

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 10/03/2013
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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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R000000	<p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on July 24, 2013.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on July 24, 2013 to the Investigation of Complaint IN00115494 completed on March 26, 2013.</p> <p>Survey date: October 3, 2013</p> <p>Facility number: 001136 Provider number: 001136 AIM number: N/A</p> <p>Survey team: Lara Richards, RN, TC Jennifer Redlin, RN</p> <p>Census bed type: Residential: 117 Total: 117</p> <p>Census payor type: Medicaid: 107 Other: 10 Total: 117</p> <p>Sample: 6</p>	R000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 6, 2013, by Janelyn Kulik, RN.</p>						

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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 medications were given as ordered for 1 of 5 residents observed during medication administration. (Resident #6)</p> <p>Findings include:</p> <p>On 10/3/13 at 9:13 a.m., RN #1 was observed preparing medications for Resident #6. The RN proceeded to hand the resident her Advair Diskus inhaler (an inhaler used to treat asthma and chronic obstructive pulmonary disease). The resident was not instructed by the RN on how many puffs to take. The resident inhaled four times. When the resident was done with the Advair inhaler, she was not instructed by the RN to rinse her mouth. The RN then handed the resident her Spiriva inhaler (an inhaler used to treat asthma). Again, the resident was not instructed on how many puffs to inhale.</p>	R000241	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? RN#1 was given a one on one in-service by the Director of Nursing with regards to the Medication pass for resident#6. The physician for Resident#6 was notified of the error made by RN#1 during the medication pass and no new orders were received. 2. How will the facility 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? Licensed Nurses and Qualified Medication Aides will be re-inserviced on the proper medication administration for residents with inhalers and nasal sprays by the Director of Nursing, Pharmacy Consultant and Registered Nurse Consultant. Pharmacy Consultant will perform a one on one medication</p>	12/06/2013			

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	<p>When the resident was done with the Spiriva inhaler, the RN handed her a bottle of Flonase nasal spray (a nasal spray to treat allergies). The resident was not instructed by the RN on how many sprays to place in each nostril. The resident placed four sprays in the right nostril and the two sprays in the left nostril.</p> <p>The record for Resident #6 was reviewed on 10/3/13 at 11:30 a.m. Review of the September 2013 Physician's Order summary, indicated the resident was to receive the following medications:</p> <p>Advair Diskus 250/50, one puff twice a day. Rinse mouth with water after each use. Spiriva handihaler, inhale contents of one capsule daily. Flonase nasal spray 50 micrograms (mcg), one spray to each nostril twice a day.</p> <p>Interview with LPN #1 on 10/3/13 at 11:45 a.m., indicated the RN should have instructed the resident to rinse her mouth after using the Advair Diskus. The LPN also indicated the RN should have waited at least five minutes in between the Advair and Spiriva inhalers. The LPN indicated the RN should have instructed the</p>		<p>administration pass with all licensed nurses and qualified medication aides to ensure that medications are being administered as ordered by the physician.4. How the corrective action or actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The Director of Nursing and/or designee will monitor licensed nurses and qualified medication aides randomly during medication pass five times per week for the next six months. Monitoring will decrease to three times per week if medication error rate is 2.5 percent or lower. The Pharmacy Consultant will observe a medication pass at each scheduled visit to ensure medications are administered as ordered and will provide a report to the Director of Nursing and Administrator.5. By what date the systemic changes will be completed. December 6, 2013.</p>				

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	<p>resident on how many sprays of the Flonase she was to receive.</p> <p>Interview with the Director of Nursing on 10/3/13 at 1:15 p.m., indicated the RN should have instructed the resident on the dosage of her medications.</p> <p>This State Residential finding was cited on July 24, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			