

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for the Investigation of Complaint IN00149598. This visit resulted in a partially extended visit-Immediate Jeopardy.</p> <p>Complaint IN00149598-Substantiated. Deficiencies related to the allegations are cited at F279 and F323.</p> <p>Survey dates: May 21, 22, 2014</p> <p>Extended survey dates: May 23 2014</p> <p>Facility number: 000383 Provider number: 155721 AIM number: 100289610</p> <p>Survey team: Chuck Stevenson, RN, TC</p> <p>Census bed type: SNF/NF: 49 Total: 49</p> <p>Census payor type: Medicare: 4 Medicaid: 33 Other: 12 Total: 49</p> <p>Sample: 3</p> <p>These deficiencies also reflect state</p>	F000000	<p>ID Prefix Tag: Survey Event ID J37311</p> <p>Cycle Date: May 2014</p> <p>Survey Date: May 2014</p> <p>Please consider this Plan of Correction as the facility credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law.</p> <p>If there are any further questions or concerns, please feel free to contact me at 317-898-1515.</p> <p>Respectfully,</p> <p>Devon Brewer, HFA, MHA Administrator</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.

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000279 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review complete on May 30, 2014 by Cheryl Fielden, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to ensure health care plans were developed on a timely basis for residents identified as at high risk for elopement. 2 of 3 residents reviewed for health care plans for</p>	F000279	<p>ID Prefix Tag: F279- D Cycle Date: May 2014 Survey Date: May 2014</p> <p>Develop Comprehensive Care Plans</p> <p>It is the policy of this facility to develop a comprehensive care plan</p>	06/22/2014

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>elopement risk (Residents #B and #D) in a population of 6 residents identified as at high risk for elopement.</p> <p>Findings include:</p> <p>1. The record of Resident #B was reviewed on 5/20/14 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's type dementia, hypertension, benign prostate hypertrophy, chronic back pain, and gastro esophageal reflux disease.</p> <p>During an interview with the Director of Nursing on 5/21/14 at 2:45 p.m. she indicated a Minimum Data Set (M.D.S.) assessment had not been complete for Resident #B, as he had not been in the facility for 14 days.</p> <p>An "Admission Assessment" for Resident #B completed 5/10/14, the day of admission, indicated Resident #B had an Elopement Risk Assessment score of 8, with 5 or greater indicating a high risk for elopement.</p> <p>Nurse's notes for Resident #B indicated:</p> <p>5/20/14 6:45 a.m. "Daily rounds done. (nickname for Resident #B) not in his room, per noc (night) nurse (name of nurse) up walking around facility."</p>		<p>for each resident that includes objectives and timetables to meet resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice?</p> <ul style="list-style-type: none"> ·R#B Appropriate care plan was immediately implemented according to current status. Resident returned home after respite stay ·R#D Appropriate care plan was already identified and completed prior to survey. ·Appropriate care plans will be implemented for every identified as having been affected by the alleged deficient practice and will be implemented after admission <p>How will the facility identify residents having the potential to be affected by the same deficient practice?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by this finding ·Residents at risk for elopement could be affected by this finding <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> ·Charge nurse will complete nursing initial assessment upon admission, including elopement 	

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 05/23/2014	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>5/20/14 7:45 a.m. "Not able to find (nickname for Resident #B). Not wandering in hall or at D/R (dining room), all rooms checked, perimeter of facility checked called police attempted to notify wife. No answer. Message left for (name of Nurse Practitioner), Admin (Administrator) (symbol for "and") DON (Director of Nursing notify (sic)."</p> <p>An "Incident Report Form" dated 5/20/14 and submitted to the State Agency on that date indicated:</p> <p>"Incident Date: 5/20/2014</p> <p>Resident Name: (Name of Resident #B)</p> <p>Brief Description of Incident: Administrator, DON, and Police notified of Resident elopement. RN completed rounds and did not see (Resident #B) in building. All staff completed elopement procedures to thoroughly check entire building and perimeter. Police still in search of (Resident #B) with Silver Alert initiated and APS (Adult Protective Services) contacted."</p> <p>An "Resident/Visitor Incident/Unusual Occurrence Report" dated 5/20/14 noted to relate to Resident #B indicated:</p>		<p>risk tool</p> <ul style="list-style-type: none"> · Social Service Director will check elopement risk tool and implement any needed care plans to ensure quality care after each admission assessment is completed · Care plans will be reviewed by the IDT during care plan meetings and care plans will be added PRN <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> · Audit sheet will be used after each admission to ensure initial care plan and assessments are completed timely (Audit Sheet #1) · Social Service Director or designee will use this audit sheet to ensure care plans are updated and accurate · Results will be presented to Quality Assurance Committee monthly. This will continue until 100% compliance has been achieved for one full quarter <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> · June 22, 2014 				

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>"Description of the Incident (Include Exact Location) Noted during rounds at 6:45 a.m. that Resident was not in his room. I notified night nurse (name of nurse) (symbol for "and") she noted 'He is up walking around.' Noted at Breakfast was not in Room. All rooms, perimeter of Build. (building), parking lots, called police."</p> <p>During an interview with the Administrator on 5/21/14 at 2:10 p.m. the Administrator indicated that Resident #B was still missing. She indicated that a facility security camera video showed Resident #B entering the West dining room, which is at the front of the facility, at 1:30 a.m. on 5/20/14. She indicated a window which faced the facility's front parking lot was found open on 5/20/14 at 8:30 a.m., and that it was secured to prevent opening at that time. She indicated she believed Resident #B had eloped through this window. She indicated that this window was sometimes left open to facilitate ventilation with the screen closed.</p> <p>The window was measured on 5/22/14 at 1:30 p.m. and found to be 30" wide when fully open, and 74" tall. The bottom sill of the window is 16" above interior floor level. The ground level outside the window is 12" below the bottom sill. The</p>			

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 05/23/2014
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>screen slides open and closed and is secured.</p> <p>Resident #B's record contained a health care plan dated 5/20/14 which indicated:</p> <p>"Focus: Resident is at risk for elopement.</p> <p>Goal: Resident will not leave the facility unattended through next review.</p> <p>Interventions: Complete risk assessment quarterly. Encourage participation in activities...Follow facility protocol and policy...Observe for hovering by exit doors, repetitive statements of wanting go home...Use redirection, distraction, and reorientation when resident attempts to exit the building..."</p> <p>During an interview on 5/22/13 at 1:30 p.m. there Social Services Director indicated this health care plan for elopement had been created after Resident #B had eloped earlier on 5/20/14.</p> <p>Resident #B's record contained no other health care plan for risk for elopement.</p> <p>2. The record of Resident #D was reviewed on 5/23/14 at 1:30 p.m. Diagnoses included, but were not limited to, history of traumatic brain injury,</p>				

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>psychosis, schizophrenia, hallucinations, diabetes mellitus, and hypertension.</p> <p>An admission Minimum Data Set assessment dated 4/11/14 indicated Resident #D had been admitted from a psychiatric hospital, was cognitively impaired, had behaviors including verbal abuse of others, and ambulated without assistance.</p> <p>An "Admission Nursing Assessment" dated 3/20/14, the date of Resident #D's admission to the facility, indicated and "Elopement Risk Assessment" score of 24, with a score of 5 or greater indicating a high risk for elopement.</p> <p>Resident #D's record contained a health care plan dated 4/14/14 which indicated:</p> <p>"Focus: Resident is at risk for elopement.</p> <p>Goal: Resident will not leave the facility unattended through next review.</p> <p>Interventions: Complete risk assessment quarterly. Encourage participation in activities...Follow facility protocol and policy...Observe for hovering by exit doors, repetitive statements of wanting go go home...Use redirection, distraction, and reorientation when resident attempts to exit the building..."</p>			

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Resident #D's record contained no health care plan from his date of admission of 3/20/14 for risk for elopement through 4/14/14 as noted above.</p> <p>3. A facility policy dated 1/2011 titled "Using the Care Plan" received from the Administrator on 5/22/14 at 11:15 a.m. indicated:</p> <p>"Policy Statement: The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.</p> <p>Policy Interpretation and Implementation:</p> <p>1. Completed care plans are placed in the resident's chart...</p> <p>2. The Nurse Supervisor uses the care plan to complete CNA's daily work assignment sheets and/or flow sheets. CNAs are aware of the need to follow the care plan as indicated.</p> <p>3. CNA's are responsible for reporting to the Nurse Supervisor any change in the resident's condition...</p> <p>4. Other facility staff noting a change in the resident's condition must also report</p>			

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000323 SS=J	<p>those changes to the Nurse Supervisor...</p> <p>5. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made. Resident condition changes will be reviewed during the daily clinical meeting and care plans updated appropriately. Care plans may be updated by any member of the interdisciplinary team including licensed nurses.</p> <p>6. Documentation must be consistent with the resident's care plan..."</p> <p>This federal tag relates to complaint IN00149598.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure residents were provided a safe and secure environment to prevent elopement by</p>	F000323	<p>ID Prefix Tag: F323-J Cycle Date: May 2014 Survey Date: May 2014</p> <p>Free of Accident</p>	06/22/2014

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 05/23/2014
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>identifying an unsecured window in a common area as a risk to elopement, resulting in an elopement and placing at risk a resident with dementia. This had the potential to affect 1 of 3 residents reviewed for elopement risk (Resident #B) in a population of 6 residents identified as at high risk for elopement.</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 5/22/14 and began on 5/20/14. The Administrator, Director of Nursing, and Social Services Director were notified of the Immediate Jeopardy on 5/23/14. The Immediate Jeopardy was removed on 5/23/14, but the facility remained out of compliance at the level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because the facility remained in the process of educating staff members, reviewing 24 hour reports for acute changes, inspecting windows for security, and auditing these findings.</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 5/20/14 at 2:00 p.m. Diagnoses included, but were not limited to, Alzheimer's type dementia, hypertension, benign prostate hypertrophy, chronic</p>		<p>Hazard/Supervision/Devices</p> <p>How will corrective action be accomplished for those residents who are affected by this alleged deficient practice?</p> <ul style="list-style-type: none"> Identified resident was found on 5/23/2014 at 9:30am. Resident alive and expected to have symptoms of dehydration and was sent to the VA hospital per families wishes All Residents were reviewed for elopement risk and care plans on 5/20/14 with no revisions to care plans warranted The facility's elopement policy was reviewed and found to be appropriate on 5/20/14. <p>How will the facility identify residents having the potential to be affected by the same deficient practice?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by this finding Residents at risk for elopement could be affected by this finding <p>What measure will be put into place or systematic changes made to ensure that the deficient practice will not recur?</p> <ul style="list-style-type: none"> Education on elopement policy, resident rounds and signs of impending or possible elopement began at 11:00 a.m. on 5/20/14 with staff present and will continue until oncoming staff. No staff member will be permitted to work until he/she has received education. 		

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 05/23/2014	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>back pain, and gastro esophageal reflux disease.</p> <p>During an interview with the Director of Nursing on 5/21/14 at 2:45 p.m. she indicated a Minimum Data Set (M.D.S.) assessment had not been complete for Resident #B, as he had not been in the facility for 14 days.</p> <p>An "Admission Assessment" for Resident #B completed 5/10/14, the day of admission, indicated Resident #B had an Elopement Risk Assessment score of 8, with 5 or greater noted to indicate high risk for elopement.</p> <p>Nurse's notes for Resident #B indicated:</p> <p>5/20/14 6:45 a.m. "Daily rounds done. (nickname for Resident #B) not in his room, per noc (night) nurse (name of nurse) up walking around facility."</p> <p>5/20/14 7:45 a.m. "Not able to find (nickname for Resident #B). Not wandering in hall or at D/R (dining room), all rooms checked, perimeter of facility checked called police attempted to notify wife. No answer. Message left for (name of Nurse Practitioner), Admin (Administrator) (symbol for "and") DON (Director of Nursing notify (sic)."</p>		<ul style="list-style-type: none"> ·Rounds were conducted to verify that all residents other than identified resident were present in house at 7:30 a.m. on 5/20/14 and will continue every two hours. ·All door alarms were inspected and found to be fully functional on 5/20/14. ·All windows were inspected on 5/20/14 and locking mechanisms installed to prevent recurrence ·Admission and Quarterly Nursing Assessment Policy was reviewed and found to be appropriate on 5/20/14. ·Our VIP program and Red Carpet Hour Program was reviewed and found to be appropriate on 5/20/14 to ensure our residents are oriented to the building timely <p>How will facility monitor its corrective actions?</p> <ul style="list-style-type: none"> ·The Maintenance Director will inspect windows for security initially on 5/20/14 and then weekly for 8 weeks and monthly thereafter. ·The Maintenance Director or designee will present audit findings to QA weekly x 8 weeks or until 100% compliance is achieved and quarterly thereafter. ·The DON or designee will review 24 hour reports daily to identify acute changes that may indicate potential identifiers to increased elopement risk and will assure proper interventions 				

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>An "Incident Report Form" dated 5/20/14 and submitted to the State Agency on that date indicated:</p> <p>"Incident Date: 5/20/2014</p> <p>Resident Name: (Name of Resident #B)</p> <p>Brief Description of Incident: Administrator, DON, and Police notified of Resident elopement. RN completed rounds and did not see (Resident #B) in building. All staff completed elopement procedures to thoroughly check entire building and perimeter. Police still in search of (Resident #B) with Silver Alert initiated and APS (Adult Protective Services) contacted."</p> <p>An "Resident/Visitor Incident/Unusual Occurrence Report" dated 5/20/14 noted to relate to Resident #B indicated:</p> <p>"Description of the Incident (Include Exact Location) Noted during rounds at 6:45 a.m. that Resident was not in his room. I notified night nurse (name of nurse) (symbol for "and") she noted 'He is up walking around.' Noted at Breakfast was not in Room. All rooms, perimeter of Build. (building), parking lots, called police."</p> <p>During an interview with the</p>		<p>are in place.</p> <ul style="list-style-type: none"> The DON will review these findings daily during Clinical IDT meeting. The DON or designee will in service all staff and new hires on our frequent checks policy which will be implemented every two hours. <p>Date the deficiency will be corrected?</p> <ul style="list-style-type: none"> June 22, 2014 	

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Administrator on 5/21/14 at 2:10 p.m. the Administrator indicated that Resident #B was still missing. She indicated that a facility security camera video showed Resident #B entering the West dining room, which is at the front of the facility, at 1:30 a.m. on 5/20/14. She indicated a window which faced the facility's front parking lot was found open on 5/20/14 at 8:30 a.m., and that it was secured to prevent opening at that time. She indicated she believed Resident #B had eloped through this window. She indicated that this window was sometimes left open to facilitate ventilation with the screen closed.</p> <p>The window was measured on 5/22/14 at 1:30 p.m. and found to be 30" wide when fully open, and 74" tall. The bottom sill of the window is 16" above interior floor level. The ground level outside the window is 12" below the bottom sill. The screen slides open and closed and is secured.</p> <p>An undated facility policy titled "Eloperments" received from the Administrator on 5/22/14 at 11:15 a.m. indicated:</p> <p>"Eloperment Risk Assessment": It is the policy of this facility to assess all residents upon admission to the facility</p>			

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>and quarterly for their risk of elopement. Residents who are assessed as being high risk for elopement will have a plan of care that identifies the risk and appropriate interventions..."</p> <p>A facility policy titled "Admission and Quarterly Nursing Assessment" dated 10/2010 and received from the Administrator on 5/22/14 at 11:15 a.m. indicated:</p> <p>"Purpose: The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission and quarterly for the purposes of managing the resident, initiating and updating the care plan, and completing required assessment instruments...</p> <p>6. This admission and quarterly assessment tool also includes the following supplemental assessments:</p> <p>e. Elopement Risk Assessment."</p> <p>An Immediate Jeopardy was identified on 5/23/14 at 9:35 a.m. The Immediate Jeopardy began on 5/20/14 when a resident eloped from the facility. The Administrator, Director of Nursing, and Social Services Director were notified on 5/23/14 at 9:35 a.m. of the Immediate</p>			

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 05/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Jeopardy related to the facility's failure to provide a safe and secure environment by not ensuring exterior windows were secured to prevent elopement. The IJ was removed on 5/23/14 at 3:55 p.m. when through observations record reviews, and interviews, it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. This was confirmed by observation of all exterior doors and windows for security, interviews with staff, review of documentation of resident elopement status assessment, review of care plan updates, and review of audits of scheduled security checks and staff inservices. Even though the facility's corrective action removed the IJ, the facility remained out of compliance at a reduced scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>This federal tag relates to complaint IN00149598.</p> <p>3.1-37(a)</p>			