

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155721	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/03/2015
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NAME OF PROVIDER OR SUPPLIER  LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 28, 29, 2015 and June 1, 2, 3, 2015.</p> <p>Facility number: 000383 Provider number: 155721 AIM number: 100289610</p> <p>Census Bed Type: SNF/NF: 35 Total: 35</p> <p>Census Payor Type: Medicare: 0 Medicaid: 29 Other: 6 Total: 35</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1 &amp; 410 IAC 16.2-5.</p>	F 0000	<p>Please accept this plan of correction as our credible allegation of compliance. Preparation and execution of corrections in general, or this corrective actions in particular does not constitute an admission or arrangement by Lawrence Manor Healthcare Center of the fact alleged or conclusion set forth in the statement of deficiencies. This plan of correction and specific corrective actions are prepared and/or executed in compliance with federal and state laws. Lawrence Manor Healthcare Center is respectfully requesting a desk review. If there are any further questions or concerns, please feel free to contact me at 317-898-1515. Respectfully, Chirag C. Patel HFA, BSHA Administrator</p>	
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving</p>			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a Physician/Nurse Practitioner regarding out of range blood sugar results for 1 of 6 residents reviewed for unnecessary medications (Resident #34).</p> <p>Findings include:</p> <p>The clinical record for Resident #34 was reviewed on 6/2/15 at 10:15 a.m. The</p>	F 0157	It is the policy of this facility to notify residents physician immediately when resident orders indicate physician to be notified. All the residents requiring blood sugar checks have the potential to be affected by this finding. Resident # 34 was assessed with no adverse reactions. Physician and family notified. An audit completed and no other residents were identified as being affected by the alleged deficient practice. An in-service	06/28/2015

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	<p>diagnoses for Resident #34 included, but were not limited to, diabetes mellitus and end stage renal disease.</p> <p>The April and May 2015 Physician's Orders indicated to perform a blood sugar test two times daily and to call the Nurse Practitioner (NP) if the blood sugar result was less than 70 or greater than 250.</p> <p>The April and May 2015 MARs (medication administration record) indicated the following blood sugar results: 4/5/15 at 4:00 p.m.=418, 4/23/15 at 4:00 p.m.=306, 5/13/15 at 4:00 p.m.=399, &amp; 5/22/15 at 4:00 p.m.=259.</p> <p>NP notification, of the above blood sugar results, was not located in the clinical record.</p> <p>During an interview with LPN #3, on 6/2/15 at 1:35 p.m., LPN #3 indicated the facility was not able to locate NP notification for the above blood sugar results.</p> <p>A policy titled, Diabetic Management, dated 6/2008, was received from LPN #3 on 6/2/15 at 1:45 p.m. The policy indicated, "...Routine Care...Results outside of ordered parameters are</p>		<p>was conducted with nursing on proper notification of resident physician when blood sugar are out of the acceptable parameters. DON or designee will audit blood sugar results and physician notifications daily for 2 weeks, then weekly for 30 days, then monthly for 6 months to ensure proper education and compliance. Results will be presented to the Quality Assurance Committee monthly. The Quality Assurance Committee will oversee continued compliance.</p>	

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F 0226 SS=D Bldg. 00	<p>communicated to the physician immediately....7. Notify the physician of abnormal blood glucose test results, symptoms exhibited and interventions implemented...."</p> <p>3.1-5(a)(3)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow policy and procedures for thoroughly investigating allegations of abuse for 2 of 5 reportable incidents reviewed. (Resident #22 and Resident #50)</p> <p>Findings include:</p> <p>An interview was conducted with Resident #22 on 5/28/15 at 11:50 a.m. Resident #50 had a BIMS score (Brief Interview for Mental Status) of 15 which indicated the resident did not have a cognitive impairment. Resident #50 indicated he could not recall the staff member's name, but this staff member yells at him and snatches the covers off of him during the night.</p>	F 0226	<p><b>It is the policy of the facility that prohibits mistreatment, neglect, and abuse of residents and misappropriation of resident property.</b> All the residents have the potential to be affected. Identified issues were addressed. Resident # 22 and #50 were assessed with no bruises or any sign of injuries. Family members and physician were notified for residents involved in reported incidents. All alert and oriented residents were interviewed by Social Service Director to determine if there were any staff concerns, any safety concerns, and to alert them on how to report any concerns. All staff was in-serviced on abuse policies and abuse reporting procedures. All department heads and supervisors were in-serviced on proper abuse investigation procedures and protocols. All</p>	06/26/2015

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	<p>An investigation of an abuse allegation by a staff member toward Resident #50 was provided by Social Services Director (SSD) on 6/3/15 at 11:28 a.m. This included a form titled, Grievance, Concern, or Missing Property. It indicated an investigation was received and resolved on 5/28/15. This investigation was conducted by the SSD. This investigation also included staff schedules, interview with Resident #50, and interviews with other residents in the facility regarding abuse. This investigation did not include any interviews conducted with staff members regarding the abuse allegation or an interview with Resident #22's roommate.</p> <p>An interview was conducted with the SSD on 6/3/15 at 11:45 a.m. She indicated during her investigation she did not interview any staff members, because she could not identify the staff member that allegedly abused the resident by the description Resident #50 provided.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/3/15 at 12:28 p.m. She indicated there was no staff interviews conducted during this abuse allegation.</p> <p>An investigation was provided by the DON on 6/3/15 at 2:45 p.m. It indicated</p>		<p>alert and oriented residents as well as staff members were in-services on different types of abuse. We are extending our investigative procedure to include more in-depth staff interviews on all alleged incidences. The new abuse investigation form generated to assist in the above. Investigations are being audited through our QA process daily for 60 days, weekly x90 days, then monthly thereafter by DON and SSD</p>	

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	<p>on 9/4/2014 an investigation was conducted about an incident with a Certified Nursing Assistant (CNA) #7 and Resident #22. The investigation included a written statement from Resident #22 and CNA #7. This investigation did not include any interviews were conducted with other residents or staff members.</p> <p>An interview was conducted with the DON and the Social Services Director (SSD) on 6/3/15 at 2:00 p.m. They indicated they were unsure why interviews with other residents and staff members were not conducted during this investigation.</p> <p>The policy titled, Abuse Prevention, dated 9/2011, was provided by the nurse consultant at 2:35 p.m. It indicated the following: "It is the policy of this facility to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program...V. Abuse Investigations.</p>			

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F 0441 SS=F Bldg. 00	<p>Policy Statement. All reports of residents abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management. Policy Interpretation and Implementation...2. The individual conducting the investigation will, at a minimum: ...f. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; g. Interview the resident's roommate, family members, and visitors; h. Interview other residents to whom the accused employee provides care and services; and ..."</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/3/15 at 3:35 p.m. She indicated during an investigation residents and staff interviews are conducted, because they might know something about the incident or the interviews could help identify a pattern if there is one.</p> <p>3.1-28(b)(d)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>			

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	<p>development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to maintain an infection control log to adequately monitor, investigate, and analyze infections in the facility. This has a potential to affect 35 of 35 residents in the facility.</p>	F 0441	<b>It is the policy of the facility to establish and maintain an infection control program designated to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. All the residents have</b>	06/28/2015

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	<p>Findings include:</p> <p>The infection control log binder was provided by the Director of Nursing (DON) on 6/3/15 at 11:58 a.m. The infection control log was completed for February 2015 through April 2015. There was no information on the facility's tracking methods or analyzing infections in the facility prior to February 2015.</p> <p>An interview was conducted with the DON on 6/3/15 at 12:00 p.m. She indicated she had not tracked infections in the facility prior to February 2015.</p> <p>The policy titled, Infection Prevention Surveillance, dated 2009, was provided by the DON on 6/3/15 at 12:25 p.m. It indicated the following: "Purpose: To conduct surveillance of resident and employee infections to guide prevention activities. Policy: The infection Preventionist does surveillance of infections among residents and employees. I. The Infection Preventionist does surveillance of healthcare-associated infections by: A. review of culture reports and other pertinent lab data...F. Follow-up on communicable disease exposure...H. Maintenance of the employee infection record...II. Specific definitions of healthcare-associated infections are used</p>		<p>the potential to be affected. Identified issues were addressed. No resident was affected by this alleged deficient practice. DON has been trained on maintaining an infection control log to adequately monitor, investigate, and analyze infections in the facility. DON or designee will be responsible for completing monthly reports on infection Rates by site, infection by device days, healthcare-associated infection by resident days and mapping of infections by units Results will be presented to the Quality Assurance Committee monthly The QA committee will over see continued compliance. The deficiency will be corrected by 06/28/2015</p>	

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F 0465 SS=E Bldg. 00	<p>consistently...Healthcare-associated infections are reported monthly on the: A. Healthcare-associated Infection Summary B. Summary of Infections by Device Days III. Surveillance documentation is maintained on the: A. Line listing of Resident Infections B. Log of Employee Infections..."</p> <p>3.1-18(a) 3.1-1.8(a)(1)(A)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility maintain a homelike environment for 5 of 35 residents residing in the facility (Resident #7, #19, #23, #25, &amp; #41)</p> <p>Findings include:</p> <p>1. During an observation on 5/28/15 at 11:16 a.m., Resident #25's room was noted with a missing section of wallpaper near the bed that was arm length long and hand width wide. Wallpaper near the head of the bed was noted to be pulled/bubbling up from the wall and torn. The bubbling wallpaper was an arm length long and 2 hand widths wide.</p>	F 0465	All the residents have the potential to be affected. Identified issues were addressed. Room #25, the wallpaper near the bed that was arm length long and hand width wide was glued and repaired. The wallpaper near the head of the bed was glued and air bubbles were removed. All the wallpapers in a building is coming down during remodel. The complete remodel will be done by August 2015. Room no #19 was deep cleaned by housekeeping on 06/03/2015 and all browning-red debris on the wall was removed. Room #41 and #7, the wallpaper was glued near #41's bed that was 2 hand length wise and 1 hand length long. Room #23, the wallpaper was glued and air bubbles were	06/28/2015

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	<p>During an environmental tour with the Maintenance Director (MD) and the Housekeeping Supervisor (HS), on 6/3/15 at 10:09 a.m., the same observation of Resident #25's wallpaper was made. The Maintenance Director indicated, during an interview on 6/3/15 at 10:10 a.m., he was unaware the wallpaper was missing or that it was pulled/bubbling from the wall, but it was easily fixable. The MD also indicated staff members were supposed to let the Maintenance Director of any environmental concerns with a communication form, so that he can fix the concern.</p> <p>2. During an observation on 5/28/15 at 12:12 p.m., Resident #19's wall near his bed was noted to have several areas of raised, brownish-red debris on the wall.</p> <p>During an environmental tour with the MD and the HS, on 6/3/15 at 10:00 a.m., the same observation of the debris was observed with the HS and MD. The HS indicated cleaning the walls was part of the facility's deep cleaning protocol and the walls were missed this week.</p> <p>3. During an observation, on 5/28/15 at 1:33 p.m., Resident #41 and #7's room had a missing section of wallpaper near</p>		<p>removed. The light brown section was cleaned on the ceiling, above the wall paper. The new maintenance work order procedure was initiated, in this procedure, there are two work order books will be kept. One at the front hall and one at the back nursing hall. The maintenance director check those work orders at least three times a day and made necessary communication to fix the repair. The maintenance director and housekeeping supervisor will be responsible. All those issue will be monitored by administrator and check periodically during his daily, weekly round and room checks. The findings will also be monitored by QA committee meeting and ensure that deficient practice does not occur. In addition to routine rounds, a performance improvement tool will be initiated that will review facility are as related to good repair. The administrator or designee will complete weekly x3, monthly x3, and then quarterly x3. Any identified issue will be immediately addressed. The toll will be reviewed by QA at regularly scheduled meeting with additional recommendations as needed based on the outcome of the tool.</p>	

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	<p>#41's bed that was 2 hand lengths wide and 1 hand length long.</p> <p>Resident #41 indicated, on 5/28/15 at 1:35 p.m., the wall had looked like that for quite awhile.</p> <p>During an environmental tour with the MD and the HS, on 6/3/15 at 10:15 a.m., the MD indicated he was unaware of the missing wallpaper near Resident #41's bed.</p> <p>4. During an observation, on 5/29/15 at 10:43 a.m., Resident #23's wallpaper above her bed, near the ceiling was noted to be pulled/bubbling from the wall. The pulled section was an arm length long. A light brown section was noted on the ceiling, above the wallpaper.</p> <p>Resident #23 indicated, during an interview on 5/29/15 at 10:50 a.m., the wallpaper had looked like the above observation for awhile.</p> <p>During an environmental tour with the MD and the HS, on 6/3/15 at 10:17 a.m., the MD indicated he was unaware the wallpaper was pulled/bubbling from the wall.</p> <p>On 6/3/15 at 10:50 a.m., the Maintenance Director indicated the previous</p>			

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F 0514 SS=A Bldg. 00	<p>Maintenance Director incorrectly adhered/stapled the wallpaper in Resident #23's room and that was why the wallpaper appeared to be bubbling from the wall.</p> <p>A policy titled, Policy and Procedure for Interdepartmental Communication, no date, was received from the Social Services Director on 6/3/15 at 10:34 a.m. The policy indicated, "To report any unsafe, broken, or out of compliance with privacy [sic], staff member is to complete an interdepartmental communication form...."</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and</p>	F 0514	It is the policy of the facility to	06/28/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155721	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/03/2015
NAME OF PROVIDER OR SUPPLIER  LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226		
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	<p>record review, the facility failed to maintain accurate documentation for treatment orders for 1 of 1 resident reviewed for pressure ulcers. (Resident #22)</p> <p>Findings include:</p> <p>The clinical record for Resident #22 was reviewed on 6/1/15 at 8:30 a.m. The diagnoses for Resident #22 included, but were not limited to, paraplegic, neurogenic bladder, and bilateral ischial ulcer.</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's right lateral (side) buttocks wound dressing was the following: 1) Apply thin film of barrier ointment to protect skin surrounding the wound. Do not get ointment into the wound bed...</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's right knee wound dressing was the following: 1) Apply thin film of barrier ointment to protect skin surrounding the wound. Do not get ointment into the wound..4) Change dressing every day or as needed for excessive drainage.</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's right</p>		<p><b>maintain accurate documentation for treatment orders.</b> All residents with pressure ulcers have the potential to be affected by the same deficient practice. Alleged issues were addressed. Resident # 22 was assessed with no adverse reactions and physician was notified and orders updated. An audit completed and no other residents were identified as being affected by the alleged deficient practice. An In-service was conducted with nursing on maintaining complete and accurate documentation for treatment orders. DON or designee will audit treatment orders on those residents with pressure ulcers 2x weekly for 2 weeks then monthly x 6 months to ensure proper education and compliance.. Results will be presented to the Quality Assurance Committee monthly. The Quality Assurance Committee will oversee continued compliance. The deficiency will be corrected by 06/28/2015</p>		

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	<p>ischial (hip) wound care was the following: 1) Apply thin film of barrier ointment to protect skin surrounding wound. Do not get ointment in to the wound bed...3) Change dressing every day or as needed for excessive drainage.</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's left ischial (hip) wound dressing was the following: 1) May shower without dressing. Apply barrier ointment to protect skin surrounding the wound...</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's sacral (lower part of back) wound dressing was the following: ...2) Apply thin film of barrier ointment to protect skin surrounding wound. Do not get ointment in the wound...4) Change dressing every day or as needed for excessive drainage...</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's left medial (middle) lower leg was the following: ..2) Apply thin film of barrier ointment to protect skin surrounding wound. Do not get ointment in wound bed...</p> <p>A physician order, dated 5/22/15 at 2:00 p.m., indicated Resident #22's left dorsal (back) foot wound care was the following: ...(2 Apply thin film of barrier</p>			

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	<p>ointment to protect skin surrounding the wound. Do not get ointment in wound bed.</p> <p>An observation was made on 6/1/15 at 9:30 a.m., of dressing changes on Resident #22's open areas. RN #4 removed old dressings and cleaned Resident #22's open areas on her buttocks and lower extremities. RN #4 donned gloves and placed calcium alginate into the open areas. She then covered the open areas with foam dressings on the resident's buttocks. RN #4 wrapped kerlex around the open areas on Resident #22's left lower extremity. RN #4 then applied calcium alginate and a foam dressing to the open area on the resident's right knee. RN #4 was not observed applying barrier cream around the surrounding open areas of Resident #22's buttocks or her lower extremities as ordered.</p> <p>An interview was conducted with RN #4 on 6/1/15 at 10:27 a.m. RN #4 indicated she was aware the barrier cream was ordered for Resident #22's wound care, but the wound dressings would not stick if the barrier cream was applied. RN #4 also indicated Resident #22's open areas were improved and the barrier cream was no longer needed for the scheduled dressing changes.</p>			

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	An interview was conducted with the Director of Nursing (DON) on 6/1/15 at 11:00 a.m. She indicated the barrier cream was not applied, because the wound dressings would not stick. She also indicated the barrier cream should be applied as needed and not at the time of Resident #22's scheduled dressing changes for her open areas.  3.1-50(a)(2)				