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 11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY ST LAKE STATION, IN46405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Post Survey Revisit (PSR) to the PSR completed on 8/1/11 to the State Licensure Survey completed on May 11, 2011. This visit was done in conjunction with the Investigation of Complaint IN00099462. Survey Dates: November 8 & 9, 2011 Facility Number: 001136 Provider Number: 001136 AIM Number: N/A Surveyors: Heather Tuttle, R.N., T.C. Janet Adams, R.N. (11/8/11) Census Bed Type: 145 Residential 145 Total Census Payor Type: 135 Medicaid 10 other 145 Total Sample: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2.	R0000		

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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	Quality review 11/14/11 by Suzanne Williams, RN			
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interviews, the facility failed to ensure Physician Orders were followed related to providing a resident with a helmet to protect him from head injury for 1 of 3 residents reviewed for falls in the sample of 7. (Resident F) Findings include: The record for Resident F was reviewed on 11/8/11 at 12:48 p.m. The resident was admitted to the facility on 9/12/11 from another Residential Facility. The resident's diagnoses included, but were not limited to, pseudo seizures, mild mental retardation, alcohol abuse, depression, hypertension, bipolar disorder, anxiety, and unspecified nonpsychotic mental disorder.	R0241	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Prior to complaint survey, Resident F received second protective helmet while in hospital per facility Administrator's request. Facility monitored resident, provided call light within reach so resident could call nurses for assistance when getting out of bed. Facility made several attempts to retrieve protective helmet that was lost with transferring agency. Facility made several attempts in calling former/closed residential care facility to locate Resident F's protective helmet.Facility travelled to local Residential Care Facility to inquire if Resident F's protective helmet was sent to local residential care facility in error and local facility denied receiving any items that didnt belong to their transferred	12/31/2011

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	Review of the transfer form from the other Residential facility dated 9/12/11, indicated the resident ambulated and used a safety helmet. Review of Physician Orders dated 9/19/11 indicated "Please supply a protective helmet for the resident." Review of the Agency Incident Report indicated the resident was seen on the floor on 9/19/11 at 4:00 a.m., by the library. The resident indicated he hit his head on the stairs and was bleeding from his forehead. Review of the Agency Incident Report dated 9/30/11 at 8:30 p.m., indicated the resident was brought to the nurse's station by another resident. The other resident told nursing staff that Resident #F was sitting in a chair and just fell backwards and his head. The resident had a one inch nodule with redness on the back of his head. Review of the Agency Incident Report indicated the resident was observed outside on 10/3/11 at 2:25 p.m. when he fell onto the gravel. The resident got up and went back inside, walked to the nurse's station where he had fallen again. The resident sustained a laceration to his forehead.		residents from State closed facility. Facility also notified Local Ombudsman, State Ombudsman and Resident F's responsible party that protective helmet didnt transfer to facility upon admission from State closed residential care facility. Facility continues to work with Local Ombudsman in securing Resident F's lost protective helmet.Resident F is currently in hospital and is being evaluated to reside in a facility that is closer to family.2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what coorective actions will be taken?Any resident that requires protective equipment have the potential to be affected by this alleged deficient practice. Director of Nursing and/ or designee will be able to identify other resdeints having the potential to be affected through pre admission screenings.Director of Nursing and/or designee will ensure all newly admitted rsidents will be admitted to the facility with all physician ordered protective equipment.3. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur?Director of Nursing and/or designee will be responsible for procurring physician ordered protective equipment for residents in facility.Director of Nursing and/or	

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	The resident was sent to the emergency room for evaluation following the fall. Review of the Emergency Department Chart 10/3/11 indicated the resident's facial area over the left side of the forehead was tender upon palpation. There was moderate traumatic soft tissue swelling over the left side of the forehead. There was a vertical laceration located over the left side of the forehead that measured seven centimeters in length, which required surgical closure. Review of the Agency Incident Report indicated the resident had fallen on 10/9/11 at 9:15 a.m., in the dining room. The resident had fallen onto the left side of his face. The resident's left eye was also swollen. The resident was alert to his name but confused to time and place. The resident was unable to tell staff what had happened. Review of Nursing Progress Notes dated 10/9/11 at 10:00 a.m., indicated the resident was sent to the hospital. The resident was admitted, and returned to the facility on 10/28/11. Review of the CT of the head dated 10/9/11 indicated stable bilateral subacute to chronic subdural hematomas overlying both cerebral hemispheres.		designee will inservice all nursing staff about ensuring that physician orders are noted and carried out in a timely manner.Director of Nursing will inform all potential transferring facilities and/or agencies that physician ordered protective equipment must accompany resident upon transfer.Nursing Staff will monitor residents daily who have protective equipment ordered by physician and will document monitoring on twenty four (24) hour nursing report forms. Nursing Staff will be inserviced on monitoring and Director of Nursing will monitor for compliance.Monitoring will be on-going.4. How the corrective actions will be monitored to ensure the alleged deficient practice will not recur.Director of Nursing and/or designee will maintain a log of residents with physician ordered protective equipment and update as physician orders change.5. Date systemic changes will be completed. December 31, 2011	

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	Review of the Multiplanar multisequence MRI of the brain dated 10/12/11 indicated there was bilateral holohemisperic mixed age subdural hematoma. Review of Nursing Progress notes dated 9/12-10/9/11 indicated the resident did not have or was not wearing a safety helmet. Interview with LPN #1 on 11/8/11 at 1:45 p.m., indicated the resident did not have a safety helmet from 9/12-10/9/11 when he was admitted to the hospital. The nurse further indicated the transferring facility had sent the resident's helmet with his belongings, however, the helmet never showed up and was lost. The LPN indicated they had even called the other Residential facility to see if some of the resident's belongings had shown up there. The LPN further indicated the helmet was just recently purchased by Medicaid a couple of months ago and Medicaid would not pay for a new one. Interview with the Director of Nursing on 11/8/11 at 2:30 p.m., indicated the resident's helmet was not sent with him from the transferring facility. She further indicated the resident was not wearing a helmet or any other protective device at the time of the above mentioned falls.			

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	The Director of Nursing further indicated at the time, no other interventions were put into place from 9/12-10/9/11 to protect the resident from falling and hitting his head. This state residential finding was cited on 8/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			