

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 03/01/2012
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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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R0000	<p>This visit was for the Investigation of Complaints IN00103472 and IN00104580.</p> <p>Complaint IN00103472-Substantiated. State residential deficiencies related to the allegations are cited at R0053 and R0268.</p> <p>Complaint IN00104580-Substantiated. State residential deficiencies related to the allegations are cited at R0268.</p> <p>Survey dates: February 29 and March 1, 2012</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Survey team: Lara Richards, RN, TC Heather Tuttle, RN</p> <p>Census bed type: Residential: 135 Total: 135</p> <p>Census payor type: Other: 135 Total: 135</p> <p>Sample: 3</p>	R0000		

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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	<p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/05/12 by Suzanne Williams, RN</p>			

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R0053	<p>410 IAC 16.2-5-1.2(w) Residents' Rights - Deficiency (w) Residents have the right to be free from verbal abuse.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents were free from verbal abuse and failed to ensure an allegation of verbal abuse was reported and investigated for 1 of 3 sampled residents. (Resident #A)</p> <p>Findings include:</p> <p>On 3/1/12 at 11:50 a.m., Dietary Employee #3 was observed placing drinks on the tables in the Main Dining Room. At this time, the lights were turned on in the Main Dining Room so the Cook could take temperatures on the steam table. At this time, Dietary Employee #3 indicated, "Who turned on the lights? They will want to come in here now." The residents were lined up in the hallway waiting for the Main Dining Room to open.</p> <p>Interview with Resident #A on 3/1/12 at 12:15 p.m., indicated most of the dietary staff were very nice, however, there are a few who are "stand-offish". The resident indicated that she preferred not to name the dietary staff member at this time. The resident's tablemate agreed to this statement.</p>	R0053	<p>1. Dietary Employee#3 was suspended upon notification by the surveyors regarding the allegation made by Resident#A and a investigation was initiated by Administrator. Resident #A states that she has no concerns with Dietary Staff at this time and that Dietary Staff is very courteous and respectful. The Dietary Manager will be disciplined regarding the non reporting of complaint made by Resident #A. Dietary Staff were inserviced on Customer Service on March 8, 2012 by the RD.2. All residents in the facility have the potential to be affected by this alleged deficient practice.3.All Lake Park staff will be re-inserviced on allegations of abuse, including reporting allegations and will be re-inserviced on customer service.4. The Dietary Manager and/or designee will randomly question residents about any issues or concerns they may have with the dietary staff to ensure that the residents are treated with dignity and respect during meal service. The Dietary Manager and /or Assistant Dietary Manager will complete two interviews per meal at least twice a week. The Dietary Manager will provide a monthly log indicating responses of</p>	04/30/2012			

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	<p>At 1:05 p.m., two residents asked if they could have another banana. Dietary Employee #3 rolled her eyes and told the Assistant Dietary Food Manager the residents had already had a banana. The Assistant Dietary Food Manager informed the residents in a pleasant tone that they were all out of bananas. At this time, Dietary Employee #3 asked if she could close the Main Dining Room and start cleaning up. The Assistant Dietary Food Manager told her to give the residents a few more minutes since lunch started a few minutes later. At this time, Dietary Employee #3 pushed her cart into the kitchen and was mumbling under her breath.</p> <p>Interview with the Dietary Food Manager at 1:10 p.m., indicated that she had been watching Dietary Employee #3 recently due to her attitude. When asked if any residents had complained about the employee, the Dietary Food Manager indicated a few weeks ago, she had gotten a complaint from a resident that Dietary Employee #3 had been "snippy" with her. The Dietary Food Manager could not remember the resident's name at the time. When asked, the Dietary Food Manager indicated that she did not report this to the Administrator.</p> <p>Review of the Dietary Inservice titled</p>		<p>residents. This will be an ongoing process, and will be completed quarterly after six months. The Administrator will monitor for compliance through reviewal of responses.5. April 30, 2012.</p>				

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	<p>Resident Rights and Customer Service, at 2:00 p.m., indicated Dietary Employee #3 had attended the inservice on 2/9/12. She had also attended the Abuse inservice on 1/4/12.</p> <p>The Employee Abuse Policy Acknowledgement form was provided by the Administrator and reviewed at 2:43 p.m. The Administrator indicated the form was current. The form indicated the following: "Residents of Lake Park Residential Care are to be treated with dignity and respect. Any individual who intentionally causes any physical or mental injury or commits any sexual offense against a resident of the facility will be subject to immediate discharge. I understand that I will be discharged from my employment at Lake Park Residential Care if I do not report all incidents of suspected or actual resident abuse. I am required to immediately report to my supervisor, Director of Nursing or Administrator any accusation or witnessed physical, verbal, mental or sexual abuse."</p> <p>Interview with the Administrator at this time, indicated she and the Director of Nursing were not aware of the allegation the resident made against Dietary Employee #3.</p>			

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	This State Residential tag relates to Complaint IN00103472.						

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R0268	<p>410 IAC 16.2-5-5.1(a) Food and Nutritional Services - Deficiency (a) The facility shall provide, arrange, or make available three (3) well-planned meals a day, seven (7) days a week that provide a balanced distribution of the daily nutritional requirements.</p> <p>Based on observation, record review, and interview, the facility failed to follow the menu that was prepared by a Registered Dietitian, ensure enough food was prepared for all the residents, offer the menued alternate substitute, and ensure the residents received the correct portion as menued for 2 of 2 meals observed. (The supper and noon meal) This had the potential to affect 135 residents who resided in the facility.</p> <p>Findings include:</p> <p>On 2/29/12 at 4:50 p.m., Dietary Cook #1 was observed behind the steam table located in the Main Dining Room. There was one large pan full of bean soup, one pan of sliced corn bread, and one pan of sausage and sauerkraut on the steam table. On the counter located by the steam table, there was one large pan of diced pears and one large pan of cottage cheese.</p> <p>Interview with Dietary Cook #1 at the time, indicated this was what he was serving for the supper meal. The main entree was the bean soup and the alternate was the sausage and sauerkraut. There</p>	R0268	<p>1. The Dietary Cook #1 was inserviced and will be disciplined about the dinner meal served on February 29, 2012 and how he didnt prepare the meal as planned by the RD.Assistant Dietary Manager and the Dietary Cook#1 was inserviced on proper scoop sizes and both will be disciplined about serving the incorrect amount of food to the residents at the dinner meal on February 29, 2012.The Dietary Staff were in-se rviced on preparation of meals, and portion sizes as planned and the proper manner in which meals should be changed on the menu cycle by the Registered Dietitian on March 8, 2012 and will be re-inserviced by the RD by April 30, 2012.2. All residents have the potential to be affected by this alleged deficicnt practice.3. Dietary Staff will receive monthly inservices conducted by the Dietary Manager and/or RD on preparation of meals and portion sizes.The Dietary Manager will be inserviced by the RD on purchasing adequate amounts of food for menu plan, including the alternates, and also on inventory practices.4.The RD will check</p>	04/30/2012			

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	<p>were no other alternates or food observed on or by the steam table. The Dietary Cook was observed placing a one six ounce ladle full of bean soup into plastic bowls and one slice of corn bread onto a plate and handing those items to the residents as they walked up to get their food. The Assistant Dietary Food Manager was also observed behind the steam table scooping out cottage cheese from a pan. The scoop size was a #12. The Assistant Dietary Food Manager was further observed placing one spoonful (with a serrated spoon) of diced pears into a small bowl. There was no measurement on the spoon. When interviewed at 5:15 p.m., the Assistant Dietary Food Manager indicated she had no idea how much pears the residents were getting nor did she know what the portion was supposed to be. She further indicated she did not know the measurement of the #12 scoop.</p> <p>Further observation at the time, indicated there was no spreadsheet of the meal available for review located by the steam table, until the Assistant Dietary Food Manager was asked to go and get it. Dietary Cook #1 was then observed using an eight ounce ladle and placing one scoop of sausage and kraut into bowls for those residents who chose not to have the bean soup. Review of the spreadsheet</p>		<p>the meal service on monthly visits and will monitor the meal for portion sizes and service of meal to ensure residents are receiving the correct amount of food as indicated on the meal plan as well as alternates. The Dietary Manager will monitor the meals at random monthly for all meal times to ensure residents are receiving correct amount of food as indicated on the meal plan as well as alternates. The combined monitoring will cover the three meal times. The Administrator will initiate a Resident Food Council Committee that will meet monthly and will be attended monthly by the Dietary Manager or Assistant Dietary Manager to discuss the menu and possible changes to menu based on majority resident preference. The Administrator will monitor for compliance by reviewing minutes taken at monthly meeting. The Administrator will randomly check the weekly food purchases and review with the Dietary Manager ongoing. 5. April 30, 2012</p>				

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	<p>indicated the residents were to receive a 1/2 cup of cottage cheese and a 1/2 cup of pears which were to be served with a #8 scoop. The residents were to be served six ounces of sauerkraut and sausage and/or six ounces of western beans.</p> <p>Review of the posted menu on the bulletin board located outside of the dining room and in the activity room, indicated the supper meal was Western Beans, cottage cheese, corn bread and margarine and pears. There were no alternates or substitutes posted at that time.</p> <p>Review of the Winter Menu week Two 2011-2012 prepared by the Registered Dietitian (RD) and signed by her, also indicated the supper meal for Wednesday was supposed to be Minestrone soup, crackers, turkey Reuben sandwich, three bean salad, and a frosted cup cake with an alternate of stuffed cabbage, wax beans, bread and margarine, and pineapple.</p> <p>Continued observation at 5:35 p.m., indicated the facility ran out of the pears and the cottage cheese. At that time, the Assistant Dietary Food Manager went into the kitchen and pulled out a container of peaches and served those to the remaining residents. She also brought out a tub of cottage cheese and continued to</p>			

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	<p>serve it to the residents.</p> <p>Interview with Dietary Cook #1 on 2/29/12 at 6:10 p.m., indicated he does not offer an alternate or substitute during the supper time and he further indicated he had been working at the facility for 10 years and generally works five days a week. He indicated he "just knows" what the residents like. He further indicated there was no other substitutes prepared other than the sausage and sauerkraut.</p> <p>Interview with the Dietary Food Manager on 2/29/12 at 6:15 p.m., indicated she had changed the menu herself due to the residents not liking the minestrone soup. She had further indicated they had stopped making the substitutes because the residents would want that over the main menued item and they would have too much left over.</p> <p>On 3/1/12 at 11:45 a.m., Dietary Cook #2 was observed preparing the food for the steam table located in the Main Dining Room. She indicated she was serving what was on the menu prepared by the RD. She indicated she was serving veal scallopini, rice pilaf, capri blend (which was mixed vegetables), bread/margarine, and fresh fruit which was a banana. The substitute offered was beef burgundy, buttered noodles, green beans, and fruit</p>						

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	<p>cocktail. Further observation at 11:55 a.m., indicated the Cook had added just broccoli to the capri blend of vegetables and stirred it together.</p> <p>Review of the Winter Menu Week Two 2011-2012, indicated Thursday's lunch menu (in which the facility had prepared) was exactly as written by the RD.</p> <p>Continued observation at 12:30 p.m., indicated the cook ran out of the capri blend (mixed vegetables). The Assistant Dietary Food Manager went into the kitchen and brought out the remaining broccoli that had been left in the pan and placed it with the vegetables.</p> <p>Further observation at 12:37 p.m., indicated the facility had completely run out of the capri blend and started to give the residents the green beans (which was the alternate). Eighteen residents had to receive the green beans and four residents indicated they did not like green beans and therefore did not get any vegetable.</p> <p>Continued observation at 12:45 p.m., indicated the facility ran out of fresh bananas. At that time, the remaining residents had to receive the alternate of fruit cocktail. Eight residents did not get a banana. At 12:46 p.m., the facility ran out of the green beans and had no</p>			

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	<p>vegetable prepared yet for the residents. There were three residents who left the tray line without any vegetable. At 12:50 p.m., a tray of stewing mixed vegetables was brought out and four residents who were still in line received those as their vegetable.</p> <p>Interview with Dietary Cook #2 on 3/1/12 at 12:50 p.m., indicated she only had prepared nine bags of the capri blend vegetables because that was all that was left in the case. She then prepared another three bags of frozen broccoli to add to the vegetables. Review of the labels on the bags of the vegetables indicated each bag had 32 ounces of vegetables in them. Therefore if the facility's menu called for a 1/2 cup of vegetables per resident there was only enough in one bag to feed five residents with a little left over.</p> <p>Interview with the Dietary Food Manager on 3/1/12 at 1:00 p.m., indicated the cook did not prepare enough of the menued item of the mixed vegetables. She further indicated they did not have enough bananas for everyone to eat also. The Dietary Food Manager indicated there were approximately 135 residents of which they cook the meals for.</p> <p>Interview with the Administrator on</p>						

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	<p>3/1/12 at 2:20 p.m., indicated the Dietary Food Manager had complete control over what she orders and her inventory in the kitchen. She indicated she was not aware of how much she food she orders for the residents.</p> <p>This State Residential Tag relates to Complaints IN00103472 and IN00104580</p>			