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	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE PARK RESIDENTIAL CARE	2075 RIPLEY ST LAKE 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00439023, IN00439472, and IN00439550. Complaint IN00439023 - State deficiencies related to the allegations are cited at R0052 and R0090. Complaint IN00439472 - State deficiencies related to the allegations are cited at R0052 and R0090. Complaint IN00439550 - State deficiencies related to the allegations are cited at R0052 and R0090. Unrelated deficiency is cited. Survey dates: July 25 & 26, 2024 Facility number: 001136 Residential Census: 99 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/31/24.	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview, and record review, the facility failed to prevent	R 0052	**R052** **1 What Corrective action(s)**	08/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joelynn Miller Johnson	Administrator	08/28/2024

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	staff-to-resident mental abuse during a skin assessment when a nurse took cell phone pictures of a resident's groin for 1 of 2 residents reviewed for abuse. (Resident B) This deficient practice resulted in Resident B being humiliated, mortified, and feeling violated. Finding includes: During an observation and interview on 7/25/24 at 10:10 a.m., Resident B was in his room sitting on the side of his bed. Resident B indicated he had concerns with pictures that were taken of his groin area. During a shower a few weeks prior, the CNA had seen skin areas of concern in the groin area and told him she would have to report the areas to the Director of Nursing (DON). He told the CNA it was nothing to be concerned about and she still reported the areas. The DON then came into his room and forced him to let her take pictures of his groin area. Resident B indicated she took the pictures with her cell phone and he felt "humiliated and mortified" and stated he had been abused. The DON had not informed him why she was taking the pictures and she was "overzealous". Resident B indicated he had not given permission verbally or in writing for the pictures to be taken. He had not reported this to anyone until 7/18/24. Resident B indicated again he felt like he had been violated and abused. During the interview, his voice was also observed to raise in volume and movements of his upper extremities and upper torso increased. During a Confidential Interview, Employee 3 (E3) indicated the DON took pictures of sores on Resident B's groin area on 7/4/24 without his permission. Resident B had not reported the indent until 7/18/24. He indicated he did not want CNA 2 to provide care to him and felt intimidated		**will be accomplished for those residents found to have been affected by the alleged deficient practice.** During the complaint visit, Resident B voiced an allegation of abuse to the ISDH surveyor. The ISDH surveyor relayed that Resident B, voiced an allegation of abuse involving the Director of Nursing (DON) to the Administrator. The Administrator informed the ISDH Surveyor that the DON would be suspended, pending investigation. The DON was suspended immediately on 7/25/2024, left the grounds of the facility and an investigation was initiated. **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 the residents of the facility have the potential to be affected by this alleged deficient practice. The Director of Nursing has been terminated from the facility pursuant to the policies of the facility, and will not have any contact with Resident B or any other residents of the facility. A sample of residents will also be interviewed about any concerns they may have about any potential allegations of abuse.	

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	and unsafe around the DON. E3 indicated the incident was reported immediately to their supervisor. During an interview on 7/25/24 at 10:43 a.m., CNA 2 indicated when she assisted Resident B with his shower several weeks prior, she found areas of skin concern in the groin area. CNA 2 informed him she needed to report this to the nurse and he said it was his personal business and it was not her business. CNA 2 indicated she had reported the area on 7/4/24 to RN 1 and RN 1 then reported it to the DON. CNA 2 was not in the room when the photograph incident occurred. During a Confidential Interview, Employee 4 indicated they were in the resident's room at the time of the incident. The DON informed Resident B she needed to see his groin area so she could notify the physician about the areas of concern. The resident stood up from the bed. The DON was demanding with him and told him to pull down his pants. She did not ask permission, it was a demand. The DON then told him to put his back up against the wall to steady himself. Resident B was trying to get his pants down and was asking why he had to do that. Employee 4 indicated there had been no discussion, the DON just stated "we need to look at the groin to tell the physician". Employee 4 indicated when the DON left the room, the resident was really mad and he stated he was "appalled" at what happened. Resident B indicated he was upset and embarrassed. Employee 4 indicated permission to take the pictures was never obtained by the DON. Employee 4 indicated the incident had not been reported to the Administrator. During a Confidential Interview, Employee 5 indicated they were in the resident's room at the		**3 .What measures will be put into place or what systemic changes the facility will make to ensure the alleged deficient practice does not recur.** Administrator and/or designee will meet with all Lake Park, Regional Health Systems, Regional Mental Health and contracted staff will be re-educated on abuse, abuse policy and reporting any allegations of abuse as well as residents' rights. In addition, all Lake Park, Regional Health Systems, Regional Mental Health and contracted staff will be re-educated on taking pictures of residents and the facility policy on taking pictures only with written consent. Residents will be informed of their residents' rights and also reporting concerns with regards to abuse in resident council and also one on one with Administrator and/or designee. **4 . How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** Administrator and/or designee will meet with residents at random monthly to ensure that any allegations of abuse are being reported and one resident right will be reviewed each month in the monthly resident council meeting to ensure their understanding of their rights for the next six	

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	time of the incident. The DON told Resident B she needed to see his groin area and told him to pull his underwear down. He did not like it and the DON told him she had to take the pictures so the physician could see the areas of concern. Employee 5 indicated the resident was very upset and had been upset since this incident happened. The DON did not ask 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 Case Manager Progress Note, dated 7/18/24 at 11:30 a.m., indicated the resident reported around July 4, 2024 he was approached by the DON and was forced to expose his groin area for her to examine the area and pictures were taken. The DON informed him she needed to show his physician. He indicated all this was done without his consent and he felt intimidated, degraded, and violated. During an interview on 7/25/24 at 11:57 a.m., the Administrator indicated the incident had been reported to the Case Manager's Supervisor on 7/18/24 and they had then reported the incident to the Corporate Office. She received and email on 7/18/24 from the Corporate Office and initiated a grievance form. The Administrator then read the email that stated the 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 voiced an allegation of abuse. She investigated the incident and received emailed statements from RN 1 and the DON.		months. Thereafter annually. 5. By what date will systemic changes be completed. August 26, 2024	

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	A facility grievance, dated 7/18/24, indicated the Administrator met with Resident B to discuss his concerns about the pictures the Director of Nursing (DON) had taken of his groin area. The grievance indicated, "...Resident states he was upset that he gave permission to the Director of Nursing to take his picture of his private area...Administrator explained to resident that she spoke to (sic) DON and that DON said he gave permission for her to take picture so she could inform physician as to what is going on with him...Administrator spoke to (RN 1) who stated resident did give permission to take picture of affected area." The grievance was signed by the Administrator. An investigation, emailed statement from RN 1 to the Administrator, dated 7/18/24 at 1:30 p.m., indicated she had been present when the pictures of the resident's groin area were taken by the DON. The DON had informed the resident she was going to take the pictures of his groin area for the physician. The DON informed the resident it was reported that he had a rash in the area and she needed a picture. After the DON left the room, the resident was "seeing red" because the pictures were taken and the CNA reported the area to the DON. An emailed statement from the DON, dated 7/18/24 at 1:30 p.m., indicated about a week prior, she had been informed by CNA 2 the resident had sores and a rash in the groin area. She requested RN 1 accompany her to the resident's room to assess the areas. She asked him if she could take pictures to show the physician and the resident agreed. She asked him twice about taking the pictures and he agreed both times. The resident rose from his bed and positioned himself so they			

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	could see the areas and she had taken two pictures of his groin with his consent and then exited the room. During an interview on 7/25/24 at 12:07 p.m., the DON indicated CNA 1 reported areas of concern in the groin area. She and RN 1 went to his room so the areas could be assessed. The resident was in bed and she told him why they were there and she needed to look at the skin areas of concern on his groin. She indicated she asked his permission twice and he agreed. She informed him the physician was not going to be in the facility that day, but she would show the physician the pictures when they came to the facility. He stood up and pulled his pants and underwear down and she informed him she was only going to take a picture of the areas of concern. The Physician came in a week later and she showed them the pictures. She indicated the resident was always upset. The policy was to ask the resident if pictures could be taken. There was no signed statement of approval. She indicated neither the Physician nor the Nurse Practitioner had ordered or asked her to take the pictures of the groin area. Resident B's record was reviewed on 7/25/24 at 2:01 p.m. The diagnoses included, but were not limited to, multiple sclerosis and sociopathic personality disorder. A consent for photographs was signed by the resident on 11/23/22, which indicated the photo would be used to assist the facility staff in resident identification and treatment. During an interview on 7/28/24 at 2:15 p.m., the Administrator indicated the photo consents were only signed for if the facility had a special event and were going to take pictures.			

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A Six-Month Assessment, dated 11/13/23, indicated the resident was alert and understood, there was no confusion or forgetfulness.

A Service Plan, dated 3/30/24, indicated the resident had independent decision-making skills He was independent for mobility and transfers. Assistance from staff was required for hygiene and grooming. The staff were to monitor for behaviors. There were no behaviors listed on the service plan.

A Progress Note, dated 7/7/24 at 5:36 p.m. and signed by facility Mental Health Technician 6, indicated the resident was educated on the importance of controlling his anger and using coping skills. He had stated, "I felt violated and felt exposed". Resident B no longer wanted to work with the staff who had not respected his privacy and he felt embarrassed.

During an interview on 7/25/24 at 3:14 p.m., the Administrator indicated the facility Mental Health Technician 6 had not reported the allegation of feeling violated, exposed, and embarrassed to her.

A Nurse Practitioner's (NP) Progress Note, dated 7/11/24 at 3:15 p.m., indicated the resident's rash was resolved and "noted pictures of the before stages." He was oriented to time, place, person, and situation with appropriate mood and affect.

A Case Manager Progress Note, dated 7/18/24 at 11:30 a.m., indicated Resident B reported on 7/4/24, he was forced to expose his groin area for the DON to examine his skin and the DON took pictures without his consent. The note indicated the DON informed Resident B the photographs were necessary to show the skin impairment to the

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	physician. The note indicated Resident B reported he felt intimidated, degraded, and violated. A facility policy for photograph consents, dated 7/2023 and received from the Assistant Director of Nursing as current, indicated photographs may be obtained with prior written consent. The resident had the right to revoke permission at any time. Consent for the photograph would expire 180 days from the date of signature unless otherwise specified. A facility abuse policy, dated January 2024 and received from the DON as current, indicated the residents of the facility were to be treated with dignity and respect. Any individual who intentionally caused any physical or mental injury against a resident will be subject to immediate discharge. This citation relates to Complaints IN00439023, IN00439472, and IN00439550.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;			

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	(B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to staff not reporting allegations of mental abuse to the Administrator and the Administrator not reporting an allegation of mental abuse to the Indiana Department of Health (IDOH), Adult Protective Service, and the Indiana	R 0090	**R 090** **1 . What Corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice.**	10/31/2024

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	Ombudsman's Office, for 1 of 1 allegation of abuse reviewed. (Resident B, Employee 4, Employee 5, and Mental Health Technician 6) See R0052 for additional information regarding Resident B. Finding includes. During an observation and interview on 7/25/24 at 10:10 a.m., Resident B was in his room sitting on the side of his bed. Resident B indicated he had concerns with pictures that were taken of his groin area. During a shower a few weeks prior, the CNA had seen skin areas of concern in the groin area and told him she would have to report the areas to the Director of Nursing (DON). He told the CNA it was nothing to be concerned about and she still reported the areas. The DON then came into his room and forced him to let her take pictures of his groin area. Resident B indicated she took the pictures with her cell phone and he felt "humiliated and mortified" and stated he had been abused. The DON had not informed him why she was taking the pictures and she was "overzealous". Resident B indicated he had not given permission verbally or in writing for the pictures to be taken. He had not reported this to anyone until 7/18/24. Resident B indicated again he felt like he had been violated and abused. During the interview, his voice was also observed to raise in volume and movements of his upper extremities and upper torso increased. A facility grievance, dated 7/18/24, indicated the Administrator met with Resident B to discuss his concerns about the pictures the Director of Nursing (DON) had taken of his groin area. The grievance indicated, "...Resident states he was upset that he gave permission to the Director of		Nursing employees on duty during survey, were re-educated verbally on reporting allegations of abuse to the Administrator and/or designee. The Director of Nursing was placed on immediate suspension by the Administrator when notified of allegation of Abuse from Resident B by ISDH Surveyor. Administrator notified ISDH by electronic reporting the allegation of Abuse made by Resident B. The Director of Nursing was terminated. **2 . What Corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice.** All residents have the potential to be affected. Residents will be identified through interviews. 3 . **What measures will be put into place or what systemic changes the facility will make to ensure the alleged deficient practice does not recur.** All Lake Park, Regional Case Management and contracted staff will be re-educated by Corporate Nursing Officer, on reporting allegations of abuse within a timely manner to Administrator and/or designee. Administrator and/or designee will in-service all Lake Park, Regional	

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	Nursing to take his picture of his private area...Administrator explained to resident that she spoke to (sic) DON and that DON said he gave permission for her to take picture so she could inform physician as to what is going on with him...Administrator spoke to (RN 1) who stated resident did give permission to take picture of affected area." The grievance was signed by the Administrator. During an interview on 7/25/24 at 11:57 a.m., the Administrator indicated the incident had been reported to the Case Manager's Supervisor on 7/18/24 and they had then reported the incident to the Corporate Office. She received and email on 7/18/24 from the Corporate Office and initiated a grievance form. The Administrator then read the email that stated the 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 voiced an allegation of abuse. She investigated the incident and received emailed statements from RN 1 and the DON. Cross reference R0052. A Progress Note, dated 7/7/24 at 5:36 p.m. and signed by facility Mental Health Technician 6, indicated the resident was educated on the importance of controlling his anger and using coping skills. He had stated, "I felt violated and felt exposed". Resident B no longer wanted to work with the staff who had not respected his privacy and he felt embarrassed. During an interview on 7/25/24 at 3:14 p.m., the Administrator indicated the facility Mental Health Technician 6 had not reported the allegation of Resident B feeling violated, exposed, and		Case Management and Contracted Staff on facility Abuse Policy and Resident Rights. All residents will be educated on abuse and reporting abuse immediately to staff and/or Administrator. All residents will be educated on resident rights. 4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** Administrator and/or designee will randomly speak to residents monthly for the next six months, about and issues and concerns as it may relate to allegations for abuse. Administrator will speak with a random sample of residents quarterly thereafter. Activity staff will review one resident right monthly at resident council meeting. 5. **By what date the systemic changes will be completed.** August 26, 2024.	

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	embarrassed to her. During a Confidential Interview, Employee 4 indicated they were in the resident's room at the time of the incident. The DON informed Resident B she needed to see his groin area so she could notify the physician about the areas of concern. The resident stood up from the bed. The DON was demanding with him and told him to pull down his pants. She did not ask permission, it was a demand. The DON then told him to put his back up against the wall to steady himself. Resident B was trying to get his pants down and was asking why he had to do that. Employee 4 indicated there had been no discussion, the DON just stated "we need to look at the groin to tell the physician". Employee 4 indicated when the DON left the room, the resident was really mad and he stated he was "appalled" at what happened. Resident B indicated he was upset and embarrassed. Employee 4 indicated permission to take the pictures was never obtained by the DON. Employee 4 indicated the incident had not been reported to the Administrator. During a Confidential Interview, Employee 5 indicated they were in the resident's room at the time of the incident. The DON told Resident B she needed to see his groin area and told him to pull his underwear down. He did not like it and the DON told him she had to take the pictures so the physician could see the areas of concern. Employee 5 indicated the resident was very upset and had been upset since this incident happened. The DON did not ask 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			

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		A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE PARK RESIDENTIAL CARE	2075 RIPLEY ST LAKE 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator because the DON said she was taking the pictures for the physician. The facility abuse policy, dated January 2024 and received as current from the DON, indicated employees were required to report all incidents of suspected or actual abuse immediately to the Administrator. Allegations of abuse was to be reported to the IDOH, Adult Protective Services, and the Indiana Ombudsman's Office. This citation relates to Complaints IN00439023, IN00439472, and IN00439550.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure resident evaluations were completed semi-annually for 3 of 3 residents reviewed for semi-annual evaluations. (Residents B, C, D) Findings includes: 1) Resident B's record was reviewed on 7/25/24 at 2:01 p.m. The diagnoses included, but were not limited to, multiple sclerosis. The Semi-Annual Nursing Assessment was last completed on 11/13/23. 2) Resident C's record was reviewed on 7/26/24 at	R 0214	**1 1.** **WhWhat Corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice.** Resident B's Semi-Annual Assessment was completed by the Assistant Director of Nursing on 8/8/2024. Resident C's Semi-Annual Assessment was completed by the Assistant Director of Nursing on 8/8/2024. Resident D's Semi-Annual	08/26/2024

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	3:30 p.m. The diagnoses included, but were not limited to, schizophrenia. The Semi-Annual Nursing Assessment was last completed on 11/12/23. 3) Resident D's record was reviewed on 7/26/24 at 9:25 a.m. The diagnoses included, but were not limited to, schizophrenia. The Semi-Annual Nursing Assessment was last completed on 7/24/23. During an interview on 7/26/24 at 9:10 a.m., the ADON indicated the Semi-Annual Nursing Assessments had not been completed timely.		Assessment was completed by the Assistant Director of Nursing on 8/8/2024. 2. **2 What Corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice.** All residents have the potential to be affected by this alleged deficient practice. Nursing will audit all semi-assessment forms to ensure they are in compliance. 3 3. **What measures will be put into place or what systemic changes the facility will make to ensure the alleged deficient practice does not recur.** The Chief Nursing Officer of Regional Health Systems and/or Designee will in-service all nursing staff on the regulation regarding completion of semi-annual assessments on all Lake Park Residents. The in-service will include competing assessments every six months, a known substantial change in condition or more often at the resident's or facility's request. 4 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	

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			completion of semi-annual assessments completion and revisions monthly at random for the next six months. The monitoring/audit will include that 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**	