

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00149820.</p> <p>Complaint IN00149820-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 4 & 5, 2014</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Survey team: Cynthia Stramel, RN-TC Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: Residential: 126 Total: 126</p> <p>Census payer type: Medicaid: 117 Other: 9 Total: 126</p> <p>Sample: 12</p> <p>These State residential findings are cited in accordance with 410 IAC 16.2.</p>	R000000		
---------	---	---------	--	--

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.

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R000144	<p>Quality review completed on June 11, 2014, by Janelyn Kulik, RN.</p> <p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to maintain a clean and orderly environment related to marred walls, stained carpets and floor tile, cracked floor tile, urine odors, torn upholstery, and lime build up in bathtubs for 2 of 2 units throughout the facility. (The 100 and 200 hallways)</p> <p>Findings include:</p> <p>1. During the Environmental Tour with the Maintenance Supervisor on 6/5/14 at 12:00 p.m., the following was observed:</p> <p>a. A strong urine odor was noted in Room 120. The floor tile in the bathroom was discolored around the base of the toilet and the carpet had large areas of discoloration by the foot of bed 1. Two residents resided in this room.</p> <p>b. The floor tile in Room 124 was discolored in the bathroom. The walls</p>	R000144	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. The strong urine odor in Room 120 was cleaned and removed. A work order has been put in to replace the floor tile in the bathroom. The carpet in Room 120 has been cleaned. b. The floor tile in Room 124 will be replaced that was discolored in the bathroom and the marred walls is being repainted. c. The twelve floor tiles located outside of Room 124 will be replaced. d. A work order has been put in to replace the wallpaper in Room 172. e. The bathroom fixture in Room 208 was replaced and the accumulation of lime buildup on the faucet in the tub as well as the caulking around the tub will be cleaned. The wall with the missing wallpaper will be repaired and the orange and brown substance will be removed. f. The chair in Room 224 was removed and replaced with another chair. g. The carpet in</p>	08/27/2014

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>were also paint chipped and marred. Two residents resided in this room.</p> <p>c. Twelve floor tiles located outside of Room 124 were cracked along the edges.</p> <p>d. The wallpaper located next to the edge of the tub in Room 172 was peeling in sections. One resident resided in this room.</p> <p>e. The bathroom light fixture was missing in Room 208. There was also an accumulation of lime build up on the faucet in the tub as well as discolored caulking around the bath tub. The wall underneath the sink was missing a section of wall paper and the wall was discolored with an orange/brown substance. Two residents resided in this room.</p> <p>f. The chair in Room 224, which had a blue plastic seat cover, was torn in sections. Two residents resided in this room.</p> <p>g. The carpet in Room 234 was stained in sections. Two residents resided in this room.</p> <p>h. The hallway carpeting located outside of Room 234 was stained in sections.</p> <p>i. The floor tile in the 100 and 200</p>		<p>Room 234 has been cleaned. h. The hallway carpeting located outside of Room 234 will be cleaned. i. The floor tile in the 100 and 200 hallways will be stripped, and rewaxed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by the alleged deficient practice. 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 housekeeping and maintenance staff will review the facility's current cleaning and repair policy, procedures and schedules and will be in serviced on the same. The Environmental Services Director and/or designee will do a Room to Room check for any repair or cleaning concerns and will report findings to the Administrator. The facility will be contracting with a vendor to repair cracked tiles within the facility and will repair and/or replace tiles on quarterly basis beginning in July of 2014. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur? The Environmental Services Director will make weekly random rounds to monitor cleanliness and repairs of resident rooms and common</p>	

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R000154	<p>hallways was discolored with a wax build up. Further, there was an area of dark black discoloration along the metal tile strips located next to room doors.</p> <p>Interview with the Maintenance Supervisor at the time, indicated all of the above were in need of cleaning and/or repair.</p> <p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview the facility failed to ensure a safe and sanitary kitchen related to dirt accumulation on a food prep table and on metal serving pans. This had the potential to effect all 126 of the residents who receive meals prepared in that kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 6/4/14 at 9:40 a.m., with the Kitchen Manager the following were observed:</p> <p>a. There was an accumulation of grime and dirt along the bottom edge of the food preparation counter.</p>	R000154	<p>areas to ensure compliance. Monitoring will be ongoing for compliance. 5. By what date the systemic changes will be completed? August 27th, 2014</p> <p>1. What corrective actions will be accomplished for those residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a. The accumulation of grime and dirt along the bottom edge of the food prep counter was immediately cleaned and the shelves in which they were stored were cleaned also by the Dietary Staff. 2. How will facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes the facility will make to ensure the</p>	08/27/2014

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R000241	<p>b. The counter had shelves below where metal serving pans were stored. There were four serving pans stacked on top of each other, there was an accumulation of crumbs along the edges of the pans.</p> <p>The Kitchen Manager indicated the edge of the prep counter was in need of cleaning, and she removed the pans from the shelf and placed them in the dishwashing area at that time.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure meter dose inhalers were properly administered and failed to follow Physician Orders related to the administration of Lasix (a diuretic medication) and Potassium (a supplemental medication) for 1 of 5 residents observed during medication</p>	R000241	<p>deficient practice does not recur. The Dietary Staff will review and will be inserviced on the policya nd procedures of cleaning the food prep area on a daily basis. The Dietary Staff will be inserviced by the Dietary Supervisor on the cleaning schedules for the Dietary Department. 4.How will the corrective action will be monitored to ensure the deficient practice will not recur. The Dietary Supervisor and/or Cook will monitor the kitchen on a daily basis to ensure that the prep counter is cleaned after each meal. 5. By what date the systemic changes will be completed. August 27th, 2014</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident number#10 has been educated on the importance of waiting five minutes in between usage of inhalers and now understands and will also look at time when he uses the first inhaler. LPN#1 was in serviced and counseled by</p>	08/27/2014

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 06/05/2014	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>pass and for 1 of 8 residents reviewed for Physician Orders. (Residents #6 and #10)</p> <p>Findings include:</p> <p>1. On 6/5/14 at 8:25, LPN #1 was observed preparing medication for Resident #10. At that time, she removed two metered dose inhalers from the medication cart. One of the inhalers was Spiriva and the other was Advair. She further indicated at the time, the resident knows how to self administer his own inhalers. After pouring all of his other medication, she asked the resident to step into the Nurse's Station. At that time, Resident #10 sat down, took his oral medications and then picked up the Spiriva medication to administer. LPN #1 indicated to the Resident that he needed to wait five minutes in between the two different inhalers. At 8:28 a.m., the resident inhaled the contents of the capsule in the Spiriva inhaler. The LPN indicated again he needed to wait five minutes before self administering the Advair. At 8:31 a.m., the resident indicated it had been five minutes and he was going to use the Advair inhaler. The LPN looked at the resident, and indicated "I really did not check the time when you inhaled the Spiriva." The resident then picked up the Advair inhaler and inhaled</p>		<p>Director of Nursing about the improper procedure used with Resident#10's inhaler and not following the correct procedures. The physician was called regarding the medication orders for Resident#6 and the physician made an adjustment in the medication order for the Lasix and Potassium to be given two times a day. The physician was notified that the resident did not receive the Bromfed cough syrup and no new orders were given and that cough syrup should remain PRN 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. All resident physician orders were reviewed by two sets of nursing to ensure accuracy of orders. 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. All nurses and QMA's have been inserviced on the administration of medications with the nurses being inserviced on the proper procedures of transcribing physician orders. All nursing staff have been inserviced on the proper procedures of transcribing medication orders. 4. How will the corrective actions be monitored to ensure the</p>				

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 06/05/2014	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>the contents at 8:31 a.m.</p> <p>Interview with LPN #1 on 6/5/14, at 8:45 a.m., indicated she did not check the time, when the resident had inhaled Spiriva.</p> <p>Interview with the Director of Nursing on 6/5/14 at 10:00 a.m., indicated all of the nurses have been inserviced and instructed to wait five minutes in between two different metered dose inhalers.</p> <p>2. The record for Resident #6 was reviewed on 6/4/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, peripheral vascular disease and high blood pressure.</p> <p>Review of a Physician Order Progress Note dated 3/20/14 indicated "Here is a summary of the plan discussed. Please contact us if you have any further questions or concerns. Plan: Prescribe Bromfed DM (a cough syrup) oral syrup 10 milliliters (ml) every 4 hours times 10 days. Resume 40 milligrams (mg) of Lasix and Potassium 20 mg daily."</p> <p>Review of Physician Orders dated 3/20/14 to 6/3/14 indicated there were no orders for the Lasix and Potassium to be given on a daily basis.</p>		<p>deficient practice will not recur. All Nurses and QMA's will be randomly chosen monthly to complete a medication pass with pharmacy consultant to ensure medications are passed according to physician orders and accurately. All Lake Park Nurses and QMA's will complete the medication pass with pharmacy consultant.</p> <p>4.How will the corrective actions will be monitored to ensure the deficient practice will not recur. The Director of Nursing will randomly chose resident clinical charts and double check medication orders on a weekly basis. The Director of Nursing will randomly check resident charts to ensure that medication orders have been transcribed accurately and properly. At random on a weekly basis the Director of Nursing will monitor a medication pass with one Nurse or QMA. Monitoring will be ongoing. 5.By what date the systemic changes will be put into place. August 27th, 2014</p>				

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 06/05/2014	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
R000273	<p>Review of Physician Orders dated 3/15/14 indicated Furosemide (generic name for Lasix) 40 mg one tablet twice a day and Potassium Chloride 20 milliequivalence (meq) one tablet two times a day.</p> <p>Review of the Medication Administration Record (MAR) for the months of 4/2014 and 5/2014 and from 3/20-3/31/14 and 6/1-6/3/14 indicated the resident received the Lasix and the Potassium two times a day rather than one time a day as ordered by the Physician on 3/20/14.</p> <p>Continued review of the 3/2014 MAR indicated the resident did not receive the Bromfed Dm oral syrup four times a day for 10 days. There was no evidence the medication had been signed out and administered to the resident.</p> <p>Interview with the Director of Nursing on 6/4/14 at 1:00 p.m., indicated the resident sees his Physician at the office and when he returns the Nursing staff were to transcribe the new orders onto the Medication Record.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency</p>						

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to ensure a safe and sanitary kitchen related to the storage of leftover food beyond the policy timeframe. This had the potential to effect all 126 residents that received meals from the kitchen.</p> <p>Findings include:</p> <p>An initial tour of the kitchen was done on Tuesday, 6/4/14 at 9:40 a.m., with the Kitchen Manager and the following was observed:</p> <p>In the walk in refrigerator, there were four metal serving pans containing prepared food with plastic wrap covering them. Beets dated 5/26, pizza sauce dated 5/28, vegetable soup dated 5/31, and minestrone dated 5/21. The Kitchen Manager indicated they were leftovers.</p> <p>She indicated at that time that leftover food should be discarded after 2 or 3 days, and that the refrigerator was supposed to be cleaned out on Monday and Wednesday. She indicated the above leftovers should have been disposed of.</p>	R000273	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Beets dated 5/26, pizza sauce dated 5/28, vegetable soup dated 5/31 and minestrone soup dated 5/21 were all removed from the walk-in refrigerator and disposed of immediately by the Dietary Manager. The walk-in refrigerator was thoroughly checked again by Dietary manager for any other leftovers that needed to be disposed of.</p> <p>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 this alleged deficient practice.</p> <p>3.What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur. All Dietary Staff will be reinserviced about the policy for usage of leftovers. All Dietary Technicians who are assigned to cook will check the walk in refrigerator on a daily basis to ensure that outdated leftovers are disposed of and will be re in serviced on checking the walk in refrigerator. 4 .How will the</p>	08/27/2014

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
R000301	<p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, and interview, the facility failed to properly label prescription medications in accordance with the State Law related to ensuring the resident's name, dose and Physician's name were labeled on the medication for 1 of 5 residents observed during</p>	R000301	<p>corrective action be monitored to ensure the deficient practice will not recur. The Dietary manager will check the walk-in refrigerator weekly to ensure Dietary staff has disposed of leftovers in a timely manner on a weekly basis. The Consultant Dietitian will check the walk in refrigerator on monthly consultation visits to ensure compliance with the disposal of leftovers. Monitoring will be ongoing 5. By what date the systemic changes will be completed. August 27th, 2014</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident#10's inhalers were both labeled with the residents name, physicians name and dosage on the bag in which it is contained.</p>	08/27/2014

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 06/05/2014	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
R000306	<p>medication pass. (Resident #10)</p> <p>Findings include:</p> <p>On 6/5/14 at 8:25 a.m., LPN #1 was observed preparing medications for Resident #10. At that time, she removed a gallon sized zip lock plastic bag from the medication cart. In black marker across the bag was the resident's name. Inside the bag, there were two inhalers. One inhaler was Spiriva and the other was Advair. Each of those inhalers were not in any type of box with the resident's name, dose or Physician's name on them. The inhalers had no information on them, just the name of the drug.</p> <p>Interview with LPN #1 at that time, indicated when other nurses open the boxes of medications that come from the pharmacy, they throw them away and place the inhalers in their plastic baggies.</p> <p>Interview with the Director of Nursing on 6/5/14 at 10:00 a.m., indicated all of the resident's medications were to be labeled with the resident's name, dose, and Physician's name.</p>		<p>2.How will the facility identify other residents having the potential to be affected by the same deficient practice. All the residents have the potential to be affected by the alleged deficient practice. 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. Pharmacy will ensure that all inhalers have proper labeling in the packaging for nursing staff identify residents name, physicians name and dosage. 4. How will the corrective action be monitored to ensure the deficient practice will not recur. Upon receipt of medication from pharmacy, nursing staff will ensure that medication is received with the residents name, physicians name and dosage on the packaging. Director of Nursing and/or designee will randomly check inhalers to ensure that they are properly labeled for administration on a weekly basis. Pharmaceutical Consultant will monitor for compliance by randomly checking for proper labeling and packaging of inhalers during monthly consultation to ensure compliance. Monitoring will be ongoing. 5. By what date the systemic changes will be completed. August 27, 2014.</p>				
	410 IAC 16.2-5-6(g)(1-9)						

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>Pharmaceutical Services - Noncompliance</p> <p>(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:</p> <ol style="list-style-type: none"> (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. <p>Based on observation, record review and interview, the facility failed to ensure discontinued medications were disposed of properly for 1 of 1 residents who were receiving Copaxone (a medication used to treat Multiple Sclerosis) injections. (Resident #13)</p> <p>Findings include:</p> <p>On 6/5/14 at 12:45 p.m., a box of Copaxone (a medication used to treat Multiple Sclerosis) 20 milligram (mg) per 1 milliliter (ml) pre-filled syringes were observed in a plastic bag with Resident #13's name. Review of the Pharmacy label indicated the medication had been delivered to the facility on 7/10/13. On top of the box written in</p>	R000306	<ol style="list-style-type: none"> 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Medication for Resident #13 was disposed of by Director of Nursing during the survey and documented according to facility policy for disposition of medications. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this alleged deficient practice. 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. Nursing Refrigerators will be checked daily by Nursing Staff on the 11pm-7am shift and discontinued 	08/27/2014

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 06/05/2014	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
R000349	<p>ink, someone had written "d/c'd 7/12/13."</p> <p>Review of the facility policy titled "Disposal of Medications, Syringes and Needles" on 6/5/14 at 1:30 p.m., which was provided by the Director of Nursing and identified as current indicated the following:</p> <p>4. Returning Medications to Pharmacy</p> <p>Policy: Except for controlled substances or where prohibited by state law, discontinued or unused medications are returned to the pharmacy for credit whenever possible.</p> <p>a. Medications (other than controlled medications) may be returned to the pharmacy if the medication is in a sealed package or container (such as a unit-dose package or sealed bottle).</p> <p>Interview with the Director of Nursing on 6/5/14 at 1:30 p.m., indicated when the Pharmacy had been in the facility previously to pick the medication up, it had been placed in the lock box rather than the refrigerator and staff was not aware of where the medication was.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records</p>		<p>medications will be returned to pharmacy within forty eight hours. All nursing staff will be in-serviced on policies with regards to medication disposition and returns. 4. Director of Nursing will randomly check refrigerator for medications to ensure compliance on a weekly basis. Pharmacy Consultant will also check refrigerator on monthly visit to facility to ensure compliance. Monitoring will be ongoing. 5. By what date the systemic changes will be completed. August 27th, 2014</p>				

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 06/05/2014
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>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:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure each resident's medical record was complete and accurate related to not documenting a resident's refusal of a medication and not obtaining a Physician's order to discontinue the medication for 1 of 8 residents reviewed for clinical records in the sample of 12. (Resident #7)</p> <p>Findings include:</p> <p>The record for Resident #7 was reviewed on 6/4/14 at 1:00 p.m. The resident was admitted to the facility on 3/13/14. The resident's diagnoses included, but was not limited to, chronic obstructive pulmonary disease (COPD).</p> <p>A Physician's order was dated 5/22/14 for a DuoNeb (an inhaled respiratory medication) breathing treatment every 6 hours for COPD.</p> <p>Nursing note dated 5/23/14 at 5:45 p.m., indicated the resident tolerated all medications well and was pleasant and</p>	R000349	<p>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident#7's medication was discontinued with an order from the physician and documented in the clinical record. 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 the residents have the potential to be affected by the alleged deficient practice.</p> <p>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. All Nursing Staff will be in serviced on proper documentation and policy of any refusal of medications by residents and disciplinary action will be instituted for non compliance.</p> <p>4.How will the corrective action will be monitored to ensure the deficient practice will not recur. Director of Nursing will randomly check clinical records of residents who are refusing medications on a weekly basis for documentation</p>	08/27/2014

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 06/05/2014	
NAME OF PROVIDER OR SUPPLIER LAKE PARK RESIDENTIAL CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2075 RIPLEY ST LAKE STATION, IN 46405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>cooperative.</p> <p>Nursing note dated 5/24/14 at 4:30 p.m., indicated the resident took all scheduled medications with no refusals, and was pleasant and cooperative.</p> <p>Nursing note dated 5/25/14 at 6:33 p.m., indicated resident was wearing oxygen, and continued on antibiotic for COPD. There was no documentation the resident had refused any medications.</p> <p>The May 2014 Medication Administration Record indicated DuoNeb were initiated on 5/22/14 and discontinued on 5/25/14.</p> <p>There was not a Physician order to discontinue the DuoNeb.</p> <p>Interview with the Director of Nursing on 6/5/14 at 7:45 a.m., indicated the DuoNeb were discontinued because the resident had refused to take them. She indicated there was no documentation of the resident refusing the treatments or a Physician's order to discontinue the medication in the resident's record.</p>		<p>compliance. Monitoring will be ongoing. 5. By what date the systemic changes will be completed. August 27th, 2014</p>				