PRINTED: 09/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
			B. WING		07/26/2024
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	R		RIPLEY ST	
I I AKE PA	ARK RESIDENTIAL	CARE		STATION, IN 46405	
	T				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
R 0000					
Dida 00					
Bldg. 00	This wish for a	1. I	D 0000		
	This visit was for the Investigation of Complaints IN00439023, IN00439472, and IN00439550.		R 0000		
	11100439023, 11100	439472, and 1100439330.			
	Complaint IN00//3	9023 - State deficiencies related			
	•	re cited at R0052 and R0090.			
	to the anegations a	re cited at R0032 and R0030.			
	Complaint IN0043	9472 - State deficiencies related			
	•	re cited at R0052 and R0090.			
	Complaint IN0043	9550 - State deficiencies related			
	_	re cited at R0052 and R0090.			
	Unrelated deficien	cy is cited.			
	Survey dates: July	25 & 26, 2024			
	Facility number: 0	01136			
	Residential Census	s: 99			
		ential Findings are cited in			
	accordance with 4	10 IAC 16.2-5.			
	0 111	1 . 1 . 7/21/24			
	Quality review cor	npleted on 7/31/24.			
R 0052	410 IAC 16.2-5-1	2(v)(1-6)			
11.0002	Residents' Rights				
Bldg. 00		ve the right to be free from:			
Blug. 00	(1) sexual abuse	_			
	(2) physical abuse				
	(3) mental abuse				
	(4) corporal punis				
	(5) neglect; and	minorit,			
	(6) involuntary se	clusion			
	(o) involuntary se	G. G	R 0052	R052	08/26/2024
	Based on observat	on, interview, and record	10032		00/20/2024
	review, the facility			1 What Corrective action	(s)
	, , , , , , , , , , , , , , , , , , , ,				X=1
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE
	iller Johnson		Administ		08/28/2024
INDENVIOLIN	mer joanson		Administ	uaud	UKLZKLZUZA

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.

State Form Event ID: B5HK11 Facility ID: 001136 If continuation sheet Page 1 of 15

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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  07/26/2024	
	ROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP COD RIPLEY ST STATION, IN 46405	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ntal abuse during a skin		will be accomplished for the	
	assessment when a nurse took cell phone pictures of a resident's groin for 1 of 2 residents reviewed			residents found to have bee	n
	_			affected by the alleged	
	· ·	t B) This deficient practice		deficient practice.	
		B being humiliated, mortified,		During the complaint visit,	
	and feeling violated			Resident B voiced an allegation	
	Einding ingludge			abuse to the ISDH surveyor.	ine
	Finding includes:			ISDH surveyor relayed that Resident B, voiced an allegat	ion of
	Design of the second of the se			abuse involving the Director of	
	During an observation and interview on 7/25/24 at 10:10 a.m., Resident B was in his room sitting on			Nursing (DON) to the	"
	the side of his bed. Resident B indicated he had			Administrator. The Administra	tor
		res that were taken of his		informed the ISDH Surveyor t	
	_	shower a few weeks prior, the		the DON would be suspended	
	CNA had seen skin areas of concern in the groin			pending investigation. The DO	
		ne would have to report the		was suspended immediately	
		r of Nursing (DON). He told		7/25/2024, left the grounds of	
		ning to be concerned about		facility and an investigation w	
		d the areas. The DON then		initiated.	
	•	and forced him to let her take			
		area. Resident B indicated		2 . How will the facility iden	tifv
	-	s with her cell phone and he		other residents having the	
	_	mortified" and stated he had		potential to be affected by the	ne
	been abused. The D	ON had not informed him why		same deficient practice and	
	she was taking the p	pictures and she was		what corrective action will b	e
	"overzealous". Resi	dent B indicated he had not		taken.	
	given permission ve	erbally or in writing for the		All the residents of the facility	
	_	. He had not reported this to		have the potential to be affect	ed
	anyone until 7/18/24	4. Resident B indicated again		by this alleged deficient pract	ce.
		een violated and abused.		The Director of Nursing has b	een
		v, his voice was also observed		terminated from the facility	
		nd movements of his upper		pursuant to the policies of the	
	extremities and upp	er torso increased.		facility, and will not have any	
				contact with Resident B or an	-
		ial Interview, Employee 3 (E3)		other residents of the facility.	
		took pictures of sores on		sample of residents will also be	
	Resident B's groin area on 7/4/24 without his			interviewed about any concer	
	-	at B had not reported the		they may have about any potential	ential
		. He indicated he did not want are to him and felt intimidated		allegations of abuse.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  07/26/2024	
	PROVIDER OR SUPPLIEF		2075 F	ADDRESS, CITY, STATE, ZIP COD RIPLEY ST STATION, IN 46405	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	• · · · · · · · · · · · · · · · · · · ·
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	+	the DON. E3 indicated the		3 .What measures will be pu	
		ed immediately to their		into place or what systemic	
	supervisor.	•		changes the facility will make	
	1			to ensure the alleged deficie	
	During an interview on 7/25/24 at 10:43 a.m., CNA			practice does not recur.	
	2 indicated when she assisted Resident B with his			Administrator and/or designe	e will
	shower several wee	eks prior, she found areas of		meet with all Lake Park, Regi	
	skin concern in the	groin area. CNA 2 informed		Health Systems, Regional Me	
	him she needed to r	report this to the nurse and he		Health and contracted staff w	ill be
	said it was his personal business and it was not			re-educated on abuse, abuse	<b>.</b>
	her business. CNA 2 indicated she had reported			policy and reporting any	
	the area on 7/4/24 to RN 1 and RN 1 then reported			allegations of abuse as well a	is
	it to the DON. CNA	A 2 was not in the room when		residents' rights. In addition, a	all
	the photograph incident occurred.			Lake Park, Regional Health	
				Systems, Regional Mental He	ealth
		ial Interview, Employee 4		and contracted staff will be	
		e in the resident's room at the		re-educated on taking picture	<b>I</b>
		t. The DON informed Resident		residents and the facility police	-
		e his groin area so she could		taking pictures only with writte	en
		about the areas of concern.		consent.	
		up from the bed. The DON		Residents will be informed of	
	_	h him and told him to pull		residents' rights and also rep	- I
	_	e did not ask permission, it was		concerns with regards to abu	
		N then told him to put his back		resident council and also one	
		to steady himself. Resident B		one with Administrator and/or	
		s pants down and was asking nat. Employee 4 indicated		designee.	
	-	* *		4 How the corrective action	m(a)
		liscussion, the DON just look at the groin to tell the		4. How the corrective actio will be monitored to ensure	
		yee 4 indicated when the DON		deficient practice will not	tile
	1	esident was really mad and he		recur.	
		alled" at what happened.		Administrator and/or designer	e will
	Resident B indicate			meet with residents at randor	
		oyee 4 indicated permission to		monthly to ensure that any	"
	_	as never obtained by the DON.		allegations of abuse are being	n l
	_	ted the incident had not been		reported and one resident rig	-
	reported to the Adn			be reviewed each month in the	<b>I</b>
				monthly resident council mee	
	During a Confident	ial Interview, Employee 5		to ensure their understanding	=
	_	e in the resident's room at the		their rights for the next six	
1	1		1	1	i

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
			B. W	ING		07/26/2024	
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			IPLEY ST		
IAKEDV	RK RESIDENTIAL	CARE			STATION, IN 46405		
		Unite .		LAKE 3	, 1 A 1 O N, IN 40400		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t. The DON told Resident B she			months. Thereafter annually.		
	_	roin area and told him to pull					
		n. He did not like it and the			5. By what date will systemic		
	DON told him she had to take the pictures so the				changes be completed. Augu	ust	
		the areas of concern.			26, 2024		
		ted the resident was very upset					
	_	since this incident happened.					
		sk permission to take the					
	pictures, she told him she was going to do it.						
	Resident B's body language was stiff. Employee 5						
	indicated Resident B never said anything and "he						
	had to be humiliated." Employee 5 indicated the						
	incident had not been reported to the Administrator because the DON said she was						
	taking the pictures	for the physician.					
	A Casa Managar Dr	rogress Note, dated 7/18/24 at					
	_	ed the resident reported around					
		s approached by the DON and					
	1 -	se his groin area for her to					
	_	nd pictures were taken. The					
		she needed to show his					
		ated all this was done without					
		felt intimidated, degraded, and					
	violated.	, <u>-</u> ,					
	During an interview	v on 7/25/24 at 11:57 a.m., the					
		cated the incident had been					
	reported to the Case	e Manager's Supervisor on					
	_	ad then reported the incident to					
		ee. She received and email on					
	7/18/24 from the Co	orporate Office and initiated a					
	grievance form. The	e Administrator then read the					
	email that stated the	e DON had taken pictures of					
	the resident's groin area and the resident stated he						
	felt violated. The Administrator indicated after she						
	received the email, she spoke with the resident						
	and he had not voic	ed an allegation of abuse. She					
	investigated the inc	ident and received emailed					
	statements from RN						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
			B. W	ING	_	07/26/	/2024
	PROVIDER OR SUPPLIER			2075 RI	ADDRESS, CITY, STATE, ZIP COD PLEY ST TATION, IN 46405		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	A facility grievance Administrator met v concerns about the Nursing (DON) had grievance indicated upset that he gave p Nursing to take his areaAdministrator spoke to (sic) DON permission for her t inform physician as himAdministrator resident did give pe affected area." The Administrator.  An investigation, er the Administrator.  An investigation, er the Administrator, or indicated she had be of the resident's gro DON. The DON had was going to take the physician. The I was reported that he she needed a picture the resident was "see pictures were taken area to the DON.  An emailed stateme 7/18/24 at 1:30 p.m. she had been inform sores and a rash in the RN 1 accompany he assess the areas. She pictures to show the agreed. She asked he pictures and he agreed.	e, dated 7/18/24, indicated the with Resident B to discuss his pictures the Director of I taken of his groin area. The picture of his private rexplained to resident that she and that DON said he gave to take picture so she could to to what is going on with respoke to (RN 1) who stated rmission to take picture of grievance was signed by the mailed statement from RN 1 to dated 7/18/24 at 1:30 p.m., the pictures of his groin area for DON informed the resident it the had a rash in the area and the CNA reported the and the CNA reported the mailed stated about a week prior, and by CNA 2 the resident had the groin area. She requested the resident in the resident in the resident in the groin area. She requested the resident in the positioned himself so they					

State Form Event ID: B5HK11 Facility ID: 001136 If continuation sheet Page 5 of 15

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/26/2024	
	ROVIDER OR SUPPLIER		•	2075 RI	DDRESS, CITY, STATE, ZIP COD PLEY ST TATION, IN 46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		and she had taken two n with his consent and then					
	DON indicated CN in the groin area. Si so the areas could be in bed and she told she needed to look his groin. She indicatwice and he agreed physician was not go day, but she would pictures when they up and pulled his pashe informed him spicture of the areas came in a week later pictures. She indicatupset. The policy was pictures could be ta statement of approximately approached the policy was pictured to take the policy was a statement of approximately provided the pr	ov on 7/25/24 at 12:07 p.m., the A 1 reported areas of concern the and RN 1 went to his room the assessed. The resident was thim why they were there and the askin areas of concern on the asked his permission of the informed him the going to be in the facility that show the physician the came to the facility. He stood ants and underwear down and the was only going to take a concern. The Physician the cannot she showed them the stated the resident was always was to ask the resident if the ask of the pictures of the groin area.					
	2:01 p.m. The diag	I was reviewed on 7/25/24 at noses included, but were not sclerosis and sociopathic r.					
	resident on 11/23/2	ographs was signed by the 2, which indicated the photo ssist the facility staff in on and treatment.					
	Administrator indic	w on 7/28/24 at 2:15 p.m., the cated the photo consents were ne facility had a special event take pictures.					

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	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMP	PLETED 6/2024
	PROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP COD IPLEY ST STATION, IN 46405		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	A Six-Month Asses indicated the resident there was no confus A Service Plan, data resident had independent the was independent Assistance from state and grooming. The behaviors. There we service plan.  A Progress Note, dasigned by facility Mindicated the resident importance of controping skills. He has felt exposed. Resident work with the staff privacy and he felt of During an interview Administrator indicated the resident of the feeling violated, explant A Nurse Practitione 7/11/24 at 3:15 p.m. was resolved and "restages." He was original situation with a A Case Manager Private of the resident of the feeling violated and situation with a A Case Manager Private of the resident of the feeling violated and "restages." He was original situation with a A Case Manager Private of the resident of the feeling violated and "restages." He was original situation with a A Case Manager Private of the resident of the feeling violated and "restages." He was original situation with a A Case Manager Private of the resident of the feeling violated and "restages."	sment, dated 11/13/23, and was alert and understood, sion or forgetfulness.  ed 3/30/24, indicated the andent decision-making skills to for mobility and transfers. If was required for hygiene staff were to monitor for the ere no behaviors listed on the lated 7/7/24 at 5:36 p.m. and lental Health Technician 6, and was educated on the olling his anger and using distated, "I felt violated and lent B no longer wanted to who had not respected his	TAG			DATE
	7/4/24, he was force the DON to examin pictures without his the DON informed	ed to expose his groin area for e his skin and the DON took consent. The note indicated Resident B the photographs how the skin impairment to the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COM	E SURVEY PLETED 6/2024	
	ROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP CO IPLEY ST STATION, IN 46405	D	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE	(X5) COMPLETION
TAG	physician. The note	LSC IDENTIFYING INFORMATION indicated Resident B reported degraded, and violated.	TAG	DEFICIENCY)		DATE
	A facility policy for 7/2023 and received Nursing as current, sobtained with prior had the right to revo Consent for the phot days from the date of specified.  A facility abuse police received from the Dresidents of the facility and respect, intentionally caused against a resident widischarge.	photograph consents, dated I from the Assistant Director of indicated photographs may be written consent. The resident oke permission at any time. tograph would expire 180 of signature unless otherwise icy, dated January 2024 and ON as current, indicated the lity were to be treated with Any individual who any physical or mental injury ill be subject to immediate to Complaints IN00439023,				
	IN00439472, and IN	-				
R 0090	410 IAC 16.2-5-1.3 Administration and	3(g)(1-6) I Management - Deficiency				
Bldg. 00	overall manageme responsibilities of tinclude, but are not (1) Informing the di (24) hours of beco occurrence that dit welfare, safety, or of unusual occurre telephone, followe a written report on electronic mail to to twenty-four (24) hours of the control of t	tor is responsible for the ent of the facility. The the administrator shall of limited to, the following: livision within twenty-four ming aware of an unusual rectly threatens the health of a resident. Notice ence may be made by d by a written report, or by ly that is faxed or sent by he division within the our time period. Unusual de, but are not limited to: reaks;				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>00</u> Co		(X3) DATE SURVEY COMPLETED 07/26/2024
	PROVIDER OR SUPPLIE		2075 F	S ADDRESS, CITY, STATE, ZIP COD RIPLEY ST STATION, IN 46405	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	SIATE CONTENTION
TAG	(B)poisonings; (C) fires; or (D) major accided of the division care be made to the expublished by the (2) Promptly arrathe provision of mursing care or or requested by the representative. (3) Obtaining directly admission of an inverse of age to a (4) Ensuring the expression of an inverse of age to a (4) Ensuring the expression of an inverse of age to a (4) Ensuring the expression of an inverse of age to a (5) Posting the expression of a control of the expression of the exp	mergency telephone number division. Inging for or assisting with medical, dental, podiatry, or ther health care services as resident or resident's legal ector approval prior to the individual under eighteen (18) in adult facility. Facility maintains, on the urate record of actual time attes the: Ill name; and urs worked during the past ins. Insults of the most recent the facility conducted by any plan of correction in exit to the facility, and any eys. The results must be mination in the facility in a essible to residents and a cheir availability. It is ports of surveys conducted each facility for a period of a making the reports ection to any member of the	R 0090	R 090  1. What Corrective action( will be accomplished for th residents found to have be affected by the alleged deficient practice.	DATE  10/31/2024 s) ose

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/26/2024		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	•	
LAKE PA	RK RESIDENTIAL	CARE			IPLEY ST STATION, IN 46405		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID	DROWING DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ce, for 1 of 1 allegation of abuse			Nursing employees on duty du	•	
	`	t B, Employee 4, Employee 5,			survey, were re-educated verb	•	
	and Mental Health	Technician 6)			on reporting allegations of abu	ıse	
					to the Administrator and/or		
		tional information regarding			designee.		
	Resident B.				The Director of Nursing was		
					placed on immediate suspens		
	Finding includes.				by the Administrator when not	ified	
	7/25/24				of allegation of Abuse from		
	During an observation and interview on 7/25/24 at				Resident B by ISDH Surveyor		
	10:10 a.m., Resident B was in his room sitting on the side of his bed. Resident B indicated he had				Administrator notified ISDH by		
	concerns with pictures that were taken of his				electronic reporting the allega		
	-				of Abuse made by Resident B	•	
	groin area. During a shower a few weeks prior, the				The Director of Nursing was		
	CNA had seen skin areas of concern in the groin area and told him she would have to report the				terminated.		
		or of Nursing (DON). He told			2 Miles Compositive action (a)		
		thing to be concerned about			2 . What Corrective action(s)		
		ed the areas. The DON then			will be accomplished for tho residents found to have been		
	•	and forced him to let her take			affected by the alleged	•	
		n area. Resident B indicated			deficient practice.		
	-	es with her cell phone and he			All residents have the potentia	ıl to	
	_	d mortified" and stated he had			be affected. Residents will be		
		OON had not informed him why			identified through interviews.		
		pictures and she was					
		ident B indicated he had not			3 . What measures will be pu	t	
	given permission v	erbally or in writing for the			into place or what systemic		
	pictures to be taken	a. He had not reported this to			changes the facility will mak	е	
	anyone until 7/18/2	4. Resident B indicated again			to ensure the alleged deficie	nt	
	he felt like he had b	been violated and abused.			practice does not recur.		
	During the intervie	w, his voice was also observed			All Lake Park, Regional Case		
		and movements of his upper			Management and contracted s	staff	
	extremities and upp	per torso increased.			will be re-educated by Corpora	ate	
					Nursing Officer, on reporting		
		e, dated 7/18/24, indicated the			allegations of abuse within a		
		with Resident B to discuss his			timely manner to Administrato	r	
		pictures the Director of			and/or designee.		
		d taken of his groin area. The					
		l, "Resident states he was			Administrator and/or designee		
	upset that he gave p	permission to the Director of			in-service all Lake Park, Region	onal	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	UILDING	onstruction 00	(X3) DATE COMPL <b>07/26</b> /	ETED
	PROVIDER OR SUPPLIER			2075 R	ADDRESS, CITY, STATE, ZIP COD IPLEY ST STATION, IN 46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAGENCY DEFICIENCY)		TE	(X5) COMPLETION DATE
	Nursing to take his areaAdministrator spoke to (sic) DON permission for her to inform physician as himAdministrator resident did give per affected area." The Administrator.  During an interview Administrator indicated to the Case 7/18/24 and they have the Corporate Office 7/18/24 from the Corporate form. The email that stated the the resident's groin felt violated. The Areceived the email, and he had not voice investigated the incurve statements from RN Cross reference ROG A Progress Note, dasigned by facility Mindicated the reside importance of controping skills. He has felt exposed". Residuors work with the staff privacy and he felt of During an interview Administrator indicated the recipient of had not rechnician 6 had not re	picture of his private r explained to resident that she r and that DON said he gave to take picture so she could r to what is going on with r spoke to (RN 1) who stated remission to take picture of grievance was signed by the  of on 7/25/24 at 11:57 a.m., the rated the incident had been re Manager's Supervisor on at then reported the incident to re. She received and email on reported Office and initiated a re Administrator then read the re DON had taken pictures of area and the resident stated he dministrator indicated after she she spoke with the resident red an allegation of abuse. She rident and received emailed red 1 and the DON.  of 2.  ated 7/7/24 at 5:36 p.m. and fental Health Technician 6, nt was educated on the realing his anger and using and stated, "I felt violated and dent B no longer wanted to who had not respected his			Case Management and Contracted Staff on facility Ab Policy and Resident Rights. All residents will be educated abuse and reporting abuse immediately to staff and/or Administrator. All residents will be educated resident rights.  4. How the corrective action will be monitored to ensure to deficient practice will not recur. Administrator and/or designed randomly speak to residents monthly for the next six month about and issues and concern it may relate to allegations for abuse. Administrator will spea with a random sample of resid quarterly thereafter. Activity staff will review one resident right monthly at resid- council meeting.  5. By what date the systemic changes will be completed. August 26, 2024.	use on on (s) the e will us, us as k lents	
	1 Resident B recining	violatea, exposea, and	I				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.			A. BUILDING 00 COMPLETED  B. WING 07/26/2024				ETED
	PROVIDER OR SUPPLIER			2075 RI	ADDRESS, CITY, STATE, ZIP COD PLEY ST		
LAKE PA	ARK RESIDENTIAL	CARE		LAKE S	TATION, IN 46405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	During a Confident indicated they were time of the incident B she needed to see notify the physician The resident stood to was demanding with down his pants. She a demand. The DOI up against the wall was trying to get his why he had to do the there had been no distated "we need to I physician". Employ left the room, the restated he was "appa Resident B indicate embarrassed. Employ take the pictures was Employee 4 indicate they were time of the incident indicated they were time of the incident needed to see his grain by the physician could see Employee 5 indicate and had been upset The DON did not as pictures, she told his Resident B's body Is indicated Resident I leaded to see in the physician could see Employee 5 indicate and had been upset The DON did not as pictures, she told his Resident B's body Is indicated Resident I leaded to see in the physician could see Employee 5 indicate and had been upset The DON did not as pictures, she told his Resident B's body Is indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see Employee 5 indicated Resident I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I leaded to see in the physician could see I le	ial Interview, Employee 4 in the resident's room at the . The DON informed Resident his groin area so she could about the areas of concern. up from the bed. The DON h him and told him to pull edid not ask permission, it was N then told him to put his back to steady himself. Resident B s pants down and was asking at. Employee 4 indicated iscussion, the DON just ook at the groin to tell the ee 4 indicated when the DON sident was really mad and he lled" at what happened. d he was upset and oyee 4 indicated permission to us never obtained by the DON. ed the incident had not been ninistrator.  ital Interview, Employee 5 in the resident's room at the . The DON told Resident B she oin area and told him to pull h. He did not like it and the nad to take the pictures so the the areas of concern. ed the resident was very upset since this incident happened. sk permission to take the m she was going to do it. anguage was stiff. Employee 5 B never said anything and "he d." Employee 5 indicated the					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/26/2024	
	ROVIDER OR SUPPLIER		20	REET ADDRESS, CITY, STATE, ZIP COD 75 RIPLEY ST .KE STATION, IN 46405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PREF	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	taking the pictures for the facility abuse p	use the DON said she was for the physician.  solicy, dated January 2024 and from the DON, indicated				
	suspected or actual Administrator. Alle reported to the IDO and the Indiana Om	to Complaints IN00439023,				
R 0214	410 IAC 16.2-5-2( Evaluation - Defici					
Bldg. 00	(a) An evaluation each resident sha admission and sha semiannually and change in the resident often at the resident change in the residen	of the individual needs of Il be initiated prior to all be updated at least upon a known substantial dent 's condition, or more ent 's or facility 's request. shall evaluate the nursing				
	failed to ensure resi completed semi-anr reviewed for semi-a B, C, D)	view and interview, the facility dent evaluations were nually for 3 of 3 residents annual evaluations. (Residents	R 0214	1 1. WhWhat Corrective action(s will be accomplished for tho residents found to have been affected by the alleged deficient practice.	se	
	2:01 p.m. The diagr limited to, multiple The Semi-Annual N	Nursing Assessment was last		Resident B's Semi-Annual Assessment was completed by the Assistant Director of Nursion 8/8/2024. Resident C's Semi-Annual Assessment was completed by	ing by	
	completed on 11/13  2) Resident C's rec	ord was reviewed on 7/26/24 at		the Assistant Director of Nurs on 8/8/2024. Resident D's Semi-Annual	ing	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00  B. WING		COMPLETED 07/26/2024	
	PROVIDER OR SUPPLIER		2075 R	ADDRESS, CITY, STATE, ZIP COD RIPLEY ST STATION, IN 46405	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE	
TAG	3:30 p.m. The diagral limited to, schizoph  The Semi-Annual National Completed on 11/12  3) Resident D's recessions. The diagral limited to, schizoph  The Semi-Annual National Completed on 7/24/2  During an interview ADON indicated the	oses included, but were not renia.  Fursing Assessment was last /23.  ord was reviewed on 7/26/24 at oses included, but were not renia.  Fursing Assessment was last	TAG	Assessment was completed to the Assistant Director of Nurs on 8/8/2024.  2.  2. What Corrective action will be accomplished for the residents found to have bee affected by the alleged deficient practice.  All residents have the potentiable affected by this alleged deficient practice. Nursing will audit all semi-assessment for to ensure they are in compliant 3. What measures will be put into place or what system changes the facility will make to ensure the alleged deficient practice does not recur. The Chief Nursing Officer of Regional Health Systems and Designee will in-service all nustaff on the regulation regardicompletion of semi-annual assessments on all Lake Park Residents. The in-service will include competing assessment every six months, a known substantial change in condition more often at the resident's of facility's request.  4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Assistant Director of Nursing and/or designee will monitor	(s) see n  al to I ms nce.  pe mic se ent  l/or rrsing ng c I nts nor r

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 07/26/2024			
NAME OF PROVIDER OR SUPPLIER  LAKE PARK RESIDENTIAL CARE				STREET ADDRESS, CITY, STATE, ZIP COD 2075 RIPLEY ST LAKE STATION, IN 46405				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VE ACTION SHOULD BE CED TO THE APPROPRIATE		
					completion of semi-annual assessments completion and revisions monthly at random for the next six months. The monitoring/audit will include the semi annual assessments are accurate and done timely. Nursing staff will be subject to disciplinary action if semi annual assessments are not done timely or not accurate.  5. By what date the systemic changes will be completed. August 26, 2024	at ual ely		

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