

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2013
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NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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F000000	<p>This visit was for the Investigation of Complaint IN00134982 and Complaint IN00136291.</p> <p>Complaint IN00134982 Substantiated, federal/state deficiencies related to the allegations are cited at F253.</p> <p>Complaint IN00136291 Substantiated, federal/state deficiencies related to the allegations are cited at F314.</p> <p>Survey dates: September 23 &amp; 24, 2013</p> <p>Facility number: 0000032 Provider number: 155077 AIM number: 100273330</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF: 17 SNF/NF: 105 Total: 122</p> <p>Census payor type: Medicare: 16 Medicaid: 97 Other: 9 Total: 122</p>	F000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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>Sample: 5</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 10/02/2013 by Brenda Marshall Nunan, RN</p>			

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F000253 SS=E	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation, interview, and review of facility records, the facility failed to ensure 3 of 3 sampled shower rooms were in good repair, functional, and sanitary (Shower rooms on B wing, C wing, and D wing).</p> <p>Findings include:</p> <p>Observations were made of 3 of the facility's shower rooms, on 09/23/13 at 11:10 a.m. - 11:33 a.m., with the Maintenance Supervisor present. The B wing shower room was observed to have water covering the floor with a wet towel and wash cloth in the middle of the floor. The water was observed to have ran under the door into the hallway where the carpet was observed wet for about a foot in front of the door.</p> <p>The B wing shower room was observed to have 2 broken and chipped tiles with ragged edges on the lower wall which separated the shower stalls. The tiles were observed to be approximately 4 inches by 4 inches square.</p>	F000253	<p>Shower rooms on B wing, C wing, and D wing were affected. The clog in the B wing shower room causing the wet floor was an acute problem that was repaired immediately. The tiles in the shower rooms on B wing, C wing and D wing were replaced. The floor in the D wing shower stall was immediately cleaned. All shower rooms have the potential to be affected. All shower rooms checked to ensure they provide a sanitary, orderly and comfortable interior. Housekeeping staff will be in-serviced on sanitizing the shower rooms, (please see attachment C). Shower rooms are cleaned daily and as needed ongoing. As a measure to ensure ongoing compliance the shower rooms will be checked by the Maintenance Supervisor or designee weekly and as needed to ensure any needed repairs are fixed timely, (please see attachment D). The Housekeeping supervisor or designee will complete an audit daily on regular scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly to ensure shower rooms are sanitary, (please see attachment E). As a quality measure, the</p>	10/10/2013			

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	<p>The C wing shower room was observed to have 2 broken and chipped tiles with ragged edges on the lower part of the wall which separated the shower stalls. One of the shower stalls was shut down due to 5 missing tiles located on the back wall of the stall. The floor of the other stall had black substance between the floor tiles which looked mildew and a brown clump of substance which resembled bowel movement.</p> <p>The D wing shower room was observed to have 1 broken chipped tile with ragged edges located on the lower wall which separated the shower stalls.</p> <p>Interview with the Maintenance Supervisor, on 09/23/13 at 11:20 a.m., indicated when he finished working at another facility, he planned to work on the shower rooms and remove and replace all the old tiles.</p> <p>Interview with the Administrator, on 09/24/13 at 3:30 p.m., indicated the C wing shower stall floor tiles were old, stained, and discolored. The Administrator indicated the facility was going to start remodeling the shower rooms soon. The Administrator indicated she was</p>		Maintenance Supervisor and Housekeeping Supervisor or designee will review any finding and subsequent corrective action in the quarterly Quality Assurance meeting.	

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	<p>aware of the floor being covered with water that ran out in the hall on B wing.</p> <p>The facility's protocol, entitled, "C-WING HOUSEKEEPING ROUTINE" dated 09/23/13 - 09/29/13, indicated a routine schedule list of housekeeping duties to be completed on the C wing. Among those duties was the shower room which was initialed when completed.</p> <p>This federal deficiency is related to Complaint IN00134982.</p> <p>3.1-19(f)</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on closed record review and interview, the facility failed to ensure 1 of 4 sampled residents who entered the facility without pressures did not develop stage 2 pressure ulcers (skin breaks open and the sore expands into deeper layers of the skin) on the right and left buttocks (Resident B).</p> <p>Findings include:</p> <p>Resident B closed clinical record was reviewed, on 09/23/13 at 2:15 p.m., and indicated Resident B was admitted from the hospital to the facility. Resident B had diagnoses which included, but were not limited to, encephalopathy, anoxic brain damage, myocardial infarction, hypoglycemia, syncope, collapse, pneumonia, atrial fibrillation, tracheostomy, hypertension, gastro-esophageal reflux disorder,</p>	F000314	<p>The facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The 2567 alleges "the facility failed to ensure 1 of 4 sampled residents who entered the facility without pressure ulcers did not develop stage 2 pressure ulcers (skin breaks open and the sore expands into deeper layers of the skin) on the right and left buttocks." The facility does not agree that the pressure ulcers which developed were unavoidable. Rather, the facility contends that the pressure ulcers were unavoidable due to resident B's clinical status which declined. The physician provided a</p>	10/10/2013			

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	<p>multidrug resistant organism, malnutrition, respiratory failure, atypical psychosis, dysphagia, gastrostomy, methicillin resistant staphylococcus aureus, debility, and hyperlipidemia. Hospital records, dated 06/28/13, indicated Resident B was in the hospital from March 21, 2013 to June 28, 2013, and had no pressure sores.</p> <p>Resident B's Nursing Admission Assessment, dated 06/28/13, indicated "no skin issues."</p> <p>Resident B's Braden Scale Assessment, dated 06/28/13, indicated a score of "16" which represents a high risk for pressure sores.</p> <p>Resident B's initial care plan, dated 06/28/13, indicated, "At risk for alteration in skin integrity R/T (related to): incontinence decreased mobility (bedrest)" had as a goal, "Resident will be free from skin breakdown thru next review." Interventions included: "*Assess skin daily for signs of breakdown &amp; report to MD and responsible party PRN (as needed). *Resident to be monitored by SWAT weekly for 30 days. *Assist with turning &amp; repositioning at least every 2 hours. *Peri care per policy after</p>		<p>statement noting the pressure areas were unavoidable, (please see attachment 1). Resident B's diagnosis upon admission included, but were not limited to; severe malnutrition, respiratory failure, cardiac arrest s/p resuscitation with possible anoxic brain injury, encephalopathy, pneumonia, atrial fibrillation, respiratory MRSA, and s/p cardiac arrest, (please see attachment 2). There were preventative measures in place as to prevent pressure areas which included, but not limited to; an alternating air flow mattress upon admission, pressure redirecting cushion to wheelchair, preventative care every shift (Keep clean and dry. Prevent skin on skin contact. Pad bony prominences. Provide peri care after each incontinent episode. Apply lotion PRN. Turn and reposition PRN), (please see attachment 3), a head to toe skin assessments was completed weekly and PRN, the resident was turned and repositioned at least every two hours and was monitored on hourly checks, he received a tube feeding that met 100% of his nutritional needs (thus additional vitamins were not recommended), the BRADEN scale was completed weekly, and resident B was reviewed weekly in the SWAT meeting. The 2567 on page 6 noted a "Pressure Ulcer Flow Sheet" dated 7/9/13, however there was an additional</p>	

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	<p>each incontinent episode."</p> <p>Review of Resident B's Medication Administration Record (MAR), dated June and July 2013, indicated a prn (as needed) medication, "Miconazole Cream 2% - Apply to peri-area &amp; coccyx BID...." This medication was for a yeast infection and the MARs lacked documentation as being administered. House barrier cream to peri area &amp; buttocks prn redness as a preventative measure was also ordered on 06/28/13. This was documented as done on the MAR on 07/06/13 only.</p> <p>Review of the "WEEKLY SKIN ASSESSMENT", dated 07/02/13, indicated, "Head to toe skin assessment completed &amp; no skin alterations noted."</p> <p>Physician telephone orders, dated 07/06/13 at 2:00 p.m., indicated an order for "Xenederm to open areas on the buttock q (every) shift and PRN incontinent care...." The orders also indicated, "turn q 2 hours strict." Resident B's clinical record lacked documentation of a schedule for positioning.</p> <p>The "PRESSURE ULCER FLOWSHEET", dated 07/08/13,</p>		<p>flow sheet completed on 7/6/13, (please see attachment 4), which notes family and physician notification with new orders obtained. Plan of Correction; Resident B was affected. One should note resident B had multiple diagnoses upon admission which included respiratory failure, cardiac arrests/p resuscitation with possible anoxic brain injury and a drug resistant respiratory infection upon admission to the facility thus development of pressure areas is likely unavoidable. Interventions were in place as to help prevent pressure ulcers such as; an alternating air flow mattress, pressure redirecting cushion to wheel chair, turning and repositioning at least every 2 hours, preventative care every shift (Keep clean and dry. Prevent skin on skin contact. Pad bony prominences. Provide peri care after each incontinent episode. Apply lotion PRN. Turn and reposition PRN), and he received a tube feeding that met 100% of his nutritional needs. Upon noting the stage II open areas, the physician and responsible party were notified and orders were obtained and followed. Resident B had care plans Resident B had an order for Risperidone to treat atypical psychosis which is a risk factor for pressure ulcers; however he required this medication until his condition warranted it be discontinued.</p>				

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	<p>indicated a stage II pressure ulcer was found on the right and left buttocks. The measurements, dated 07/09/13, indicated the right buttock pressure ulcer was 7 centimeters (cm) x 4 cm x &lt;0.1 cm and the left buttock pressure ulcer was 8 cm x 6 cm x &lt;0.1 cm. Small brown areas on the right buttock measured 1.0 cm x 1.0 cm on the upper part of the open area and the mid brown area measured 1.0 cm x 1.0 cm. The left buttock had a small brown area in the middle of pressure ulcer which measured 1.0 cm x 2.0 cm. Last measurements for the right buttocks was 6.5 cm x 3.0 cm x &lt;0.1 cm which showed improvement. The left buttock ulcer stayed the same in size.</p> <p>Resident B's admission Minimum Data Set (MDS) assessment, dated 07/09/13, indicated Resident B was severely cognitively impaired and was a high risk for pressure sores.</p> <p>The skin assessment, dated 07/09/13, indicated, "Head to toe skin assessment completed. New skin alteration found. See: Pressure Ulcer flowsheet." Resident B's record lacked documentation of Resident B having any problems on his buttocks prior to the finding of the stage II pressure sores which were large in</p>		<p>Resident B had care plans in place which included current treatment interventions. All residents at high risk for pressure areas have the potential to be affected. Braden scores were updated on all residents. All residents' at high risk for pressure ulcers care plans and assignment sheets were reviewed and revised as indicated to include appropriate interventions. Head to toe skin assessments were completed on each resident. Any alterations in skin integrity were noted the appropriate skin management form. Interventions implemented as indicated/ordered. Nurses were in-serviced on skin management including pressure ulcer prevention and treatment, care planning, and assessment. All CNA's were in-serviced on proper positioning and prevention of pressure ulcers, (please see attachment A). As a measure to ensure ongoing compliance each resident will have a head to toe skin assessment completed weekly and as needed. If any new areas are noted the physician will be notified and a treatment order requested. The noted problem skin areas are measured on a weekly basis. The status of all pressure ulcers will be reviewed weekly in SWAT meeting and if no improvement is noted after 2 weeks or the area had worsened, a change in the treatment regimen will be requested and</p>				

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	<p>size when found.</p> <p>Review of the Nutritional Assessment Form, dated 06/28/13, indicated the current formula for the tube feeding was meeting 100% of estimated needs at this time. There were no new interventions when Resident B developed his pressure sores.</p> <p>Documentation on the admission MDS assessment, dated 07/09/13, indicated the resident had a problems with friction and shearing per observation during assessment period and Braden, dated 07/05/13. The resident's care plans lacked documentation of using a bed sheet to pull resident up in bed.</p> <p>Physician telephone orders, dated 07/09/13 indicated, "order clarification Xenaderm to pink areas of wound (L) &amp; (R) buttocks, Santyl to brown areas of wound. Cover with nonstick telfa then 4 x 4's and ABD pad secure with Medifix tape qd (every day) and prn soilage."</p> <p>Resident B's care plan, dated 07/11/13, for at risk for development of pressure ulcers indicated a goal of "The resident will be free from pressure ulcers. (sic) By (sic) next review." Interventions included, head</p>		<p>implemented. Care plans and assignment sheets will be updated accordingly. Braden scale scores will be completed upon admission and weekly for four weeks, then quarterly, annually, and with any significant changes. All residents with pressure areas and residents at high risk for pressure areas will be observed by the DON or designee to ensure proper positioning with pressure reducing devices and that treatments in place as ordered which will include all shifts daily on regularly scheduled days for 30 days, then weekly for 30 days, then monthly ongoing. As a quality measure, the DON or designee will review any finding and subsequent corrective action in the quarterly Quality Assurance meeting.</p>				

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	<p>to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, notify the charge nurse of any skin problems for further assessment and possible MD and responsible party notification, pressure redirecting cushion to chair, pressure redirecting mattress to bed, encourage and assist resident with turning and repositioning at least every two hours and as needed, apply preventative topical medication as ordered, monitor labs as ordered, encourage food and fluid intake as diet permits, refer to dietician as indicated, strict turn every 2 hours 07/06/13, administer medication per physician orders, treatment to pressure ulcers per physician orders.</p> <p>Resident B's care plan, dated 07/11/13 with update of 07/16/13, indicated, "The resident has a pressure area located: right buttocks" indicated goal of "The pressure area will decrease in size or heal without complications thru next review." Interventions included: Notify physician and responsible party of area and as needed, apply treatment as ordered, daily skin inspection by nursing assistants, head to toe skin assessment by licensed nurse weekly and PRN, provide pressure</p>			

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	<p>redistribution mattress to bed, provide pressure redistribution cushion for wheel chair, refer to Registered Dietician as indicated, monitor for treatment efficacy, if area is not improving, consult physician for further instruction, Braden risk assessment to be completed per policy and procedure, assist with turning and repositioning at least every two hours and as needed, therapy referral as needed, educated resident and responsible party on risk factors of skin breakdown and interventions, also see incontinence care plan, also see dietary care plan, administer nutrition or hydration interventions as ordered, Xenaderm &amp; Santyl per physician orders, D/C Santyl, Xenaderm only 7/16/13.</p> <p>Resident B also had a care plan for the left buttock with the same interventions, but the Santyl was not discontinued.</p> <p>Physician telephone orders, dated 07/16/13, indicated, "Risperidone 0.5 mg DC (discontinue) Rocephin 1 gm x 1 - may use lidocaine (2 cc) DT (due to) possible URI (Upper Respiratory Infection) CXR (chest x-ray) - DT possible URI CBC (complete blood count), BMP (blood metabolic panel) - DT possible URI." According to</p>			

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	<p>documentation found on the Admission MDS assessment, Risperidone increases the risk for pressure sore development and was not discontinued until 07/16/13. The record lacked laboratory test results.</p> <p>Physician telephone orders, dated 07/17/13, indicated, "Transfer to _____ (name of hospital) ER (emergency room) Pneumonia on cxr (chest x-ray) Increased lethargy, etc."</p> <p>Interview with Resident B's daughter, on 09/23/13 at 8:08 p.m., indicated Resident B was in the hospital several days prior to coming to the facility and had no pressure sores upon admission to the facility. Resident B's daughter indicated she called the medical doctor due to her father was not himself, was more lethargic, had run a temperature, and not in the same condition as he was upon admission to the facility where he was talking, joking, and much more alert. Resident B's daughter indicated her father had double pneumonia and was sent to the hospital and was started on 4 different antibiotics at the hospital. Resident B's daughter indicated the resident improved and was moved to another facility and his pressure ulcers were like new skin before he passed away.</p>			

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NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(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>Interview with the Administrator, Director of Nursing (DON), and Corporate Nurse at exit, on 09/24/13 at 3:45 p.m., indicated the resident was in bad shape and staff was in his room all the time. The Corporate Nurse indicated the resident had a yeast infection on his peri area, which could have contributed to his skin breakdown.</p> <p>Review of the facility's policy for "INTERVENTIONS TO REDUCE THE RISK OF PRESSURE ULCER DEVELOPMENT &amp; PRESSURE ULCER MANAGEMENT", dated 01/10/10, indicated, to add multivitamin with minerals daily.</p> <p>This deficiency is related to Complaint IN00136291.</p> <p>3.1-40(a)(1)</p>				