PRINTED: 09/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155721		A. BUI	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			(X3) DATE SURVEY COMPLETED 08/23/2017	
	ROVIDER OR SUPPLIE	R LTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG F 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 00	Complaints INO IN00238286. Complaint IN00 Deficiencies relicited at F279, F Complaint IN00 Deficiencies relicited at F279, F Unrelated deficited at F279, F	2237729- Substantiated. ated to the allegations are 282, and F514. 2238286- Substantiated. ated to the allegations are 282, and F514. iency cited ugust 22 and 23, 2017 1: 000383 2r: 155721 200289610 2:	F 000	00	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 fort on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by state and federal law.	h	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000383

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155721		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 23/2017	
	PROVIDER OR SUPPLIEF		8935 E	ADDRESS, CITY, STATE, ZIP CO 46TH ST IAPOLIS, IN 46226	ODE .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	findings cited in IAC 16.2.3-1.	accordance with 410				
	Quality review of 2017	completed on August 29,				
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIV (b) Comprehensiv	/E ASSESSMENTS e Assessments				
	facility must make assessment of a r strengths, goals, I preferences, using instrument (RAI) s	esident's needs,				
	information (ii) Customary ro (iii) Cognitive pat (iv) Communicati (v) Vision. (vi) Mood and be (vii) Psychologica (viii) Physical problems. (ix) Continence. (x) Disease diagi conditions. (xi) Dental and no (xii) Skin Conditio (xiii) Activity p (xiv) Medicatio	terns. on. havior patterns. I well-being. functioning and structural nosis and health utritional status. ns. oursuit.				
	(xvi) Discharg	e planning. ntation of summary				

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STATEMENT OF DEFICIENCIES X1) PI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155721	B. W	NG		08/23/	/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOIT EIEF			8935 E	46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN	APOLIS, IN 46226		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
	assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).						
	•	• • • • • • • • • • • • • • • • • • • •					
		assessment process					
	must include direc						
		ation and communication as well as communication					
	with licensed and	as well as communication					
		ensed direct care staff					
	members on all sh	nifts.					
		process must include direct communication with the					
		as communication with					
		licensed direct care staff					
	members on all sh						
	Based on record	review, the facility failed	F 02	272	What corrective action(s) will be		09/20/2017
	to ensure resider	nt assessments were			accomplished for those residents		
	complete and ac	curate, when an			found to have been affected by the		
	admission Minir	num Data Set (M.D.S.)			deficient practice? Affected		
		not accurately reflect a			resident no longer resides in facility. How will other residents having the		
		iors, or bowel function. 1			potential to be affected by the	•	
		viewed for accurate			same deficient practice be		
	assessments. (Re				identified and what correct actions		
	(10	 - ,			will be taken? All residents have the	e	
	Findings include	·	1		potential to be affected by this		
	i mamgs merade				deficient practice. An audit of		
	The record of D	esident B was reviewed			assessments will be completed by	£	
			1		DON/Designee to ensure accuracy o assessments.	'I	
		00 P.M. Diagnoses			What measures will be put into		
	1	ere not limited to, end			place or what systemic changes wil	l	
	_	ise, coronary artery	1		be made to ensure that the		
	, , , , , , , , , , , , , , , , , , ,	ral vascular disease,			deficient practice does not recur? A	A	
		ial fibrillation, and an			review of assessments will be		
	ascending aortic	aneurysm.	1		completed by DON/Designee daily		
					for 4 weeks. Licensed staff will be		
	An admission M	Iinimum Data Set			inserviced on accuracy of		
	The warmout of the same of the				assessments by 9/20/2017.		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	ETED	
		155721	B. WI	NG		08/23/	2017	
NAME OF I	PROVIDER OR SUPPLIE	D.	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	K.		8935 E	46TH ST			
LAWREN	NCE MANOR HEAL	THCARE CENTER	INDIANAPOLIS, IN 46226					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	(M.D.S.) assessi	ment dated 8/01/17			How will the corrective action be			
	indicated Reside	ent B was not cognitively			monitored to ensure the deficient			
	impaired, had no	o noted mood disorders or			practice will not recur, i.e. what			
	behaviors, requi	red minimal to moderate			quality assurance program will be			
		activities of daily living,			put into place? DNS/designee is			
		er or wheelchair for			responsible for the completion of the assessment audit QAPI took			
		ut the facility. It also			weekly time 4 weeks, monthly times	.		
		•			6 months. The results of these	´		
	indicated Reside				audits will be reviewed by the QA			
		ulcers, an ileostomy, and			committee overseen by the			
		icoagulants for the 7 days			administrator. If threshold of 95% is	s		
		nt period. Active			not achieved an action plan will be			
	diagnoses in the	M.D.S. included, but			developed to ensure compliance.			
	were not limited	l to, coronary artery						
	disease, periphe	ral vascular disease, renal						
	insufficiency, ar	nd malnutrition.						
	_	kin conditions were noted						
	to include applic	cation of nonsurgical						
	dressings, and a							
		cations to the feet, and						
	areas other than	•						
	areas offici than	the rect.						
	The behavior se	ction of the M.D.S.,						
		ical behavioral symptoms						
	-							
		s others" was coded						
		xhibited", "Other						
		otoms not directed at						
	others" was cod	ed "Behavior not						
	exhibited", "Re	jection of Care" was						
	coded as "Behav	vior not exhibited,						
	"Wandering" wa	as coded indicating						
	"Behavior not e	_						
	A mate 1-1-17/6	06/17 in linetal III						
		26/17 indicated "It was						
	brought to the a	ides' attention that						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
THEFTERN	or conduction	155721	B. W.		00	08/23/	
		100721		CTDEET A	DDDEGG CITY CTATE ZID CODE	00/20/	2017
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE 46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			APOLIS, IN 46226		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DE CAMPANA DE LA CORRESCIONA DE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	`	ght be in the main dining					
	_	noking a cigarette					
	through the wind	dow."					
	A mata 7/26/17 :	ndicated "Aides cought					
		ndicated "Aides caught ing to put in door code to					
		let residents out the					
	door."	ict residents out the					
	door.						
	Care plans for R	esident B related to					
	behaviors, dated	7/31/17, indicated: "I					
	am sometimes d	emanding and/or have					
	attention seeking	g behaviors when I want					
	or need somethin	ng""Resident is at risk					
	for elopement"	."I exhibit verbal and					
	physical aggress	ion and resistance at					
		it negative behavior					
	toward my room	nmate."					
	The M.D.S. sect	ion for Bladder and					
		d "Appliances", Resident					
	•	ny (including urostomy,					
	ileostomy, and c						
	· · · · · · · · · · · · · · · · · · ·	- 37					
	The M.D.S. sect	ion "Bowel Continence"					
	was coded as inc						
	continent""No	t rated, resident had an					
	ostomy or did no	ot have a bowel					
	movement for th	ne entire 7 days."					
	A1 (10 3	11411					
		lity policy titled "Nursing					
		from the Regional					
		/17 at 2:45, indicated					
	Policy: It is the	policy of this facility to					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	JILDING ING	00	COMPL	
		155721	B. W			08/23/	2017
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
1 AVA/DEN	IOE MANOD LIEAL	THE ADE CENTED			46TH ST		
LAWKEN	ICE MANOR HEAL	THCARE CENTER		INDIAN	APOLIS, IN 46226		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		ents are afforded a					
	comprehensive a						
	completed accura	•					
	_	federally mandated					
	Resident Assessi	ment Instrument."					
	3.1-31(a)						
F 0279	483.20(d);483.21(b)(1)					
SS=D		REHENSIVE CARE					
Bldg. 00	PLANS						
	483.20						
		must maintain all resident pleted within the previous					
		esident's active record					
		s of the assessments to					
	•	nd revise the resident's					
	comprehensive ca	re plan.					
	483.21						
	(b) Comprehensiv	e Care Plans					
	(A) T I 6 1111						
	· '	st develop and implement person-centered care plan					
		consistent with the					
		forth at §483.10(c)(2) and					
		t includes measurable					
	objectives and tim						
		, nursing, and mental and Is that are identified in the					
	comprehensive as						
		re plan must describe the					
	following -						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155721	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/23/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	attain or maintain practicable physic	being as required under						
	required under §4 but are not provide	nat would otherwise be 83.24, §483.25 or §483.40 ed due to the resident's under §483.10, including treatment under						
	rehabilitative servi provide as a resul- recommendations the findings of the	d services or specialized ces the nursing facility will t of PASARR . If a facility disagrees with PASARR, it must indicate resident's medical record.						
	(iv)In consultation resident's represe	with the resident and the ntative (s)-						
	(A) The resident's desired outcomes	goals for admission and						
	for future discharg document whethe return to the comm any referrals to loc	preference and potential e. Facilities must r the resident's desire to nunity was assessed and cal contact agencies opriate entities, for this						
	care plan, as appr with the requireme (c) of this section.							
	the facility failed	review and interview, I to ensure a resident I 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 e			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155721 B. WING 08/23/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG consistent with admitting diagnoses, longer resides in facility. Resident C's plan of care updated to reflect conditions requiring treatment, the focus, goals, and interventions for presence of an iliostomy, and scheduled chronic pain. outside treatments, and a resident with a How will other residents having the diagnosis and interventions for chronic potential to be affected by the pain had appropriate care plans. same deficient practice be (Resident C). 2 of 3 residents reviewed identified and what correct actions will be taken? All residents have the for care plans. potential to be affected by this deficient practice. All residents' care Findings include: plans reviewed for accuracy by DON/designee to ensure care plans The record of Resident B was reviewed are accurate and consistent with on 8/22/17 at 2:00 P.M. Diagnoses What measures will be put into included, but were not limited to, end place or what systemic changes will stage renal disease, coronary artery be made to ensure that the disease, peripheral vascular disease, deficient practice does not recur? malnutrition, atrial fibrillation, and an Licensed staff to be inserviced by ascending aortic aneurysm. 9/20/17 by DON/designee regarding Comprehensive Care Plan policy, including accuracy of the MDS and An admission Minimum Data Set accuracy of careplans. Resident care (M.D.S.) assessment dated 8/01/17 plan and most recent MDS will be indicated Resident B was not cognitively reviewed quarterly and when impaired, had no noted mood disorders or significant change occurs during IDT behaviors, required minimal to moderate clinical meeting and weekly care assistance with activities of daily living, plan meetings to ensure the care plan is an accurate reflection of the and used a walker or wheelchair for most current comprehensive locomotion about the facility. It also assessment. indicated Resident B had 6 How will the corrective action be venous/arterial ulcers, an ileostomy, and monitored to ensure the deficient had been on anticoagulants for the 7 days practice will not recur, i.e. what quality assurance program will be of the assessment period. Active

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diagnoses in the M.D.S. included, but

disease, peripheral vascular disease, renal

were not limited to, coronary artery

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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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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155721	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/23/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	to include applic dressings, and ap ointments/medic areas other than	in conditions were noted ation of nonsurgical oplication of ations to the feet, and the feet.			6 months. The results of these audits will be reviewed by the QA committee overseen by the administrator. If threshold of 95% i not achieved an action plan will be developed to ensure compliance.	s		
	which accompanadmission, indications, indica	NS (normal saline) and Pat dry. Apply rrounding areas", pen areas) to RLE (right with NS (normal saline) ter. Pat dry. Apply rrounding areas", A note dated 7/21/17 at ated "meds rified with (facility						
	A physician's ord indicated "Silver 4.25" X (by) 4.2: LLE and O/A's to "Sodium chlorid (irrigation bottle) to RLE as directed	der dated 7/21/17 cell DRSG (dressing) 5" Apply topically to o RLE as directed",						

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ANDILAN	OF CORRECTION	155721	B. W		00	08/23	
		133721	J. ,,,			00/23/	2017
NAME OF F	ROVIDER OR SUPPLIEF	3		1	DDRESS, CITY, STATE, ZIP CODE		
ΙΔ\MREN	ICE MANOR HEAL	THCARE CENTER			46TH ST APOLIS, IN 46226		
				<u> </u>	W OLIO, IIV 40220		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		et Give 1 tablet by mouth		ing	<u> </u>		DATE
	. • /	FIB (for the diagnosis of					
	1	` •					
	atrial fibrillation	i.)"					
	A C 14 .	. C D :1 (D)					
		ssion from Resident B's					
	•	ysician's office dated					
	8/03/17 indicate	• •					
		(Resident B)to hold					
	Eliquis starting	• /					
	_	ogram is scheduled for					
	1	7Take last dose of					
	•	lay 8/7/17. No Eliquis on					
		Wednesday) 8/9, or					
	Thurs (Thursday	v) 8/10"					
	Resident B's car	e plans did not include					
	any focus, goals	, or interventions for:					
	Admitting diagn	oses which included, but					
	were not limited	to, peripheral vascular					
	disease, end stag	ge renal disease, coronary					
	artery disease, e	dema, atrial fibrillation,					
	or gastro-esopha	igeal reflux disease;					
	• • • • • • • • • • • • • • • • • • •						
	The daily use of	an anti-coagulant					
	medication;	•					
	The presence of	an ileostomy;					
		3 /					
	The presence of	multiple vascular					
	-	ower extremities,					
		ssessment and treatment;					
	1 2 yaning aany a	socialization and treatment,					
	The requirement	t to attend appointments					
		to attend appointments					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
ANDIEM	or conduction	155721	B. W.		00	08/23	
		100721			DDDEGG CITY GTATE ZID CODE	00/20/	2011
NAME OF I	PROVIDER OR SUPPLIEF	R		1	ADDRESS, CITY, STATE, ZIP CODE		
LAWREN	ICE MANOR HEAL	THCARE CENTER			APOLIS, IN 46226		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	receive wound to	ity on a weekly basis to					
	receive wound th	reatment,					
		pointment for a vascular					
	surgical procedu	ire.					
		esident C was reviewed					
		15 P.M. Diagnoses are not limited to, acute					
		rombosis of right					
		ognitive communication					
	1 ^ ^	abuse, adult failure to					
	·	hemical induced diabetes					
		urological complications					
		uropathy, and chronic					
	pain.	mopum, una emonie					
	P						
	A quarterly Min	imum Data Set					
	assessment dated	d 8/04/17 indicated					
	Resident C was	not cognitively impaired,					
	required minima	l to moderate staff					
		tivities of daily living,					
		nent of bladder and					
		C had limited day-to-day					
		e of pain; Resident C					
	_	n a scale of 0 through 10,					
		pain, and 10 as the worst					
	pain you can ima	agme.					
	A recanitulation	of physician's orders for					
	_	licated a diagnosis of					
	chronic pain.	aragnosis or					
	F						
	A physician's or	der dated 6/07/17					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155721		ì	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/23	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE		
	Give 1 tablet by chronic pain", "A caplet Give 2 cap mouth every 6 he A physician's ordindicated "Hydro 5-325 Give 1 tab hours as needed Resident C's card any focus, goals, concern of chron not limited to, as non-pharmacolo medication admite effectiveness of An undated facil MDS" received and Director on 8/23 "Policy: It is the ensure all Resident Comprehensive according to the Resident Assessing comprehensive of the comprehe	e plans did not include , or interventions for the nic pain, including, but sessment, gical interventions, nistration, or interventions. ity policy titled "Nursing from the Regional /17 at 2:45, indicated policy of this facility to ents are afforded a assessment that is ately and timely federally mandated ment InstrumentUpon eMDS assessment, a care plan is developed"							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155721	B. WI	NG		08/23/	2017
NAME OF B	DOMBER OF CLIPPLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			8935 E	46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIANAPOLIS, IN 46226			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFTING INFORMATION)	+	TAG			DATE
F 0282 SS=D Bldg. 00	3.1-35(a) 483.21(b)(3)(ii) SERVICES BY QUECARE PLAN (b)(3) Comprehense The services provifacility, as outlined care plan, musticare plan, mus	ded or arranged by the by the comprehensive qualified persons in ach resident's written plan review and interview, to ensure a resident eived a surgical eduled for 1 of 3 ed for out of procedures. : :: :: :: :: :: :: :: :: :: :: :: ::	F 02	282	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		DATE 09/20/2017
		nent dated 8/01/17			deficient practice does not recur?		
					Licensed staff to be inserviced by 9/20/17 by DON/designee on		
		nt B was not cognitively			placing orders in residents' medical		
	•	noted mood disorders or			records upon receiving per Charting		
	benaviors, requir	red minimal to moderate			and Documentation policy.		

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NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155721	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMP! 08/23	LETED		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID DEPOSITION (8	8935 E 46TH ST					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE		
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) 8/08Your angiogram is scheduled for Thursday 8/10/17Take last dose of Eliquis on Monday 8/7/17. No Eliquis on Tues 8/8, Wed (Wednesday) 8/9, or Thurs (Thursday) 8/10/17 at 9:15 at (name of vascular surgery practice). It is imperative that pt (patient) arrives early		assistance with a and used a walked locomotion about indicated Resided venous/arterial used had been on antidiagnoses in the were not limited disease, peripher insufficiency, and Treatment for sketo include applied dressings, and appointments/medicareas other than A faxed transmission vascular care phy 8/03/17 indicated instructions for (Eliquis starting Taylor) 8/08 Your angion Thursday 8/10/1 Eliquis on Mondon Tues 8/8, Wed (Thurs (Thursday A faxed transmission vascular care phy 8/09/17 received "Patient (Resided (appointment) 8/05 of vascular surged of vascular surged of vascular surged surged in the sur	activities of daily living, er or wheelchair for at the facility. It also ant B had 6 alcers, an ileostomy, and coagulants. Active M.D.S. included, but to, coronary artery ral vascular disease, renal d malnutrition. in conditions were noted eation of nonsurgical oplication of rations to the feet, and the feet. Sision from Resident B's sysician's office dated d "Angiogram Resident B)to hold a fues (Tuesday) ogram is scheduled for 7Take last dose of lay 8/7/17. No Eliquis on Wednesday) 8/9, or and 8/10" Sision from Resident B's sysician's office dated lat 2:15 P.M., indicated and B) has appt approactice). It is			monitored to ensure the deficie practice will not recur, i.e. wha quality assurance program will put into place? DNS/designee responsible for the completion 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. threshold of 95% is not achieved action plan will be developed to	ent t be is of n ,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155721	B. W	ING		08/23/	2017
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LAWREN	ICE MANOR HEAL	THCARE CENTER			46TH ST APOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LEG INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) nent."		TAG	BEHELEVETY		DATE
	3:30 P.M., indicate appointment) can to hold Eliquis X surgery as ordered. Thur Aug (August Medication admindicated Reside mg tablets twice including on 8/0 8/10/17. On 8/23/17 at 10 Nursing (DON), and Regional Ditthe previous Directived the inst Resident B's sch 8/10/17, including anticoagulant maindicated the preinformation "lochad not entered to resident's medication adminad not informed presurgery requirescheduled.	ass note dated 8/09/17 at ated "Res appt (resident's neeled d/t (due to) failure (times) 2 days prior to edAppt rescheduled for ast) 17th" Inistration records a day as ordered, 8/17, 8/09/17, and O A.M., the Director of with the Administrator rector present, indicated ector of Nursing had ructions related to eduled procedure of a holding the edication. The DON vious DON had kept this ked in her office" and this information in the all record or the nistration records, and I nursing of the rements, resulting in gical procedure being					
	A facility policy	titled "Charting and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155721		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY LETED 3/2017		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 0514 SS=D Bldg. 00	Documentation" received form the 8/23/17 at 2:15 F Statement: All se residentshall be resident's medica. This federal tag is IN00237729 and 3.1-35(g)(2) 483.70(i)(1)(5) RES RECORDS-COMF SSIBLE (i) Medical records (1) In accordance professional stand	dated August 2006, e Regional Director on P.M., indicated "Policy ervices provided to the e documented in the al record." relates to Complaints I IN00238286. PLETE/ACCURATE/ACCE s. with accepted lards and practices, the ain medical records on are-	TAG	DEFICIENCY)		DATE	
	(iii) Readily access						
	(iv) Systematically	organized					
	(5) The medical re	cord must contain-					
	(i) Sufficient inform resident;	nation to identify the					
	(ii) A record of the	resident's assessments;					
	(iii) The comprehe	nsive plan of care and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155721	B. W	ING		08/23/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
					GEIG, IIV 16226		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	services provided	•					
	(iv) The regulte of	any preadmission					
		sident review evaluations					
		ns conducted by the State;					
		is contained by the state,					
	(v) Physician's, ทเ	urse's, and other licensed					
	professional's pro	gress notes; and					
	(vi) Laboratory, ra						
	diagnostic services reports as required						
	under §483.50.	or to and token to	ГО	514	National community of the Control of		00/20/2017
		review and interview,	F 0:	514	What corrective action(s) will be accomplished for those residents		09/20/2017
	the facility failed to maintain complete,				found to have been affected by the		
	accurate, and readily accessible medical				deficient practice? Resident B no	!	
	records, by not e	ensuring assessments			longer resides in facility.		
	were accurate, ca	are plans were complete			How will other residents having the	.	
	and reflected res	sident needs, and not			potential to be affected by the	-	
		required to inform			same deficient practice be		
		scheduled procedure			identified and what corrective		
	*	lent's medical record,			actions will be taken? All residents		
					have the potential to be affected by	,	
		procedure requiring			this deficient practice.		
		esident B; 1 of 3 residents			Documentation of services provided	i	
	reviewed for me	dical records.			to resident or changes in condition		
					will be included in medical record		
	Findings include	· ·			per Charting and Documentation		
					policy.		
	The record of Re	esident B was reviewed			What measures will be put into		
	on 8/22/17 at 2:0	00 P.M. Diagnoses			place or what systemic changes will be made to ensure that the	•	
		ere not limited to, end			deficient practice does not recur?		
	· ·	ise, coronary artery			Licensed staff to be inserviced by		
		ral vascular disease,			9/20/17 by DON/designee on		
					Charting and Documentation policy.		
		ial fibrillation, and an			How will the corrective action be		
	ascending aortic	aneurysm.			monitored to ensure the deficient		
					practice will not recur, i.e. what		
	An admission M	Iinimum Data Set			quality assurance program will be		
	I		1		i .		l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155721	B. W	ING		08/23/	2017
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			8935 E	46TH ST		
LAWRENCE MANOR HEALTHCARE CENTER				INDIAN	APOLIS, IN 46226		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	` /	ment dated 8/01/17			put into place? DNS/designee is		
		nt B was not cognitively			responsible for the completion of the charting and documentation		
	-	noted mood disorders or			QAPI took weekly time 4 weeks,		
	behaviors, requii	red minimal to moderate			monthly times 6 months. The		
	assistance with a	ectivities of daily living,			results of these audits will be		
	and used a walke	er or wheelchair for			reviewed by the QA committee		
	locomotion abou	it the facility. It also			overseen by the administrator. If		
	indicated Reside	nt B had 6			threshold of 95% is not achieved an		
	venous/arterial u	llcers, an ileostomy, and			action plan will be developed to		
		coagulants. Active			ensure compliance.		
	diagnoses in the M.D.S. included, but						
	_	to, coronary artery					
		ral vascular disease, renal					
	insufficiency, an						
		in conditions were noted					
		ation of nonsurgical					
	dressings, and ap						
		ations to the feet, and					
	areas other than	the feet.					
	The M.D.S., indi	icated "Physical					
	· · · · · · · · · · · · · · · · · · ·	toms directed towards					
		ed as "Behavior not					
		er behavioral symptoms					
	· ·	thers" was coded as					
		khibited", "Rejection of					
		l as "Behavior not					
		ndering" was coded as					
	"Behavior not ex	anioitea."					
	Δ note dated 7/2	6/17 indicated "It was					
		des' attention that					
	·	ght be in the main dining					
	room at night sm	noking a cigarette					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155721	B. W	ING		08/23/	2017
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LAWREN	ICE MANOR HEAL	THCARE CENTER			46TH ST APOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	through the wind	low."					
	(Resident B) tryi	ndicated "Aides caught ing to put in door code to let residents out the					
	behaviors, dated am sometimes do attention seeking or need somethin for elopement.", physical aggress	esident B related to 7/31/17, indicated: "I emanding and/or have g behaviors when I want ng.", "Resident is at risk "I exhibit verbal and ion and resistance at it negative behavior mate."					
	The M.D.S. assessment, Bladder and Bowel section indicated "Appliances" had an "Ostomy (including urostomy, ileostomy, and colostomy)."						
	Continence" was						
	vascular care phy 8/03/17 indicated instructions for (Eliquis starting 1	Resident B)to hold					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
THIND I LIMIT	or conduction	155721	B. W		00	08/23/	
		100721		CTDEET A	DDRESS, CITY, STATE, ZIP CODE	00/20/	2017
NAME OF F	PROVIDER OR SUPPLIEF	₹			46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			APOLIS, IN 46226		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		7Take last dose of					
	*	lay 8/7/17. No Eliquis on					
		Wednesday) 8/9, or					
	Thurs (Thursday	7) 8/10"					
	Resident R's car	e plans did not include					
		, or interventions for:					
	, 10 00 0, 5 0015	, 0.2					
	Admitting diagn	oses which included, but					
	were not limited	to, peripheral vascular					
	disease, end stag	ge renal disease, coronary					
	artery disease, edema, atrial fibrillation,						
	or gastro-esopha	igeal reflux disease;					
	The deily use of	'an anti accaulant					
	medication;	an anti-coagulant					
	inedication,						
	The presence of	an ileostomy;					
	The presence of	multiple vascular					
	wounds of the lo	ower extremities,					
	requiring daily a	ssessment and treatment;					
	TTI :						
	•	t to attend appointments					
		ity on a weekly basis to					
	receive wound to	reatment;					
	A scheduled app	pointment for a vascular					
	surgical procedu						
	- -						
		ess note dated 8/09/17 at					
		ated "Res appt (resident's					
		nceled d/t (due to) failure					
	to hold Eliquis X	X (times) 2 days prior to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155721		lì í	UILDING	NSTRUCTION 00	(X3) DATE COMPL 08/23/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	surgery as ordere Thur Aug (Augu	edAppt rescheduled for st) 17th"						
	indicated Reside mg tablets twice	inistration records nt B received Eliquis 5 a day as ordered, 8/17, 8/09/17, and						
	Nursing (DON), and Regional Directived the instructive of the instructive of the previous Directive of the previous Directive of the instructive of the instructive of the instruction of the indicated the president of the information of the information of the information of the information admit had not informed presurgery requirection of the information	edication. The DON vious DON had kept this ked in her office" and his information in the al record or the nistration records, and I nursing of the rements, resulting in gical procedure being						
	not contain any or resident going or wound clinic app going out to, or a clinic appointme	se's progress notes did documentation of the act of the facility to a pointment on 7/27/17, or returning from, a wound not on 8/02/17 including, o, an assessment of the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155721		l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 08/23/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	returning to the finot contain any communication is vascular surgeon indicating Residuaccompanying princluding holding medications. On 8/23/17 at 10 indicated that, we resident had left scheduled appoints that the facility resident had not indicated outside noted in a scheduled in a schedu	ntment, how would a so noted the resident was a condition, could know the eloped. The DON appointments were alle book, but noted this of the resident's medical titled "Charting and dated 2001 and revised fived from the Regional (17 at 2:15 P.M., ervices provided to the changes in the resident's all condition, shall be the resident's medical dents, accidents, or esident's condition must						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155721	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 08/23	LETED
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			8935 E	ADDRESS, CITY, STATE, ZIP CODE 46TH ST IAPOLIS, IN 46226		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	This Federal tag IN00237729 and 3.1-50(a)(10 3.1-50 (a)(2)	relates to Complaints I IN00238286.				

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