

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 05/29/2012
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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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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on April 19, 2012.</p> <p>Survey date: May 29, 2012</p> <p>Facility number: 000383 Provider number: 155721 AIM number: 100289610</p> <p>Survey team: Diana Zgonc, RN, TC Connie Landman, RN Christi Davidson, RN Lori Brettnacher, RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 1 Medicaid: 40 Other: 7 Total: 48</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Provider respectfully requests that the 2567 Plan of Correction be considered our letter of credible allegation.</p>	
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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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	Quality review completed on June 5, 2012 by Bev Faulkner, RN			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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, interview, and record review, the facility failed to develop care plans for 3 of 4 residents identified by the facility as being at risk for elopement (Resident #1, Resident #2, and Resident #19).</p> <p>Findings include:</p> <p>1. Resident #1's record was reviewed on 5/29/2012 at 9:30 A.M. Resident #1 was admitted on 4/15/11 and had current diagnoses which included but were not limited to chronic pain and bipolar disorder with delusions and</p>	F0279	Resident #1, #2 and #19 have been reassessed for elopement and all have documented assessments and care plans addressing the risk of elopement issue. These care plans are now on the residents medical record and are available for interdisciplinary review as needed. (See Attached) All residents that could have been affected by this deficient practice have been assessed and residents who are at risk for elopement have been identified with assessments and care plans now on each residents chart. Copies of the assessments and	06/25/2012	

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	<p>hallucinations.</p> <p>The facility's current policy, dated 4/20/12, titled "Protocol for Elopement" provided by the Director of Nursing (DON) was reviewed on 5/29/2012 at 10:15 A.M. This facility policy indicated residents identified as an elopement risk would have an orange dot on their chart, diet card, and their bed.</p> <p>Resident #1's medical chart and bed was observed to have an orange dot sticker.</p> <p>During an interview on 5/29/2012 at 12:40 P.M., The Social Service Director indicated Resident #1 was an elopement risk due to a diagnoses of some kind of cognitive impairment. The Social Service Director indicated it was his responsibility to complete the elopement assessments and develop individualized care plans for each resident that was considered an elopement risk. He further indicated most residents in the facility were elopement risk because of their cognitive status. The Social Service Director was unable to provide documentation of an assessment or care plan regarding Resident #1's elopement risk.</p>		<p>care plans have been given to the Administrator. The Social Service Director will receive directed in-service training on the facility policy and procedure for the completion of risk of elopement assessment documents from an outside contractor. This directed in-service training was completed on June 11, 2012 with a copy of the completed training included with this Plan of Correction. The Administrator or designee will monitor that the assessments and care plans are completed and on the resident medical record. This will be accomplished by the Administrator or designee reviewing 5 residents medical records per day to verify that assessments and care plans are complete and on the medical record for review, if needed, by the interdisciplinary team. Following completion of aforementioned audits, ongoing audit will be completed for newly admitted residents, quarterly and for those residents who incur a significant change in condition. The Administrator will report to the Quality Assurance Committee findings and any corrective actions taken at the next quarterly meeting his findings.</p>		

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	<p>2. Resident #2's record was reviewed on 5/29/2012 at 9:30 A.M. Resident #2 was admitted on 8/11/2011 and had current diagnoses which included but were not limited to alcohol abuse, malnutrition, hypertension, anemia, left upper extremely weakness, and a history of cocaine abuse. A Social Service note, dated 2/13/2012, indicated Resident #2 was an elopement risk.</p> <p>During an interview on 5/29/2012 at 12:40 P.M., The Social Service Director indicated Resident #2 was an elopement risk. The Social Service Director indicated it was his responsibility to complete the elopement assessments and develop individualized care plans for each resident which was considered an elopement risk. He further indicated most residents in the facility were elopement risk because of their cognitive status. The Social Service Director was unable to provide documentation of an assessment or care plan regarding Resident #2's elopement risk.</p> <p>During an interview on 5/29/2012 at 10:00 A.M., The Director of Nursing (DON) indicated the Social Service Director was responsible for the elopement care plans and she or her</p>			

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	<p>staff did not have access to them.</p> <p>3. The record for Resident # 19 was reviewed on 5/29/12 at 9:20 A.M.</p> <p>Current diagnoses included, but were not limited to, hypertension, congestive heart failure, anemia, peripheral neuropathy, alcoholic dementia, and bipolar disorder.</p> <p>Resident #19's care plan had been reviewed and updated on 5/23/12.</p> <p>During an interview with the Social Services Director (SSD) on 5/29/12 at 12:40 P.M., he indicated Resident #19 was an elopement risk. Resident #19's record lacked documentation of an assessment or care plan that addressed the risk of elopement. During this interview, the SSD indicated he was unable to provide documentation of an assessment or care plan which addressed Resident #19's elopement risk.</p> <p>This deficiency was cited on April 19, 2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(a)</p>						

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