

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 08/12/2015
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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 a State Residential Licensure Survey.</p> <p>Survey dates: August 11 and 12, 2015</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Residential Census: 126</p> <p>Sample: 12</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>	R 0000		
R 0144 Bldg. 00	<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 ensure the facility was clean and in a state of good repair related to burned out light bulbs, chipped paint and an accumulation of dirt on the molding of the bar, missing and stained ceiling tiles, holes in ceiling tiles, scuffed</p>	R 0144	R144 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Activity Room a. Light bulbs will be replaced. b. Molding will be cleaned and bar will be repaired. c. Ceiling tiles will be replaced over the vending machines. The	10/09/2015

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>and marred walls and doors, an accumulation of dirt along the cove bases, discolored caulking around bath tubs and toilets, holes in the ceiling, discolored floor tiles, and soiled and stained hallway carpet on 2 of 2 floors. (The Activity Room, The Main Dining Room, and The First and Second Floors).</p> <p>Findings include:</p> <p>During the Environmental Tour with the Facility Operations Director on 8/12/15 at 3:45 p.m., the following was observed:</p> <p>The Activity Room:</p> <p>a. Three over head light fixtures had burned out light bulbs.</p> <p>b. The bar had chipped paint and an accumulation of dirt on the molding.</p> <p>c. There were two missing ceiling tiles over the vending machines.</p> <p>The Main Dining Room</p> <p>a. There were multiple stained ceiling tiles.</p> <p>b. The walls were scuffed and marred.</p> <p>c. There was an accumulation of dirt</p>		<p>Main Dining Room a. Stained ceiling tiles will be replaced b. Scuffed and marred walls will be repaired c. Cove bases will be cleaned d. Overhead light fixture bulb will be replaced. The First Floor a. Overhead light fixture in the patio entrance will be replaced. b. Scuffed and marred walls will be repaired. c. Cove bases along first hall will be cleaned. d. The entrance door and door frame to the second hall will be painted e. The entrance door and door frame to Room 100 will be repainted. f. Caulking around the bathtub in Room 133 will be recaulked. The dirt around the base of the toilet will be cleaned. g. The ceiling tiles in front of Room 155 will be replaced. h. Discolored floor tiles under the sink in Room 163 will be cleaned. Discolored caulking in same room will be recaulked. The bathroom door will be repainted. The Second Floor a. The ceiling tiles near the entrance to the second hall will be replaced. b. The carpet on second hall will be cleaned. c. The discolored caulking around the tub in Room 214 will be recaulked. The discolored floor tile will be cleaned. d. Discolored floor tiles in front of toilet in Room 234 will be cleaned. 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</p>	

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	<p>along the cove bases.</p> <p>d. One over head light fixture had burned out light bulbs.</p> <p>The First Floor</p> <p>a. There was an over head light fixture with burned out light bulbs in the patio entrance hallway.</p> <p>b. The walls were scuffed and marred in the patio entrance hallway.</p> <p>c. The cove bases along the first hall had an accumulation of dirt.</p> <p>d. The entrance door and door frame to the second hall was marred.</p> <p>d. The entrance door and door frame was scuffed and marred in Room 100. The bedroom walls were scuffed and marred. Two residents resided in this room.</p> <p>e. There was discolored caulking around the bath tub in Room 133. There was an accumulation of dirt around the base of the toilet. Two residents resided in this room.</p> <p>d. There were holes in the ceiling tile in front of Room 156.</p>		<p>potential to be affected by the same 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 Environmental Services Director will review current work order system in place with regards to needed repairs and special cleaning. The Housekeeping Staff will review checklist/inspection form to complete when cleaning rooms and common areas on a daily basis. 4. How will the corrective action s be monitored to ensure the deficient practice will not recur. The housekeeping and maintenance staff will be re-in serviced on current cleaning practices and repairs for the facility. All staff will be in serviced on reporting any repairs, cleaning or other concerns with a work order provided by the Maintenance Director. The facility will contract a vendor to repair and discolored tiles and cove bases beginning with the first hall of the facility. The Environmental Services and/or designee will make weekly random rounds which will include Room to room checks and common areas to areas are cleaned and repaired appropriately and will report findings to the Administrator. Monitoring will be ongoing for compliance. 5. By what date the systemic changes will be</p>	

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	<p>e. There was a hole in the ceiling above the sink in Room 157. Two residents resided in this room.</p> <p>f. There was discolored floor tiles under the sink in Room 163. There was discolored caulking around the bath tub. The bathroom door paint was peeling. Two residents resided in this room.</p> <p>The Second Floor</p> <p>a. The ceiling tiles near the entrance to the second hall were stained. The ceiling tiles had multiple holes.</p> <p>b. The carpet was stained and soiled on the second hall.</p> <p>c. There was discolored caulking around the bath tub in Room 214. There was discolored floor tile behind the toilet. Two residents resided in this room.</p> <p>d. There was discolored floor tiles in front of the toilet in Room 234. Two residents resided in this room.</p> <p>Interview at the time with the Facility Operations Director indicated all the above was in need of cleaning and/or repair.</p>		completed. October 9, 2015				

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R 0154 Bldg. 00	<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 all kitchen areas were clean and in a state of good repair related to, a dusty light fixture over the stove, an accumulation of grease on the stove and grill, water between stacked dishes, and food stored on the top shelf of the freezer closer than 18 inches for 1 of 1 kitchens..</p> <p>Finding includes:</p> <p>During the Kitchen Sanitation tour on 8/11/2015 at 8:40 a.m., with the Dietary Supervisor, the following was observed:</p> <p>a. The light fixture over the stove was dusty.</p> <p>b. The stove top burners and grill had an accumulation of grease.</p> <p>c. In the clean dish closet there were 8 bowels stacked on one another with water between them.</p>	R 0154	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. The light fixture over the stove was cleaned. b. The stove stop burners and grill were cleaned. c. The dishes in the clean dish closet were rewashed and stacked without water in between. d. The 6 boxes on the top shelf were stored at the appropriate levels. 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 residents of 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 Dietary Supervisor will review the current cleaning policies and dishwashing policies as well as cleaning schedules with the Dietary Staff and will be in serviced on all. 4. How will the corrective action will be monitored to ensure the deficient practice</p>	10/09/2015

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R 0241 Bldg. 00	<p>d. There were 6 boxes on the top shelf stored closer than 18 inches from the ceiling of the freezer.</p> <p>Interview at that time with the Dietary Supervisor indicated all the above were in need of cleaning and/or restocking.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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 medications were administered as ordered by the Physician related to the administration of the incorrect amount of nasal inhalations and the administration of a cardiac medication without checking an apical pulse. (Resident #7)</p> <p>Finding includes:</p> <p>On 8/12/15 at 8:05 a.m., RN #1 was preparing medication for Resident #7. RN #1 retrieved the resident's</p>	R 0241	<p>will not recur?The Dietary Supervisor and/or designee will make rounds weekly to ensure that Dietary Staff is following cleaning and dishwashing policies and schedules to ensure compliance by completing a checklist.The Dietary Supervisor will report any concerns to the Administrator.Monitoring will be ongoing for compliance.5. By what date the systemic changes will be completed.October 9, 2015</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? a. Resident#7- Physician was notified that resident self administered two sprays to each nose instead of one. No new orders given. b. Resident#7- Physician was notified that apical pulse was not taken as ordered prior to be administered Digoxin. No new orders given by physician. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what</p>	10/09/2015

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	<p>medications from her medication cart. The medications included, but were not limited to, Fluticason (nasal spray) 50 mcg (micrograms), the label on the box read, "One spray each nostril." She then walked over to the window of the nursing station and handed the medication to the resident and then turned her back and walked away without giving the resident administration instructions. The resident was observed administering two sprays into each nostril. The nurse then returned to the resident and retrieved the nasal spray and placed it back into the box. During continued observation the RN was observed preparing the resident's pills. The pills included, but were not limited to, Digoxin (a cardiac medication) 0.125 milligrams (mg). The nurse dispensed the resident's medications into a white pill cup, walked back to the nursing station window and handed the resident her medications with a cup of water. The resident was then observed swallowing her pills. Interview at this time with RN #1 indicated she did not take an apical pulse prior to administering the cardiac medication because there were no orders indicating the resident's apical pulse should have been taken.</p> <p>The record for Resident #7 was reviewed on 8/12/15 at 2:20 p.m. The resident's</p>		<p>corrective action will be taken? All 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? The Director of Nursing will in-service the nursing staff on administering medications as ordered by the physicians and monitoring the residents when self administering nasal sprays. The Director of Nursing will put a flagging system in place to ensure the nurse is aware that apical pulses are taken as ordered when administering a cardiac medication. 4. How will the corrective action will be monitored to ensure the deficient practice will not recur? The Director of Nursing will in-service the Nursing staff and will make random audits weekly to ensure the nursing staff is administering medications as ordered. The Director of Nursing will make random checks weekly to ensure that residents are self administering nasal sprays as ordered. Monitoring will be ongoing for compliance. 5. By what date the systemic changes will be completed. October 9, 2015</p>				

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	<p>diagnoses included, but were not limited to hypertension and diabetes.</p> <p>The Medication Administration Record (MAR), dated 8/2015, indicated, Fluticason Spray 50 mcg, install one spray in each nostril twice daily. And Digoxin 0.125 mg, take one tablet by mouth daily, hold if apical pulse is less than 60. The documentation on the MAR indicated the resident's apical pulse had not been recorded on 8/11/15 and 8/12/15.</p> <p>The Nursing Service Plan, dated 12/7/14, indicated to monitor self administration of medications.</p> <p>Interview with the Director of Nursing (DON) on 8/12/15 at 2:30 p.m., indicated there were Physician orders on the MAR indicating an apical pulse should be taken prior to the administration of Digoxin and the medication should be held if the resident's pulse was less than 60. Continued interview indicated the RN should have given the resident instructions prior to handing her the nasal spray and she should have observed her as she self administered the nasal spray.</p>			