STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/16/2019

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 15 and 16, 2019. Facility number: 001136 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review competed on 4/22/19.	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure annual Resident Rights and Dementia training was completed for 4 of 5 employee files reviewed. (LPN 1, RN 1, Activity Aide 1, and Dietary Aide 1) Findings include: 1. The employee file for LPN 1 was reviewed on 4/16/19 at 10:06 a.m. The LPN was hired on 10/20/08. There was no documentation to indicate the LPN completed any annual Resident Rights or Dementia training for 2018. 2. The employee file for RN 1 was reviewed on 4/16/19 at 10:10 a.m. The RN was hired on 2/8/16. There was no documentation to indicate the LPN completed any annual Resident Rights or Dementia training for 2018. 3. The employee file for Activity Aide (AA) 1 was reviewed on 4/16/19 at 10:18 a.m. The AA was hired on 8/25/06. There was no documentation to indicate the AA completed any annual Resident	R 0120	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The LPN1, RN1, Activity Aide1 and Dietary Aide1 have been re-inserviced on Resident Rights and Alzheimers Training. 2. How the facility will 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 the alleged deficient practice. 3.What measures will be put into	06/14/2019

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	Rights or Dementia training for 2018. 4. The employee file for Dietary Aide (DA) 1 was reviewed on 4/16/19 at 10:23 a.m. The DA was hired on 1/9/15. There was no documentation to indicate the DA completed any annual Resident Rights or Dementia training for 2018. Interview with the Administrator on 4/16/19 at 2:27 p.m., indicated there was no documentation to indicate the above employees had received their annual Resident Rights and Dementia training for 2018.		place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur. The individual Department Managers will ensure that their staff members participate in scheduled in-services for their respective departments and all facility training and in-services. All staff, including Department Managers, will be in-serviced on the importance of attending all scheduled in-services. If staff member will be counseled and inserviced one on one should they miss any scheduled in-service training. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. The Administrator will in-service all Department Managers on the importance of all employees attending scheduled in-service training. The administrator and/or designee will cross check and audit attendance sheets to ensure that staff attends in-service training. In addition all attendance records will be kept in in-service training binders and also in each employees human resource file.	

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			5. By what date the systemic changes will be completed. June 14, 2019	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.			
	Based on observation and interview, the facility failed to ensure each resident had a functioning call system for 2 of 7 resident rooms observed. (Rooms 218 and 240) Finding includes: During the Environmental Tour with the Maintenance Supervisor on 4/16/19 at 9:50 a.m., the following was observed: a. In Room 218, when the bathroom call light was pulled, the light outside above the room door did not light up. When the call light near the bed area was pulled, the light outside above the room door did not light up. The Maintenance Supervisor	R 0148	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The call lights were functioning on the main board which indicated which rooms call light was being pulled by residents or staff. During the survey process the main panel board was working properly to indicate which call light was being pulled. The repair company was also called to inspect and repair call light system. Call Light switches for Room 218 and 240 have been	06/14/2019

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	exchanged the light bulb with one from an unoccupied room and the light still would not turn on when either call light string was pulled. b. In Room 240, when the bathroom call light was pulled, the light outside above the room door did not light up. When the call light near the bed area was pulled, the light outside above the room door did not light up. The Maintenance Supervisor exchanged the light bulb with one from an unoccupied room and the light still would not turn on when either call light string was pulled. Interview with the Maintenance Supervisor on 4/16/19 at 10:20 a.m., indicated he was not sure why the call lights were not working and would get someone out to look at them immediately.		ordered to repair call lights to ensure that call lights are functioning properly. 2. How the facility will 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 the alleged deficient practice. Maintenance Director is checking all call lights in the facility to ensure that all lights are functioning properly. 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. All staff will be in-serviced on reporting call lights not working properly and to report to Maintenance Director and/or designee. Staff will be in serviced that any call lights not functioning properly should be reported immediately to Maintenance Director and/ or designee. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. Maintenance Director and/or	

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			designee will randomly check call lights weekly on different halls to ensure that call lights are functioning properly. 5. By what date the systemic changes will be completed. June 14, 2019	
R 0241 Bldg. 00	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. Based on record review and interview, the facility failed to ensure medications were administered as ordered related to resident not receiving the correct medications for 1 of 7 records reviewed. (Resident 6) Finding includes: The record for Resident 6 was reviewed on 4/15/19 at 1:46 p.m. Diagnoses included, but were not limited to, major depression with suicidal ideations, angina pectoris, severe coronary artery disease, and hyperthyroid. The Physician's Order Summary (POS) for January 2019 indicated the resident was to receive Synthroid (a thyroid medication) 75 micrograms (mcg) daily at 6:00 a.m., and Metoprolol (a cardiac medication) 25 milligrams (mg) a half tablet twice a day at 6:00 a.m., and 8:00 p.m.	R 0241	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The nurse responsible for administering the medication is no longer employed by the facility. The resident has been seen by his primary physician and has not had any problems nor has the resident received the incorrect medications. The nursing staff was in-serviced by the Director of Nursing regarding administering medications, especially to residents that have the same first name. 2. How the facility will identify	06/14/2019

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	An entry in the nursing progress notes, dated 1/6/18 (sic) at 5:40 a.m., indicated the resident was sent to the emergency room to be treated and evaluated for accidentally receiving the wrong medications. An unusual event report, dated 1/6/19 at 5:40 a.m., indicated the resident was given the wrong medication. The resident returned 45 minutes later indicating he was itching and had a rash. The resident was assessed by an RN and it was determined the resident had a full body rash. The resident was given Triamcinolone 1% cream (a steroid cream) to apply to the rash to help reduce the itching. The resident returned 15 minutes later and indicated he thought he was given the wrong medication. The medication cart was checked and he indeed received the wrong medication. The resident received Aspirin 325 mg, Clonazepam (a medication used to treat seizures and anxiety) 0.5 mg, Entresto (a cardiac medication) 24-26 mg, Gabapentin (a medication used to treat nerve pain and convulsions) 300 mg, Niacin (a medication used to treat high cholesterol and high triglycerides) and Colace (a stool softener) 100 mg. The Physician was notified and orders were received to give the resident Benadryl (a medication used to treat allergic reactions) and send to the emergency room for evaluation and treatment. The resident returned to the facility at 12:00 p.m. on 1/6/19 with no new orders. Interview with LPN 1 on 4/16/19 at 3:00 p.m., indicated she was aware the resident received the wrong medications but she did not know any further details of the incident except that a medication inservice was held afterwards.		other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All resident have the potential to be affected by the alleged deficient practice. The Nursing staff was re in-serviced by the Director of Nursing regarding administration of medications after the incident occurred. 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 Nursing Staff will be re-inserviced by the Director of Nursing to ensure that medications are administered as ordered to the correct resident. Nursing staff have and will be re-inserviced to ask every resident ,prior to administering their medications, for their first and last names along with the room number that they reside in. The Nursing staff will also check the Medication Administration Record along with the information given and should also look at the resident's picture that is available to ensure that the medication is given to the correct person especially if resident's have similar	

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			names. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. The Director of Nursing will randomly monitor a medication pass weekly for a month, and then will randomly check a medication pass once monthly to ensure medications are administered correctly. 5. By what date the systemic changes will be completed. June 14, 2019	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (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. Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to an accumulation of dust and food spillage on top of the convection oven as well as the sides of the oven, no thermometer in the refrigerator, and an accumulation of dust on the fan blades in the dish room for 1 of 1 kitchens. (The Main Kitchen) Finding includes: During the initial tour of the kitchen on 4/15/19 at	R 0273	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The thermometer was placed in the walk in cooler by the Dietary Supervisor on the same day when it was noted that the thermometer could not be found by surveyor. The temperature readings on outside of walkin were within normal limits.	06/14/2019

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	9:25 a.m. with the Dietary Manager (DM), the following was observed: a. An accumulation of dust was observed on top of the convection oven. There was also an accumulation of dried food spillage on the side of the convection oven next to the stove top. b. There was no thermometer present inside the walk in refrigerator. c. There was a large fan in the dish room. There was an accumulation of dust on the fan blades and fan grate. The fan was on at the time and blowing directly on a tray of silverware identified as clean by the DM. Interview with the DM at the time indicated the convection oven and fan needed to be cleaned and she would get a thermometer for the refrigerator.		The accumulation of dust observed on top of convection oven was cleaned by Dietary Staff on April 15, 2019. The accumulation of dried food spillage on the side of the convection oven next to stove top was removed and cleaned by Dietary Staff on April 15, 2019. The fan in the dish room was removed and cleaned and the clean silverware identified as clean was put in dish machine to ensure cleanliness. 2. How the facility will 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 the alleged deficient practice. 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 convection oven, stove and fan will be incorporated into the cleaning schedule for all equipment. The Dietary Manager will re-inservice all dietary staff on following the cleaning schedule for all equipment and the importance that all equipment is cleaned as	

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			scheduled. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. The Dietary Manager and/or designee will make random rounds weekly to ensure that equipment is cleaned properly by the cleaning schedule and as needed when equipment is used. The Cooks will be in serviced by the Dietary Manager on the importance of cleaning all cooking equipment when used. 5. By what date the systemic changes will be completed. June 14, 2019	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and			

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	(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure the consultant pharmacist reviewed the drug regimen of each resident receiving services at least once every sixty (60) days for 1 of 7 records reviewed. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 4/16/19 at 9:00 a.m. Diagnoses included, but were not limited to, asthma, paranoid personality, schizophrenia, history of alcohol and substance abuse, history of suicide attempt, and chronic obstructive pulmonary disease. Physician's orders, dated 1/18/19, indicated the resident was to receive Ambien (a hypnotic) 10 milligrams (mg) every evening and Lorazepam (an anti-anxiety medication) 0.5 mg twice a day. A Physician's order, dated 2/27/19, indicated the resident was to receive Risperdal (an antipsychotic medication) 2 mg every 4 hours as needed (prn) not to exceed 4 doses in a 24 hour period for agitation. There was no documentation to indicate the resident's medications were reviewed by the Pharmacist in December 2018. The Pharmacist visited the facility on 1/26, 2/24, and 3/17/19. The resident's medications were not reviewed at those times. Interview with the Administrator on 4/16/19 at 2:45 p.m., indicated the resident's medications were to be reviewed every 60 days.	R 0298	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The Administrator did not interview with the surveyors with regards to the residents medications being reviewed by the Consultant Pharmacist for the facility. Resident 2 was in the regional mental health inpatient unit in February and April when the Consultant pharmacist came to review medications at the facility. The Consultant Pharmacist indicated that Resident 2's medications were reviewed while he was on the in patient unit during this time. Resident 2 medications were reviewed 2/23/19-2/27/19, 03/10/19-03/15/19 and 04/12/19-05/13/19. 2. How the facility will identify other residents having the potential to be affected by the same alleged 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	06/14/2019

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			that the alleged deficient practice does not recur. The Consultant Pharmacist does review the drug regimen of each resident receiving services every sixty (60) days. The Administrator will consult with consultant Pharmacist and inform them of the State of Indiana's rules that medications of every resident in the facility must be reviewed every sixty days. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. The Director of Nursing will random check Consultant Pharmacy Services Report to ensure all residents medications are reviewed every sixty (60) days. The Director of Nursing will check on residents who were hospitalized to ensure the medications were reviewed by the Consultant Pharmacist. 5. By what date the systemic changes will be completed. June 14, 2019	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious			

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	symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure there was a complete infection control program which identified and monitored all infections. This had the potential to affect the 110 residents who resided in the facility. Finding includes: The infection control logs were reviewed on 4/16/19 at 9:45 a.m. The last 6 months (10/2018 - 3/2019) of infections were logged on a sheet of paper by month. The resident's name, onset date, infection related diagnosis, culture, x-ray, organism, antibiotic, isolation, re-cultured date, and date resolved were all completed. There was lack of documentation of any symptoms for each infection or if the criteria for a true infection was met. Interview with the Director of Nursing on 4/16/19 at 11:35 a.m., indicated any signs of symptoms of the infections were charted in the Nurses' Notes for each individual resident. She had not included this information on her infection control logs. She had not regularly used any specific criteria for determining a true infection other than a resident must have three symptoms for it be an infection.	R 0407	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Director of Nursing was tracking infections, but going forward Director of Nursing will document any symptom for each infection or if the criteria for a true infection was met. 2. How the facility will identify other residents having the potential to be affected by the same alleged 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 alleged deficient practice does not recur. The Director of Nursing created an Infection Control/ antibiotic log sheet that includes the will include documentation of symptoms and	06/14/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/16/2019

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			also criteria for a true infection that was met. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. The ABT Log will be completed monthly by Director of Nursing and/or designee to ensure all signs and symptoms are met and documented. Director of Nursing will submit this information from Infection Control Logs when attending quarterly QA/QI meetings. 5. By what date the systemic changes will be completed. June 14, 2019	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks			

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	after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure 2nd step tuberculin (TB) tests were completed upon admission for 2 of 7 records reviewed. (Residents 5 and 8) Findings include: 1. The record for Resident 5 was reviewed on 4/16/19 at 9:12 a.m. Diagnoses included, but were not limited to, schizoid-affective disorder, hypertension, and obesity. She was admitted on 2/19/19. There was no documentation to indicate a 2nd step TB test had been completed. 2. The record for Resident 8 was reviewed on 4/15/19 at 2:22 p.m. Diagnoses included, but were not limited to, major depression, congestive heart failure, chronic obstructive pulmonary disease, and diabetes. She was admitted on 2/11/19. There was no documentation to indicate a 2nd step TB test had been completed. Interview with the Director of Nursing on 4/16/19 at 11:02 a.m., indicated she was unaware the above residents required a 2nd step TB test.	R 0410	1.What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 5 will have the TB Test redone although TB Test was done prior to admission to facility. Resident 8 has been discharged to the community.Both residents had also received chest x-rays prior to admission and it is documented. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken. All residents in the facility have the 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 alleged deficient practice does not recur. The Director of Nursing will inservice all Nursing Staff on completing 2 step tuberculin tests on all new resident admissions to	06/14/2019

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			the facility. 4. How will the corrective action will be monitored to ensure the alleged deficient practice will not recur and what quality assurance program will be put into place. The Director of Nursing and/or designee will audit all new admission charts to ensure that the two step tuberculin test has been completed. 5. By what date the systemic changes will be completed. June 14, 2019	