not limited to, diabetes. An interview was conducted with Resident 5 on 2/20/26 at 11:10 a.m. She indicated it took thirty minutes for staff to answer her call light. She was normally waiting for something to drink. 6. The clinical record for Resident 44 was reviewed on 2/20/26 at 11:14 a.m. Her diagnosis included, but was not limited to, diabetes. An interview was conducted with Resident 44 on 2/20/26 at 11:19 a.m. He indicated it usually took staff over thirty minutes to answer her call light. Normally, she just needed assistance to the dining room for meals. They assisted her, but by the time she got down there, the dining room was full. She would like to get down there earlier. 7. A resident council meeting was held on 2/20/26 at 1:30 p.m. Resident 8, Resident 38, and Resident 44 were in attendance and indicated there were not enough staff to assist them, when they needed it. They discussed it every month during council, and were always told the same thing, that they were working on it. The Resident Council Meeting minutes, dated 1/1/26 and 2/25/26, were provided by the ED (Executive Director) on 2/20/26 at 1:00 p.m. The 2/5/26 minutes indicated call light wait times on the second shift were long. The 1/1/26 minutes indicated there were long call light wait times. Resident 38 indicated her daughter came to help her with showers, because she was scared to shower alone, in case she fell. Having to wait for assistance made her feel like the staff didn't care, like she didn't matter. She worried about it, was humiliated by it, and it made her worry. Resident 8 indicated she had to wait an hour to use the restroom before. It made her feel uncomfortable. She felt bad asking for help, because she knew the facility was short staffed. Resident 13 indicated having to wait too long for assistance made her feel like she was not a person. One aide for three halls, even on third shift, was not reasonable. Resident 8 agreed with Resident 13's comments. An interview was conducted with Certified Resident Care Assistant (CRCA) 6 on 2/24/26 at 2:00 p.m. She indicated she normally worked from 6:00 p.m. to 6:00 a.m., all over the skilled nursing part of the facility. Sometimes they only had one CRCA from 10:00 p.m. to 6:00 a.m. for the entire facility. When she was the only CRCA working, she was not always able to get her work done. She normally assisted residents with using the restroom/incontinence care on her last round, but with her being the only aide, she did not have time to make sure all of the residents' briefs were changed before she left at 6:00 a.m., so they would have to lay there in a soiled brief until the next shift CRCAs assisted them. She started to assist residents at about 2:30 a.m. to get everyone done by 6:00 a.m., but by then, some of the residents she already assisted, soiled themselves again. Resident 30, Resident 10, and Resident 12 were residents who needed changed every two to three hours, that were wet again before she left, but would have to wait until the next shift to be changed, because her shift was over. There was no time to check and change residents every couple of hours, when she was the only (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CRCA working. It wasn't fair or safe for the residents to only have one aide at night. There were normally one or two nurses also scheduled to work the night shift with her, but not all of them would help with direct care. Resident 30 was scheduled for showers on third shift, but half the time, they skipped it, because there was only one aide working. Resident 30 would have to wait for the next shift to have his shower. When she worked alone on third shift, she would answer a resident's call light, but there would be two or three more on at once by the time she finished assisting the first resident. By the time she got to the final call light, that resident had waited at least thirty minutes for her to answer their call light. This was typically how a night working alone as the only CRCA in the facility went. The nursing schedules, dated 1/30/26 through 2/24/26, were provided by the ED on 2/20/26 at 2:00 p.m. They indicated only one CRCA worked or was scheduled to work from 10:00 p.m. to 6:00 a.m. on the following dates: 1/30/26, 2/3/26, 2/6/26, 2/16/26, 2/20/26, and 2/24/26. An interview was conducted with the DHS on 2/23/26 at 1:00 p.m. She indicated they started tracking call light response times in November of 2025, after it was identified as a concern. The activity director usually responded to resident council about their concerns. The Perineal Care for Incontinence policy was provided by the ED on 2/25/26 at 12:20 p.m. It indicated, OVERVIEW To provide incontinence care that will keep skin from being exposed to prolonged periods of urine and feces. The Guidelines for Answering Call Lights policy was provided by the ED on 2/25/26 at 12:20 p.m. It indicated, The purpose of this policy is to: To respond to the resident's request and needs.Answer the resident's call light as quickly as possible. The Resident Rights Guidelines policy was provided by the ED on 2/23/26 at 1:44 p.m. It indicated, The purpose of this policy is to: To ensure resident rights are respected and protected and provide an environment in which they can be exercised.1. Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff at [name of facility:] 2. Our residents have a right to.a. Be treated with dignity and respect. 410 IAC (Indiana Administrative Code) 3.1-3(t)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to timely address a resident's family grievance, regarding missing pajamas, for 1 of 1 resident reviewed for personal property. (Resident 39) Findings include:The clinical record for Resident 39 was reviewed on 2/20/26 at 12:15 p.m. Her diagnoses included, but were not limited to: dysphagia, chronic kidney disease, chronic obstructive pulmonary disease (a progressive, treatable, but generally irreversible lung disease characterized by long-term inflammation and restricted airflow,) and diabetes. She received hospice services at the facility. An interview was conducted with Family Member 5 on 2/20/26 at 12:18 p.m. She indicated Resident 39 was currently missing a set of red plaid pajamas and a set of green plaid pajamas. The pajamas had been missing since Christmas of 2025. She'd asked staff about it several times since then, including several Certified Resident Care Assistants (CRCAs) and a nurse, described as Licensed Practical Nurse (LPN) 7. The Executive Director (ED) provided the grievance log from 9/1/25 to present on 2/23/26 at 12:38 p.m. It did not include any missing pajamas for Resident 39. An interview was conducted with the ED and Social Services Director (SSD) on 2/24/26 at 2:50 p.m. The ED indicated she had not heard anything about missing pajamas for Resident 39. Typically, staff should fill out a grievance form for missing items. The SSD indicated she hadn't heard anything about missing pajamas for Resident 39 either. Resident 39's family member did not mention the missing pajamas at her care plan meeting a few days ago, but they did not ask specifically about missing items, just about any general concerns. An interview and observation were conducted with the Director of Environmental Services (DES) on 2/24/26 at 3:07 p.m. The DES was coming out of Resident 39's room, holding several pajama pieces in her hand. She indicated no one mentioned anything to her about the missing pajamas until today. They kept notes posted in the laundry room of missing items, but none of them were for Resident 39. She found the articles she was currently holding in the laundry room and had just checked to see if they were the ones missing, but they weren't. The Resident Concern Process policy was provided by the ED on 2/23/26 at 12:38 p.m. It indicated, Purpose To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service. Procedures: 1. The facility will provide an open and customer friendly atmosphere for residents and their families and representatives to voice concerns and problems with the assurance that their concerns will be heard and acted upon. 2. The facility will be committed to the on-going education of their employees on immediately responding to and resolving customer concerns. 3. The facility staff will follow the Resident Concern Process flow chart when any concern or complaint is voiced.5. Enter the concern using the desktop icon labeled ?Resident Concern Form'. All concerns should be entered electronically, however Environmental and Dining departments may use a paper Resident Concern Form, submitting to their supervisor who will enter. We never ask a family member to complete the form. 6. Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution. 7. Follow up from the department leader will occur within 24-48 [sic] with resolution entered in [name of database.] 8. The Executive Director will review and manage the follow up of the concerns. 410 IAC (Indiana Administrative Code) 3.1-7(b)

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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, observation, and record review, the facility failed to provide nail care to an dependent resident for 1 of 4 residents reviewed for activities of daily living. (Resident 10) The clinical record for Resident 10 was reviewed on 2/24/2026 at 11:07 a.m. The medical diagnoses included, but were not limited to, acute respiratory failure and metabolic encephalopathy. An annual MDS assessment, dated 1/8/2026, indicated Resident 10 had mild cognitive impairment, did not exhibit behaviors of rejection of care, had impairments of one upper extremity and both lower extremities, substantial to maximal assistance with personal hygiene needs. An ADL care plan, revised 1/19/2026, indicated Resident 10 required staff assistance for self care and mobility. The interventions included, but were not limited to, staff were to provide nail care on shower days and as needed. During an observation and interview, on 2/19/2026 at 1:06 p.m., Resident 10 was observed in bed. Resident 10's fingernails were long and had yellow substance under them. Resident 10 indicated he would like his fingernails trimmed.During an observation and interview, on 2/20/2026 at 11:30 a.m., Resident 10 was observed in bed. Resident 10's fingernails were long and he indicated he would like his fingernails trimmed.During an observation and interview, on 2/23/2026 at 11:46 a.m., Resident 10 was observed in bed. Resident 10's were long. LPN 4 indicated Resident 10's fingernails nailed needed to be trimmed and Resident 10 was not a diabetic so it should be completed with Resident 10's bathing. During an interview, on 2/23/2026 at 2:14 p.m., Director of Health Services indicated nail care should be provided to residents weekly during bathing and as needed. The direct care nurses and aides were responsible for providing nail care. 410 IAC (Indiana Administrative Code) 3.1-38(a)(3)(E)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview, observation, and record review, the facility failed to ensure the placement of a palmgrip as ordered for 1 of 1 residents reviewed for range of motion. (Resident 10)The clinical record for Resident 10 was reviewed on 2/24/2026 at 11:07 a.m. The diagnoses included, but were not limited to, acute respiratory failure and metabolic encephalopathy. An annual MDS assessment, dated 1/8/2026, indicated Resident 10 had mild cognitive impairment, did not exhibit behaviors of rejection of care, had impairments of one upper extremity and both lower extremities, substantial to maximal assistance with personal hygiene needs. A pain care plan, revised 1/19/2026, indicated Resident 10 was at risk for skin breakdown and pain related to left hand join contracture. The interventions included, but were not limited to, to ensure there was protective padding to prevent skin on skin contact and palmgrip per MD orders. Resident 10's palmgrip was a soft cushion device intended to be placed in the palm of the left hand. A physician's order, dated 1/05/2026, indicated for Resident 10 to wear a left palm protector daily to decrease risk of further loss of range of motion and to maintain skin integrity. The resident's palm protector was to be removed daily for activities of daily living and to be laundered as needed.During an observation and interview, on 2/19/2026 at 1:06 p.m., Resident 10 was observed in bed. Resident 10's left hand was observed to be contracted without any padding or brace in place.During an observation and interview, on 2/20/2026 at 11:30 a.m., Resident 10 was observed in bed. Resident 10's left hand was observed to be contracted without any padding or brace in place.During an observation and interview, on 2/23/2026 at 11:46 a.m., Resident 10 was observed in bed. Resident 10's left hand was noted to be contracted without any padding or brace in place. LPN 4 indicated Resident 10 should have a palmgrip in place. The palmgrip was located in the top drawer of the bedside table but was soiled. LPN 4 took it to be laundered at that time. During an interview, on 2/23/2026 at 2:14 p.m., Director of Health Services indicated direct care nurses and aides were responsible for ensuring the palmgrip or other padding was in place for Resident 10's left hand contracture.410 IAC (Indiana Administrative Code) 3.1-42 (a)(2)

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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. Based on observation, interview, and record review the facility failed to transfer a resident in a manner that was safe and comfortable and failed to follow the resident's care profile for a mechanical lift for 1 of 2 residents reviewed for accidents (Resident 43). Finding include:During an interview with Resident 43's family member on 2/19/2026 at 1:39 p.m., the family member indicated the resident was unable to bare weight during transfers on either leg. The facility staff transferred the resident by lifting her underneath her arms with two people and no gait belt. The family member was concerned this was painful to the resident because the resident would moan during transfers. During an observation on 2/23/2026 at 10:45 a.m., the Assistant Director of Health Services (ADHS) and Certified Resident Care Assistant (CRCA) 5 placed a gait belt around Resident 43's waist, the staffs' hands were underneath the resident's arms and transferred the resident from the geriatric chair to the bed. The resident was unable to bare weight on either of her legs and moaned during the transfer. The ADHS and CRCA 5 had to lift the resident underneath her arms to get her to the bed, the resident was totally dependent on the staff during the transfer. CRCA 5 indicated the resident needed to be transferred a 100% (percent) by a mechanical lift, it was not fair to the resident because staff had to tug on her. The ADHS and CRCA transferred the resident with a gait belt and their hands underneath the resident's arms from the bed back to the geriatric chair and the resident did not bare weight and moaned during the transfer. The ADNS indicated he would report the resident was not baring weight during transfers and have therapy assess the resident. Review of the clinical record for Resident 43 on 2/23/26 at 1:00 p.m., indicated the resident's diagnoses included, but were not limited to, chronic kidney disease, depression, hemiplegia and hemiparesis (paralysis) left non dominant side and cerebral infarction (stroke caused by blockage). The admission Minimum Data Set (MDS) assessment for Resident 43, dated 1/29/26, indicated the resident severely impaired for daily decision making. The resident was totally dependent on staff for transfers. The care profile for Resident 43, dated 1/26/26, indicated the resident was to be transferred using a mechanical lift. During an interview with the Director of Health Services (DHS) on 2/23/2026 at 12:50 p.m., the DHS indicated a lift assessment should have been completed for Resident 43 if the resident was unable to bare weight during a transfer. During an interview with the ADHS on 2/23/2026 at 1:19 p.m., the ADHS indicated it was communicated to staff how to transfer residents by the care profile in the electronic health record. During an interview with CRCA 5 on 2/23/2026 at 1:25 p.m., the CRCA indicated she reported that Resident 43 was unable to bare weight during transfer to nursing, but was unable to remember which nurse she had reported it to. 410 IAC (Indiana Administrative Code) 3.1-45(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure a resident's code status post form and physician order matched the resident's wishes for end of life care for 1 of 1 resident reviewed for accurate documentation (Resident 67). Finding include :During an interview with the Director Of Health Services (DHS) on 2/23/26 at 12:50 p.m., the DHS indicated the admitted nurse and the clinical review team were responsible to ensure Resident 67's post form for code status and her doctors orders matched each other. The facility did talk with Resident 67 and she decided at this time she would like to be a full code. Review of the clinical record of Resident 67 on 2/23/2026 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, acute on chronic diastolic (congestive) heart failure, acute respiratory failure with hypercapnia and acute and chronic respiratory failure with hypoxia, acute. The post form for Resident 67, dated 10/30/25, indicated the resident wished to be a Do Not Resuscitate (DNR). The post form was signed by Resident 67 and the physician. The physician's order for Resident 67, dated February 2026 indicated the resident was ordered to be a full code. The advanced directives policy provided by the Executive Director (E.D.) on 2/23/26 at 1:44 p.m., indicated the facility would ensure to obtain and follow the resident's advanced directives regarding end of life care. The resident would be advised on admission and quarterly regarding their wishes for end of life directives and code status. The nursing staff would confirm the code status and obtain a physician order. The DNR form would be completed documenting these desires and scanned in the medical record. 410 IAC (Indiana Administrative Code) 3.1-50(a)(2)