

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 07/19/2013
--	---	--	---

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 IN00132481.</p> <p>Complaint IN00132481 - Substantiated. Federal/state deficiency related to the allegations is cited at F360.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: July 17, 18, 19, 2013</p> <p>Facility number: 000383 Provider number: 155721 AIM number: 100289610</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 1 Medicaid: 39 Other: 7 Total: 47</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
---------	--	---------	--	--

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 07/19/2013
--	---	--	---

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
	Quality review 7/23/13 by Suzanne Williams, RN			

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 07/19/2013
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	
F000161 SS=C	<p>483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS</p> <p>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.</p> <p>Based on record review and interview, the facility failed to ensure a surety bond was in effect in sufficient amount to protect residents' personal funds deposited with the facility for 36 of 36 residents for whom the facility managed personal funds.</p> <p>Findings include:</p> <p>During an interview with the Administrator on 7/17/13 at 3:00 p.m., she indicated that prior to 7/01/13, the facility had a surety bond in effect in the amount of \$20,000 (twenty thousand) dollars. She indicated she was aware this amount was insufficient to cover all daily ending balances for the resident trust fund account.</p> <p>A "Notice of Cancellation of Bond" form dated 7/10/13, indicated a surety bond in the amount of \$20,000 (twenty thousand) was in force beginning 2/02/07 and was due to be canceled on 9/03/13.</p>	F000161	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective August1, 2013 to the complaint survey completed on 7/19/2013. The facility also request that our plan of correction be considered for paper review compliance. The facility would be happy to submit to you any compliance paper work you would need.</p>	08/01/2013	

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 07/19/2013
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 trust fund account daily ending balances reviewed for the period of 4/01/13 through 7/17/13 indicated the following daily closing balances that were above the surety bond amount that was in force:</p> <p>5/03/13 \$20,837.23 5/06/13 \$20,807.23 5/20/13 \$26,578.29 5/21/13 \$26,574.69 5/24/13 \$23,867.01 5/30/13 \$22,108.01 5/31/13 \$26,795.02 6/03/13 \$41,358.16 6/05/13 \$40,591.72 6/07/13 \$26,731.32 6/10/13 \$22,731.32 6/11/13 \$22,835.32 6/17/13 \$21,492.26 6/19/13 \$21,818.06 6/20/13 \$22,428.06</p> <p>During an interview on 7/18/13 at 11:00 a.m., the Administrator indicated the above amounts were as represented on the resident trust fund bank statements, and that the facility had obtained a surety bond effective 7/01/13 in the amount of \$45,000 (forty five thousand).</p> <p>3.1-6(i)</p>		<p>F161</p> <p>Lawrence Manor has purchased a surety bond to assure the security of all personal funds of residents deposited with the facility.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Facility has obtained surety bond in the amount of \$45000 effective 7/1/2013.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All Residents with personal funds in a Resident Trust account were identified through accounting audit and are at risk. Please see below for measures implemented to prevent reoccurrence.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>Resident Trust Policy was reviewed and found to be appropriate. Surety bond will be maintained in excess of amount present in Resident Trust accounts.</p> <p>The corrective action taken to monitor performance to assure</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 07/19/2013
--	---	--	---

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><i>compliance through quality assurance is:</i></p> <p>The Administrator will review Resident Trust balances monthly and Surety bond to assure proper security is maintained. Any issues identified will be immediately corrected. The results of this audit and any actions will be reviewed by QA Committee quarterly.</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 07/19/2013
--	---	--	---

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
F000360 SS=F	<p>483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT</p> <p>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.</p> <p>Based on record review and interview, the facility failed to ensure residents received food of adequate quality and quantity to meet their nutritional needs for 49 of 49 residents dependent on the facility for food services in a population of 49, including 3 of 3 residents interviewed regarding the food (Residents E, F, G).</p> <p>Findings include:</p> <p>A facility "Communication/Concern Form" completed by LPN #1, the Charge Nurse on duty, dated 7/07/13 and identified as relating to the morning of 7/06/13 indicated:</p> <p>"Not enough breakfast, no eggs...Either had 1 piece of bacon and 1 toast...(Dietary Manager) said "No eggs and nothing to work with" and said (Dietary Manager) "had to buy the bread (symbol for "and") butter herself this a.m..."</p> <p>The Director of Nursing (D.O.N.) was interviewed on 7/17/13 at 1:45 p.m.</p>	F000360	<p>F360 Lawrence Manor does provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. The correction action taken for those residents found to be affected by the deficient practice include: Residents E, F and G are receiving food of adequate quality and quantity to meet their nutritional needs in accordance with their physician prescribed diets. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. Please see below for measures implemented to prevent reoccurrence. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: A policy entitled "Nutritional Adequacy – Meal Service" was drafted and implemented. All dietary employees were educated on this policy. A plan for dietary oversight was drafted and implemented. The plan is as follows:</p> <p>1. Leadership</p>	08/01/2013

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 07/19/2013
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>She indicated that on Monday July 8th she received a call from the Assistant Director of Nursing (A.D.O.N.) who advised her of the food shortage of 7/06/13 at breakfast. The D.O.N. indicated she had been advised that residents got 1 piece of bacon and 1 piece of toast, that some residents got cold cereal, and that there was no butter, sugar, or cream.</p> <p>L.P.N. # 1, the A.D.O.N., was interviewed on 7/17/13 at 1:50 p.m. She indicated that she worked on 7/06/13, and that at breakfast time on that date the Dietary Manager came to her and indicated she "didn't have anything to work with" to prepare breakfast. The A.D.O.N. indicated she observed the Dietary Manager call the Administrator to report the food shortage, and the Administrator hung up on her. The A.D.O.N. indicated "several" residents complained about not getting enough food, including, but not limited to, residents E, F, and G.</p> <p>Q.M.A. #2 was interviewed on 7/17/13 at 2:05 p.m. She indicated she had worked on the morning of 7/06/13. She indicated there were no eggs available, some residents got cold cereal only, some residents got 1 piece of bacon and 1 piece of toast,</p>		<p>Dietary Manager from sister facility will be present in facility at least three times per week to oversee food service operations. Dietician will monitor on Tuesdays, Thursday and one day on the weekend. The facility is actively recruiting for qualified dietary manager.</p> <p>1. Inventory Management Visiting Dietary Manager will review food inventory 3 x's weekly to assure inventory is present to meet the demands of the upcoming meal/menu plan. Visiting Dietary Manager will prepare and enter food orders each week based on upcoming menu requirements. Visiting Dietary Manager will review food delivery to assure food is delivered according to order. Cooks who realize they are without the necessary food items will be educated to contact Manager on Duty to obtain necessary food items.</p> <p>1.Meal Service Visiting Dietary Manager will educate dietary staff on proper food preparation and portion sizes according to recipes and menus. ADON, DON and charge nurse will be inserviced on verifying food according to menus. ADON will monitor breakfast, DON will monitor lunch and dinner and charge nurses will monitor weekends. If there are issues monitors will be instructed to call the visiting Dietary Manager and if she is unavailable</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 07/19/2013	
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 there was "not enough bread to go around." She indicated that some residents who normally got hot cereal got no breakfast at all.</p> <p>Q.M.A. #3 was interviewed on 7/17/13 at 2:15 p.m. She indicated she worked on the morning of 7/06/13. She indicated that most residents got 1 piece of bacon and 1 piece of toast. She indicated that "several" residents were upset, and noted one resident was particularly "unhappy and upset" stating he "wanted more of everything and couldn't get it."</p> <p>C.N.A. #4 was interviewed on 7/17/13 at 2:25 p.m. She indicated she had worked the morning of 7/06/13. She indicated residents got 1 piece of bacon and 1 piece of toast and residents were upset they could not get more food. She indicated one resident stated "I wouldn't feed this to a dog."</p> <p>Resident E was identified by the facility as interviewable. She was interviewed on 7/18/13 at 9:10 a.m. She indicated she got no breakfast of any kind on 7/06/13. She indicated the Dietary Manager came to see her that morning and "cried because she didn't have food to feed the residents."</p>		<p>they will call the Dietitian.</p> <p>1.Auditing Residents will be interviewed to insure quality and quantity of meal service three times per week. ADON will monitor breakfast, DON will monitor lunch and dinner and charge nurses will monitor weekends. If there are issues monitors will be instructed to call the visiting Dietary Manager and if she is unavailable they will call the Dietitian. The results of these audits will be presented to Administrator, DON, ADON, visiting Dietary Manager and Dietician. Deficiencies will be addressed promptly through the progressive disciplinary process.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is: Visiting Dietary Manager will review food inventory 3 x's weekly to assure inventory is present to meet the demands of the upcoming meal/menu plan. Residents will be interviewed by Administrator or designee to insure quality and quantity of meal service three times per week. ADON will monitor breakfast, DON will monitor lunch and dinner and charge nurses will monitor weekends. If there are issues monitors will be instructed to call the visiting Dietary Manager and if she is unavailable they will call the Dietitian. These audits will continue until 100% compliance is achieved for 30 consecutive</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 07/19/2013
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 F was identified by the facility as interviewable. He was interviewed on 7/17/13 at 2:50 p.m. He indicated that on 7/06/13 he got 1 piece of bacon and 1 piece of toast for breakfast. He indicated he asked for more but was told "that's all they had."</p> <p>Resident G was identified by the facility as interviewable. He was interviewed on 7/19/13 at 9:30 a.m. He indicated that on 7/06/13 he got "nothing" for breakfast and stated "they didn't have anything to give me."</p> <p>The Administrator was interviewed on 7/18/13 at 7:45 a.m. She indicated that she was appointed as Administrator on 7/12/13, and had not been associated with the facility on 7/06/13. She indicated she had been made aware of the concern about lack of food on 7/06/13, had investigated the concern, and instituted procedures to ensure dietary needs would be met on an ongoing basis.</p> <p>An undated facility policy, titled "Nutritional Adequacy-Meal Service," received from the Administrator on 7/19/13 and identified as a current</p>		<p>days. The results of these audits will be presented to Administrator, DON, ADON, visiting Dietary Manager and Dietician daily during IDT meeting. Deficiencies will be addressed promptly through the progressive disciplinary process. The Quality Assurance Committee will review the audit results at the scheduled meetings with recommendations as needed.</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 07/19/2013
--	---	--	---

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>facility policy, indicated:</p> <p>"Policy Statement: Residents will be provided with meals that meet their nutritional needs, are prepared according to a standardized menu in a manner that conserves nutritional value and is served in a palatable, attractive and proper temperature.</p> <p>Each Resident shall be provided with a breakfast, lunch and dinner meal...</p> <p>Portions shall be served according the (sic) menu plan...."</p> <p>This Federal tag relates to Complaint IN00132481.</p> <p>3.1-20(a)</p>			