

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 08/19/2013
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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 #IN00134384.</p> <p>Complaint IN00134384 - Substantiate. Federal/state deficiencies related to the allegations are cited at F280, F282, F312 and F514.</p> <p>Survey date: August 19, 2013</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Survey team: Shannon Pietraszewski, RN</p> <p>Census bed type: SNF: 14 NF: 110 Total: 124</p> <p>Census payor type: Medicare: 17 Medicaid: 100 Other: 7 Total: 124</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000	<p>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. Please find enclosed the plan of correction for the survey ending August 19, 2013. Due to the low scope and severity of the survey findings, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm compliance, feel free to contact me. Respectfully, Sara Charles 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.

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	IAC 16.2. Quality review completed on 08/24/2013 by Brenda Marshall Nunan, RN.				

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F000157 SS=D	<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 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 record review and interview, the facility failed to notify a physician regarding changes in condition for 1 of 3 resident reviewed for change in condition. (Resident F)</p>	F000157	<p>1. Residents F's physician was notified of her change in condition and she was sent to the hospital for evaluation per the physicians order. 2. Any resident experiencing a change in</p>	09/06/2013			

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	<p>Findings include:</p> <p>Resident F's record was reviewed on 8/19/13 at 12:20 p.m. Resident's F's diagnoses included, but were not limited to, bilateral leg amputations, diabetes mellitus, hypertension, and depressive disorder.</p> <p>A nursing note dated 8/2/13 at 9:30 a.m., indicated the resident had been vomiting moderate amount of thick brown fluid. There was no documentation to indicate if the physician was notified.</p> <p>A nursing note dated 8/2/13 at 10:00 a.m., indicated the resident continued to vomit thick brown fluid and incontinent of liquid brown stool. The note indicated the resident had periods of apnea, lethargic and minimally verbal. There was no documentation to indicate if the physician was notified.</p> <p>A nursing note dated 8/2/13 at 11:30 a.m., indicated the resident remained lethargic and 911 was called. There was no documentation to indicate if the physician was notified.</p> <p>An interview with LPN #3 on 8/19/13 at 1:40 p.m., indicated she did not</p>		<p>condition has the potential to be affected. All 24 hour report sheets were reviewed to note any changes in condition. If a change in condition was noted, an audit was completed to ensure the physician was notified with such documented. All nurses will be in-serviced on the facility's policy on Physician and Family Notification as well as documentation of such, (Attachment A). 3. As a measure for ongoing compliance, the DON or designee will review 24 hour report sheets and nurses notes as well as complete an audit daily on regularly scheduled days for 3 months, then three times weekly for 3 months, then weekly for three months, then monthly ongoing to ensure any changes in condition have proper physician notification with such documented, (Attachment B). 4. As a measure of quality assurance, the DON or designee will report any findings from the ongoing audits and subsequent corrective actions taken to the Quality Assurance Committee during quarterly meetings. The corrective action plan will be revised accordingly, if warranted.</p>		

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	<p>know if the physician was notified.</p> <p>This Federal Tag relates to complaint number IN00134384.</p> <p>3.1-5(a)(2) 3.1-5(a)(4)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to revise and individualize care plans related to ADL (Activities of Daily Living) care for 2 of 3 resident reviewed for revision to care plans. (Resident E, and F)</p> <p>Findings include:</p> <p>1. Resident E record was reviewed on 8/19/13 at 2:00 p.m. Resident E diagnoses included, but were not limited to, Parkinson's, dementia, and urinary retention. Resident E was admitted into a hospice program on 6/17/13.</p>	F000280	<p>1. Resident E's ADL care plan was revised to include hospice services, frequency of services, and coordination of care. Resident F's ADL care plan was revised to include her bathing choices/preferences. 2. All residents have the potential to be affected. Social Services will complete preference interviews for all residents. Care plans and assignment sheets will be updated as indicated to reflect resident preferences, hospice services provided and confirm assist required to complete ADL's. Nursing and Social Service staff will be in-serviced on assessing resident preferences and updating care plans and</p>	09/06/2013			

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	<p>Review of the ADL care plan revised on 8/5/13, did not indicate the resident was receiving hospice services, frequency of services and did not establish coordination of care.</p> <p>An interview with the ADoN (Assistant Director of Nursing) on 8/19/13 at 3:30 p.m., indicated the resident's care plan should had been updated to reflect her hospice services.</p> <p>2. Resident F's record was reviewed on 8/19/13 at 12:20 p.m. Resident's F's diagnoses included, but were not limited to, bilateral leg amputations, diabetes mellitus, hypertension, and depressive disorder.</p> <p>Review of the ADL care plan revised on 8/14/13, indicated the resident required assistance of two for performing ADL's. The goal indicated the resident will "present a neat, clean & (and) odor free appearance daily thru next review." The interventions indicated "Showers/bath per schedule and more frequently prn (as needed) or requested, offer bathing choices...." The care plan was not updated or individualized to reflect the resident's bathing choices/preferences.</p>		<p>assignment sheets accordingly, (Attachment C). Resident preferences will then be added to the appropriate care plan and assignment sheet. 3. As a measure for ongoing compliance, Social Services will complete resident preference interviews upon admission, quarterly, and with any significant changes and ensure the care plan is updated accordingly. The Social Services Director will complete an audit of at least three residents from each unit weekly ongoing to ensure hospice services/coordination of care, resident preferences and assist required to complete ADL's are accurate on the care plan and assignment sheet, (Attachment D). 4. As a measure of quality assurance, the Social Services Director or designee will report any findings from the ongoing audits and subsequent corrective actions taken to the Quality Assurance Committee during quarterly meetings. The corrective action plan will be revised accordingly, if warranted.</p>				

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	<p>An interview with CNA #1 on 8/19/13 at 1:40 p.m., indicated the resident would refuse ADL care until 12:00 p.m.</p> <p>An interview with the ADoN on 8/19/13 at 3:30 p.m., indicated the resident's care plan should had been updated to reflect her bathing choices/preferences.</p> <p>This Federal Tag relates to complaint number IN00134384.</p> <p>3.1-35(d)(2)(B)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to follow care plan interventions related to foley catheter care for 1 of 6 residents observed with foley catheters. (Resident E)</p> <p>Findings include:</p> <p>Resident #was observed in bed on 8/19/13 at 10:15 a.m. Resident E gravity bag was observed on the floor, uncovered, under the resident's bed. During this time, CNA #2 was interviewed. CNA #2 indicated the bag should not have been on the floor or left uncovered.</p> <p>Resident E record was reviewed on 8/19/13 at 2:00 p.m. Resident E diagnoses included, but were not limited to, Parkinson's, dementia, and urinary retention.</p> <p>Review of the foley care plan, revised on 8/5/13, indicated the resident required the use of a foley catheter due to urinary retention and was at risk for infection. The goal indicated</p>	F000282	<p>1. Resident E was affected. Upon noting the gravity bag on the floor, CNA# 2 immediately placed the gravity bag into the dignity bag hooked to the resident's bed frame. 2. All residents utilizing a Foley catheter have the potential to be affected. All residents with catheters were observed to have the gravity bag positioned and covered appropriately. All staff were in-serviced on catheter care and maintenance, (Attachment A). 3. As a measure for ongoing compliance, the DON or designee will complete an audit daily on regularly scheduled days for 3 months, then three times weekly for 3 months, then monthly ongoing to ensure catheter gravity bags are positioned and covered appropriately, (Attachment E). 4. As a measure of quality assurance, the DON or designee will report any findings from the ongoing audits and subsequent corrective actions taken to the Quality Assurance Committee during quarterly meetings. The corrective action plan will be revised accordingly, if warranted.</p>	09/06/2013	

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	<p>the resident will be free from signs and symptoms of infection thru next review. The interventions indicated "...Position catheter tubing and drainage bag in such a way to avoid contact with the floor...Keep catheter drainage bag covered as to maintain resident dignity and privacy..."</p> <p>An interview with the DoN (Director of Nursing) on 8/19/13 at 2:50 p.m., indicated she had started educating the staff regarding catheter care. The DoN indicated the bag was left on the floor when the resident was put to bed after breakfast.</p> <p>This Federal Tag relates to complaint number IN00134384.</p> <p>3.1-35 (g)(2)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure extensive and dependent residents received necessary services to maintain good grooming for 2 of 3 residents reviewed for ADL's (Activities of Daily Living). (Resident E and F).</p> <p>Findings include:</p> <p>1. Resident E was observed in bed on 8/19/13 at 10:15 a.m. and 1:55 p.m. Resident E's hair appeared oily and unclean.</p> <p>Resident E record was reviewed on 8/19/13 at 2:00 p.m. Resident E diagnoses included, but were not limited to, Parkinson's, dementia, and urinary retention. Resident E was admitted into a hospice program on 6/17/13.</p> <p>Review of the quarterly MDS (Minimum Data Set) Assessment dated 7/22/13, indicated the resident was totally dependent for personal</p>	F000312	<p>1. Resident E has a schedule for showers/baths (which includes her hair being washed) each Tuesday and Friday on day shift. Resident E had a complete bed bath which included her hair being washed. Resident F has a schedule for showers/baths every Wednesday and Saturday Evening shift (which includes hair being washed). Resident F had a shower which included her hair being washed. Resident F has patches of very short natural hair, thus wears a wig or cap most often. There are no hospital records indicating resident F required her hair to be cut. 2. All residents have the potential to be affected. All nursing staff will be in-serviced on shower/bath schedules and what a bath/shower entails which includes hair being washed unless otherwise specified as a specific resident preference for care, (Attachment A). 3. As a measure for ongoing compliance, the DON or designee will complete an audit to include 10 residents daily on regularly scheduled days of work for 3 months, then three times weekly for 3 months, then weekly for</p>	09/06/2013	

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	<p>hygiene and bathing.</p> <p>Review of the July 2013 and August 2013 ADL schedule indicated the resident had received a shower on day shift on July 12. The remaining days indicated partial baths were given daily for all three shifts. The ADL schedule did not indicate a schedule for washing Resident E's hair.</p> <p>Review of the CNA assignment sheet updated on 8/6/13, indicated the resident was supposed to receive showers on Tuesday and Friday on day shift.</p> <p>An interview with the DoN (Director of Nursing) on 8/19/13 at 2:20 p.m., indicated the resident "doesn't typically get showers, she usually get bed baths" due to her chronic pain and inability to sit very long.</p> <p>2. An interview with Resident F on 8/19/13 at 12:15 p.m., indicated her hair had not been combed or washed "in a long time". Resident F indicated while she was in the hospital recently, she could not get a comb through her hair and had asked the hospital staff to cut her hair. The resident's hair was observed to be covered with a cloth cap.</p>		<p>three months, then monthly ongoing to ensure residents have a neat clean odor free appearance. (Attachment F) Should concerns be noted, the same shall be investigated/addressed to ensure baths/showers/shampoos continue to be provided per schedule, or the schedule altered, if indicated. 4. As a measure of quality assurance, the DON or designee will report any findings from the ongoing audits and subsequent corrective actions taken to the Quality Assurance Committee during quarterly meetings. The corrective action plan will be revised accordingly, if warranted.</p>				

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	<p>Resident F's record was reviewed on 8/19/13 at 12:20 p.m. Resident's F's diagnoses included, but were not limited to, bilateral leg amputations, diabetes mellitus, hypertension, and depressive disorder.</p> <p>Review of the quarterly MDS (Minimum Data Set) Assessment dated 7/16/13, indicated the resident was cognitively intact and needed extensive assistance of one person for personal hygiene and bathing.</p> <p>Review of the July 2013 and August 2013 ADL schedule indicated the resident received a shower on July 20th on the day shift. The remaining days indicated partial baths were given daily for all three shifts. There was no documentation to indicate when the resident's hair was washed.</p> <p>Review of the CNA assignment sheet updated on 4/25/13, indicated the resident's shower days were Wednesday and Saturday on evening shift.</p> <p>An interview with CNA #1 on 8/19/13 at 1:40 p.m., indicated the resident refused ADL care until 12:00 p.m. CNA #1 indicated the resident refused to have her hair washed and</p>			

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	<p>combed on day shift but did not know if she refused on the other shifts.</p> <p>An interview with the SSA (Social Service Assistant) on 8/19/13 at 2:20 p.m., indicated the resident went to a beautician outside of the facility to have her hair done, otherwise she wore a wig or a cap.</p> <p>An interview with the DoN (Director of Nursing) on 8/19/13 at 2:50 p.m., indicated she was not made aware of the condition of the resident's hair prior to her hospitalization. The DoN also indicated she was not made aware of the resident getting her hair cut during her hospitalization.</p> <p>This Federal Tag relates to complaint number IN00134384.</p> <p>3.1-38(a)(3)(B) 3.1-38(f)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 record review and interview, the facility failed to document every occurrence of a resident's refusal regarding ADL (Activities of Daily Living) care for 1 of 3 records reviewed for complete and accurate documentation. (Resident F)</p> <p>Findings included:</p> <p>1. Resident F's record was reviewed on 8/19/13 at 12:20 p.m. Resident's F's diagnoses included, but were not limited to, bilateral leg amputations, diabetes mellitus, hypertension, and depressive disorder.</p> <p>Review of the July 2013 and August 2013 ADL schedule indicated the resident had received a shower on</p>	F000514	<p>1. Resident F did exhibit refusals of care. Staff involved were re-educated on completing documentation when refusals were noted. 2. All residents which exhibit refusal of care have the potential to be affected. All nursing and social services staff will be in-serviced on the facility's mood and behavior policy and documentation, (Attachment C). 3. As a measure for ongoing compliance, all behaviors and 24 hour report sheets will be reviewed in the daily Department Head meeting. During the meeting, the Nurse Managers and Social Serviced Director will ensure all reported behaviors are documented appropriately in an effort the same is communicated to the interdisciplinary team and necessary interventions and/or alternate treatment/interventions offered. The Social Services</p>	09/06/2013			

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 08/19/2013
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	<p>July 20th on day shift. The remaining days indicated partial baths were given daily for all three shifts. There was no documentation on the form to indicate the resident had refused her showers or ADL care.</p> <p>Review of nursing notes from 7/2/13 to last entry dated 8/14/13 , did not specifically indicate Resident F refused her showers or hair care (ADL care).</p> <p>An interview with CNA #1 on 8/19/13 at 1:40 p.m., indicated the resident refused ADL (Activities of Daily Living) care until 12:00 p.m. CNA #1 indicated the resident had received showers daily on day shift. The CNA indicated shower times were changed to evening shift. CNA #1 indicated the amount of showers went from daily to a few times a week. CNA #1 indicated the resident refused showers a lot now. CNA #1 indicated when the resident refused care, a "Mood and Behavior" sheet would be filled out and given to the Unit Manager.</p> <p>An interview with the SSD (Social Service Director) and the SSA (Social Service Assistant) on 8/19/13 at 1:55 p.m., indicated they were not made aware of the resident's constant</p>		<p>Director or designee will complete an audit daily on regularly scheduled days for 3 months, then three times weekly for 3 months, then monthly ongoing to ensure behaviors are documented appropriately, (Attachment G). 4. As a measure of quality assurance, the Social Services Director or designee will report any findings from the ongoing audits and subsequent corrective actions taken to the Quality Assurance Committee during quarterly meetings. The corrective action plan will be revised accordingly, if warranted.</p>		

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	<p>refusal for showers or hair care (ADL care). The SSA reviewed her behavior book and indicated she had one behavior for August 17th on the 3-11 shift for refusal of a shower. The SSA indicated she had 8 recorded behaviors for July with day and night shift only. The SSA indicated the forms provided indicated "rejection of care". The form did not specify the type of care rejected. The SSA indicated she had 5 recorded behaviors for June with day shift only.</p> <p>An interview with the Administrator and the DoN (Director of Nursing) on 8/19/13 at 2:20 p.m., indicated the resident refused care a lot and the staff should have notified social service. The Administrator and the DoN indicated the staff should have documented every refused care.</p> <p>This Federal Tag relates to complaint number IN00134384.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			