STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intake IN00464900. Intake IN00464900 - State deficiency related to the allegations is cited at R0217. Survey date: October 14, 2025 Facility number: 001136 Residential Census: 90 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/15/25.	R 0000		
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be	R 0217	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice. The service plan for Resident B was updated on October 15th, 2025, to reflect the unauthorized	11/14/2025

	provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to		use of Benadryl use and the daily interventions. 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 affected by the deficient practice. The Director of Nursing is reviewing all service plans for all residents to ensure they have any updated information needed. 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. The Director of Nursing will re-Inservice all Nursing staff to ensure that all resident service plans will be updated as needed outside of the scheduled six month assessment date for each resident. Nursing will also be In serviced to update service plans with needed information at assessment date as well. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not recur. The Director of Nursing and/or designee will audit all resident service plans to ensure update	

	ensure Service Plans were revised and updated for 1 of 2 residents reviewed for Service Plans. (Resident B) Finding includes: The record for Resident B was reviewed on 10/14/25 at 9:59 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar, anxiety, and chronic obstructive pulmonary disease (COPD). A Service Plan, dated 8/19/25, indicated the resident needed assistance with decisions for new situations and/or tasks and to enhance his self-performance patterns. He also needed assistance in ordering and picking up medications as needed and for monitoring the effectiveness of his medications. A Psychiatric Progress Note, dated 9/2/25 at 4:29 p.m., indicated staff had been finding Benadryl (an antihistamine) and other prohibited items in the resident's room. A Short Integrated Note, dated 9/7/25 at 4:18 p.m., indicated staff found an empty bottle of Benadryl in the resident's room. Staff educated the resident on the side effects of taking the Benadryl with the other medications he was currently taking. A Contact Note, dated 9/10/25		informed is added outside of the six month assessment date by November 14th 2025. Thereafter the Director of Nursing and/or designee will audit 5 service plans at random to ensure updated is reflected at assessment date and any time in between. 5. By what date the systemic changes will be completed. November 14th, 2025	

at 1:14 p.m., indicated staff saw the resident put something in his jacket pocket that was in his closet. The resident's room was searched and 8 packs of Benadryl and two needles were found. The items were taken to the nurse's station and the Administrator was notified.

A Short Integrated Note, dated 9/23/25 at 4:00 p.m., indicated the resident was sent to the emergency room for evaluation due to sweating and he could barely stand. The resident also smelled of alcohol. He denied drinking and opened Benadryl packets were found in his room. The resident indicated the packets of Benadryl were old. The resident returned to the facility the same evening.

The Service Plan for the resident had not been updated related to his Benadryl use or the medication being found in his room on numerous occasions and ongoing interventions.

During an interview on 10/14/25 at 1:00 p.m., the Director of Nursing (DON) indicated the resident's room was checked daily for medications and any other prohibited items. The resident received counseling from psychiatric services and had been offered inpatient rehab services. The DON indicated the Service Plan

should have been updated to reflect the unauthorized Benadryl use and the daily interventions.

This citation relates to Intake IN00464900.

Based on record review and interview, the facility failed to ensure Service Plans were revised and updated for 1 of 2 residents reviewed for Service Plans. (Resident B)

Finding includes:

The record for Resident B was reviewed on 10/14/25 at 9:59 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar, anxiety, and chronic obstructive pulmonary disease (COPD).

A Service Plan, dated 8/19/25, indicated the resident needed assistance with decisions for new situations and/or tasks and to enhance his self-performance patterns. He also needed assistance in ordering and picking up medications as needed and for monitoring the effectiveness of his medications.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJoelynn Miller Johnson	TITLEAdministrator	(X6) DATE11/10/2025