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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 03/29/2016 |
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| NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC | STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405 |
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| R 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaints IN00194314 and IN00195742.</p> <p>Complaint IN00194314- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00195742- Substantiated. State Residential findings related to the allegation are cited at R0086, R0349, R0352, R0381, R0383, and R0384.</p> <p>Survey dates: March 28 & 29, 2016</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Residential census: 122</p> <p>Sample: 4</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review was completed by 32883 on 3/30/16.</p> | R 0000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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| R 0086 Bldg. 00 | <p>410 IAC 16.2-5-1.3(a)(1-2) Administration and Management - Deficiency The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee. Based on record review and interview, the facility failed to maintain compliance with all applicable laws related to the failure to provide information related to an investigation of an unusual occurrence for 1 of 2 residents reviewed for reportable events in a sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 3/28/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder, depression, seizure disorder, high blood pressure, and a history of anemia. The</p> | R 0086 | <p>1. Progress notes from the Psychiatrist treating Resident#B were submitted to ISDH via USPS Certified Mail and electronic mail to ISDH legal counsel and Breda Buroker, Division of Long Term Care. ISDH legal counsel confirmed via e-mail5/23/16 that all requested progress notes have been received. Should additional records or informationconcerning Resident #B be required, the facility will provide any additionalrecords or information upon request . 2. The records of any residents diagnosed with mental illness may include psychiatric progress notes similar to the records in question with respect to Resident # B.</p> | 05/24/2016 |

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| | <p>resident was being followed by his Primary Physician and a Psychiatrist. The last Progress Note completed by the attending Physician was dated 1/23/16. No Progress Notes from the Psychiatrist were available or provided upon request.</p> <p>A semi-annual Nursing assessment was completed on 1/8/16. The assessment indicated the resident needed redirection and encouragement.</p> <p>The resident's Service Plan was last updated on 4/22/15. The Service Plan indicated staff were to monitor the resident for early signs of problem behavior.</p> <p>The 3/2016 Medication Record was reviewed. There were Physician orders for the resident the following medications: Risperidone (an antipsychotic medication) 4 milligrams every night at bedtime. Haloperidol (an antipsychotic medication) 150 milligrams injections once every three weeks. Haloperidol 5 milligrams by mouth every 8 hours as needed. Lorazepam (a medication for anxiety) 0.5 milligrams every night at bedtime.</p> <p>An Unusual Event Report was completed</p> | | <p>These notes will made available to ISDH staff through the survey and during subsequent investigations. 3. The facility will provide all information requested relating to the investigation of an unusual occurrence in compliance with applicable law. 4. The Administrator and/or designee will be responsible for ensuring that all records are properly maintained and for responding to all requests to ensure all information is provided in compliance with applicable law. 5. Systemic changes will be completed by May 24, 2016.</p> | |

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| | <p>on 3/14/16 at 1:54 a.m. The report was completed by RN #1. The report indicated on 3/13/16 at 9:20 p.m., RN #1 was called by CNA #1 and the CNA yelled that the resident had hung himself. RN #1 entered the room and observed the resident with a cord around his neck and attempted to get the cord from around his neck but could not get her fingers under the cord. 911 was called. LPN #2 entered with scissors and the cord was cut. The resident was positioned flat and CPR was initiated. The local police and Fire Department EMT's arrived and transported Resident #B to the hospital. The report listed the "Type of Event" as "Suicide Attempt."</p> <p>The Nurse's Notes were reviewed. The following entries were noted: 9/15/15 at 10:40 a.m. - The resident was seen by (Psychiatrist name) 10/13/15 at 10:15 a.m.- The resident was seen by (Psychiatrist name) 1/15/16 at 11:30 a.m.- The resident was seen by (Psychiatrist name) 3/11/16 at 11:30 a.m. - The resident was seen by (Psychiatrist name) No Progress Notes or any other notes written by or completed by the Psychiatrist were available in the resident's record or upon being requested.</p> <p>When interviewed on 3/28/16 at 10:30</p> | | | |

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| R 0349 Bldg. 00 | <p>a.m., the facility Administrator indicated Resident #B expired at the hospital. The Administrator indicated she was not able to provide any Physician Progress Notes completed by the resident's Psychiatrist.</p> <p>This Residential tag relates to Complaint IN 00195742.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain complete, accurately documented and readily accessible clinical records related to not allowing access to Progress Notes completed by the Psychiatrist for</p> | R 0349 | 1.The facility completed, accurately documented, systemically organized and made record readily accessible for each resident of Lake Park Residential. Progress notes from the Psychiatrist treating Resident#B | 05/17/2016 |

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| | <p>residents with diagnoses of mental illness for 1 of 4 residents reviewed for Medical Records in a sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 3/28/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder, depression, seizure disorder, high blood pressure, and a history of anemia. The resident was being followed by his Primary Physician and a Psychiatrist. The last Progress Note completed by the attending Physician was dated 1/23/16. No Progress Notes from the Psychiatrist were available or provided upon request.</p> <p>The Nurse's Notes were reviewed. The following entries were noted: 9/15/15 at 10:40 a.m. - The resident was seen by (Psychiatrist name) 10/13/15 at 10:15 a.m.- The resident was seen by (Psychiatrist name) 1/15/16 at 11:30 a.m.- The resident was seen by (Psychiatrist name) 3/11/16 at 11:30 a.m. - The resident was seen by (Psychiatrist name) No Progress Notes or any other notes written by or completed by the Psychiatrist were available in the resident's record or upon being requested.</p> | | <p>were submitted to ISDH May 3, 2016 via USPS Certified Mail and electronic mail to ISDH legal counsel and Breda Buroker, Division of Long Term Care. ISDH legalcounsel confirmed via e-mail 5/23/16 that all requested progress notes have been received. Should additional records or information concerning Resident #B be required, the facility will provide any additional records or information upon request 2. The records of any residents diagnosed with mental illness may include psychiatric progress notes similar to the records in question to Resident #B. 3. The facility will provide all information requested relating to the investigation of an unusual occurrence in compliance with applicable law. 4. The Administrator and/or designee will be responsible for ensuring that all records are properly maintained and for responding to all requests to ensure all information is provided in compliance with applicable law. 5. Date systemic changes will be completed is May 24, 2016.</p> | | | | |

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| R 0352 Bldg. 00 | <p>When interviewed on 3/28/16 at 10:30 a.m., the facility Administrator indicated Resident #B expired at the hospital. The Administrator indicated she was not able to provide any Physician Progress Notes completed by the resident's Psychiatrist.</p> <p>This Residential tag relates to Complaint IN 00195742.</p> <p>410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the resident's clinical records contained accessible Progress Notes as required for 1 of 4 residents reviewed for Progress Notes in a sample of (4).</p> | R 0352 | 1. Progress notes from the psychiatrist treating Resident#B were submitted to ISDH via USPS Certified Mail and electronic mail to ISDH legal counsel and Breda Buroker, Division of Long Term Care. | 05/17/2016 |

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| | <p>(Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 3/28/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder, depression, seizure disorder, high blood pressure, and a history of anemia. The resident was being followed by his Primary Physician and a Psychiatrist. The last Progress Note completed by the attending Physician was dated 1/23/16. No Progress Notes from the Psychiatrist were available or provided upon request.</p> <p>The Nurse's Notes were reviewed. The following entries were noted: 9/15/15 at 10:40 a.m. - The resident was seen by (Psychiatrist name) 10/13/15 at 10:15 a.m.- The resident was seen by (Psychiatrist name) 1/15/16 at 11:30 a.m.- The resident was seen by (Psychiatrist name) 3/11/16 at 11:30 a.m. - The resident was seen by (Psychiatrist name) No Progress Notes or any other notes written by or completed by the Psychiatrist were available in the resident's record or upon being requested.</p> <p>When interviewed on 3/28/16 at 10:30 a.m., the facility Administrator indicated</p> | | <p>ISDH legal counsel confirmed via e-mail 5/23/16 that all requested progress notes have been received. Should additional records or information concerning Resident #B be required, the facility will provide any additional records or information upon request. 2. The records of any residents diagnosed with mental illness may include psychiatric progress notes similar to the records in question with respect to Resident #B. 3. The facility will provide all information requested relating to the investigation of an unusual occurrence in compliance with applicable law. 4. Administrator and/or designee will be responsible for ensuring that all records are properly maintained and for responding to all requests to ensure all information is provided in compliance with applicable law. 5. Date of systemic change will be May 24, 2016.</p> | | | | |

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| R 0381 Bldg. 00 | <p>she was not able to provide any Physician Progress Notes completed by the resident's Psychiatrist.</p> <p>This Residential tag relates to Complaint IN 00195742.</p> <p>410 IAC 16.2-5-11.1(e)(1-2) Mental Health Screening - Offense (e) The residential care facility shall not admit residents with a major mental illness if: (1) the mental health service provider determines that the resident ' s needs cannot be met; and (2) the residential care facility does not have a means to access needed services to carry out the comprehensive care plan.</p> <p>Based on record review and interview, the facility failed to ensure they were able to meet the needs of residents with major mental illness related to providing the residents with individual treatment plans of care to meet their needs for 1 of 3 residents reviewed with major mental</p> | R 0381 | 1.The facility does not admit residents that the facility cannot meet the needs of or does not have means to access needed services to carry out the comprehensive care plan. The facility was able to meet the needs and did meet the needs of | 05/17/2016 |

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| | <p>illness in a sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 3/28/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder, depression, seizure disorder, high blood pressure, and a history of anemia. The resident was being followed by his Primary Physician and a Psychiatrist. The last Progress Note completed by the attending Physician was dated 1/23/16. No Progress Notes from the Psychiatrist were available or provided upon request.</p> <p>The Nurse's Notes were reviewed. The following entries were noted: 9/15/15 at 10:40 a.m. - The resident was seen by (Psychiatrist name) 10/13/15 at 10:15 a.m.- The resident was seen by (Psychiatrist name) 1/15/16 at 11:30 a.m.- The resident was seen by (Psychiatrist name) 3/11/16 at 11:30 a.m. - The resident was seen by (Psychiatrist name) No Progress Notes or any other notes written by or completed by the Psychiatrist were available in the resident's record or upon being requested.</p> <p>A semi-annual Nursing assessment was completed on 1/8/16. The assessment</p> | | <p>Resident#B. Progress notes from the psychiatrist treating Resident#B were submitted to ISDH May 3,2016 via USPS Certified Mail and electronic mail to ISDH legal counsel and Breda Buroker,Division of Long Term Care. ISDH legalcounsel confirmed via e-mail 5/23/16 that all requested progress notes havebeen received. Should additional recordsor information concerning Resident #B be required, the facility will provideany additional records or information upon request. 2. The records of any residents diagnosed with mental illness may include psychiatric progress notes similar to the records in question with respect to Resident #B. The Facility Administrator and Director of Nursing review all admission requests prior to acceptance. Each potential resident submits a clinical summary that includes a psychiatric treatment summary. This summary includes 1) contact information of the provider, 2)diagnosis, 3) treatment provided and psychiatric medications used past and current, 3) patient compliance, 4) hospitalizations including number and dates. Any concerns or questions raised in reviewing the summary or by applicant visit are addressed by; 1) verbal contact with the provider of the treatment, 2) consultation with the local CMHC or FQHC (as appropriate),</p> | |

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| | <p>indicated the resident needed redirection and encouragement.</p> <p>The resident's Service Plan was last updated on 4/22/15. The Service Plan indicated staff were to monitor the resident for early signs of problem behavior.</p> <p>The 3/2016 Medication Record was reviewed. There were Physician orders for the resident the following medications: Risperidone (an antipsychotic medication) 4 milligrams every night at bedtime. Haloperidol (an antipsychotic medication) 150 milligrams injections once every three weeks. Haloperidol 5 milligrams by mouth every 8 hours as needed. Lorazepam (a medication for anxiety) 0.5 milligrams every night at bedtime.</p> <p>Physician orders were electronically completed by the Psychiatrist on 3/11/16. The orders were to reorder the above Haloperidol, Risperidone, and Lorazepam. No Progress Notes related to the continued use of the above antipsychotic and anti anxiety medications were provided to ensure the resident's plan or care was being monitored.</p> | | <p>3)assessing the facility's capacity to meet applicants needs either directly or through community providers. Clients are admitted where the setting is deemed appropriate and consistent with theevaluation of the mental health service provider. Clients with needs that can't be met are not admitted. 3.The Facility will provide all information requested relating to the investigation of an unusual occurrence in compliance with applicable law and will review all admission requests for appropriatenessin accordance with the procedures previously outlined. 4. The Administrator and/or designee will be responsible for ensuring that all records are properly maintained and for responding to all requests to ensure that all information is provided in compliance with applicable law , and for ensuring that all admission requests for appropriateness in accordance with the procedures previously outlined. 5. Date of completion for systemic changes will be May 24, 2016</p> | | | | |

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| R 0383 Bldg. 00 | <p>When interviewed on 3/28/16 at 10:30 a.m., the facility Administrator indicated she was not able to provide any Physician Progress Notes completed by the resident's Psychiatrist.</p> <p>This Residential tag relates to Complaint IN 00195742.</p> <p>410 IAC 16.2-5-11.1(g)(1-2) Mental Health Screening - Deficiency (g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following: (1) Psychosocial rehabilitation services that are to be provided within the community. (2) A comprehensive range of activities to meet multiple levels of need, including the following: (A) Recreational and socialization activities. (B) Social skills. (C) Training, occupational, and work programs. (D) Opportunities for progression into less restrictive and more independent living arrangements. Based on record review and interview the</p> | R 0383 | 1. The plan of care for Resident#B was developed in | 05/17/2016 |
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| NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC | STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405 |
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| | <p>facility failed to ensure a resident's plan of care was developed in cooperation with the mental health services related to the lack of Progress Notes including a physical and mental examination of the resident, an assessment of his symptoms, monitoring of the resident's medications, and evaluating if each residents needs were met for 1 of 4 residents reviewed for mental health services. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 3/28/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder, depression, seizure disorder, high blood pressure, and a history of anemia. The resident was being followed by his Primary Physician and a Psychiatrist. The last Progress Note completed by the attending Physician was dated 1/23/16. No Progress Notes from the Psychiatrist were available or provided upon request.</p> <p>The Nurse's Notes were reviewed. The following entries were noted: 9/15/15 at 10:40 a.m. - The resident was seen by (Psychiatrist name) 10/13/15 at 10:15 a.m.- The resident was seen by (Psychiatrist name) 1/15/16 at 11:30 a.m.- The resident was</p> | | <p>cooperation with the mental health services provider. Progress notes from the psychiatrist treating Resident#B were submitted to I S D H May 3,2016 via USPS Certified Mail andelectronic mail to ISDH legal counsel and Breda Buroker, Division of Long TermCare. ISDH legal counsel confirmed viae-mail 5/23/16 that all requested progress notes have been received. Should additional records or informationconcerning Resident #B be required, the facility will provide any additionalrecords or information upon request. 2. The records of any resident diagnosed with mental illness may include psychiatric progress notes, similar to the records in question with respect to Resident #B. Treatment notes related to services provided by thepsychiatrist/mental health service provider will be included in the Facility record. These notes will be reviewed and addressedwhen developing the Facility care plan and in subsequent revisions. Further, a licensed nurse will collaboratewith the psychiatrist/mental health service provider to provide an overview ofthe resident's condition as necessary to facilitate the resident's treatmentand development and/or modification of the plan of care. 3.The facility will provide all information requested relating to the investigation of an unusual</p> | |

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| | <p>seen by (Psychiatrist name) 3/11/16 at 11:30 a.m. - The resident was seen by (Psychiatrist name) No Progress Notes or any other notes written by or completed by the Psychiatrist were available in the resident's record or upon being requested.</p> <p>A semi-annual Nursing assessment was completed on 1/8/16. The assessment indicated the resident needed redirections and encouragement</p> <p>The resident's Service Plan was last updated on 4/22/15. The Service Plan indicated staff were to monitor the resident for early signs of problem behavior.</p> <p>The 3/2016 Medication Record was reviewed. There were Physician orders for the resident the following medications: Risperidone (an antipsychotic medication) 4 milligrams every night at bedtime. Haloperidol (an antipsychotic medication) 150 milligrams injections once every three weeks. Haloperidol 5 milligrams by mouth every 8 hours as needed. Lorazepam(a medication for anxiety) 0.5 milligrams every night at bedtime.</p> | | <p>occurrence in compliance with applicable law, and will develop and/or modify the resident's plan of care in cooperation with the psychiatrist/mental health provider in accordance with the procedures previously outlined 4. The Administrator and/or designee will be responsible for ensuring that all records are properly maintained and for responding to all requests to ensure that all information is provided in compliance with applicable law and for ensuring that residents' plans of care are developed in cooperation with the psychiatrist/mental health services providers in accordance with the procedures previously outlined 5. Date of completion for systemic change will be May 24, 2016.</p> | | | | |

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| R 0384 Bldg. 00 | <p>When interviewed on 3/28/16 at 10:30 a.m., the facility Administrator indicated she was not able to provide any Physician Progress Notes completed by the resident's Psychiatrist.</p> <p>This Residential tag relates to Complaint IN 00195742.</p> <p>410 IAC 16.2-5-11.1(h) Mental Health Screening - Deficiency (h) The residential care facility shall provide or arrange for services to carry out the resident ' s comprehensive care plan. Based on record review and interview the facility failed to ensure arrangements were made to carry out the resident's comprehensive plan of care related to failure to provide Progress Notes from the Psychiatrist for 1 of 2 residents reviewed for mental health care plans in a sample of 4. (Resident #B)</p> <p>Findings includes:</p> | R 0384 | <p>1. The facility did ensure that arrangements were made to carry out Resident#B's comprehensive plan of care. Progress notes from the psychiatrist treating Resident#B's were submitted to the ISDH on May 3, 2016 via USPS Certified Mail and electronic mail to ISDH legal counsel and Breda Buroker, Division of Long Term Care. ISDH legalcounsel confirmed via e-mail 5/23/16 that all requested progress notes havebeen received.</p> | 05/17/2016 |

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| | <p>The closed record for Resident #B was reviewed on 3/28/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder, depression, seizure disorder, high blood pressure, and a history of anemia. The resident was being followed by his Primary Physician and a Psychiatrist. The last Progress Note completed by the attending Physician was dated 1/23/16. No Progress Notes from the Psychiatrist were available or provided upon request.</p> <p>A semi-annual Nursing assessment was completed on 1/8/16. The assessment indicated the resident needed redirections and encouragement</p> <p>The resident's Service Plan was last updated on 4/22/15. The Service Plan indicated staff were to monitor the resident for early signs of problem behavior.</p> <p>The 3/2016 Medication Record was reviewed. There were Physician orders for the resident the following medications: Risperidone (an antipsychotic medication) 4 milligrams every night at bedtime. Haloperidol (an antipsychotic medication) 150 milligrams injections</p> | | <p>Should additional records or information concerning Resident #B be required, the facility will provide any additional records or information upon request</p> <p>2. The records of any residents diagnosed with mental illness may include psychiatric progress notes similar to the records in question with respect to Resident# B.</p> <p>A licensed nurse will provide medication administration to admitted residents.</p> <p>The psychiatrist/mental health services provider and/or case managers will provide mental health treatment and counseling as needed. The recommendations from each party shall be taken into consideration in the development and execution of the plan of care. All actions of the plan of care shall be noted in the individual resident's clinical record. The facility makes space available on site for residents to meet with and receive treatment services from their psychiatrist/mental health services providers. In the event that it is not logistically possible to provide needed services on site (for example, inpatient hospitalization, outpatient therapy and/or Adult Intensive Care Services), residents are transported to the local CMHC. Additionally, the facility has access to emergency services 24 hours a day through the local CMHS, which includes assessment and</p> | |

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| | <p>once every three weeks. Haloperidol 5 milligrams by mouth every 8 hours as needed. Lorazepam 0.5 milligrams every night at bedtime.</p> <p>An Unusual Event Report was completed was completed on 3/14/16 at 1:54 a.m. The report was completed by RN #1. The report indicated on 3/13/16 at 9:20 p.m., RN #1 was called by CNA #1 and the CNA yelled that the resident had hung. RN #1 entered the room and observed the resident with a cord around his neck and attempted to get the cord from around his neck but could not get her fingers under the cord. 911 was called. LPN #2 entered with scissors and the cord was cut. The resident was positioned flat and CPR was initiated. The local police and Fire Department EMT's arrived and transported Resident #B to the hospital. The report listed the "Type of Event" as "Suicide Attempt."</p> <p>The Nurse's Notes were reviewed. The following entries were noted: 9/15/15 at 10:40 a.m. - The resident was seen by (Psychiatrist name) 10/13/15 at 10:15 a.m.- The resident was seen by (Psychiatrist name) 1/15/16 at 11:30 a.m.- The resident was seen by (Psychiatrist name) 3/11/16 at 11:30 a.m. - The resident was</p> | | <p>hospitalization, if appropriate. 3. The facility will provide all information requested relating to the investigation of an unusual occurrence in compliance with applicable law, and provide or arrange for the provision of services as necessary to carry out the residents' plans of care in accordance with the procedures previously outlined 4. The Administrator and/or designee will be responsible for ensuring that all records are properly maintained and for responding to all requests to ensure that all information is provided in compliance with applicable law ,and for ensuring that the residents' plans of care are carried out in accordance with the procedures previously outlined. 5. Date systemic changes will be complete May 24, 2016.</p> | | | | |

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| | <p>seen by (Psychiatrist name) No Progress Notes or any other notes written by or completed by the Psychiatrist were available in the resident's record or upon being requested.</p> <p>When interviewed on 3/28/16 at 10:30 a.m., the facility Administrator indicated Resident #B expired at the hospital. The Administrator indicated she was not able to provide any Physician Progress Notes completed by the resident's Psychiatrist.</p> <p>This Residential tag relates to Complaint IN 00195742.</p> | | | |