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	01/18/2024

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00419576 and IN00424759. Complaint IN00419576 - No deficiencies related to the allegations are cited. Complaint IN00424759 - State deficiencies related to the allegations are cited at R0060 and R0349. Survey dates: January 17 and 18, 2024 Facility number: 001136 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/22/24.	R 0000		
R 0060 Bldg. 00	410 IAC 16.2-5-1.2(dd) Residents' Rights - Deficiency (dd) The facility shall provide reasonable access to any resident, consistent with facility policy, by any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident ' s right to deny or withdraw consent at any time. Based on record review and interview, the facility failed to provide reasonable access to any resident to an entity that provided health services related to allowing residents to attend scheduled appointments during a facility COVID-19 outbreak for 1 of 7 sampled residents. (Resident B)	R 0060	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. The initial referral was given October 25th to Regional Mental	03/30/2024

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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	Finding includes: During an interview on 1/18/24 at 1:30 p.m., Resident B indicated they had several ultrasound appointments made for them and they had not gone to any of them. The resident indicated, "I will believe it when I leave here and actually go." The record for Resident B was reviewed on 1/17/24 at 11:10 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, major depressive disorder, neuropathy (nerve damage), cellulitis, and an open wound to the right great toe with damage to the nail. Physician's Orders, dated 12/5/23, indicated the resident was to receive an arterial doppler (ultrasound) of the bilateral lower extremities for ischemic (reduced blood flow) toes. There were no results of a previous arterial doppler in the clinical record to be reviewed. There was a doppler scheduled for 1/22/24. During an interview on 1/17/24 at 3:35 p.m., Case Manager 1 indicated she had emailed the Case Manager Supervisor a list of scheduled appointments for the resident. The resident had an arterial doppler scheduled for 12/28/23. During an interview on 1/18/23 at 8:17 a.m., the Case Manager Supervisor indicated the resident's scheduled appointments were canceled due to a COVID-19 outbreak in the facility. She received a text message on 12/27/23 at 10:16 p.m. from the Administrator that stated, "I have officially shut down the building tonight due to additional positive residents and staff. Assistant Director of Nursing [name] please have residents come down who are negative by halls and we will discuss		Health Case Manager. The manager failed to make referral appt in timely manner. Resident did see physician December 5th, 2023 and had Dopler on 01/22/2024. Administrator was not aware that Case Manager had rescheduled the appointment for second time. 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 the deficient practice does not recur. All appointments will be kept as scheduled and referral appointment will be made in a timely manner. Case Manager will notify Director of Nursing and Assistant Director of Nursing of all physician appointments. Cancellations of appointments will not be made until the Nursing Management staff is made aware.	

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	everything tomorrow. I am going to get pop and snacks again to keep them in rooms. Director of Nursing [name] we need to call family members about all COVID positive residents and also call families who have residents who refuse to stay in their rooms. Please remove all chairs by the television in library and disconnect televisions. All residents need to stay in their rooms and cannot sit in lobbies or activities. If anyone wants to volunteer to work evenings to make rounds let me know. Otherwise, I will schedule staff to come in to enforce the shut down procedures. I have informed others [names] of the shut down as well as transportation." During the interview, the Case Manager Supervisor called the hospital's central scheduling to find out the exact dates and times the appointments were canceled and rescheduled. On 12/21/23, the 12/28/23 doppler was canceled by the Case Manager Supervisor and was rescheduled for 1/5/24. The 1/5/24 doppler was again canceled by the Case Manager Supervisor and rescheduled for 1/22/24. She indicated she did not have any information on why the first appointment was canceled, however, the 1/5/24 appointment was canceled because of the COVID-19 outbreak in the building. During an interview on 1/18/24 at 9:30 a.m., the Director of Nursing (DON) indicated the building was not completely shut down during their COVID-19 outbreak, it was a "Soft Shut Down" and residents were allowed to leave the facility with their families and attend appointments. During an interview on 1/18/24 at 2:50 p.m., the Administrator indicated the number of residents who tested positive for COVID-19 was increasing so that was why she used the words "shut		Case Management will be in serviced on the importance of making appointments timely when a referral is received from the physician. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. All appointments will be put on a schedule and emailed weekly to the Nursing Management Staff as well as the Administrator. Nursing will monitor appointments weekly ongoing. If a resident tests positive for Covid, Nursing and Case Managment will notify the physicians office if a cancellation has to be made because of positive covid test. Monitoring will be ongoing. 5. By what date the systemic changes will be completed. March 30, 2024	

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	down." She indicated she told the Case Managers if the appointments were necessary to not cancel them and to take those residents out who needed to be seen by the doctor or had testing to be done. There were several residents who left the facility for appointments and left with their families as well. This citation relates to Complaint IN00424759.			
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; (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)			

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	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 a resident to resident altercation was reported to the State Agency for 1 of 1 abuse allegations reviewed. (Residents 7 and 8) Finding includes: The record for Resident 7 was reviewed on 1/18/24 at 10:09 a.m. Diagnoses included, but were not limited to, bipolar disorder, right toe osteomyelitis (bone infection), and diabetes mellitus. An Unusual Event Report, dated 12/1/23 at 6:30 p.m., indicated during the shift Resident 8 reported that Resident 7 hit his arm for moving a chair. Resident 8 told the nursing staff and the residents were separated. Resident 8 had visible redness to his left arm. He denied medical attention and the authorities were contacted due to the nature of the incident.	R 0090	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. An incident report (#117) was reported to Indiana state Department of Health by the Administrator. Administrator met with Resident 8 about the 12/01/23 incident and he stated that the incident was no big deal at all. He stated that resident 7 pushed a chair towards him that may have hit his arm, but he didn't feel that he needed medical attention. Administrator was unable to meet with Resident 7 because she was	03/30/2024

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	During an interview on 1/18/24 at 2:30 p.m., the Administrator indicated there was no documentation of the incident being reported to the State Agency. The facility abuse policy, provided by the Administrator on 1/18/24 at 3:00 p.m., indicated law enforcement, the Indiana Department of Health, adult protective services, and the Ombudsman's office would be immediately notified of the offense and the offender. Staff were also required to immediately report any accusation or witnessed physical, verbal, mental, or sexual abuse to their immediate supervisor, Director of Nursing, and the Administrator.		hospitalized. 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 the deficient practice does not recur. All staff will be in serviced on the facility Abuse Policy and to report incidents immediately to the Administrator and/or Director of Nursing when incident occurs. This will ensure that Administrator can report incident to Indiana State department of Health. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. 5. Administrator and Director of Nursing will meet with residents and staff at random to ensure that any allegations of abuse are being reported to facilitate proper and	

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			timely reporting to Indiana State Department of Health. Administrator and or designee will review incident reports as they occur and will ensure that incidents that require reporting will be done timely. This monitoring will be ongoing. 5. By what date the systemic changes will be completed. March 30, 2024	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure a criminal history background check was completed through the Indiana State Police repository for 1 of 2 employees hired within the last 120 days. (Housekeeper 1) Findings include: The employee file for Housekeeper 1 was reviewed on 1/18/24 at 3:25 p.m. The employee was hired on 12/4/23. The employee's criminal history background check was obtained through a national database and not the Indiana State Police	R 0116	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. The Criminal History Background check For Dietary 1 was obtained from the State of Missouri as well as the Indiana State Police. The Criminal History Background check was done with ISP on 11/14/2023 and the employee was hired 11/27/2023.	03/30/2024

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	repository. During an interview on 1/18/24 at 3:45 p.m., the Administrator indicated a criminal history background check should have been obtained through the Indiana State Police rather than just the national database.		The Criminal History Background check for Housekeeper 1 was obtained through Indiana State Police 11/14/2023 and employee was hired 12/4/2023. Facility has copies of the Indiana State Police Criminal Background checks. 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 the deficient practice does not recur. Human Resources has done all the Criminal Background Checks with ISP and they have also done a Nationwide search. Human Resources will continue to obtain Criminal History Background checks through the Indiana State Police (ISP).	

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			4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. The Business Office Manager will monitor all new hires and ensure all Criminal History Background Checks are completed by the Corporate Office Human Resources. 5. By what date the systemic changes will be completed. March 30, 2024	
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.			

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	(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of 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 dementia training was provided for 3 of 5 employee files reviewed. (LPN 1, RN 1, and QMA 1) Finding includes: The employee files were reviewed on 1/18/24 at 3:20 p.m. LPN 1, RN 1, and QMA 1 had no documentation of 3 hours of annual dementia training. During an interview on 1/18/24 at 3:45 p.m., the Administrator indicated the facility had recently transitioned to Relias online training, however, corporate did not add dementia training to the list of courses.	R 0120	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. LPN 1 had Dementia Training for three hours after licensure survey exit. RN 1 had Dementia Training for three hours after licensure survey exit. QMA 1 had Dementia Training for three hours after licensure survey exit. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice	03/30/2024

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			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 the deficient practice does not recur. Facility Administrator is working with Corporate Human Resources Department to add Dementia Training as mandated by Indiana State Department of Health to the Relias Online Training. Staff will be directed to complete dementia training online with Relias to ensure compliance. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. Corporate Human Resources will monitor completion of Dementia Online training to ensure compliance monthly and will send reminders to staff for completion. Administrator will also monitor compliance monthly ongoing. 5. By what date the systemic changes will be completed.	

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R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen was clean related to dirt and debris on the floor, stained ceiling tiles, and dirty PVC pipes for 1 of 1 kitchens. (The Main Kitchen) Findings include: During the full kitchen sanitation tour on 1/17/24 at 9:00 a.m. with the Dietary Food Manager (DFM), the following was observed: a. There was a large amount of food, crumbs, and debris behind the food equipment and against the wall. b. There was adhered dirt and debris under the food prep table. c. The ceiling tiles were stained and discolored throughout the kitchen. d. The white plastic board in the dish room had food splattered on it. There was a large accumulation of adhered dirt and the tile was discolored black along the base board under the dish machine and the white PVC pipes were dirty. During an interview on 1/17/24 at 9:30 a.m., the DFM indicated all of the above was in need of	R 0154	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. The food, crumbs, debris behind the food equipment and against the wall has been removed- sept and mopped. The majority of ceiling tiles in the kitchen have been replaced by maintenance. The adhered dirt and debris under the prep table has been cleaned. The white blackboard in the dish room has been cleaned and sanitized. The accumulation of adhered dirt and the tile was discolored black along the baseboard under the dish machine and the white PVC pipes were cleaned and a deep clean is scheduled for February 5th- 10th, 2024. 2. How the facility will identify	03/30/2024

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	cleaning and/or repair.		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 the deficient practice does not recur. The Dietary Supervisor has revised a cleaning and sanitation checklist of duties to be completed by the dietary staff daily to ensure consistent cleanliness and sanitation of the kitchen and surrounding areas. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. The Dietary Supervisor and/or designee will monitor the daily sanitation checklists to ensure duties are being completed and will follow up with a physical inspection of each area to verify completion. All Dietary Staff will be in serviced on cleanliness and sanitation.	

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			All Dietary Staff will be in serviced by the Maintenance Director on reporting ceiling tiles that need replacing or items to be repaired. 5. By what date the systemic changes will be completed. March 30, 2024	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure residents had Physician's Orders for and an assessment to self-administer their own medications for 1 of 7 sampled residents. (Resident B) Finding includes: During an interview on 1/18/23 at 1:30 p.m., Resident B indicated they were doing their own treatment in their room. The nursing staff gave them a cup of triple antibiotic ointment and told	R 0216	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. Director of Nursing met with Resident B on January 19th, 2023 after surveyors exited building for survey, to reschedule the time for the resident to have his foot soaks and treatment done in the afternoon because it was more convenient for the resident than in	03/30/2024

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	them after they were finished soaking their foot, to put the ointment on their toe and put a Band-Aid over it. The resident indicated they had not been soaking their foot for the last 10 days because they ran out of ointment. The record for Resident B was reviewed on 1/17/24 at 11:10 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, major depressive disorder, neuropathy (nerve damage), cellulitis, and an open wound to right great toe with damage to the nail. Physician's Orders, dated 12/8/23, indicated the resident was to receive antibacterial soaks once a day for 10 minutes on their right foot until re-evaluated, after soaking please put triple antibiotic cream and cover with a bandage. There was no Physician's Order for the resident to self-administer their own treatment and there was no self-administration of medication assessment for the resident. During an interview on 1/18/24 at 1:30 p.m., the Director of Nursing indicated there were no residents in the facility who were allowed to do their own treatments.		the morning. Director of Nursing also met with resident on January 25th, 2024 about his refusal to have foot soaks and treat done on January 23rd and 24th, 2024. Resident stated that he was tired and went to bed after he took his medication and didn't want to have the treatment done nor the foot soaks. At this time Lake Park has no residents that self administers. 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 the deficient practice does not recur. Director Of Nursing and Asst. Director of Nursing in serviced the nursing staff on January 19th, 2024 and informed them that residents cannot self administer	

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			medications without a self administration medication evaluation and a self administration test. A Pre test inservice was completed by the nursing staff to ensure that they understood that self administration can only be done if the resident passes the return demonstration test and understands the process. A Post test will be done in February 15th to ensure the staff understands self administration of medication. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. The Director of Nursing and/ or designee will audit treatment log weekly and will do random observations of treatments weekly. Director of Nursing and/ or designee will also speak with residents and ask if treatment have been done and who completed the treatment. Monitoring will be done weekly for 90 days, and then monthly thereafter by Director of Nursing and/or designee. 5. By what date the systemic	

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			changes will be completed. March 30, 2024	
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 prepared and stored under sanitary conditions related to labeling of food, outdated food, a dirty oven hood, greasy and dirty convection ovens, and debris on the freezer floor for 1 of 1 kitchens. (The Main Kitchen) Findings include: During the full kitchen sanitation tour on 1/17/24 at 9:00 a.m., with the Dietary Food Manager (DFM), the following was observed: a. There was a heavy accumulation of grease and burned food on the inside of both convection ovens. The oven doors were greasy and dirty with dried food spillage. The sides of the oven were dirty with dried food spillage. b. The oven hood slats were dirty and greasy. c. The stove top grates were dirty with burned food. d. The sink was dirty with dried food and debris. e. The shelf above the 3 compartment sink was greasy and dirty.	R 0273	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. a. The convection oven is being cleaned and will be re cleaned or replaced. b. The oven hoods were cleaned professionally prior to survey in October 2023 and will be recleaned. c. The stovetop grates were cleaned and burned food removed. d. The three compartment sink had food debris from the dishwater let ot after the dishes were washed, and was cleaned. e. The shelf above the three compartment sink had the grease removed and was cleaned. f. The freezer floor was cleaned and food particles and debris was removed prior to cleaning.	03/30/2024

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	f. The freezer floor was dirty with food particles and debris. e. There were 4 danish in the refrigerator with a date opened of 1/7/24, a pan of fresh diced tomatoes with a date opened of 1/8/24, and a full pan of leftover stuffed shells with a date of 1/12/24. During an interview at that time, the DFM indicated leftover food was to be thrown out after 3 days. f. The food heating cart by the steam table was dirty with a heavy accumulation of dried food on the bottom bumper and on the shelves inside. g. There were 11 containers of opened spices with no date opened on them. During an interview on 1/17/24 at 9:30 a.m., the DFM indicated all of the above was in need of cleaning.		g. It was labelled e on state form but apparently should be g. All of the expired food was removed from refrigerator immediately. h. it was labelled f on State form but should be h. The food heating cart was cleaned on the inside and outside, including the bumper. i. It was labelled g on the State Form but should be labelled i. The 11 containers of open spices had a purchase date and expiration date on them during survey, and now have been relabelled. 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 the deficient practice does not recur. The Dietary Supervisor will develop a new schedule for cleaning ovens, food grates, food heating	

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			carts, cooler and freezer. Once it is determined if convection oven will be replaced or repaired, a routine cleaning schedule will be put into place. The hood grates are professionally cleaned every six months with the next appointed cleaning date being March of 2024. The Dietary Staff will be in serviced on labelling all spices when opened. The sinks and shelves will be cleaned and maintained on a daily basis and will be on a cleaning schedule. The Maintenance Director and/or designee will in-service staff on reporting repairs needed in dietary. Freezer and cooler floors will be kept clean on a daily basis and cleaning will be included on schedule. Food in cooler will be checked for freshness and proper dates on a daily basis. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. The Dietary Supervisor will be responsible for monitoring all	

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			schedules and checklists weekly for 90 days, and then monthly ongoing. The Maintenance Director will monitor the ceiling tiles for cleanliness monthly for 90 days and then will make random checks quarterly. 5. By what date the systemic changes will be completed. March 30, 2024	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review, and interview, the facility failed to ensure clinical records were complete and accurately documented related to wound treatments and checking blood pressures for 2 of 7 sampled residents. (Residents B and C) Findings include: 1. On 1/18/23 at 1:30 p.m., Resident B removed their shoe and sock so their right foot could be observed. At that time, the right foot was dry with	R 0349	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. Director of Nursing met with Resident C to change the time of his treatment to be done because resident states he is out of the facility most days when treatment is scheduled in the morning. Director of Nursing gave the	03/30/2024

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	flaky skin. The resident had a small wound to the great toe with a small black area. During an interview on 1/18/23 at 1:30 p.m., Resident B indicated they were doing their own treatment in their room. The nursing staff gave them a cup of triple antibiotic ointment and told them after they were finished soaking their foot, they were to put the ointment on their toe and put a Band-Aid over it. The resident indicated they had not been soaking their foot for last 10 days because they ran out of ointment. The record for Resident B was reviewed on 1/17/24 at 11:10 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, major depressive disorder, neuropathy (nerve damage), cellulitis, and an open wound to the right great toe with damage to the nail. Physician's Orders, dated 12/8/23, indicated the resident was to receive antibacterial soaks once a day for 10 minutes on their right foot until re-evaluated, after soaking please put triple antibiotic cream and cover with a bandage. The Treatment Administration Record (TAR) for the month of 1/2024, indicated the treatment was signed out with the letters "oob" with a handwritten note indicating out of building. During an interview on 1/18/24 at 1:30 p.m., the Director of Nursing indicated the resident left the facility every day after breakfast, came back for lunch, and left again until dinner time. Nursing staff did not try and reschedule the treatment at a different time when the resident was in the facility. 2. The record for Resident C was reviewed on 1/18/24 at 10:05 a.m. Diagnoses included, but were		resident an afternoon treatment time that is more convenient for him. The Director of Nursing met with the resident after the survey to change the treatment time. Resident agreed to the time change with the Director of Nursing. The Director of Nursing met with the nursing staff to indicate that the treatment time had been changed to the afternoon. Nursing Staff was in serviced that Resident B's treatment and foot soak was to be done by staff and not by the resident. The blood pressure for Resident C was done in January with no missed blood pressures. Resident has orders for blood pressure to be taken twice weekly and nursing documentation indicates blood pressures have been done. On January 19th, 2024 Director of Nursing met with Nursing staff to educate on checking blood pressures as ordered by physicians. 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.	

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	not limited to, anxiety, syncope, schizoaffective disorder, fracture of the right foot, and hypotension (low blood pressure). Physician's Orders, dated 10/17/23, indicated to check blood pressure daily. Physician's Orders, dated 11/16/23, indicated to check blood pressure twice a week. The Treatment Administration Record (TAR) for the months of 10/2023 and 11/2023, indicated there was no documentation the resident's blood pressure was checked daily on 10/29, 10/30, 10/31, and 11/1-11/5/23. There were no blood pressures checked twice a week from 11/6-11/30/23. During an interview on 1/18/23 at 4:00 p.m., the Director of Nursing indicated there were no blood pressures checked for the above days. This citation relates to Complaint IN00424759.		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 the deficient practice does not recur. Director of Nursing and/or designee will do a weekly audit of Treatment Administration Record (TAR) to ensure that blood pressures are completed by Nursing Staff. The audit will be done weekly for 90, then monthly thereafter. An additional Inservice meeting will be done by Director of Nursing and Assistant Director of Nursing to educate Nursing Staff on following orders in the TAR. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. 5. By what date the systemic changes will be completed. March 30, 2024	

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R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure an annual health statement was obtained which indicated the residents showed no evidence of tuberculosis in an infectious stage for 5 of 7 records reviewed. (Residents 2, 7, 3, B, and C) Findings include: 1. The record for Resident 2 was reviewed on 1/17/24 at 11:04 a.m. Diagnoses included, but were not limited to, type 2 diabetes, schizoaffective disorder, and depression. There was no annual health statement by the Physician indicating the resident was free from communicable disease. During an interview on 1/18/24 at 2:45 p.m., the Director of Nursing indicated there was no annual health statement completed. 2. The record for Resident 7 was reviewed on 1/18/24 at 10:09 a.m. Diagnoses included, but were not limited to, bipolar disorder, right toe osteomyelitis (bone infection), and diabetes mellitus. There was no annual health statement by the Physician indicating the resident was free from communicable disease.	R 0409	1, What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident 2. 3, have no evidence of tuberculosis in an infectious stage. Resident 7 is currently hospitalized. Resident B and C are unidentified on Resident Care Sample Matrix-State Form 53718 R421. There are no residents at Lake Park that show evidence of tuberculosis in an infectious stage. 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	03/30/2024

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	During an interview on 1/18/24 at 2:45 p.m., the Director of Nursing indicated there was no annual health statement completed. 3. The record for Resident 3 was reviewed on 1/17/24 at 11:00 a.m. Diagnoses included, but were not limited to, Huntington's disease, chronic obstructive pulmonary disease (COPD), and depression. There was no annual health statement by the Physician indicating the resident was free from communicable disease. During an interview on 1/18/24 at 2:45 p.m., the Director of Nursing indicated there was no annual health statement completed.4. The record for Resident B was reviewed on 1/17/24 at 11:10 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, major depressive disorder, neuropathy (nerve damage), cellulitis, and an open wound to the right great toe with damage to the nail. There was no annual health statement by the Physician indicating the resident was free from communicable disease. During an interview on 1/18/24 at 2:45 p.m., the Director of Nursing indicated there was no annual health statement completed. 5. The record for Resident C was reviewed on 1/18/24 at 10:05 a.m. Diagnoses included, but were not limited to, anxiety, syncope, schizoaffective disorder, fracture of right foot, and hypotension (low blood pressure). There was no annual health statement by the		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 the deficient practice does not recur. A manual paper copy of the Annual Health Statement will be done for all residents for the Month of February 2024 and each one will be signed For the Month of March 2024 and going forward, the Annual Health Statement will be included in the Electronic medical Records that will be available for the physician to sign electronically to indicate whether or not the resident was free of communicable disease. 4. How the corrective action will be monitored to ensure the alleged deficient practice will not recur; i.e. what quality assurance program will be put into place. 5. By what date the systemic changes will be completed. March 30, 2024	

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	Physician indicating the resident was free from communicable disease. During an interview on 1/18/24 at 2:45 p.m., the Director of Nursing indicated there was no annual health statement completed.			