STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY ST LAKE STATION, IN 46405

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R 0000 Bldg. 00	This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00195742 completed on March 29, 2016. Complaint IN00195742 - Corrected. Unrelated deficiencies cited. Survey date: June 3, 2016 Facility number: 001136 Provider number: 001136 AIM number: N/A Residential census: 122 Sample: 5 These State residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed by 32883 on 6/6/16.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse;			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure abuse did not occur related to a staff member grabbing, pushing, and yelling at a resident who did not want to take her medications for 1 of 2 unusual occurrences reviewed. (Resident #C) Finding includes: The record for Resident #C was reviewed on 6/3/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, bipolar schizophrenia, diabetes mellitus, congestive heart failure, and coronary artery disease. A Service Plan dated 5/9/16 indicated the resident required Nursing assistance with medications. The Service Plan indicated the resident was alert and orientated x 2 and had delayed responses when questioned. An Investigation dated 6/2/16 indicated Resident #C informed the Director of Nursing that a person had hurt her. The resident physically described the staff member. The resident was asked to repeat her concerns and pointed to her	R 0052	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An investigation was intitiated immediately upon notification of the allegation by Resident#C. RN#1 involved in the allegation was suspended and taken off working schedule pending the investigation. RN#2, #3 and LPN#1 who failed to report the allegation was immediately inserviced on resident rights, facility abuse policy and allegations of abuse. The facility Administrator had initiated one on one in-services with facility staff on facility abuse policy just days prior to the report of the alleged incident. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All of the residents of the facility have the potential to be affected by the alleged deficient practice. RN#1 has been terminated from the facility. RN#2,#3 and LPN#1 were immediately re-inserviced on resident rights, facility abuse policy and reporting allegations of abuse. Administrator did interview other residents who had contact with RN#1 and there were no	07/15/2016

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	right shoulder and repeated her statement. The resident stated it had happened a couple of days ago. The Investigation indicated the Director of Nursing informed the Administrator and then began interviewing staff members. RN #2 was interviewed and indicated RN #3 told her she observed RN #1 pinning Resident #C to the desk or wall and pointing her finger at the resident's face. RN #3 also indicated LPN #1 was also present at the time of the incident. The Director of Nursing contacted LPN #1 on 6/2/16. The LPN described the incident over the telephone. LPN #1 indicated on Sunday 5/29/16 around 11:00 a.m., Resident #C needed her blood sugar level checked. The LPN heard RN #1 getting loud with the Resident because the resident was refusing to take her medications and to have her blood sugar level checked. RN #1 pushed the residents hand down form her mouth and forced the resident against the counter and took the resident's right arm and put the arm on the resident's left shoulder. RN #1 loudly stated "You will never raise your hand to me." RN #1 forced the resident to the counter and had pushed Resident #C's body with her hip.		incidents or concerns regarding abuse. Administrator also spoke with RN#2,#3 and LPN#1 and there were no other incidents that occurred on the date reported incident occurred or any other dates prior. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Director of Nursing will in-service Nursing Staff annually on resident rights and reporting allegations of abuse. The Administrator and/or designee will continue have all staff in-services meetings on resident rights, facility abuse policy and reporting allegations of abuse. The Administrator and/or designee will attend Resident Council and have all resident Meetings annually to inform residents about reporting any allegations of abuse immediately. Residents will receive resident a copy of the Residents Rights upon admission which indicates that residents have the right to be free from restraint and abuse living in a residential care facility. 4.How will the corrective action will be monitored to ensure the deficient practice will not recur. The Administrator and/or designee will review Nursing Staff inservice meetings quarterly. Administrator and/or designee will review any concerns from residents as reported and ask at random if they have any concerns.	

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	When interviewed on 6/3/16 at 10:45 a.m., the Director of Nursing indicated she was first informed of the above occurrence on 6/2/16. The Director of Nursing indicated she saw Resident #C in morning and began talking to her. The resident then stated someone had hurt her. An investigation was started and other staff members were interviewed. The Director of Nursing indicated RN #2 and RN #3 informed her about the incident where RN #1 pointed her finger at the resident and picked up the resident's right arm and pulled it to her left shoulder. The Director of Nursing indicated LPN #1 informed her she had seen the occurrence. RN #1 leaned into the resident with her hips to pin the resident against the wall and pointing her finger at Resident #C. The Director of Nursing indicated the occurrence happened around 11:00 a.m. on 5/29/16. RN #1 had continued to work the rest of the day shift and also doubled to work the Evening shift on 5/29/16. The Director of Nursing indicated RN #2 and LPN #2 should have reported the incident they witnessed to the Administrator or the Director of Nursing at the time it occurred on 5/29/16. When interviewed via telephone on		Administrator and/or designee will monitor residents when making rounds and interview at random if they have any concerns with regards to abuse. 5. Date systemic changes will be completed July 15th, 2016.	

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	6/3/16 at 11:51 a.m., LPN #1 indicated Resident #C was quiet and did not speak to many staff. The LPN indicated she admitted the resident and the resident seemed to be familiar with her and would seek her out and talk to her. LPN #1 continued to describe the occurrence she had seen on 5/29/15. The LPN indicated the she was assigned to Cart #2 for medication pass. RN #1 was assigned to Cart #1 and RN #2 was assigned to Cart #3. The Aides had assisted Resident #C to the Nursing station for her blood sugar check and then she assisted her over to RN #1's area/cart. LPN #1 indicated she saw RN #1 complete a blood sugar test on the resident and then heard RN#1 yelling at the resident stating "I need you to take your pills." and "You are going to take your pills." The RN repeated this many times to the resident. Resident #C put her hand over her mouth and RN#1 "pushed" the resident's hand away from her mouth. The RN "grabbed" the resident's right hand and put the resident's hand on the left shoulder and stated " You will never raise your hand to me again." LPN #1 indicated she felt intimidated by RN #1 at the time and continued to feel intimidated by the RN. LPN #1 indicated she then walked over the area and brought the resident to her			

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	area and had the resident sit down. The resident agreed and was given her oral medications by LPN #1. The LPN indicated she had not informed the Administrator or Director of Nursing of the above occurrence she observed. LPN #1 indicated she felt intimidated by RN #1 related to the RN making statements about having a black belt and guns. The LPN indicated she still feels intimidated by RN #1. The LPN indicated she was aware of the Abuse Policy and had signed acknowledgement and the incident should have been reported right away on 5/29/16. When interviewed on 6/3/16 at 10:45 a.m., the facility Administrator indicated she was first made of aware if the above occurrence on 6/2/16 when the Director notified her of the Resident #C's statement. The Administrator indicated the Nursing staff that observed the treatment of the resident should have reported to herself and/or the Director of Nursing on 5/29/16 at the time observed RN #1's treatment of the resident.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency			

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	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure an allegation of Staff to Resident abuse was reported to the Indiana State Department of Health as within 24 hours of the Abuse being witnessed by other staff members for 1 of 2 unusual occurrences reviewed. (Resident #C) Finding includes: The record for Resident #C was reviewed on 6/3/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, bipolar schizophrenia, diabetes mellitus, congestive heart failure, and coronary artery disease. A Service Plan dated 5/9/16 indicated the resident required Nursing assistance with medications. The Service Plan indicated the resident was alert and orientated x 2 and had delayed responses when questioned. An Investigation dated 6/2/16 indicated Resident #C informed the Director of Nursing that a person had hurt her. The resident physically described the staff	R 0090	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An investigation was initiated immediately upon notification of the allegation made by the Resident#C. RN#1 involved in the allegation was suspended and taken off the working schedule pending investigation. RN#2,#3 and LPN#1 who failed to report the allegation was immediately inserviced resident rights, facility abuse policy and reporting any allegations of abuse. The facility Administrator had intitated one on one inservices with facility staff on facility abuse policy just days prior to report of the alleged incident. The Administrator spoke to a random sample residents who had contact with the nurse to ensure there were no other incidents that had not been reported. 2. How will the facility identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. RN#1 has been terminated from the facility. RN#2,#3 and LPN#1	07/15/2016

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	member. The resident was asked to repeat her concerns and pointed to her right shoulder and repeated her statement. The resident stated it had happened a couple of days ago. The Investigation indicated the Director of Nursing informed the Administrator and then began interviewing staff members. RN #2 was interviewed and indicated RN #3 told her she observed RN #1 pinning Resident #C to the desk or wall and pointing her finger at the resident's face. RN #3 also indicated LPN #1 was also present at the time of the incident which occurred on 5/29/16. When interviewed on 6/3/16 at 10:45 a.m., the Director of Nursing indicated she was first informed of the above occurrence on 6/2/16. The Director of Nursing indicated she saw Resident #C in morning and began talking to her. The resident then stated someone had hurt her. An investigation was started and other staff members were interviewed. The Director of Nursing indicated RN #2 and RN #3 informed her about the incident where RN #1 pointed her finger at the resident and picked up the resident's right arm and pulled it to her left shoulder. The Director of Nursing indicated LPN #1 informed her she had seen the occurrence. RN #1 leaned into		were immediately re-inserviced on resident rights, facility abuse policy and reporting allegations of abuse. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. The Director of Nursing will inservice Nursing Staff annually on resident rights and reporting allegations of abuse. The Administrator and/or designee will continue to have all staff inservice meetings on resident rights, facility abuse policy and reporting allegations of abuse. The Administrator and/or designee will attend Resident Council Meetings Annually to inform residents about reporting any allegations of abuse. All newly admitted residents will receive a copy of the Resident Rights issued by The Long Term Care Division of the State of Indiana which indicates that residents have the right to free of abuse and restraint living in a residential care facility. Administrator will also have annual all resident meetings to discuss abuse and reporting abuse to staff should it occur or if it is witnessed. 4. How will the corrective action will be monitored to ensure the deficient practice will not recur. Administrator and/or designee will review Nursing Staff inservice meetings quarterly. Administrator and/or designee will review any	

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	the resident with her hips to pin the resident against the wall and pointing her finger at Resident #C. The Director of Nursing indicated none of the above staff members reported the above to wither herself, the Administrator, or any Management staff. When interviewed on 6/3/16 at 10:45 a.m., the facility Administrator indicated she was first made of aware if the above occurrence on 6/2/16 when the Director notified her of the Resident #C's statement. The Administrator indicated the Nursing staff who observed the treatment of the resident should have reported to herself and/or the Director of Nursing on 5/29/16 at the time they observed RN#1's treatment of the resident. The Administrator indicated the allegation was reported to the Indiana State Department of Health on 6/2/16 when the resident informed the Director of Nursing of her allegation of abuse.		concerns from residents as reported and ask at random if they have any concerns. 5. Date systemic changes will be put into place. July 15, 2016	