STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	08/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE MANOR HEALTHCARE CENTER	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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00237729 and IN00238286. Complaint IN00237729- Substantiated. Deficiencies related to the allegations are cited at F279, F282, and F514. Complaint IN00238286- Substantiated. Deficiencies related to the allegations are cited at F279, F282, and F514. Unrelated deficiency cited Survey dates: August 22 and 23, 2017 Facility number: 000383 Provider number: 155721 AIM number: 100289610 Census bed type: SNF/NF: 38 Total: 38 Census payor type: Medicare: 5 Medicaid: 31 Other: 2 Total: 38 These deficiencies also reflect state	F 0000	Please accept this plan of correction as our credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2.3-1. Quality review completed on August 29, 2017			
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional			

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	assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.			
	Based on record review, the facility failed to ensure resident assessments were complete and accurate, when an admission Minimum Data Set (M.D.S.) assessment did not accurately reflect a resident's behaviors, or bowel function. 1 of 3 residents reviewed for accurate assessments. (Resident B) Findings include: The record of Resident B was reviewed on 8/22/17 at 2:00 P.M. Diagnoses included, but were not limited to, end stage renal disease, coronary artery disease, peripheral vascular disease, malnutrition, atrial fibrillation, and an ascending aortic aneurysm. An admission Minimum Data Set	F 0272	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Affected resident no longer resides in facility. **How will other residents having the potential to be affected by the same deficient practice be identified and what correct actions will be taken?** All residents have the potential to be affected by this deficient practice. An audit of assessments will be completed by DON/Designee to ensure accuracy of assessments. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? A review of assessments will be completed by DON/Designee daily for 4 weeks. Licensed staff will be inserviced on accuracy of assessments by 9/20/2017.	09/20/2017

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	(M.D.S.) assessment dated 8/01/17 indicated Resident B was not cognitively impaired, had no noted mood disorders or behaviors, required minimal to moderate assistance with activities of daily living, and used a walker or wheelchair for locomotion about the facility. It also indicated Resident B had 6 venous/arterial ulcers, an ileostomy, and had been on anticoagulants for the 7 days of the assessment period. Active diagnoses in the M.D.S. included, but were not limited to, coronary artery disease, peripheral vascular disease, renal insufficiency, and malnutrition. Treatment for skin conditions were noted to include application of nonsurgical dressings, and application of ointments/medications to the feet, and areas other than the feet. The behavior section of the M.D.S., indicated "Physical behavioral symptoms directed towards others" was coded "Behavior not exhibited", "Other behavioral symptoms not directed at others" was coded "Behavior not exhibited", "Rejection of Care" was coded as "Behavior not exhibited, "Wandering" was coded indicating "Behavior not exhibited." A note dated 7/26/17 indicated "It was brought to the aides' attention that		**How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** DNS/designee is responsible for the completion of the assessment audit QAPI took weekly time 4 weeks, monthly times 6 months. The results of these audits will be reviewed by the QA committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	(Resident B) might be in the main dining room at night smoking a cigarette through the window." A note 7/26/17 indicated "Aides caught (Resident B) trying to put in door code to smoking area to let residents out the door." Care plans for Resident B related to behaviors, dated 7/31/17, indicated: "I am sometimes demanding and/or have attention seeking behaviors when I want or need something"..."Resident is at risk for elopement"..."I exhibit verbal and physical aggression and resistance at times"..."I exhibit negative behavior toward my roommate." The M.D.S. section for Bladder and Bowel, indicated "Appliances", Resident B had an "Ostomy (including urostomy, ileostomy, and colostomy)." The M.D.S. section "Bowel Continence" was coded as indicating "always continent"..."Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days." An undated facility policy titled "Nursing MDS" received from the Regional Director on 8/23/17 at 2:45, indicated "Policy: It is the policy of this facility to			

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	ensure all Residents are afforded a comprehensive assessment that is completed accurately and timely according to the federally mandated Resident Assessment Instrument." 3.1-31(a)			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

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	(i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on record review and interview, the facility failed to ensure a resident (Resident B) had health care plans	F 0279	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B no	09/20/2017

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	consistent with admitting diagnoses, conditions requiring treatment, the presence of an iliostomy, and scheduled outside treatments, and a resident with a diagnosis and interventions for chronic pain had appropriate care plans. (Resident C). 2 of 3 residents reviewed for care plans. Findings include: The record of Resident B was reviewed on 8/22/17 at 2:00 P.M. Diagnoses included, but were not limited to, end stage renal disease, coronary artery disease, peripheral vascular disease, malnutrition, atrial fibrillation, and an ascending aortic aneurysm. An admission Minimum Data Set (M.D.S.) assessment dated 8/01/17 indicated Resident B was not cognitively impaired, had no noted mood disorders or behaviors, required minimal to moderate assistance with activities of daily living, and used a walker or wheelchair for locomotion about the facility. It also indicated Resident B had 6 venous/arterial ulcers, an ileostomy, and had been on anticoagulants for the 7 days of the assessment period. Active diagnoses in the M.D.S. included, but were not limited to, coronary artery disease, peripheral vascular disease, renal		longer resides in facility. Resident C's plan of care updated to reflect focus, goals, and interventions for chronic pain. **How will other residents having the potential to be affected by the same deficient practice be identified and what correct actions will be taken?** All residents have the potential to be affected by this deficient practice. All residents' care plans reviewed for accuracy by DON/designee to ensure care plans are accurate and consistent with MDS. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? Licensed staff to be inserviced by 9/20/17 by DON/designee regarding Comprehensive Care Plan policy, including accuracy of the MDS and accuracy of careplans. Resident care plan and most recent MDS will be reviewed quarterly and when significant change occurs during IDT clinical meeting and weekly care plan meetings to ensure the care plan is an accurate reflection of the most current comprehensive assessment. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** DNS/designee is responsible for the completion of the care plan/MDS audit QAPI took weekly time 4 weeks, monthly times	

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	insufficiency, and malnutrition. Treatment for skin conditions were noted to include application of nonsurgical dressings, and application of ointments/medications to the feet, and areas other than the feet. A Medication Review Report from the resident's previous long term care facility, which accompanied the resident on admission, indicated: "Cleanse OAs (open areas) to LLE (left lower extremity) with NS (normal saline) and soap and water. Pat dry. Apply moisturizer to surrounding areas...", "Cleanse OAs (open areas) to RLE (right lower extremity) with NS (normal saline) and soap and water. Pat dry. Apply moisturizer to surrounding areas...", A nurse's progress note dated 7/21/17 at 5:00 P.M., indicated "...meds (medications) verified with (facility medical director)...(symbol for "checked") for open areas on BLE (bilateral lower extremities..." A physician's order dated 7/21/17 indicated "Silvercell DRSG (dressing) 4.25" X (by) 4.25" Apply topically to LLE and O/A's to RLE as directed", "Sodium chloride 0.9% irrig btl (irrigation bottle) cleanse LLE and O/A's to RLE as directed", "Eliquis (an anticoagulant; blood thinner) 5 mg		6 months. The results of these audits will be reviewed by the QA committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	(milligram) tablet Give 1 tablet by mouth 2 times a day-AFIB (for the diagnosis of atrial fibrillation.)" A faxed transmission from Resident B's vascular care physician's office dated 8/03/17 indicated "Angiogram instructions for (Resident B)...to hold Eliquis starting Tues (Tuesday) 8/08...Your angiogram is scheduled for Thursday 8/10/17...Take last dose of Eliquis on Monday 8/7/17. No Eliquis on Tues 8/8, Wed (Wednesday) 8/9, or Thurs (Thursday) 8/10..." Resident B's care plans did not include any focus, goals, or interventions for: Admitting diagnoses which included, but were not limited to, peripheral vascular disease, end stage renal disease, coronary artery disease, edema, atrial fibrillation, or gastro-esophageal reflux disease; The daily use of an anti-coagulant medication; The presence of an ileostomy; The presence of multiple vascular wounds of the lower extremities, requiring daily assessment and treatment; The requirement to attend appointments			

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	outside the facility on a weekly basis to receive wound treatment; A scheduled appointment for a vascular surgical procedure. The record of Resident C was reviewed on 8/23/17 at 1:15 P.M. Diagnoses included, but were not limited to, acute embolism and thrombosis of right popliteal vein, cognitive communication deficit, alcohol abuse, adult failure to thrive, drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, and chronic pain. A quarterly Minimum Data Set assessment dated 8/04/17 indicated Resident C was not cognitively impaired, required minimal to moderate staff assistance for activities of daily living, and was incontinent of bladder and bowel. Resident C had limited day-to-day activities because of pain; Resident C rated pain at 7 on a scale of 0 through 10, with 0 being no pain, and 10 as the worst pain you can imagine. A recapitulation of physician's orders for August 2017 indicated a diagnosis of chronic pain. A physician's order dated 6/07/17			

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	indicated "Gabapentin 600 mg tablet Give 1 tablet by mouth every 8 hours for chronic pain", "Acetaminophen 500 mg caplet Give 2 caplets (1000 mg) by mouth every 6 hours as needed for pain." A physician's order dated 6/16/17 indicated "Hydrocodone-Acetaminophen 5-325 Give 1 tablet by mouth every 4 hours as needed for severe pain." Resident C's care plans did not include any focus, goals, or interventions for the concern of chronic pain, including, but not limited to, assessment, non-pharmacological interventions, medication administration, or effectiveness of interventions. An undated facility policy titled "Nursing MDS" received from the Regional Director on 8/23/17 at 2:45, indicated "Policy: It is the policy of this facility to ensure all Residents are afforded a comprehensive assessment that is completed accurately and timely according to the federally mandated Resident Assessment Instrument...Upon completion of the...MDS assessment, a comprehensive care plan is developed..." This Federal tag relates to Complaints IN00237729 and IN00238286.			

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	3.1-35(a)			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a resident (Resident B) received a surgical procedure as scheduled for 1 of 3 residents reviewed for out of procedures. Findings include: The record of Resident B was reviewed on 8/22/17 at 2:00 P.M. Diagnoses included, but were not limited to, end stage renal disease, coronary artery disease, peripheral vascular disease, malnutrition, atrial fibrillation, and an ascending aortic aneurysm. An admission Minimum Data Set (M.D.S.) assessment dated 8/01/17 indicated Resident B was not cognitively impaired, had no noted mood disorders or behaviors, required minimal to moderate	F 0282	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B no longer resides in facility. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** All residents have the potential to be affected by this deficient practice. New orders for residents will be placed in residents chart upon receiving per Charting and Documentation policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? Licensed staff to be inserviced by 9/20/17 by DON/designee on placing orders in residents' medical records upon receiving per Charting and Documentation policy.	09/20/2017

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	assistance with activities of daily living, and used a walker or wheelchair for locomotion about the facility. It also indicated Resident B had 6 venous/arterial ulcers, an ileostomy, and had been on anticoagulants. Active diagnoses in the M.D.S. included, but were not limited to, coronary artery disease, peripheral vascular disease, renal insufficiency, and malnutrition. Treatment for skin conditions were noted to include application of nonsurgical dressings, and application of ointments/medications to the feet, and areas other than the feet. A faxed transmission from Resident B's vascular care physician's office dated 8/03/17 indicated "Angiogram instructions for (Resident B)...to hold Eliquis starting Tues (Tuesday) 8/08...Your angiogram is scheduled for Thursday 8/10/17...Take last dose of Eliquis on Monday 8/7/17. No Eliquis on Tues 8/8, Wed (Wednesday) 8/9, or Thurs (Thursday) 8/10..." A faxed transmission from Resident B's vascular care physician's office dated 8/09/17 received at 2:15 P.M., indicated "Patient (Resident B) has appt (appointment) 8/10/17 at 9:15 at (name of vascular surgery practice). It is imperative that pt (patient) arrives early		**How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** DNS/designee is responsible for the completion of the charting and documentation QAPI took weekly time 4 weeks, monthly times 6 months. The results of these audits will be reviewed by the QA committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	for this appointment." A nurse's progress note dated 8/09/17 at 3:30 P.M., indicated "Res appt (resident's appointment) canceled d/t (due to) failure to hold Eliquis X (times) 2 days prior to surgery as ordered...Appt rescheduled for Thur Aug (August) 17th..." Medication administration records indicated Resident B received Eliquis 5 mg tablets twice a day as ordered, including on 8/08/17, 8/09/17, and 8/10/17. On 8/23/17 at 10 A.M., the Director of Nursing (DON), with the Administrator and Regional Director present, indicated the previous Director of Nursing had received the instructions related to Resident B's scheduled procedure of 8/10/17, including holding the anticoagulant medication. The DON indicated the previous DON had kept this information "locked in her office" and had not entered this information in the resident's medical record or the medication administration records, and had not informed nursing of the presurgery requirements, resulting in Resident B's surgical procedure being rescheduled. A facility policy titled "Charting and			

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	155721	A. BUILDING 00 B. WING	08/23/2017

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	Documentation" dated August 2006, received form the Regional Director on 8/23/17 at 2:15 P.M., indicated "Policy Statement: All services provided to the resident...shall be documented in the resident's medical record." This federal tag relates to Complaints IN00237729 and IN00238286. 3.1-35(g)(2)			
F 0514 SS=D Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and			

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	services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to maintain complete, accurate, and readily accessible medical records, by not ensuring assessments were accurate, care plans were complete and reflected resident needs, and not ensuring records required to inform facility staff of a scheduled procedure were in the resident's medical record, resulting in the procedure requiring rescheduling. Resident B; 1 of 3 residents reviewed for medical records. Findings include: The record of Resident B was reviewed on 8/22/17 at 2:00 P.M. Diagnoses included, but were not limited to, end stage renal disease, coronary artery disease, peripheral vascular disease, malnutrition, atrial fibrillation, and an ascending aortic aneurysm. An admission Minimum Data Set	F 0514	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B no longer resides in facility. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?** All residents have the potential to be affected by this deficient practice. Documentation of services provided to resident or changes in condition will be included in medical record per Charting and Documentation policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**? Licensed staff to be inserviced by 9/20/17 by DON/designee on Charting and Documentation policy. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be**	09/20/2017

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	(M.D.S.) assessment dated 8/01/17 indicated Resident B was not cognitively impaired, had no noted mood disorders or behaviors, required minimal to moderate assistance with activities of daily living, and used a walker or wheelchair for locomotion about the facility. It also indicated Resident B had 6 venous/arterial ulcers, an ileostomy, and had been on anticoagulants. Active diagnoses in the M.D.S. included, but were not limited to, coronary artery disease, peripheral vascular disease, renal insufficiency, and malnutrition. Treatment for skin conditions were noted to include application of nonsurgical dressings, and application of ointments/medications to the feet, and areas other than the feet. The M.D.S., indicated "Physical behavioral symptoms directed towards others" was coded as "Behavior not exhibited", "Other behavioral symptoms not directed at others" was coded as "Behavior not exhibited", "Rejection of Care" was coded as "Behavior not exhibited", "Wandering" was coded as "Behavior not exhibited." A note dated 7/26/17 indicated "It was brought to the aides' attention that (Resident B) might be in the main dining room at night smoking a cigarette		**put into place?** DNS/designee is responsible for the completion of the charting and documentation QAPI took weekly time 4 weeks, monthly times 6 months. The results of these audits will be reviewed by the QA committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	through the window." A note 7/26/17 indicated "Aides caught (Resident B) trying to put in door code to smoking area to let residents out the door." Care plans for Resident B related to behaviors, dated 7/31/17, indicated: "I am sometimes demanding and/or have attention seeking behaviors when I want or need something.", "Resident is at risk for elopement.", "I exhibit verbal and physical aggression and resistance at times.", "I exhibit negative behavior toward my roommate." The M.D.S. assessment, Bladder and Bowel section indicated "Appliances" had an "Ostomy (including urostomy, ileostomy, and colostomy)." The M.D.S. assessment section "Bowel Continence" was coded as "always continent", "Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days." A faxed transmission from Resident B's vascular care physician's office dated 8/03/17 indicated "Angiogram instructions for (Resident B)...to hold Eliquis starting Tues (Tuesday) 8/08...Your angiogram is scheduled for			

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	Thursday 8/10/17...Take last dose of Eliquis on Monday 8/7/17. No Eliquis on Tues 8/8, Wed (Wednesday) 8/9, or Thurs (Thursday) 8/10..." Resident B's care plans did not include any focus, goals, or interventions for: Admitting diagnoses which included, but were not limited to, peripheral vascular disease, end stage renal disease, coronary artery disease, edema, atrial fibrillation, or gastro-esophageal reflux disease; The daily use of an anti-coagulant medication; The presence of an ileostomy; The presence of multiple vascular wounds of the lower extremities, requiring daily assessment and treatment; The requirement to attend appointments outside the facility on a weekly basis to receive wound treatment; A scheduled appointment for a vascular surgical procedure. A nurse's progress note dated 8/09/17 at 3:30 P.M., indicated "Res appt (resident's appointment) canceled d/t (due to) failure to hold Eliquis X (times) 2 days prior to			

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	surgery as ordered...Appt rescheduled for Thur Aug (August) 17th..." Medication administration records indicated Resident B received Eliquis 5 mg tablets twice a day as ordered, including on 8/08/17, 8/09/17, and 8/10/17. On 8/23/17 at 10 A.M., the Director of Nursing (DON), with the Administrator and Regional Director present, indicated the previous Director of Nursing had received the instructions related to Resident B's scheduled procedure of 8/10/17, including holding the anticoagulant medication. The DON indicated the previous DON had kept this information "locked in her office" and had not entered this information in the resident's medical record or the medication administration records, and had not informed nursing of the presurgery requirements, resulting in Resident B's surgical procedure being rescheduled. Resident B's nurse's progress notes did not contain any documentation of the resident going out of the facility to a wound clinic appointment on 7/27/17, or going out to, or returning from, a wound clinic appointment on 8/02/17 including, but not limited to, an assessment of the			

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	resident's condition on leaving and returning to the facility. Nurse's notes did not contain any documentation of communication received from the vascular surgeon's office on 8/03/17 indicating Resident B was to have a vascular procedure on 8/10/17, with accompanying presurgical instructions, including holding of anticoagulant medications. On 8/23/17 at 10 A.M., the DON indicated that, without documentation a resident had left the facility for a scheduled appointment, how would a staff member who noted the resident was not in the facility, could know the resident had not eloped. The DON indicated outside appointments were noted in a schedule book, but noted this was not a part of the resident's medical record. A facility policy titled "Charting and Documentation" dated 2001 and revised April 2008, received from the Regional Director on 8/23/17 at 2:15 P.M., indicated "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record...All incidents, accidents, or changes in the resident's condition must be documented..."			

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