PRINTED: 11/27/2019 FORM APPROVED OMB NO. 0938-039

· '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  O  O			(X3) DATE SURVEY  COMPLETED	
			B. WING	i 		11/04/	2019	
NAME OF PROVIDER OR SUPPLIER  LAKE CITY PLACE  STREET ADDRESS, CITY, STATE, ZIP COD 425 CHINWORTH CT WARSAW, IN 46580					NWORTH CT			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX			PR	EFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DATE			
R 0000								
Bldg. 00	This visit was for a Survey.  Survey dates: Nov	State Residential Licensure ember 4, 2019	R 0000	0				
	Facility number: 0							
	Residential Census							
	These State Reside accordance with 41							
	Quality Review was completed on November 8, 2019.							
R 0246	410 IAC 16.2-5-4 Health Services -							
Bldg. 00	(6) PRN medicati a qualified medicati authorization by a physician. The QI authorization for e PRN medication. physician not on a authorization to a	ons may be administered by ation aide (QMA) only upon a licensed nurse or MA must receive appropriate each administration of a All contacts with a nurse or the premises for dminister PRNs shall be e nursing notes indicating						
Based on record review and intervier failed to ensure authorizations for as medications administered by a quality medication aide were documented in record in 1 of 7 residents reviewed functions. (Resident 3)		view and interview, the facility horizations for as needed istered by a qualified ere documented in the medical idents reviewed for	R 024	6	Submission of this response a Plan of Correction is NOT a le admission that a deficiency ex or, that this Statement of Deficiency was correctly cited is also NOT to be construed a admission against interest by	egal xists I, and as an the	12/04/2019	
	Finding includes:				facility, or any employees, ago or other individuals who drafte			
	A clinical record review was completed on 11/4/19				may be discussed in the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/04/2019				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 425 CHINWORTH CT WARSAW, IN 46580					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	at 10:50 A.M., and included, but were a spinal stenosis, chrows a spin	indicated Resident 3 diagnoses not limited to: atrial fibrillation, onic pain and hypertension.  an orders, dated 10/29/19, periving Oxycodone (a narcotic) onis) 1 tablet every 8 hours as  inistration Record, dated Resident 3 had received the on 10/12/19, 10/13/19 and on aide).  Ited 10/12/19, 10/13/19 and commentation to show the time of the entire was contacted for the entire was contacted for the entire the medication.  In the medical record of the entire should have a in the medical record of the ed.  P.M. a policy was requested, vided.  P.M., the Director of Nursing y follows the state guidelines		Response and Plan of Correln addition, preparation and submission of this Plan of Correction does NOT constituted an admission or agreement of kind by the facility of the truth any facts alleged or the correctness of any conclusion set forth in this allegation by survey agency.  R246 Health Services-Deficient.  1. The documentation for Resident 3 cannot at this time fixed.  2. An audit of current resident's Medication Administration Record (MAR be completed by the Care Services Manager (CSM) on 11/25/2019 to identify like residents and any issues like like like like like like like like	etion.  Lute of any of of ons the ency le be le			
i			1	1	1			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED			
			B. W	NG		11/04/2019			
NAME OF B	DOLUDED OD CLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER				425 CHINWORTH CT					
LAKE CIT	TY PLACE			WARSA	AW, IN 46580				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG			DATE		
					determine if continued auditing	-			
					necessary based on 3 consecutive months of compliance.				
					5. Completion date: 12/4/20	019			
R 0356	410 IAC 16.2-5-8.	1(i)(1-8)							
	Clinical Records -								
Bldg. 00	(i) A current emergency information file shall								
	be immediately accessible for each resident,								
	in case of emergency, that contains the								
	following: (1) The resident 's name, sex, room or								
	apartment number, phone number, age, or								
	date of birth.								
	(2) The resident 's hospital preference.								
	(3) The name and phone number of any								
	legally authorized representative.								
		phone number of the							
	resident 's physici								
	<ul><li>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</li><li>(6) Information on any known allergies.</li><li>(7) A photograph (for identification of the resident).</li></ul>								
	(8) Copy of advance directives, if available.								
		view and interview, the facility	R 0.	356	Submission of this response a		12/04/2019		
		emergency file was available			Plan of Correction is NOT a le	-			
		ding in the facility. This			admission that a deficiency ex	ists			
	effected 29 out of 29 residents in the facility.				or, that this Statement of Deficiency was correctly cited,	and			
	Finding includes:				is also NOT to be construed a				
	<i>G</i>				admission against interest by				
	During an interview, on 11/4/19 at 2:55 P.M., an emergency binder was requested from the Director				facility, or any employees, age				
					or other individuals who drafte				
	of Nursing.				may be discussed in the				
					Response and Plan of Correct	ion.			
	On 11/4/19 at 3:29 P.M., the Director of Nursing				In addition, preparation and				
	indicated she could not locate an emergency				submission of this Plan of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2019		
NAME OF PROVIDER OR SUPPLIER  LAKE CITY PLACE			425 CH	ADDRESS, CITY, STATE, ZIP COD HINWORTH CT AW, IN 46580	
(X4) II PREFI TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	A policy on emerg requested on 11/4/ On 11/4/19 at 3:56 indicated the facili	uired resident information. ency resident information was	IAG	Correction does NOT constitution an admission or agreement of kind by the facility of the truth any facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency.  R356 Clinical Records-Noncompliance  1. An emergency file was created for current residents of 11/19/2019 by the Care Service Manager (CSM) and designed 2. An audit of the emergen file was completed on 11/20/2 by CSM and any issues identified were corrected.  3. The Care Services Mana (CSM) was re-trained by the Regional Director of Care Ser (RDCS) on 11/5/2019 regarding the emergency file regulation. will be in-serviced on 12/4/20 CSM on the requirement to enthe emergency file for resident complete and immediately accessible to staff.  4. The CSM is responsible sustained compliance. The CS or designee, will audit the emergency files for completion and accessibility to staff week for 4 weeks, the monthly for 3 months. Results of the audit we be discussed in monthly QI meeting. The QI Committee we determine if continued auditing necessary based on 3 consecution of the compliance.	of fany of ss he  on ces e. cy o19 fied ager vices ng Staff 19 by nsure ts is  for SM, n ely vill vill g is

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED  B. WING 11/04/2019						
NAME OF PROVIDER OR SUPPLIER  LAKE CITY PLACE			STREET ADDRESS, CITY, STATE, ZIP COD 425 CHINWORTH CT WARSAW, IN 46580					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	BE PRECEDED BY FULL PREFIX GACH CORRECTION GACH CORRECTION GACH CORRECTION TAG DEFICIENCY)  BE PRECEDED BY FULL PREFIX GACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
		5. Completion date: 12/4/2019		019				
R 0410	410 IAC 16.2-5-12 Infection Control -							
Bldg. 00	(e) In addition, a tu completed within the admission or upon forty-eight (48) to see the result shall be receinduration with the by whom administ (f) For residents with documented negal result during the performed within content of the first step is negative performed within conference with tuberculosis. (g) All residents with tuberculin shave a chest x-ray laboratory examina a diagnosis.	aberculin skin test shall be hree (3) months prior to admission and read at seventy-two (72) hours. The orded in millimeters of date given, date read, and ered and read. ho have not had a tive tuberculin skin test receding twelve (12) ne tuberculin skin testing two-step method. If the ve, a second test should be one (1) to three (3) weeks The frequency of repeat I on the risk of infection ho have a positive reaction kin test shall be required to vand other physical and attions in order to complete						
	Based on record review and interview, the facility failed to ensure residents receive timely Mantoux Tuberculosis screenings for 4 of 7 residents reviewed. (Residents 3, 8 & 7)  Findings Include:		R 0410	Submission of this response a Plan of Correction is NOT a le admission that a deficiency ex or, that this Statement of Deficiency was correctly cited is also NOT to be construed a	gal vists , and			
	1. A clinical record 11/4/19 at 10:50 A.I was admitted on 2/1	review was completed on M., and indicated Resident 3 8/19. His diagnoses included, to: atrial fibrillation, spinal in and hypertension.		admission against interest by facility, or any employees, age or other individuals who drafted may be discussed in the Response and Plan of Correct In addition, preparation and submission of this Plan of	the ents, ed or			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/04/2019				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
LAKE CI	LAKE CITY PLACE			425 CHINWORTH CT WARSAW, IN 46580					
(X4) ID	SUMMARY	I	ID PROVIDER'S PLAN OF CORRECTION			(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE		
		sting/ Vaccines Consents/			Correction does NOT constitu				
		Resident 3, indicated he received			an admission or agreement of	-			
		st for tuberculosis) 1st step on			kind by the facility of the truth	of			
	3/6/19, / days after	admission into the facility.			any facts alleged or the				
	During an interview	v on 11/4/10 at 2:05 D.M. the			correctness of any conclusion				
	_	w, on 11/4/19 at 2:05 P.M., the g indicated the Mantoux test			set forth in this allegation by the	ie			
	should have been g				survey agency. R410 Infection				
	should have been g	iven on admission.			Control-Noncompliance				
	2 A clinical record	review was completed on			Control-Noncompliance				
		M., and indicated Resident 8			A tuberculin skin test wa	9			
		25/19. Her diagnoses included,			re-initiated on 11/20/2019 for	Ö			
	but were not limited to: dementia, hypertension and hyerlipidemia.				Resident 3. Resident 8 and				
					Resident 7 no longer reside in	the			
	, . ,				community.				
	A Tuberculosis Tes	sting/ Vaccines Consents/			An audit of current resident	ent			
		Resident 8, indicated she			tuberculin skin tests will be				
	received a Mantoux	x (skin test for tuberculosis) 1st			completed by 11/20/2019 by 0	Care			
	step on 3/6 /19, 9 d	ays after admission into the			Services Manager (CSM) and				
	facility.				issues identified will be correc	ted.			
					<ol><li>The Care Services Mana</li></ol>	ager			
	_	v, on 11/4/19 at 1:45 P.M., the			(CSM) was re-trained by the				
		g indicated the Mantoux test			Regional Director of Care Ser	vices			
	should have been g	given on admission.			(RDCS) on 11/14/2019 regard	ing			
					the resident tuberculosis				
		review was completed on			screening requirements. The				
		1., and indicated Resident 7 was			will in-services licensed nurse	-			
		17. His diagnoses included, but			11/22/2019 on the tuberculosi	S			
		: hypertension, depression,			screening requirements.				
	confusion and gout				4. The Care Services Mana	ager			
	A Tuberculosis To	eting/Vaccines Consents/			is responsible for sustained				
	A Tuberculosis Testing/ Vaccines Consents/ Records form for Resident 7 indicated she				compliance. The CSM, or designee, will audit new reside	nnt.			
					tuberculin skin tests within 3 d				
	received a Mantoux (skin test for tuberculosis) 1st step on 10/17/17. The form lacked the documentation to show a 2nd step Mantoux had been administered to Resident 7. The next				of move in x 2 months then we	•			
					x 3 months to ensure complian	-			
					with tuberculosis screening				
		Mantoux test being			requirements. Results of the a	udit			
	administered was o	_			will be discussed in the month				
					QI meetings. The QI Committee	-			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(x2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/04/2019				
NAME OF PROVIDER OR SUPPLIER  LAKE CITY PLACE				STREET ADDRESS, CITY, STATE, ZIP COD 425 CHINWORTH CT WARSAW, IN 46580					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	During an interview, on 11/4/19 at 3:10 P.M., the Director of Nursing indicated the 2nd step Mantoux should have been administered 1 to 3 weeks after the 1st step.  On 11/4/19 at 3:14 P.M., the Director of Nursing provided the policy titled, "TB (Tuberculosis) Testing", dated 9/1/16, and indicated the policy was the one currently used by the facility The policy indicated"TB testing will be completed per state regulations for residents, staff and volunteers"				will determine if continued audis necessary based on 3 consecutive months of compliance.  5. Completion date: 12/4/20	•			

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