

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 07/24/2013
--	---	--	---

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 Complaints IN00127921 and IN00127416.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00115494 completed on March 26, 2013.</p> <p>Complaint IN00127921-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00127416-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 23 & 24, 2013</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: 120 Total: 120</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 07/24/2013
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>Census payor type: Medicaid: 118 Other: 2 Total: 120</p> <p>Sample: 12</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 28, 2013, by Janelyn Kulik, RN.</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 07/24/2013	
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>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 environment was clean and in a state of good repair related to chipped paint on door frames and table bases, dusty and dirty ceiling exhaust vents and ceiling fans, paint chipped walls, a rusty shower stall, and dirty floors for 1 of 1 shower room, 1 of 1 dining room, and for 1 of 1 Activity room. This deficient practice had the potential to affect the 120 residents residing in the facility. (The large dining room, the shower room and the Activity room area.)</p> <p>Findings include:</p> <p>1. On 7/24/13 at 1:00 p.m., during the Environmental Tour, the following were observed:</p> <p>A. The yellow walls by the stairwell were discolored in many areas. The walls were also stained.</p> <p>B. The two white ceiling fans in the main lobby were dirty and discolored. All the fan blades were black in color.</p>	R000144	R1441.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The yellow walls will be repainted and free of stains, the two white ceiling fans in the main lobby will be cleaned and fan blades will be cleaned as well, the four return vents in the main lobby will clean and free of rust, the floor by the heating/cooling register in the main lobby will be free of rust, the eleven black tables in the main lobby will be cleaned and free of spillages and also repainted, the two ceiling vents in the activity room will be clean and free of dirt, the floor by the baseboards will be cleaned and free of dirt, the two glass entrance doors by the Activity Room will be cleaned, the doors marred and gouged near the second floor entrance will be repaired.The doors and walls in the shower room have been cleaned and free of black stains, the entire first shower stall is cleaned and free of rust and stains, the privacy curtain for the second shower stall has been replaced, the two ceiling light covers will be replaced, the ceiling has been repainted and is free of chipped paint, the floor tile has been power washed clean	09/17/2013			

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 07/24/2013	
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>C. Four return vents in the main lobby were rusty and dirty.</p> <p>D. The floor was rusty by the heating/cooling register in the main lobby.</p> <p>E. There were 11 black table bases in the main dining room that were paint chipped and noted with food and/or beverage spillage on them.</p> <p>F. There were two ceiling vents in the Activity room that had a heavy accumulation of dust and dirt. There was adhered dirt noted on the floor by the windows along the base board.</p> <p>G. The two glass entrance doors were dirty by the Activity room.</p> <p>H. The doors were marred and gouged by the orange hall near the second floor entrance.</p> <p>I. The doors and walls were marred with black stains in the shower room. The entire first shower stall was rusty and stained. There was no privacy curtain noted on the second shower stall. Two ceiling lights were missing covers. The paint was noted to be chipping and peeling away from the ceiling. The floor tile was stained and/or discolored. There were cob</p>		<p>and is free of discoloration, the cob webs in the window along the ceiling and walls have been removed, the emergency call light bulb was replaced before the exit of survey and is in proper working order, the three compartment drawer and its contents in the shower room was thrown away during the tour with surveyor and will be replaced.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions 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? All housekeeping and maintenance staff will review and be inserviced on cleaning and repair policies and procedures. All housekeeping and maintenance staff will be inserviced on housekeeping concerns and maintenance issues and that these concern areas should be cleaned and/or repaired immediately and reported to Environmental Services Director as needed.Nursing staff will be inserviced on proper labeling of soaps stored in shower for resident usage. All facility staff will be inserviced on reporting areas that require repairs and/ or cleaning.4.How will the corrective actions be monitored to ensure</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 07/24/2013	
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>webs in the window corners and along the walls. The emergency call light was not lighting up outside of the room. The bulb was broken on the inside of the cover. There was a three compartment drawer set observed in the room. Inside the drawers were used and unused bars of soap, open containers of shampoo that spilled all over the inside of the drawer, and containers of lotions and powders. None of those items were labeled with resident's names.</p> <p>Interview with the Maintenance Director at the time, indicated all of the above was in need of cleaning and/or repair.</p>		<p>the deficient practice will not recur?The newly hired Environmental Services Director will revise cleaning and repair schedules and will make daily rounds of facility while on duty weekly. Environmental Services Director and Food Service Director will monitor cleanliness of common areas (halls, lobby, dining rooms) weekly to ensure compliance.Monitoring will be ongoing for compliance.5.By what date the systemic changes will be completed?September 17, 2013.</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 07/24/2013
--	---	--	---

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>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 1 of 1 kitchen area was clean and maintained in good repair related to an accumulation of dust and debris on top of the convection oven, stained floor tile and dust and debris along the baseboard.</p> <p>Findings include:</p> <p>During the Kitchen sanitation tour on 7/24/13 at 1:45 p.m., with the Dietary Food Manager, the following was observed:</p> <p>a. The top of the convection oven had a thick accumulation of dust and debris.</p> <p>b. The floor tile along the base board behind the dishwasher had an accumulation of dust and debris.</p> <p>c. The ceramic floor tile underneath the shelving unit in the walk in refrigerator was stained with a black substance.</p>	R000154	<p>R1541. What corrective action (s) will be accomplished for those residents found to be affected by the deficient practice?The top of the convection oven was cleaned of dust and debris before the exit of licensure survey, the floor tile along the base board behind dishwasher will be cleaned, the ceramic tile underneath the shelving unit in the refridgerator has been cleaned and is free of a black substance.2.How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?All the residents have the potential to be affected by the 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? All Dietary Staff will review policies and procedures on cleaning kitchen equipment and environment? Dietary Staff will be inserviced by Dietary Supervisor and Assistant Dietary Supervisor on cleaning schedule of kitchen and equipment.4. How the corrective actions will be monitored to ensure the deficient practice will not recur?The</p>	09/17/2013

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 07/24/2013
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	
	Interview with the Dietary Food Manager at the time, indicated all the above areas were in need of cleaning.		Dietary Supervisor and Assistant Dietary Supervisor will monitor the cleaning of the kitchen and equipment and will ensure the staff is adhering to the cleaning schedule by doing daily and weekly rounds. Staff not adhering to the cleaning schedules will be subject to disciplinary action. Daily and weekly rounds monitoring will be ongoing for compliance.5. By what date will the systemic changes will be completed? September 17, 2013		

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 07/24/2013	
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>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 insulin was given as ordered for 1 of 3 residents reviewed for insulin administration in the sample of 12. The facility also failed to ensure medications were given as ordered for 2 of 5 residents observed for medication administration. (Residents #7, #11, and #12)</p> <p>Findings include:</p> <p>1. The record for Resident #7 was reviewed on 7/24/13 at 12:35 p.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p> <p>A Physician's order dated 7/25/12 and listed on the July 2013 Physician's Order Summary (POS), indicated the resident was to have his blood sugar check three times a day and he was to receive the following Novolin Regular sliding scale insulin coverage:</p>	R000241	R2411. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All nurses have been in-serviced on performing blood glucose monitoring as ordered by the physician. All nurses have been in-serviced on administering insulin for blood glucose results as ordered by the physician. R7's physician was notified of insulin coverage not documented on 6/3/13 at 6 am. R7's physician was notified of insulin coverage not documented on 6/4/13 at 6 am. R7's physician was notified of insulin coverage not documented on 6/5/13 at 6 am. R7's physician was notified of insulin coverage not a documented on 6/8/13 at 6 am. R7's physician was notified of insulin coverage not documented on 7/8/13 at 4 pm. R7's physician was notified of insulin coverage not documented on 7/12/13 at 6 am. R7's physician was notified of insulin coverage error for insulin administered 7/14/13 at 6 am. Resident's physician was notified of no blood glucose monitoring documentation for	09/17/2013			

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 07/24/2013	
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>150-200=1 unit 201-250=2 units 251-300=3 units</p> <p>Review of the June 2013 Sliding Scale Insulin Coverage Administration Record, indicated the following:</p> <p>6/3/13 at 6:00 a.m. blood sugar 151, no documentation of insulin administration. 6/4/13 at 6:00 a.m. blood sugar 178, no documentation of insulin administration. 6/5/13 at 6:00 a.m. blood sugar 166, no documentation of insulin administration. 6/8/13 at 6:00 a.m. blood sugar 171, no documentation of insulin administration.</p> <p>Review of the July 2013 Sliding Scale Insulin Coverage Administration Record, indicated the following:</p> <p>7/8/13 at 4:00 p.m. blood sugar 328, no documentation of insulin administration. 7/12/13 at 6:00 a.m. blood sugar 154, no documentation of insulin administration. 7/14/13 at 6:00 a.m. blood sugar 160, the resident received two units of insulin rather than one unit.</p>		<p>7/13/13 at 6 am Resident's physician was notified of no blood glucose monitoring documentation for 7/15/13 at 4 pm All Nurses have been in-serviced on giving all prescribed medication at the ordered times. R11's physician was notified of nurse not administering all ordered medications at time specified by the physician. R11 was given her ordered Miralax and Mylanta. R12's physician was notified that her medications given at 11:15AM. 2. How will the facility identify other residents that will be affected by the 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? All nursing staff will be reinserviced on performing blood glucose monitoring as ordered by the physician. All nursing staff will be inserviced on administering insulin for blood glucose results as ordered by the physician. All nursing staff will be inserviced on documentation for blood glucose and insulin coverage. All nursing staff will be inserviced on Medication Administration times and policy initiated for residents who refuse to take medications at ordered administration times. 4. How will the corrective actions will be monitored to ensure deficient</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 07/24/2013	
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>No 6:00 a.m. blood sugar was documented on 7/13 and no 4:00 p.m. blood sugar was documented on 7/15/13.</p> <p>Interview with the Director of Nursing on 7/24/13 at 2:30 p.m., indicated the resident did not receive his insulin as ordered.</p> <p>2. On 7/24/13 at 8:30 a.m., LPN #1 was observed preparing medications for Resident #11. The resident received Amitriptyline (an antidepressant) 10 milligrams (mg), Aspirin 81 mg, Cogentin (a medication used to treat Parkinson's disease) 0.5 mg, Sinemet (a medication used to treat Parkinson's disease) 10-100 mg, Divalproex (a medication used for seizures) 500 mg, Docusate sodium (a stool softener) 200 mg, Pepcid (a medication used to treat esophageal reflux) 20 mg, Isosorbide (a heart medication) 30 mg, Levothyroxine (a thyroid medication) 100 micrograms, Potassium 10 milliequivalents, Propranolol (a blood pressure medication) 60 mg, and Artane (a medication used to treat Parkinson's disease) 2 mg.</p> <p>The resident's record was reviewed on 7/24/13 at 8:35 a.m. Review of the</p>		<p>practice will not recur? Director of Nursing and/or designee will monitor the blood glucose results on a daily basis to ensure that insulin coverage is documented and given as ordered. Director of Nursing will monitor medication administration at random, checking ten percent of residents weekly to ensure medication is given as ordered. Staff will receive disciplinary action for failure to adhere to policies and procedures with regards to Blood Glucose Monitoring, documentation and Medication Administration. Monitoring will be ongoing for compliance. 5. By what date the systemic changes will be completed? September 17, 2013</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 07/24/2013
--	---	--	---

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>July 2013 Physician's Order Summary (POS), indicated the resident was to receive Miralax (a laxative) 17 grams in fluid and drink daily at 9:00 a.m. and Mylanta (an antacid) 15 milliliters (ml) by mouth three times a day. She was to receive a dose at 9:00 a.m.</p> <p>Interview with LPN #1 at 8:45 a.m., indicated she would give the resident her powder and liquid medications after she was done passing her pills to everyone else. The LPN had been observed administering powder and liquid medications to other residents.</p> <p>Interview with the Director of Nursing on 7/24/13 at 2:30 p.m., indicated the LPN should have given the resident her Miralax and Mylanta at the same time she received her pills.</p> <p>3. On 7/24/13 at 11:15 a.m., LPN #2 was observed preparing medications for Resident #12. The resident received Norvasc (a blood pressure medication) 10 milligrams (mg), Atenolol (a heart medication) 50 mg, Diclofenac sodium (a medication used to treat inflammation) 75 mg, Bentyl (a stomach medication) 10 mg, Namenda (a medication used to treat Alzheimer's) 5 mg, and Oyster Calcium (a calcium supplement) 500</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 07/24/2013	
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>mg.</p> <p>The residents record was reviewed on 7/24/13 at 11:25 a.m. Review of the July 2013 Physician's Order Summary (POS), indicated the above medications were to be given at 9:00 a.m.</p> <p>Interview with LPN #2 at 11:25 a.m., indicated the resident gets tired from standing sometimes and does not wait in line for her medications.</p> <p>Interview with the Director of Nursing on 7/24/13 at 2:30 p.m., indicated the resident should have received her medications in a more timely manner and the Physician should have been contacted to see if it was okay to give the resident her medications at 11:15 a.m.</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 07/24/2013	
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>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records 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: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to daily weight and daily blood pressure for 2 of 12 records reviewed. (Residents #3 and #9)</p> <p>Findings include:</p> <p>1. The closed record for Resident #9 was reviewed on 7/24/13 at 1:05 p.m. The resident's diagnosis included, but was not limited to, hypertension (high blood pressure).</p> <p>A Physician's order dated 7/31/11 and listed on the June 2013 Physician's Order Summary (POS), indicated the resident's blood pressure was to be taken daily. A Physician's order dated 11/14/11 and listed on the June 2013 POS, indicated the resident's blood pressure medications were to be held if the systolic (top number)</p>	R000349	<p>R3491. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? R9 no longer resides in the facility. R 3 no longer resides in the facility.2. how will facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions 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? All nurses will be in-serviced on maintaining clinical records that are complete and accurately documented relating to daily weight and daily blood pressure.4. How the corrective actions will be monitored to enure the deficient practice doe not recur?The Director of Nursing and or designee will randomly check ten percent of residents clinical records on a weekly basis</p>	09/17/2013			

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 07/24/2013
--	---	--	---

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>blood pressure was 100 or less.</p> <p>Review of the March 2013 Medication Administration Record (MAR), indicated there was no blood pressure documented on 3/6, 3/7, 3/10, 3/12, 3/13, 3/15-3/22, 3/25-3/28, 3/30, and 3/31/13.</p> <p>Review of the May 2013 MAR, indicated there was no blood pressure documented on 5/2, 5/6-5/10, 5/12, 5/14-5/16, 5/22, 5/25-5/30/13.</p> <p>Interview with the Director of Nursing on 7/24/13 at 3:15 p.m., indicated the resident's blood pressure should have been documented daily.</p> <p>2. The record for Resident #3 was reviewed on 7/23/13 at 12:15 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure.</p> <p>Review of Physician Orders dated 3/16/13, indicated daily weight-diagnosis congestive heart failure.</p> <p>Review of the April 2013 Medication Administration Record (MAR), indicated there was no daily weight</p>		<p>to ensure that documentation relating to daily weights and blood pressures are noted .5. By what date the systemic changes will be complete? September 17, 2013</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 07/24/2013
--	---	--	---

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>recorded for the entire month.</p> <p>Review of the May 2013 MAR, indicated there was no daily weight recorded for the entire month.</p> <p>Review of the June 2013 MAR, indicated there was no daily weight recorded on 6/9-6/13, 6/16-6/19, 6/24-6/27, and 6/29-6/30/13.</p> <p>Review of the July 2013 MAR, indicated only the Licensed Nurse's initials were recorded on 7/2-7/5 (no weights were recorded), 7/9, 7/10, and 7/15/13. There was no weight or initials recorded on 7/22/13.</p> <p>Interview with LPN #1 on 7/24/13 at 10:30 a.m., indicated she had only documented her initials on the MAR for the above mentioned days for the daily weight. She further stated "I guess I forgot to put the weight down." The LPN indicated she was the full time nurse who worked the front hall where the resident resided.</p>			