PRINTED: 12/12/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION		(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED 11/02/2018		
AND FLAN	OF CORRECTION	155721	B. WING	00				
	PROVIDER OR SUPPLIE	R LTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWINERIC BLANCE CORRECTS	ON	(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI	BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE		
F 0000								
Bldg. 00	Licensure Survey. Investigation of Co Complaint IN0027 deficiencies related	155721	F 0000					
F 0576 SS=D Bldg. 00	accordance with 4: Quality review cor 483.10(g)(6)-(9) Right to Forms of §483.10(g)(6) Th have reasonable telephone, includ and a place in the made without bei	reflect State Findings cited in						

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

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155721	B. WI	ING		11/02/	2018
	PROVIDER OR SUPPLIER	THCARE CENTER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	\top	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	the resident's own	expense.					
	§483.10(g)(7) The facilitate that resid with individuals an external to the fac access to: (i) A telephone, in services; (ii) The internet, to facility; and (iii) Stationery, pos and the ability to seemed and receive packages and othe facility for the resident and a postal serv (i) Privacy of such consistent with this (ii) Access to static implements at the seemed and video internet research. (i) If the access is (ii) At the resident expense is incurred such access to the	e facility must protect and dent's right to communicate and entities within and cility, including reasonable cluding TTY and TDD to the extent available to the stage, writing implements send mail. The resident has the right to mail, and to receive letters, are materials delivered to the dent through a means other rice, including the right to: a communications is section; and onery, postage, and writing a resident's own expense. The resident has the right to access to and privacy in concern communications such to communications and for available to the facility 's expense, if any additional and by the facility to provide					
	Based on interview failed to ensure resi on Saturdays. This l	and record review, the facility idents received his or her mail had a potential to affect 29 to side in the facility. (Resident	F 05	576	F576 The practice of timely delivery resident mail affects all resider including resident F who voice her concern at the time of the	nts,	12/02/2018

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155721	B. W	ING		11/02/2	2018
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	ICE MANOD LIEAL	THE ADE CENTED			46TH ST		
LAWKER	NCE MANOR HEAL	THCARE CENTER		INDIAN	IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					survey. The practice for ensu	ring	
	Findings include:				the timely delivery of resident	mail	
					was clarified with facility mana	agers	
	During a resident c	ouncil meeting, on 10/30/18 at			at the time of survey, and		
	11:07 a.m., Residen	nt F indicated she was the			reinforced with one-on-one		
	Resident Council President and mail was delivered				inservices beginning 11/19/18	and	
	only Monday through Friday. Residents do not				ongoing.		
	receive his or her mail on Saturdays.						
					The practice of timely delivery	of	
	An interview was conducted with the Business				resident mail affects all reside	nts.	
	Office Manager on 11/1/18 12:02 p.m. She				The practice of ensuring the ti	mely	
	indicated the week	end Manager on Duty passes			delivery of mail to all residents	3	
	the mail out to the residents on Saturdays. There				was clarified and reinforced to	all	
	have been times, w	hen she had come in on			facility managers, in accordan	ce	
	Monday, and reside	ents' mail had been sitting on			with applicable regulations an	d	
		een delivered on Saturday			Chosen's "Mail and Electronic	;	
	needing to be passe	ed out to the residents.			Communication" policy.		
	A "Mail and Electr	onic Communication" policy			Resident mail will be delivered	t t	
	indicated "Policy	Statement. Residents are			Monday through Friday by the		
	allowed to commu	nicate privately with individuals			Activity Director or, in her		
	of their choice and	may send and receive personal			absence, the Business Office		
	mail, email and oth	er electronic forms of			Manager. Saturday mail will b	ре	
	communication cor	nfidentially Policy			delivered by the manager on o	duty.	
	Interpretation and I	mplementation4. Mail and			This was addressed at the time	e of	
	packages will be de	elivered to the resident within			the survey and reinforced duri	ng	
	twenty-four (24) ho	ours of delivery on premises or			one-on-one inservices.		
	to the facility's pos	t office (including Saturday			Administrator or designee will	use	
	deliveries)"				a mail delivery audit tool to en	sure	
					mail is delivered in a timely		
	3.1-3(s)				manner.		
					The Administrator or designed	will	
					use the audit tool to monitor		
					compliance weekly for six		
					months. The audits will be		
					reviewed monthly by the QAP	ı	
					committee and corporate risk		
					management to ensure at leas	st	
					95% compliance. If this		

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DEPARTMENT	FO	RM APPROVED					
CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155721	B. W	ING		11/02/	/2018
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					46TH ST		
LAWREN	NCE MANOR HEAL	_THCARE CENTER		INDIAN	IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					benchmark is not met, an act	ion	
					plan will be developed and		
				implemented to ensure			
				compliance.			
F 0577	483.10(g)(10)(11))					'
SS=C	Right to Survey F	Results/Advocate Agency					
Bldg. 00	Info						
	§483.10(g)(10) T	he resident has the right to-					
	(i) Examine the re	esults of the most recent					
	survey of the faci	lity conducted by Federal or					
	State surveyors a	and any plan of correction in					
	effect with respec	ct to the facility; and					
	(ii) Receive inform	nation from agencies acting					
	as client advocate	es, and be afforded the					
	opportunity to cor	ntact these agencies.					
	§483.10(g)(11) T	ho facility must					
		e readily accessible to					
		mily members and legal					
		of residents, the results of the					
	1 .						
	most recent surve	with respect to any surveys,					
		d complaint investigations					
		the facility during the 3					
		and any plan of correction in					
		ct to the facility, available for					
	1	review upon request; and					
		f the availability of such					
	reports in areas of	of the facility that are			1		1

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residents.

prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or

Based on observation and interview, the facility

Indiana State Department of Health were available

to the residents for review. This had the potential

failed to ensure the survey reports from the

to affect 29 of 29 residents that reside in the

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The availability of survey reports

from the Indiana State Department

of Health for resident review affects

all residents, including resident F

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			f '			ľ	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155721	B. W	ING		11/02	/2018
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD		
					46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN	IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility. (Resident)	F)			who voiced her concern at the	;	
					time of the survey. The		
	Findings include:				requirement to ensure that su	-	
					reports are readily available to)	
	-	ouncil meeting, on 10/30/18 at			residents was reviewed with		
	· ·	nt F indicated she was the			facility staff at the time of the		
		resident, and she did not know			survey, and reinforced with		
	where the survey reports from the Indiana State				one-on-one inservices beginn	ing	
	Department of Health were located to review.				11/19/18 and ongoing.		
	A random observat	ion of the facility was made on			The availability of survey repo	rts	
	11/1/18 at 11:00 a.m. There was no posting of where the Indiana State Department of Health survey reports were located.				from the Indiana State Depart		
					of Health for resident review a		
					all residents. The requiremen		
	J 1				ensure that survey reports are		
	An interview was c	onducted with the Activities			readily available to residents v		
	Director on 11/1/18	3 at 11:15 a.m. She indicated			clarified and reinforced to all		
	the survey reports a	are kept in a binder up front. If			facility staff.		
		lls them the binder was up					
		elf that was mounted on the			Survey reports will be made		
	wall next to the Ad				readily available for resident		
					review. The location of the su	irvey	
	An observation was	s made on 11/1/18 at 11:18 a.m.,			reports will also be prominent	-	
	of a plastic shelf the	at was mounted next to the			posted. Residents will be not	•	
	•	ice. The shelf included a green			of availability and location of		
	binder which indica	ated it was the vendor sign in			survey reports. Administrator	or	
		d behind the green binder was			designee will use an audit too		
	_	der that indicated it was the			ensure survey reports remain		
		rtment of Health survey			available and accessible to		
	_	no posting on the wall the			residents.		
	location of the bind	ler.					
					The Administrator or designed	e will	
	An interview was conducted with the Administrator on 11/1/18 at 11:20 a.m. She indicated there was no posting indicating the location of the survey reports. The binder did have the reports in it, but a former staff person				use the audit tool to monitor		
					compliance daily for six month	ıs.	
					The audits will be reviewed		
					monthly by the QAPI committe	ee	
					and corporate risk manageme		
	had removed.				ensure at least 95% complian		
					If this benchmark is not met, a	an	
	3.1-3(b)(1)				action plan will be developed		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BUII	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURV COMPLETED 11/02/2015				
	PROVIDER OR SUPPLIER			8935 E	DDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
					implemented to ensure compliance.		
F 0583 SS=D Bldg. 00	§483.10(h) Privace The resident has a and confidentiality medical records. §483.10(h)(l) Pers accommodations, and telephone corcare, visits, and mresident groups, befacility to provide a resident. §483.10(h)(2) The residents right to privacy spoken), written, a communications, i and promptly receother letters, pack delivered to the faincluding those deother than a postal secure and confidence and confidence and confidence and confidence applicable federal (ii) The facility must the Office of the S	Confidentiality of Records y and Confidentiality. a right to personal privacy of his or her personal and onal privacy includes medical treatment, written inmunications, personal eetings of family and ut this does not require the a private room for each of acility must respect the personal privacy, including or in his or her oral (that is, and electronic including the right to send ive unopened mail and ages and other materials cility for the resident, livered through a means I service. Tesident has a right to ential personal and medical is the right to refuse the all and medical records dat §483.70(i)(2) or other					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medical, social, and administrative records in accordance with State law. Based on interview and record review, the facility F 0583 F 583 12/02/2018 failed to ensure a resident's medical The practice of securing residents' documentation was kept secure and confidential medical documentation to ensure for 1 of 14 residents' records reviewed. (Resident confidentiality affects all residents, M and Q) including resident Q whose records were reviewed at the time Findings include: of the survey. The necessity and legal requirement to secure The clinical record for Resident O was reviewed residents' medical documentation on 10/31/18 at 9:00 a.m. The diagnosis for was reviewed with facility staff at Resident Q included, but was not limited to, major the time of the survey, and depressive disorder. reinforced with one-on-one inservices beginning 11/19/18 and A physician order dated 3/29/18, indicated the ongoing. Resident Q's medical staff was to obtain Resident Q's ammonia level documentation was secured and and depakote level every 3 months. placed out of reach of Resident M. The clinical record for Resident Q's did not The practice of securing residents' include the lab that contained ammonia or medical documentation to ensure depakote level. confidentiality affects all residents. All residents' An interview was conducted with the Assisted documentation was secured and Director of Nursing on 11/1/18 at 2:20 p.m. She placed out of reach of other indicated she was able to locate Resident Q's residents. Access to residents' ammonia and depakote lab. Resident M had medical documentation was removed it from the nurse's station and had been limited to facility staff. The fax writing on the back of it. machine at the nurse's station was relocated to prevent An interview was conducted with the Director of unauthorized access to Nursing on 11/1/18 at 2:24 p.m. She indicated the documents. Organization and fax machine was too close to the counter. We will storage of medical documents at consider moving the fax machine, so residents are the nurse's station was revised to unable to reach the documents. Resident M prevent unauthorized access. The should not have had Resident Q's lab result. necessity and legal requirement to

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3.1 - 3(0)

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secure residents' medical

documentation was clarified and reinforced to all facility staff.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155721	A. BU B. WI	JILDING NG	00	COMPL 11/02/	
		100721	D. W1	_		11/02/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER	INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
		CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	
F 0607 SS=D Bldg. 00	483.12(b)(1)-(3) Develop/Implemer §483.12(b) The fa implement written that: §483.12(b)(1) Prol neglect, and explo	nt Abuse/Neglect Policies cility must develop and policies and procedures hibit and prevent abuse, itation of residents and of resident property, ablish policies and		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY) Residents' medical documenta will be properly secured to ensign confidentiality in adherence will help a regulations. The Direct of Nursing and Assistant Direct of Nursing will use an audit to ensure that residents' medical documentation is kept secure all times. The Director of Nursing and Assistant Director of Nursing will use the audit tool to monitor compliance daily for six month. The audits will be reviewed monthly by the QAPI committed and corporate risk manageme ensure at least 95% compliance of this benchmark is not met, a action plan will be developed a implemented to ensure compliance.	ation sure th tor ctor ol to at	DATE
	paragraph §483.9	ude training as required at 5, and record review, the facility	F 06	607	F607		12/02/2018

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failed to implement their abuse policy and ensure

Business Office Manager on 11/2/18 at 2:47 p.m.

documentation regarding LPN 24's completion of

She indicated she was unable to provide any

a staff person was provided annual abuse

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 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 11/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE

	abase pensy, menaning annian
in-servicing training for 1 of 10 employee files	abuse in-service training of staff
reviewed. (License Practical Nurse (LPN) 24)	affects all staff, including LPN 24
	whose employee file was reviewed
Findings include:	during the survey. Details of
	facility abuse policy and the
The Abuse policy was provided by the	importance of corresponding
Administrator on 10/29/18 at 1:20 p.m. It indicated	adherence was reviewed with
"Policy Each resident has the right to be free	facility staff at the time of the
from abuse, neglect, and misappropriation of	survey, and reinforced with
resident property. All allegations will be reported	one-on-one inservices beginning
according to State and Federal Law and	11/19/18 and ongoing. The facility
investigated. This policy applies to all	abuse policy will also be reviewed
employeesTraining The facility will train	during planned staff in-service
employees, through orientation, annually and	11/26/18.
on-going sessions, on issues related to abuse	
prohibition practices such as: Appropriate	The implementation of the facility
Interventions to deal with aggressive and/or	abuse policy, including annual
catastrophic reactions or residents; How staff	abuse in-service training of staff
should report their knowledge related to	affects all staff. Details of facility
allegations without fear of reprisal; How to	abuse policy and the importance
recognize signs of burnout, frustration, and stress	of corresponding adherence was
that may lead to abuse, and The identification of	clarified and reinforced to all
abuse, neglect and misappropriation of resident	facility staff. This information will
property"	be reviewed and reinforced during
	planned staff in-service 11/26/18
The Employee Records were reviewed on 10/2/18	and ongoing. All staff records will
at 10:30 a.m. The Employee Records form	be reviewed to ensure that every
indicated LPN 24's start date was 9/20/07, and she	staff member has received
was a part time employee.	in-service abuse training upon
	employment, and annually
The personnel file for LPN 24 did not include	thereafter.
annual abuse in-servicing training.	
	All staff will receive in-service
An interview was conducted with the Regional	abuse training upon employment,

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annual abuse training.

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and annually thereafter. The

Director of Nursing will use an

Director of Nursing and Assistant

audit tool to ensure that employee

The implementation of the facility

abuse policy, including annual

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155721	A. BU B. W.		00	11/02/	
			1	_	ADDRESS, CITY, STATE, ZIP COD	, 02/	* - =
NAME OF P	PROVIDER OR SUPPLIER				46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER	INDIANAPOLIS, IN 46226				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	3.1-28(a)				records reflect completion of the required training. Weekly surveillance will ensure new employees and staff who miss scheduled in-services receive required information in a timely manner. This includes all part-time and PRN staff. After an initial review and remediation of employee files training, the Director of Nursin and Assistant Director of Nursin and Assistant Director of Nursin will use the audit tool to monito compliance weekly for six months. The audits will be reviewed monthly by the QAP committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an actic plan will be developed and implemented to ensure compliance.	and g ing or	
F 0638 SS=D Bldg. 00	§483.20(c) Quarter A facility must assign quarterly review in State and approve frequently than on Based on interview failed to complete a mental status) as pa (Minimum Data Set)	at Least Every 3 Months orly Review Assessment ess a resident using the estrument specified by the ed by CMS not less ce every 3 months. and record review, the facility BIMS (brief interview for rt of the Quarterly MDS assessment for 1 of 14 bS assessments were t C)	F 00	638	F638 The accurate and timely completion of BIMS as part of quarterly MDS assessment affall residents, including resident whose record was reviewed dithe survey period. The practice	fects It C uring	12/02/2018

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CENTERS FO	ENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED
		155721	B. WING		11/02	/2018
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEF	3		46TH ST		
LAWRE	NCE MANOR HEAL	THCARE CENTER		NAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	Findings include:			timely and accurate quarterly		
				MDS assessment, including		
	The clinical record	for Resident C was reviewed		BIMS, was reviewed with MDS	3	
	on 11/2/18 at 11:00	a.m. The diagnoses for		coordinator at time of survey,	and	
	Resident C include	d, but were not limited to,		reinforced to the MDS and So	cial	
	schizophrenia and A	Alzheimer's disease.		Service coordinators ongoing.		
	The 6/1/18 Annual MDS assessment indicated			The accurate and timely		
	Resident C had a B	IMS score of 12, indicating he		completion of BIMS as part of	the	
	was cognitively intact.			quarterly MDS assessment af		
	The 7/26/18 Quarterly MDS assessment indicated the BIMS interview was not conducted.			all residents. The practice of		
				timely and accurate quarterly		
				MDS assessment, including		
				BIMS, was reviewed with MDS	3	
	An interview was c	onducted with the MDS		coordinator at time of survey,		
	Coordinator and the	e Regional MDS Coordinator		reinforced to the MDS and So		
		p.m. The MDS Coordinator		Service coordinators ongoing.		
		section of Resident C's		resident records were reviewe		
	7/26/18 Quarterly N	MDS assessment was		ensure there are no overdue		
		acility's previous Social		quarterly MDS assessments a	ınd	
		The Regional MDS		corresponding BIMS.		
		ted the BIMS should have been				
	attempted to be con	npleted within the 7 day		All resident MDS assessments	S	
	look-back period.			will be completed quarterly an	d as	
	_			required with change of condit		
	The CMS (Centers	for Medicare and Medicaid		This includes BIMS as indicate		
		sident Assessment Instrument)		Resident records will be review		
		mpt to conduct the interview		to ensure that no quarterly MD		
		This interview is conducted		assessments are overdue, and		
	during the look-back period of the Assessment			calendar will be developed to		
	-	ARD) and is not contingent		ensure impending deadlines a	ıre	
	· ·	Makes Self Understood."		anticipated and met. The Dire		
				of Nursing and Assistant Direct		
	3.1-31(d)(3)			of Nursing will use an audit to		
				ensure compliance.		
				_		
				After an initial review and		
				remediation of resident record	s,	

the Director of Nursing and Assistant Director of Nursing will

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OBITIER TOT	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155721	B. WI	NG		11/02/	/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					use the audit tool to monitor compliance weekly for six months. The audits will be reviewed monthly by the QAP committee and corporate risk management to ensure at least 95% compliance. If this benchmark is not met, an actio plan will be developed and implemented to ensure compliance.	st	
F 0641 SS=D Bldg. 00	The assessment resident's status. Based on observation review, the facility MDS (Minimum Daresidents whose MI reviewed. (Resident Findings include: 1. The clinical recomposition on 11/2/18 at 11:10 Resident C included stage renal disease. The 9/5/18 Quarter Resident B received an indwelling cather An interview was considered to 10/30/18 at 12:01 probability disapparent and	acy of Assessments. nust accurately reflect the on, interview, and record failed to ensure accuracy of the ata Set) assessment for 2 of 14 OS assessments were tts B and D) ard for Resident B was reviewed a.m. The diagnoses for d, but were not limited to, end y MDS assessment indicated I dialysis treatments and used	F 00	541	F641 Accurate MDS coding affects residents, including residents and D whose records were reviewed at the time of the sur Resident B's MDS was review and coded appropriately to refithat he does not have an indwelling catheter. Resident MDS was reviewed and coded appropriately to reflect his total dependence and use of Hoyer for all transfers. The need for accurate MDS coding to reflect resident status and level of ca reviewed with MDS coordinate time of survey. This was also reinforced during subsequent in-services with the MDS coordinator and a corporate consultant.	B rvey. red rlect D's d ll ll rlift	12/02/2018

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An interview was conducted with the MDS

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Accurate MDS coding affects all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Coordinator and Regional MDS Coordinator on residents. All resident records 11/2/18 at 1:10 p.m. The MDS Coordinator were reviewed to ensure accurate indicated Resident B did not currently have a coding r/t urinary elimination and catheter, and could could not find any information method of transfer. The need for to indicate he ever did. The Regional MDS accurate MDS coding to reflect Coordinator indicated the 9/5/18 Quarterly MDS resident status and level of care assessment was coded incorrectly, in regards to reviewed with MDS coordinator at Resident B having a catheter, and a correction time of survey. This was also would be done. reinforced during subsequent in-services with the MDS 2. The clinical record for Resident D was reviewed coordinator and a corporate on 10/31/18 at 10:45 a.m. The diagnoses for consultant. Resident D included, but were not limited to: degenerative joint disease of the spine, left side Pertinent charting and most recent hemiparesis, and osteoporosis. physician orders will be reviewed at the daily morning QA meeting The 4/10/17 care plan, revised 9/14/17 indicated an to ensure that any changes in intervention, initiated 9/21/16, was to, "Provide resident condition are accurately staff assist and use of Hoyer lift up in his w/c reflected in MDS coding. The [wheel chair] daily as tolerates." MDS coordinator will continue to be in-serviced by the corporate Observations of Resident D were made on the MDS consultant regarding following dates and times with a Hoyer pad accurate MDS coding. The behind him, while sitting in his Broda chair: Director of Nursing and Assistant 10/29/18 at 11:24 a.m., 10/30/18 at 10:14 a.m., and Director of Nursing will use an 10/31/18 at 11:01 a.m. audit tool to ensure compliance. An interview was conducted with CNA (Certified After an initial review and remediation of resident records, Nursing Assistant) 4 on 11/2/18 at 12:44 p.m. She indicated Resident D required the use of a Hoyer the Director of Nursing and lift for all transfers. Assistant Director of Nursing will use the audit tool to monitor An interview was conducted with the ADON compliance weekly for six (Assistant Director of Nursing) on 11/2/18 at 12:41 months. New admissions, p.m. She indicated Resident D required the use of residents with significant change a Hoyer lift for transfers, as he was unable to bare in condition, and residents due for weight. quarterly MDS assessment will be audited by the MDS coordinator Resident D's 7 day look back documentation logs for accurate reflection of residents' used to code his 8/7/18 Quarterly MDS urinary elimination status and

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155721	B. W	ING		11/02/	2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			APOLIS, IN 46226		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	-	ed he was coded extensive			method of transfer. This audit		
		, but total dependence on all			also be completed weekly for	SiX	
	other days.				months. The audits will be		
	TI 0/7/100 1	MD0			reviewed monthly by the QAPI		
	The 8/7/18 Quarterly MDS assessment indicated				committee and corporate risk		
	Resident D required extensive assistance of 2 plus persons for transfers.				management to ensure at leas	Σ	
	persons for transfers	S.			95% compliance. If this	. n	
	An interview was a	An interview was conducted with the MDS			benchmark is not met, an action plan will be developed and	וזכ	
		gional MDS Coordinator on			implemented to ensure		
	11/2/18 at 12:15 p.m. The MDS Coordinator				compliance.		
		O required the use of a Hoyer			compilance.		
		ne Regional MDS Coordinator					
		a resident who required the					
		as coded as totally dependent					
	for transfers.						
F 0656	483.21(b)(1)						
SS=D	` ', '	nt Comprehensive Care Plan					
Bldg. 00	· ·	ehensive Care Plans					
	§483.21(b)(1) The	facility must develop and					
	implement a comp	rehensive person-centered					
	care plan for each	resident, consistent with					
	_	set forth at §483.10(c)(2)					
		, that includes measurable					
	objectives and tim						
		, nursing, and mental and					
		Is that are identified in the					
	comprehensive as						
	-	re plan must describe the					
	following -	-4 4- b- 6 1 1 4-					
		at are to be furnished to					
	practicable physic	the resident's highest					
		being as required under					
	§483.24, §483.25	•					
		at would otherwise be					
		83.24, §483.25 or §483.40					
		ed due to the resident's					
	·	under §483.10, including					

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	ILTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
THOTEM	or condition	155721	B. WI		<u></u>	11/02/2018	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD 46TH ST		
LAWRE	NCE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, and the second	R LSC IDENTIFYING INFORMATION	'	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	1	treatment under §483.10(c)					
	(6).	ed services or specialized					
		rices the nursing facility will					
	provide as a resu	_ ,					
		s. If a facility disagrees with					
		PASARR, it must indicate					
		e resident's medical record.					
		with the resident and the					
	resident's representative(s)- (A) The resident's goals for admission and desired outcomes.						
		s preference and potential for					
		Facilities must document					
	whether the resid	ent's desire to return to the					
	community was a	ssessed and any referrals					
		gencies and/or other					
		es, for this purpose.					
		ns in the comprehensive					
		ropriate, in accordance with					
	· ·	set forth in paragraph (c) of					
	this section.	and record review, the facility	F 06	56	 F656		12/02/2018
		are plan to address Resident E's	1 00	30	The need for a care plan to		12/02/2018
		idents whose care plan were			address resident pain affects a	all	
	reviewed. (Resider				residents, including resident E		
					whose record was reviewed do	uring	
	Findings include:				the survey. Resident E's pain		
					medication administration reco		
		for Resident E was reviewed on			was reviewed and an appropri		
		m. The diagnoses for Resident			care plan to address his pain v		
	E included, but well	re not limited to, heart failure.			developed and implemented. importance of a care plan to	ıne	
	The October, 2018	MAR (medication			address resident pain was		
		ord) for Resident E indicated he			reviewed with MDS coordinate	or	
	was administered P				and clinical staff at time of sur	vey,	
	Hydrocodone-Acet	aminophen 7.5-325 mg 22 times			and this was reinforced during		

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during the month, mostly for "all over" pain.

During review of Resident E's care plans, no care

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subsequent one-on-one

in-services.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155721	B. WING		11/02/2018
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIE	R		46TH ST	
LAWREN	ICE MANOR HEAL	THCARE CENTER		IAPOLIS, IN 46226	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	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
	plan to address his	•		The need for a care plan to address resident pain affects	
		conducted with the MDS		residents. All resident records	5
	(Minimum Data Set) Coordinator on 11/2/18 at 1:43			were reviewed to ensure all	
	1 ^	Resident E did not have a pain		residents have an updated ca	
		g one was discussed on		plan that addresses their pain	
	10/18/18, but it was	s never done.		The importance of a care plan	to
	2.1.25()			address resident pain was	
	3.1-35(a)			reviewed with MDS coordinate	
				and clinical staff at time of sur	·
				and this was reinforced during	
				subsequent one-on-one	
				in-services.	
				Medication Administration	
				Records will be reviewed to	
				evaluate effectiveness of	
				scheduled pain medications a	nd
				the frequency of PRN pain	nu
				medication use. Appropriate	nain
				assessment tools will be used	
				determine pain regimen	-
				effectiveness and resident	
				satisfaction and comfort. This	
				information will be reviewed	
				weekly, and the Director of	
				Nursing and Assistant Directo	r of
				Nursing will coordinate with th	
				Medical Director to make char	
				as indicated. Any changes in	
				resident orders will be reviewe	ed
				with MDS coordinator to ensu	re
				accuracy of care plan. Inform	ation
				reviewed during one-on-one	
				in-services will be reinforced of	luring
				planned clinical meeting 11/26	6/18.
				The Director of Nursing and	
				Assistant Director of Nursing	vill

use an audit tool to monitor

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DEPARTMENT CENTERS FOF		FORM APPROVED OMB NO. 0938-039				
	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/02/2018	
	PROVIDER OR SUPPLIER		8935 E	ADDRESS, CITY, STATE, ZIP COD E 46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER	INDIA	NAPOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	r E RIATE	(X5) COMPLETION DATE
				compliance. After an initial review and remediation of resident reco the Director of Nursing and Assistant Director of Nursing use the audit tool to monitor compliance weekly for six months. New admissions, residents with significant chain condition, and residents din condition, and residents din audited by the MDS coording for accurate reflection of respain regimen. This audit will be completed weekly for six months. The audits will be reviewed monthly by the QA committee and corporate rismanagement to ensure at le 95% compliance. If this benchmark is not met, an acplan will be developed and implemented to ensure compliance.	g will ange ue for will be ator idents' I also PI k ast	
F 0657 SS=D Bldg. 00	§483.21(b)(2) A comust be- (i) Developed with of the comprehense	and Revision rehensive Care Plans omprehensive care plan sin 7 days after completion sive assessment. In interdisciplinary team, that				

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resident.

the resident.

(A) The attending physician.(B) A registered nurse with responsibility for

(C) A nurse aide with responsibility for the

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X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. F 0657 F657 12/02/2018 Based on interview and record review the facility The accurate and timely failed to assure care plans were reviewed by an completion of quarterly care plan interdisciplinary team quarterly for 1 of 1 residents meetings that include the resident reviewed for participation in care planning. affects all residents, including (Resident F) resident F whose record was reviewed during the survey period. Findings include: The practice of timely and accurate quarterly care plan review The clinical record for resident F was reviewed on and corresponding resident 10/29/2018 at 2:20 p.m. The diagnosis for resident inclusion was reviewed with MDS F included, but were not limited to, paraplegia. coordinator at time of survey, and reinforced to the MDS and Social During an interview on 10/29/2018 at 12:08 p.m., Service coordinators ongoing. resident F indicated that she had not attended a care plan meeting in several months. The accurate and timely completion of quarterly care plan The clinical record contained a MDS (Minimum meetings that include the resident Data Set) Assessment dated 08/09/2018. The affects all residents. The practice assessment indicated resident F was cognitively of timely and accurate quarterly intact. care plan review and corresponding resident inclusion

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A care plan signature sheet, located in the medical

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was reviewed with MDS

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2018		
	ROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST	•	
	SUMMARY: (EACH DEFICIEN REGULATORY OR record, contained si Coordinator, Activi Manager and Reside 05/17/2018. During an interview Coordinator indicate resident F had been indicated that Reside plan meeting in Aug no documentation the	THCARE CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION gnatures of the MDS ty Director, Certified Dietary	<u> </u>	STREET A 8935 E		and cial will s tion. ers seven in ace nily will e e e ng and will ds, will entre to ce.	(X5) COMPLETION DATE
					action plan will be developed a implemented to ensure compliance.	and	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155721	B. WI	NG		11/02/	/2018
			1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0661	483.21(c)(2)(i)-(iv)						
SS=D	Discharge Summa	-					
Bldg. 00	§483.21(c)(2) Disc						
	I -	anticipates discharge, a					
		e a discharge summary					
		is not limited to, the					
	following:						
	1 ''	of the resident's stay that					
		t limited to, diagnoses,					
		reatment or therapy, and					
	l ·	ology, and consultation					
	results.						
	1 ' '	ry of the resident's status to					
		aragraph (b)(1) of §483.20,					
		discharge that is available					
		norized persons and					
	1 -	consent of the resident or					
	resident's represe						
	1	of all pre-discharge					
	medications with t						
	l ·	edications (both prescribed					
	and over-the-cour	· ·					
	1 ' ' '	rge plan of care that is					
		e participation of the					
		the resident's consent, the tative(s), which will assist					
		just to his or her new living					
	1	post-discharge plan of care					
		ere the individual plans to					
		gements that have been					
		lent's follow up care and					
		e medical and non-medical					
	services.	o medical and non medical					
		and record review, the facility	F 06	661	F661		12/02/2018
		scharge summary included a		,,,,	The need for a comprehensive	e	12,02,2010
		y, final summary of status,			discharge summary affects all		
	_	edications, and post discharge			residents, including resident G		
		f 1 resident reviewed for			whose post discharge record		
	discharge. (Resider				reviewed during the survey.		
		•			four required components of a		

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Facility ID: 000383

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STATEMENT OF DEFICIENCES 10 PROVIDERS UPPLIERCELLA 20 MENTIFICATION NUMBER 155721	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER WISHMARY STATEMENT OF DEFICIENCIE PRESENT TAG Findings include: Findings included by the size surveyor were reviewed on IT/I/I8 at 12:00 p.m. The diagnoses for Resident G included, but were not limited to, paranoid schizophrenia. She was discharged home from the facility on 8/11/18. The 8/11/18 Post Discharge Instructions form did not include a recapitulation of stay that included the course of illness. It did not include a final summary of status that included vision, mood and behavior patterns, and dental status. It did not include a final summary of status that included vision, mood and behavior patterns, and dental status. It did not include a final summary of status that included vision, mood and behavior patterns, and dental status. It did not include a final summary of status that included vision, mood and behavior patterns, and dental status. It did not include a final summary of the Resident policy was provided by the state surveyor were reviewed with clinical staff during the time of survey. This information was reinforced during one-on-one in-services with clinical staff, and will be further enforced during planned in-service 11/26/18. The need for a comprehensive discharge summary as provided by the state surveyor were reviewed with clinical staff, and will be further enforced during planned in-service 11/26/18. The need for a comprehensive included and of the necessary components in their discharge summary are provided by the state surveyor were reviewed with clinical staff, and will be further enforced during planned in-service 11/26/18. A new discharge summary that includes the following: 1) A recapitulation of the Resident policy was provided by the state surveyor were reviewed with clinical staff, and will be further enforced during planned in-service 11/26	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155721	B. W	ING		11/02/	/2018
		<u> </u>	<u> </u>	CTDEET A	ADDRESS CITY STATE 7ID COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD 46TH ST		
	ICE MANOD HEAT	THCARE CENTER			401H ST APOLIS, IN 46226		
LAWKEN	IOL WANOR FIEAL	THOARE CENTER		INDIAN	AI OLIO, IIN 40220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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
	3.1-36(a)(1)				discharges. This summary wi	ll be	
	3.1-36(a)(2)				completed to allow review by		
					Nursing, Activities, Dietary and	d	
					Therapy departments before		
					information is reviewed with		
					resident and/or		
					representative/family prior to		
					discharge to ensure		
					understanding. The Director of		
					Nursing and Assistant Directo		
					Nursing will use an audit tool t	0	
					ensure compliance.		
					The Director of Nursing and	•••	
					Assistant Director of Nursing V		
					use the audit tool to review ev	ery	
					resident discharge to monitor		
					compliance for indefinitely. The		
					audits will be reviewed monthl	у ру	
					the QAPI committee and		
					corporate risk management to		
					ensure 100% compliance. If t		
					benchmark is not met, an action	JII	
					plan will be developed and		
					implemented to ensure		
					compliance.		
F 0684	483.25						
SS=E	Quality of Care						
Bldg. 00	§ 483.25 Quality of	of care					
ag. 00		a fundamental principle that					
	•	ment and care provided to					
	facility residents. I						
	•	ssessment of a resident, the					
	•	re that residents receive					
	•	e in accordance with					
		dards of practice, the					
		erson-centered care plan,					
	and the residents'	· · · · · · · · · · · · · · · · · · ·					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Based on interview and record review, the facility

OZVI11

F 0684

Facility ID: 000383

F684

If continuation sheet

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12/02/2018

PRINTED: 12/12/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO.		
STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	X3) DATE SURVEY
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155721	B. WING		11/02/2018
			OTD FE	CADDRESS OF VICTATE ZID COD	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD	
1 A\A/DE	NOT MANOD LIEAL	THOADE OFNITED		E 46TH ST	
LAWKE	NCE MANOR HEAL	THCARE CENTER	INDIA	NAPOLIS, IN 46226	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	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 APPROPRIAT	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	failed to ensure lab	s were obtained as ordered, to		The timely and accurate follow-	-up
	administer insulin a	as ordered, to address a		of MD orders affects all resider	nts,
	recommendation to	decrease an antidepressant		including residents B, F, L and	Q
	medication, and to	flush nephrostomy tubes and		whose records were reviewed	
	accurately monitor the output of nephrostomy tubes for 1 of 1 resident reviewed for catheters, 1			during the survey. The lab was	5
				called to complete blood draw	for
	of 1 residents revie	wed for dialysis, and 2 of 5		resident B testosterone and	
	residents reviewed	for unnecessary medications.		prolactin levels and reported to	
	(Resident B, F, L, a	and Q)		resident's urologist as ordered.	
				An active order was obtained to	o
	Findings include: A. The clinical record for Resident B was reviewed			flush resident F's nephrostomy	
				tubes daily. Resident L's insuli	n
				MAR was updated to draw	
		p.m. The diagnoses for		clinician attention to the fact that	
		d, but were not limited to,		resident does not receive sliding	g
	chronic kidney dise	ease and epilepsy.		scale insulin with each	
				accucheck, only 8am and 5pm	
		tion dated 9/19/18, indicated a		indicated per MD order. Resid	l l
		obtain a testosterone and		Q's Cymbalta order was review	/ed
	prolactin level for I	Resident B.		and clarified by MD to ensure	
	1	11. 10/10/10 11.		resident receiving proper dose.	
		d dated 9/19/18, indicated to		Resident orders were reviewed	
		osterone level and prolactin		with clinical staff in each of the	
	level for Resident I	B and send results to urologist.		instances to ensure understand	•
	TEL 1: 1 1			and reinforce absolute necessi	-
		did not include a testosterone		of adherence to MD orders. The	l l
	or prolactin level.			was reinforced during one-on-o	one
	A :	and and a sith the Director of		in-services, and will be further	1
		conducted with the Director of		reinforced during planned clinic	aı
		8 at 9:30 a.m. She indicated the		meeting 11/26/18.	
	labs had not been o	olactin level was missed. The		The timeshy and accounts follows	
	laus hau not been o	ouameu.		The timely and accurate follow- of MD orders affects all resider	
	B The clinical room	ord for Resident L was reviewed			
		00 a.m. The diagnosis for		All resident records reviewed for	וע
		_		identification of missed labs,	
	diabetes mellitus ty	d, but was not limited to,		adherence to insulin	ar l
	diabetes memus ty	pe 2.		administration orders, orders for	
	A physician and	dated 7/26/19 indicated blood		care of indwelling urinary cathe	l l
	A physician order (dated 7/26/18, indicated blood	I	and accurate I&O documentation	UII,

sugar checks were to be obtained 4 times a day

and follow-up of pharmacy

12/12/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and night. Staff was to call if Resident L's blood recommendations. Resident sugar was less than 70 or greater than 350. orders were reviewed with clinical staff in each of these instances to A physician order dated 11/11/17, indicated ensure understanding and Resident L was to receive novolog insulin using a reinforce absolute necessity of

sliding scale. The sliding scale was the following: 151 - 200 blood sugars = 2 units, 201-250 blood sugars = 4 units, 251 - 300 blood sugars = 6 units, 301 -350 blood sugars = 8 units. The sliding scale was scheduled to be administered at 8:00 a.m., and 5:00 p.m.

A physician order dated 7/9/18, indicated Resident L was to receive 4 units of Novolog three times a day.

A physician order dated 8/17/18, indicated Resident L was to receive 16 units of levemir at night.

The October 2018, Medication Administration Record (MAR) indicated Resident L received the novolog sliding scale not as ordered on the following days and times:

10/3/18 - 6:00 a.m., 11:00 a.m., 9:00 p.m.,

10/4/18 - 6:00 a.m., 4:00 p.m., 9:00 p.m.,

10/5/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m.,

10/6/18 - 11:00 a.m.,

10/7/18-6:00 a.m., 11:00 a.m., 4:00 p.m.,

10/8/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m.,

10/9/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m., 9:00 p.m.,

10/11/18 - 11:00 a.m., 4:00 p.m.,

10/12/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m.,

10/13/18 - 11:00 a.m., 4:00 p.m., 9:00 p.m.,

10/14/18 - 11:00 a.m.,

10/15/18 - 11:00 a.m.,

10/16/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m.,

10/17/18 - 6:00 a.m., 11:00 p.m., 4:00 p.m., 9:00 p.m.,

10/18/18 - 6:00 a.m., 11:00 a.m., 4:00 p.m.,

adherence to MD orders. This was reinforced during one-on-one in-services, and will be further reinforced during planned clinical meeting 11/26/18.

Lab tracker developed to record labs when ordered and ensure follow-up and reporting as indicated. MD orders (yellow sheets) to be reviewed daily during morning QA meeting by Director of Nursing and Assistant Director of Nursing to ensure lab tracker being used appropriately. All residents with indwelling urinary catheters will have active orders for care and maintenance, and output will be accurately recorded per MD orders. The Director of Nursing and Assistant Director of Nursing will review documentation daily to ensure accurate documentation. Insulin administration MARs and corresponding blood sugar logs will be updated to accurately reflect MD orders and minimize possible errors. The Director of Nursing and Assistant Director of

Nursing will review documentation

recommendations will be reviewed

and delivered to MD in a timely

daily to ensure adherence to MD

orders. Pharmacv

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OZVI11

Facility ID: 000383

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/02/2018		
	PROVIDER OR SUPPLIEF	THCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
TAG	10/19/18 - 6:00 a.m 10/20/18 - 6:00 a.m 10/21/18 - 6:00 a.m 10/22/18 - 6:00 a.m 10/23/18 - 6:00 a.m 10/25/18 - 6:00 a.m 10/26/18 - 6:00 a.m 10/27/18 - 11:00 a.m 10/28/18 - 6:00 a.m 10/30/18 - 11:00 a.m An interview was c Nursing on 11/1/18 Resident L was to r scale only twice a d C. The clinical reco on 10/31/18 at 9:00 Resident Q included depressive disorder	a., 11:00 a.m., 4:00 p.m., 9:00 p.m., a., 11:00 a.m., 4:00 p.m., a., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 4:00 p.m., b., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., b., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., b., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., b., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., b., 11:00 a.m., 9:00 p.m., a., 11:00 a.m., 9:00 p.m., b.,	TAG	manner for consultation and possible order changes. Recommendations will be submitted to MD via fax upon receipt and a copy will be place in MD follow-up book for revier next visit. All pharmacy consulties will be kept on record with fax verification of delivery to MD. Director of Nursing and Assist Director of Nursing will ensure process is followed with every pharmacy consult. Audit tools be utilized by the Director of Nursing and Assistant Director Nursing to ensure compliance each of these initiatives. The Director of Nursing and Assistant Director of Nursing will ensure each of these initiatives.	red w at ults The ant this will r of with vill r/t on,	
	indicated a recomm	nsultation dated 10/16/18, nendation to decrease Resident 60 milligrams to 30 milligrams		documentation. This daily monitoring will continue for six months. The Director of Nursi and Assistant Director of Nurs will use an audit tool to monito compliance with each pharma	ing ing or	
	Record indicated R	Medication Administration esident Q had received 60 palta daily from 10/1/18 through		consult, generally completed monthly. This monthly monito will continue indefinitely. The audits will be reviewed monthl the QAPI committee and		
	Director of Nursing indicated she could	onducted with the Assisted g on 11/1/18 at 2:15 p.m. She not locate documentation the decrease Resident Q's		corporate risk management to ensure at least 95% compliant If this benchmark is not met, a action plan will be developed a	ce. n	

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cymbalta was addressed by the medical provider

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implemented to ensure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BU	A. BUILDING <u>00</u> COM			SURVEY LETED /2018	
	F PROVIDER OR SUPPLIE			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION e with the gradual dose		TAG	compliance.		DATE
	provided by the Di 1:14 p.m. It indica Medications are ad written orders of th clinical record for 10/29/2018 at 2:20 F included, but we hydronephrosis (ex to a backup of urin During an interview resident F indicate from a hospitalizat urinary infection. always empty her r into the kidney) dr. The clinical record records from 10/12 hospital Urology p at 07:22 a.m., indic3. Sepsis [wide complicated uti [ur possible nephrosto underwentbilater replacement on 1 A Quarterly MDS Assessment compl resident F was cog nephrostomy tubes The physician's ord an order to flush ri with 10 milliliters	w on 10/29/2018 at 12:13 p.m., d she had recently returned ion. She was hospitalized for a She indicated staff do not nephrostomy tube (tube going ainage bags each shift. contained hospitalization 2/2018 to 10/15/2018. The rogress noted dated 10/15/2018 cated, "Assessment/ Plan: spread infection} with inary tract infection] with my tube malfunctionpatient al nephrostomy tube 0/14/2018." (Minimum Data Set) eted 8/9/2018 indicated that initively intact and					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155721	B. W	ING		11/02	/2018
	PROVIDER OR SUPPLIER		-	8935 E	NDDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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
		bes had been flushed as					
	ordered for the mon	th of August 2018.					
	The physician's ord 2018 did not contain and left nephrostom normal saline daily. October 2018 did not that the nephrostom with normal saline. The clinical record order to discontinue nephrostomy tubes. The physician's order an order to record the of right and left each of right and left each october 2018 was redocumented for the 10/01/2018 night shift, 10/05/2018 night shift, 10/07/2018 night shift, 10/17/2018 evening night shift, 10/17/2018 evening shift, 10/17/2018 evening shift, 10/18/2018 evening night shift, 10/21/2 shift, 10/22/2018 night shift, 10/22/2018 night shift, 10/27/20	ers for September and October in an order to flush the right by tubes with 10 milliliters of in The MAR for September and oct contain any documentation by tubes had been flushed in the flushing of the in the flushing of the interest of th					
	the DON (Director	or on 11/02/2018 at 11:23 a.m., of Nursing) indicated that should have been flushed					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155721	B. W			11/02/	2018
	PROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F 0688 SS=D Bldg. 00	daily and that the or flushes had not beer output of the nephrobeen recorded as or On 11/02/2018 at 1 "Care of Nephrosto indicated "General drainage bag once produced by Measure output as f Measure output from separately 3.1-37 483.25(c)(1)-(3) Increase/Prevent §483.25(c) Mobiliti §483.25(c)(1) The	rder for the nephrostomy tube in transcribed properly. The bostomy tubes should have dered by the physician. 14 p.m., the DON provided the my Tube" policy, which al Guidelines 3. Empty ber shift and as needed5. follows: c. Every 8 hours, 6. m right and left kidneys Decrease in ROM/Mobility		IAU	BEIGHACH		DATE
	range of motion do reduction in range resident's clinical of that a reduction in unavoidable; and \$483.25(c)(2) A remotion receives a services to increase prevent further de \$483.25(c)(3) A receives appropria assistance to main with the maximum unless a reduction demonstrably una	poes not experience of motion unless the condition demonstrates range of motion is esident with limited range of ppropriate treatment and se range of motion and/or to crease in range of motion. esident with limited mobility ate services, equipment, and intain or improve mobility in practicable independence in in mobility is	EO	600	F688		12/02/2019
	review, the facility	on, interview, and record failed to implement a resident's program for 1 of 1 resident	F 00	880	A properly implemented Restorative Nursing program t	0	12/02/2018

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE reviewed for positioning and mobility. (Resident increase/prevent decrease in ROM/mobility affects all residents, including resident D whose record Findings include: was reviewed during the survey. Resident D's Restorative Nursing The clinical record for Resident D was reviewed program and related MD orders on 10/31/18 at 10:45 a.m. The diagnoses for were reviewed, and Resident D included, but were not limited to: recommendations were degenerative joint disease of the spine, left side implemented. Importance of hemiparesis, and osteoporosis. adherence to Restorative Nursing program recommendations was The 9/1/18 Restorative Nursing Program read, reviewed with staff during time of "Treatment Recommendations: ...Also apply survey. This information was wedge abductor or pillow between legs to reinforced during one-on-one decrease pressure areas. in-services and CNA training. The 9/12/18 physician's order read, "OT A properly implemented [Occupational Therapy] Recommendations: 1. Restorative Nursing program to Place the abductor wedge or folded pillow increase/prevent decrease in between pt's [patient's] [symbol for "bilateral"] ROM/mobility affects all knees. Check for redness...." residents. All residents Restorative Nursing programs and Observations of Resident D were made on related MD orders were reviewed, 10/29/18 at 11:24 a.m., 11:36 a.m., 12:53 a.m., and and recommendations were 2:31 p.m. His right leg was positioned underneath implemented. Importance of his left leg, with no pillow or abductor wedge adherence to Restorative Nursing between his knees. program recommendations was reviewed with staff during time of An observation of Resident D was made on survey. This information was 10/30/18 at 10:14 a.m. He was sitting in his Broda reinforced during one-on-one chair, with no pillow or abductor wedge between in-services and CNA training. his knees. Restorative Nursing program An observation of Resident D was made on reviewed with MDS coordinator 10/31/18 at 11:01 a.m. He was lying in his Broda and therapy representatives to chair with no pillow or abductor wedge between ensure roles and responsibilities his knees. fully understood. All resident records reviewed to ensure that all An interview was conducted with Resident D on residents deemed appropriate for

10/31/18 at 11:01. He indicated sometimes he used

Restorative Nursing have a current

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
155721		B. WING 11/02/20			2018		
			1	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			46TH ST		
	ICE MANOD HEAL	THCARE CENTER			461H ST APOLIS, IN 46226		
LAWKEN	NOE WANOR FEAL	THOARE CENTER		INDIAN	AFULIO, IIN 40220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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
		s legs, and sometimes he did			program that addresses reside	ent	
	_	up to him, if he used a pillow			needs, including pain, positior	ning,	
		lerate it between his legs for a			mobility, and splints/braces.		
	_	to irritate him. He indicated			Resident progress with therap	у	
	_	him this day, if he wanted the			will be reviewed daily during		
		knees, but he would be fine			morning QA meeting to identif	y	
	with using the pillo	w at this time.			residents who will shortly be		
					appropriate for Restorative		
		bservation was conducted			Nursing. Development of the		
		d Nursing Aide) 5 on 10/31/18			resident's individualized		
		sident D's room. She indicated			Restorative Nursing program	will	
		have a pillow between his			begin at this time, and		
	legs. The MDS Coordinator entered the room with				implementation will occur at til	me	
	a wedge, she indicated as having retrieved from				of therapy DC. Residents		
	the therapy department. The MDS Coordinator				currently on Restorative Nursi	ng	
		the wedge between Resident			program will be monitored with		
	D's knees. Residen	t D accepted the wedge.			daily review of documentation	.	
					This will be tracked with an au	ıdit	
		onducted with COTA 7 on			tool by the Director of Nursing	and	
		She indicated Resident 7 should			Assistant Director of Nursing.		
		low between his knees,					
		he knees separated, to reduce			The Director of Nursing and		
		sure skin off skin. She			Assistant Director of Nursing v	vill	
		D was total dependence for			use the audit tools to monitor	-	
		ed a Hoyer lift, and staff would			for six months. The audits wil		
	have to put a pillow	or wedge between his legs.			reviewed monthly by the QAP	I	
					committee and corporate risk		
		tive Nursing Program read,			management to ensure at leas	st	
		[passive range of motion] ex			95% compliance. If this		
	[exercises] to Res [resident's] nonfunctional				benchmark is not met, an action	on	
	1	10 reps with a 5 sec [second]			plan will be developed and		
	hold to encourage a	stretch."			implemented to ensure		
					compliance.		
	_	October, 2018 Restorative					
	Care Plan And Charting read, "Resident will						
	complete 2 sets of 15 reps [repetitions] of active						
	range of motion exercises to both upper						
	extremities to each joint through each plane						
		ng portions indicated the					
exercises were completed 12 times in September,							

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED		
155721		B. Wl	ING		11/02/	/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST					
LAWRENCE MANOR HEALTHCARE CENTER				INDIAN	APOLIS, IN 46226			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION 2018 and 15 times in October, 2018.			TAG	DEFICIENCY		DATE	
	2016 and 13 times i	III OCIODOI, 2016.						
	An interview was c	onducted with the MDS						
	Coordinator on 10/3	31/18 at 2:14 p.m. She indicated						
	Resident D's restora	ative program was supposed to						
	be implemented Mo	onday through Friday, but it						
	was not, which is pa	art of the reason the previous						
	restorative aide no l	longer worked at the facility.						
	The July 2019 Cal:	nt/Brace Restorative Care Plan						
		"Problem: Resident has BUE						
	[bilateral upper extremity] contracture's related to							
	ROM [range of motion] loss r/t [related to] stroke							
	Hx [history] with L[left] hemiparesis. Goal:							
	Resident will tolerate soft hand cone as ordered							
	without c/o [complaints of] pain or discomfort for							
	at least 4 hours daily through next review. Plan:							
	Perform PROM [passive range of motion] to prior							
	to donning cone, using fingers extend residents							
	fingers while holding fingers open place cone							
	-	nd. Observe for pain, open						
		as, or swellingRefer to						
		or increased pain or worsing						
	~ -	Week 2 Progress: 7/12						
	` /	ajority of week [symbol for						
		f pain & discomfort [cursing &						
	_ ^	aides.] Week 3 Progress: 7/20						
		let aide wash hand/or put						
		mplaint of pain. Resident						
		neld hand [symbol for "with"]						
	opposite hand to blo	ock cone."						
	An interview was conducted with COTA 7 on							
	10/31/18 at 11:19.	She indicated the splint/brace						
		mented a while back, and it						
	should have continued.							
		onducted with the MDS						
		31/18 at 2:14 p.m. She indicated menting Resident D's						

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO	ONSTRUCTION 00	· ′	(X3) DATE SURVEY COMPLETED		
155721		B. WI				/2018			
	PROVIDER OR SUPPLIE	THCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
			ı				0/5		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETION		
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE		
IAU	splint/brace programunsure if his refusin discussed with ther An interview was concept (Certified Occupation of the MDS Coordinate COTA 7 indicated discontinuing Resident regards to his used to provide discontinuing Resident of the Restorative Nurvey was provided by the at 9:02 a.m. It read to provide restoration promote the resident of living as independent.	m, because he refused, but was an or increased pain was ever apy. onducted with the COTA onal Therapy Assistant) 7 and tor on 10/31/18 at 11:55 a.m. therapy was never involved in dent D's splint/brace program e of a cone. ursing Policy and Procedure e MDS Coordinator on 11/1/18 l., "It is the policy of this facility we nursing interventions that and safely as of restorative nursing must be		IAU			DATE		
F 0756 SS=D Bldg. 00	On §483.45(c) Drug F §483.45(c)(1) The resident must be month by a licens §483.45(c)(2) This review of the resident must be month by a licens §483.45(c)(4) The any irregularities if and the facility's nof nursing, and the upon. (i) Irregularities in	eview, Report Irregular, Act Regimen Review. e drug regimen of each reviewed at least once a							

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CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED				
155721		B. WING		11/02/2018					
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			8935 E	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(VA) ID	CLDALADA	CTATEMENT OF DEPLOYENCE		1	(V5)				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA					
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
IAU	in paragraph (d) of unnecessary drug (ii) Any irregulariti during this review separate, written attending physicial director and director and director and the irregularity and the residentified. (iii) The attending in the resident's midentified irregularity what, if any, action address it. If there medication, the addocument his or medical record. §483.45(c)(5) The maintain policies a monthly drug regiliare not limited to, steps in the procepharmacist must to identifies an irregularity action to protect to Based on interview failed to timely addorecommendation for unnecessary medical. Findings include: The clinical record 10/31/18 at 3:09 p.1	es noted by the pharmacist must be documented on a report that is sent to the an and the facility's medical tor of nursing and lists, at a ident's name, the relevant gularity the pharmacist physician must document medical record that the rity has been reviewed and in has been taken to e is to be no change in the attending physician should her rationale in the resident's effacility must develop and and procedures for the men review that include, but time frames for the different less and steps the take when he or she cularity that requires urgent the resident.	F 0756	F756 The timely follow-up of pharm recommendations affects all residents, including resident E whose record was reviewed a time of the survey. All referent pharmacy recommendations reviewed with MD, recommendigoxin level obtained and repto MD as indicated. The importance of pharmacy	12/02/2018 acy to the need added ported				
l				recommendations and subsec	quent				

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The October, 2018 physician's orders for Resident

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follow-up reviewed with clinical

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE E indicated for a 125 mcg tablet of digoxin to be staff at time of survey. This was administered once a day, effective 2/1/18. reinforced during one-on-one in-services and will be further The 2/2/18 digoxin care plan indicated an reinforced at planned clinical intervention, initiated 2/2/18, was, "Serum Digoxin meeting 11/26/18. levels monthly or as ordered by physician." The timely follow-up of pharmacy The last digoxin lab result in Resident E's clinical recommendations affects all record was dated 11/30/17. residents. All pharmacy recommendations for the last The 8/9/18 pharmacy recommendation for three months (August, September, Resident E read, "[Name of Resident E] receives October) reviewed for follow-up, digoxin [Lanoxin], and does not have a digoxin including medication changes and serum concentration evaluation in the resident labs. Medical Director consulted record within the previous 6 months. as appropriate. The importance of Recommendation: Please consider monitoring pharmacy recommendations and serum digoxin concentration on the next subsequent follow-up reviewed convenient lab day and every 6 months thereafter with clinical staff at time of to monitor for potential toxicities of this therapy. survey. This was reinforced during Rationale for Recommendation: Routine serum one-on-one in-services and will be concentration monitoring is recommended with further reinforced at planned digoxin use as it is a narrow therapeutic index clinical meeting 11/26/18. medication." There was no physician response in the clinical record to this 8/9/18 pharmacy Pharmacy recommendations will recommendation. be reviewed and delivered to MD in a timely manner for consultation An interview was conducted with the DON and possible order changes. (Director of Nursing) on 11/2/18 at 10:32 a.m. She Recommendations will be indicated the facility was unable to provide a submitted to MD via fax upon response to the 8/9/18 digoxin pharmacy receipt and a copy will be placed recommendation. in MD follow-up book for review at next visit. All pharmacy consults The 10/10/18 pharmacy recommendation for will be kept on record with fax Resident E read, "Repeated Recommendation from verification of delivery to MD. The 8/9/18: Please respond promptly to assure facility Director of Nursing and Assistant compliance with Federal regulations. [Name of Director of Nursing will ensure this Resident E] receives digoxin [Lanoxin], and does process is followed with every not have a digoxin serum concentration pharmacy consult. An audit tool

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evaluation in the resident record within the

previous 6 months. Recommendation: Please

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will be utilized by the Director of

Nursing and Assistant Director of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE C A. BUILDING B. WING	OO OO	COME	(X3) DATE SURVEY COMPLETED 11/02/2018			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	consider monitoring serum digoxin concentration on the next convenient lab day and every 6 months thereafter to monitor for potential toxicities of this therapy. Rationale for Recommendation: Routine serum concentration monitoring is recommended with digoxin use as it is a narrow therapeutic index medicationPhysician's Response: I accept the recommendation(s) above with the following modification(s): digoxin level X [times] [symbol for "one"] then q [every] 3 months." 3.1-25(i)			Nursing to ensure coneach of these initiative. The Director of Nursin Assistant Director of Nuse an audit tool to moment to the compliance with each consult, generally commonthly. This monthly will continue indefinite audits will be reviewed the QAPI committee a corporate risk manage ensure 100% compliane benchmark is not met plan will be developed implemented to ensure compliance.	es. Ing and Nursing will onitor pharmacy pheted y monitoring ely. The d monthly by and ement to nce. If this , an action d and			
F 0757 SS=D Bldg. 00	Drugs §483.45(d) Unnec Each resident's dr from unnecessary drug is any drug w §483.45(d)(1) In e duplicate drug the §483.45(d)(2) For §483.45(d)(3) With or §483.45(d)(4) With for its use; or	xcessive dose (including						

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Event ID:

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Facility ID: 000383

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938						IB NO. 0938-039			
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED			
	155721		B. WING	· · · · · · · · · · · · · · · · · · ·			11/02/2018		
					DEET A	ADDRESS, CITY, STATE, ZIP COD			
	NAME OF P	ROVIDER OR SUPPLIER	8			46TH ST			
	I AMDEN	ICE MANIOD HEAL	THOADE CENTED						
LAWRENCE MANOR HEALTHCARE CENTER				INDIANAPOLIS, IN 46226					
	(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID)	PROVIDER'S PLAN OF CORRECTION		(X5)	
	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
	TAG REGULATORY OR LSC IDENTIFYING INFORMATION		TA	۸G	DEFICIENCY)		DATE		
		consequences wh	ich indicate the dose						
		should be reduced	d or discontinued; or						
		§483.45(d)(6) Any	combinations of the						
		reasons stated in	paragraphs (d)(1) through						
		(5) of this section.							
				F 0757		F757		12/02/2018	
		Based on interview	and record review, the facility			Regular monitoring of resident	labs		
		failed monitor a res	ident's digoxin medication use,			to ensure therapeutic medicati	ion		
		as care planned, for	1 of 5 residents reviewed for			regimen affects all residents,			
		unnecessary medica	ations. (Resident E)			including resident E whose red	cord		
		Findings include:				was reviewed during the surve	ey.		
						Recommended digoxin level			
						obtained and reported to MD a	as		
		The clinical record	for Resident E was reviewed on			indicated. Lab draw schedule	d for		
		10/31/18 at 3:09 p.m. The diagnoses for Resident				04/30/19 for six month			
		E included, but wer	e not limited to, atrial			surveillance. The importance	of		
		fibrillation.				pharmacy recommendations a			
						subsequent follow-up reviewed			
		The October, 2018	physician's orders for Resident			with clinical staff at time of			
		E indicated for a 12	5 mcg tablet of digoxin to be			survey. This was reinforced d	uring		
		administered once a	a day, effective 2/1/18.			one-on-one in-services and wi	-		
						further reinforced at planned			
		The 2/2/18 digoxin	care plan indicated an			clinical meeting 11/26/18.			
		intervention, initiate	ed 2/2/18, was, "Serum Digoxin			_			
		levels monthly or as	s ordered by physician."			Regular monitoring of resident	labs		
						to ensure therapeutic medicati	ion		
		There was no order	found in the clinical record,			regimen affects all residents.	All		
		regarding laboratory	y monitoring of Resident E's			resident records and pharmac			
		digoxin use.				reports reviewed to ensure lab	-		
						monitoring completed at			
		The 8/9/18 pharmac	cy recommendation for			recommended intervals. The			
		Resident E read, "[N	Name of Resident E] receives			importance of pharmacy			
		digoxin [Lanoxin],	and does not have a digoxin			recommendations and subseq	uent		
		serum concentration evaluation in the resident				follow-up reviewed with clinica			
		record within the pr	revious 6 months.			staff at time of survey. This w			
		_	Please consider monitoring			reinforced during one-on-one			
			entration on the next			in-services and will be further			
	convenient lab day and every 6 months thereafter				reinforced at planned clinical				

to monitor for potential toxicities of this therapy.

meeting 11/26/18.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155721	B. W	B. WING			11/02/2018	
	PROVIDER OR SUPPLIER	THCARE CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(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 DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE	
	Rationale for Recor	nmendation: Routine serum						
	concentration moni	toring is recommended with			Lab tracker developed to reco	rd		
	digoxin use as it is	a narrow therapeutic index			labs when ordered and ensure	9		
	medication. [Ref (I	Reference): Lanoxin (package			follow-up and reporting as			
	insert). GlaxoSmitl	hKline, Research Triangle Park,			indicated. MD orders (yellow			
	NC. December 201	16.]"			sheets) to be reviewed daily d	uring		
					morning QA meeting by Direct	_		
	The last digoxin lab	result in Resident E's clinical			Nursing and Assistant Directo	r of		
	record was dated 11	1/30/17.			Nursing to ensure lab tracker			
					being used appropriately. Upo	on		
	The 10/10/18 pharmacy recommendation for				admission resident			
	Resident E read, "Repeated recommendation from				diagnoses/medications will be			
	8/9/18: Please respond promptly to assure facility				reviewed to ensure that			
	compliance with Federal regulations. [Name of				appropriate lab monitoring is o	are		
	Resident E] receive	s digoxin [Lanoxin], and does			planned and scheduled for dra	aw.		
		serum concentration			Pharmacy recommendations v	will		
		sident record within the			be reviewed and delivered to	MD in		
	_	Recommendation: Please			a timely manner for consultation	on		
		g serum digoxin concentration			and possible lab orders.			
		ent lab day and every 6			Recommendations will be			
		monitor for potential			submitted to MD via fax upon			
		erapy. Rationale for			receipt and a copy will be place			
		Routine serum concentration			in MD follow-up book for revie			
		nmended with digoxin use as it			next visit. All pharmacy consu			
		utic index medication. [Ref			will be kept on record with fax			
		kin (package insert).			verification of delivery to MD.			
	· ·	Research Triangle Park, NC.			Director of Nursing and Assist			
	_	Physician's Response: I			Director of Nursing will ensure			
	_	endation(s) above with the			process is followed with every			
	_	tion(s): digoxin level X [times]			pharmacy consult. An audit to			
	[symbol for "one"]	then q [every] 3 months."			will be utilized by the Director			
	A • •	and and Made DONE.			Nursing and Assistant Directo			
		onducted with the DON on			Nursing to ensure compliance	WILLI		
		. She indicated she was unsure			each of these initiatives.			
	of Resident E's digo	oxin lab monitoirng schedule.			The Director of Nursing and			
	3.1-48(a)(3)				Assistant Director of Nursing V	vill		
					use an audit tool to monitor			
					compliance with each pharma	cy I		
					consult, generally completed	_		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
		155721	B. WING 11/02/2018				2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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
E 0750				monthly. This monthly monito will continue indefinitely. A separate audit tool will be used monthly to review resident recindependent of pharmacy recommendations to ensure high-risk medications are bein appropriately monitored. This monthly monitoring will also continue indefinitely. The aud will be reviewed monthly by th QAPI committee and corporate risk management to ensure 10 compliance. If this benchmark not met, an action plan will be developed and implemented to ensure compliance.	d ords g its e e e 00%		
F 0759 SS=D Bldg. 00	§483.45(f) Medica The facility must e §483.45(f)(1) Med percent or greater Based on observation review, the facility of error rate of less that observed during me opportunities with 2 medications error rate resident (Resident Marchaeles) Findings include:	nsure that its- ication error rates are not 5	F 07	759	F759 Accurate medication administration, limiting medical errors to five percent or less, affects all residents, including resident M whose record was reviewed during the survey. A active MD order to crush reside medications was obtained. Pharmacist was consulted for alternatives to extended release meds (Bupropion and Metoprot that could be safely crushed.	un ent se	12/02/2018
	Autism and hyperte				Medical Director consulted, or	ders	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155721	B. W	ING		11/02/	2018
		l		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			46TH ST		
	ICE MANOD HEAL	THCARE CENTER			461H ST IAPOLIS, IN 46226		
LAWKEN	ICE WANCK FEAL	THOARE CENTER		INDIAN	MAFULIO, IIN 40220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					obtained, resident medication		
		dated 9/26/18 indicated			regimen/MAR updated.		
		eceive Budeprion SR			Sixteen-page PDF from the		
	*	ntidepressant) 150 milligrams			Institute of Safe Medication		
	-	toprolol ER (extended release			Practices (ISMP) reviewed wit	h	
	antihypertensive) 50	0 milligrams one time daily.			clinical staff at time of survey.		
					This information was reinforce		
		present in the clinical record	1		during one-on-one inservices		
	to crush medication	s prior to administering them.			will be further reinforced at clir		
					meeting 11/26/18. A copy of t	his	
		0:32 a.m., QMA (Qualified			PDF was also placed in the		
	Medication Aide) 6 was observed administering				medication room.		
	medications to resident M. She crushed the						
	_	Metoprolol ER and mixed the			Accurate medication		
		esauce. She administered the			administration, limiting medica	ition	
	crushed medication	s to resident M.			errors to five percent or less,		
					affects all residents. All reside		
		Dosage Forms That Should			records were reviewed to ensu		
		evised on November 20, 2016			anyone receiving crushed med		
		f Safe Medications Practices			has active MD order. Resider		
		Metoprolol ER and Budeprion			records also reviewed to ensu		
	SR should not be cr	rushed prior to administration.			inappropriate meds being crus		
		10/01/0010 10 . 10			with subsequent follow-up and		
	-	on 10/31/2018 at 10:42 a.m.,			adjustment of med regimen as		
	-	ated Budeprion SR should not			indicated. Sixteen-page PDF f		
	-	administration. The possible			the Institute of Safe Medicatio		
		ning Budeprion SR include, but			Practices (ISMP) reviewed wit	n	
		gitation, constipation and			clinical staff at time of survey.		
		cated that Metoprolol ER			This information was reinforce		
		ed prior to administration.			during one-on-one inservices		
		ffects of crushing Metoprolol			will be further reinforced at clir		
	· ·	not limited to, low blood			meeting 11/26/18. A copy of t	nis	
	pressure and dizzin	CSS.			PDF was also placed in the		
	During or inter-	on 11/01/2019 at 9.55 a 4			medication room.		
	-	y on 11/01/2018 at 8:55 a.m., the			Double and about the second at 1.1.		
	· ·	Nursing) indicated that extended should not be crushed.			Pertinent charting and physicia		
	release medications	should not be crushed.			orders will be reviewed daily a		
	2.1.49(a)(1)				morning QA meeting to identif	-	
	3.1-48(c)(1)				residents with new dysphagia		
					residents with newly prescribe	a	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/02/2018	
	PROVIDER OR SUPPLIE	R THCARE CENTER	8935 E	FADDRESS, CITY, STATE, ZIP COD E 46TH ST NAPOLIS, IN 46226	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
				medications. Medical director be consulted if new crush ord are needed and/or residents or crush orders are prescribed medications that should not be crushed. The Director of Nursiand Assistant Director of Nursiand Assistant Director of Nursiand Evaluated for need to crush meds and medication regiment be evaluated for need to crush meds and medication regiment be assessed to ensure not inappropriate meds being crush assistant Director of Nursing and Assistant Director of Nursing and Assistant Director of Nursing use an audit tool to monitor compliance daily for six month Weekly monitoring will continuindefinitely thereafter. The audith be reviewed monthly by the QAPI committee and corporation risk management to ensure 1 compliance. If this benchmar not met, an action plan will be developed and implemented the ensure compliance.	ers with e sing sing or s will h n will shed. will as. ue udits ne te 00% k is
F 0760 SS=D Bldg. 00	The facility must §483.45(f)(2) Res significant medica Based on interview failed to ensure a reviewed for dialyst release medication	sidents are free of any	F 0760	F760 Accurate medication administration, preventing any all significant med errors, affe all residents, including resider and M whose records were	cts

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155721	B. W	ING		11/02/2	018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			46TH ST		
LAWREN	NCE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	errors. (Resident B	and M)			reviewed during the survey po		
					Resident B's vimpat order wa		
	Findings include:				clarified with Medical Director		
		10 P 11 . P			pharmacy. Resident B's MAF	l l	
		ord for Resident B was reviewed			was updated to bring cliniciar		
		p.m. The diagnoses for			attention to the order and limi	t	
		d, but were not limited to,			incorrect interpretation.		
	chronic kidney dise	ase and epilepsy.			Pharmacist was consulted for		
	A1	L. 10/21/10 - 1 - 1			alternatives to extended relea		
		lated 9/21/18, indicated			meds (Bupropion and Metopr		
Resident B was to receive 2 tablets of vimpat a					that could be safely crushed t	ror	
total of 400 milligrams by mouth daily.				resident M. Medical Director			
				consulted, orders obtained,			
		lated 9/21/18, indicated			resident M medication		
		receive an additional 1 tablet of			regimen/MAR updated. The		
	_	0 milligrams after dialysis on			absolute necessity of adherer		
		ys and Saturdays. Resident B			to MD orders r/t seizure meds		
	was to take the 200	milligrams with him to dialysis.			reviewed with clinical staff du	ring	
		1 . 1 1 0 /01 /10 : 1: 1			time of survey. Resident B's		
		lated 10/21/18, indicated			vimpat order also reviewed de	-	
		receive 500 milligrams of keppra			one-on-one inservices to ens		
	twice a day for seiz	ures.			understanding. Sixteen-page	PDF	
	Ah	10/21/10 in diameter			from the Institute of Safe		
		lated 10/21/18, indicated receive 250 milligrams of keppra			Medication Practices (ISMP)	4i	
	3 times a week after				reviewed with clinical staff at	-	
	J times a week alte	i diaiysis.			of survey. This information w	l l	
	A Controlled Subst	ance Record dated 9/21/18,			reinforced during one-on-one		
		B did not receive vimpat as			inservices and will be further		
		owing days and times:			reinforced at clinical meeting 11/26/18. A copy of this PDF		
	ordered on the folic	wing days and times.			also placed in the medication		
	9/29/18 - Saturday	- no dosages administered,			room.		
		Tuesday 2 tablets administered			100111.		
	= 400 milligrams,	, raceau 2 morete administered			Accurate medication		
		- no dosages administered,			administration, preventing an	v and	
	-	Saturday 1 tablet administered			all significant med errors, affe		
	= 200 milligrams,	, Saturday 1 tubiot duministered			all residents. The absolute	,013	
		no dosages administered,			necessity of adherence to ME	,	
	_	_			orders r/t seizure meds reviev	l l	
	10/9/18 - 4:00 a.m., Tuesday 1 tablet administered = 200 milligrams.				with clinical staff during time of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155721	B. W	B. WING			2018
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
	ICE MANOD LIEAL	THEADE CENTED			46TH ST		
LAWKEN	LAWRENCE MANOR HEALTHCARE CENTER			INDIAN	IAPOLIS, IN 46226		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID) PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	10/11/18 - Thursday	y = no dosages administered,			survey. This information was	also	
	10/13/18 - Saturday	= no dosages administered,			reinforced during one-on-one		
	10/16/18 - Tuesday	= no dosages administered,			inservices to ensure		
	10/18/18 - 4:00 a.m	., Thursday 1 tablet			understanding. Sixteen-page	PDF	
	administered = 200	milligrams,			from the Institute of Safe		
	10/20/18 - 4:00 a.m	., Saturday 1 tablet administered			Medication Practices (ISMP)		
	= 200 milligrams,				reviewed with clinical staff at ti	ime	
	10/21/18 - Sunday =	= no dosages administered,			of survey. This information wa	as	
	10/23/18 - Tuesday	- no dosages administered,			reinforced during one-on-one		
	10/25/18 - 4:00 a.m	., Thursday 1 tablet			inservices and will be further		
	administered = 200 milligrams,				reinforced at clinical meeting		
	10/27/18 - 4:00 a.m., Thursday 1 tablet				11/26/18. A copy of this PDF	was	
	administered = 200 milligrams,				also placed in the medication		
	10/27/18 - 11:15 a.r	n., Wednesday 1 tablet			room.		
	administered = 200	milligrams, and					
	10/30/18 - 4:00 a.m	., Tuesday 1 tablet = 200			All resident records will be		
	milligrams,				reviewed to identify		
					inconsistencies/errors in		
	The October 2018 N	Medication Administered			medication administration. An	y	
	Record for Residen	t B indicated the 500 milligrams			identified errors and/or source	s of	
	* *	nistered twice a day on			possible confusion will be clari	ified	
	_	0/30/18. The 250 milligrams of			with the Medical Director and		
		be administered 3 times a week			reviewed with clinical staff. Th	ne	
	after dialysis was no	ot administered.			Director of Nursing and Assist	ant	
					Director of Nursing will use an		
		onducted with Resident B on			audit tool to monitor compliand	ce.	
		.m. He indicated the staff does					
	not always give him	n his seizure medications.			The Director of Nursing and		
					Assistant Director of Nursing v	vill	
		onducted with License			use an audit tool to monitor		
		(N) 1 on 11/1/18 at 8:39 a.m. She			compliance daily for six month		
		B goes to dialysis on			Weekly monitoring will continu		
		s, and Saturdays. He leaves			indefinitely thereafter. The au-		
		nt B does at times refuse his			will be reviewed monthly by th		
		ver refuses his seizure			QAPI committee and corporate		
		alysis days, Resident B gets			risk management to ensure 10		
		vimpat at 4:00 a.m., and then			compliance. If this benchmark		
		of vimpat with him to take			not met, an action plan will be		
	immediately after d	ialysis due to seizures.			developed and implemented to	o	
					ensure compliance		

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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	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/02/2018				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ILD BE COMPLETION			
PREFIX TAG	An interview was consuring (DON) on indicated the staff has eizure medications determine why Residosages of vimpat of 10/13/18, 10/16/18, indicated Resident It of vimpat daily and vimpat on dialysis of indicated Resident It of keppra twice a damilligrams of keppra dialysis. B. The clireviewed on 10/31/2 diagnosis for reside limited to, Autism and A physicians order resident M was to resi	onducted with the Director of 11/2/18 at 9:37 a.m. She ad not been administrating the as ordered. She was unable to ident B had not received any on 9/29/19, 10/4/18, 10/8/18, 10/21/18 and 10/23/18. She 3 was to receive 400 milligrams an additional 200 milligrams of days after dialysis. She 3 was to receive 500 milligrams and then an additional 250 at on dialysis days after inical record for resident M was 2018 at 10:42 a.m. The nt M included, but were not and hypertension. Indeed 9/26/18 indicated deceive Budeprion SR antidepressant) 150 milligrams coprolol ER (extended release 0 milligrams one time daily. 10:32 a.m., QMA (Qualified was observed administering lent M. She crushed the Metoprolol ER and mixed the esauce. She administered the	PREFIX TAG					
	pharmacist 10 indic	ated Budeprion SR should not administration. The possible						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/02/2018		
	ROVIDER OR SUPPLIER	THCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE	
F 0704	are not limited to, a headache. He indicashould not be crush. The possible side of ER include, but are pressure and dizzing. During an interview. DON (Director of Northease medications). 3.1-48(c)(2)	ov on 11/01/2018 at 8:55 a.m., the Nursing) indicated that extended should not be crushed.						
F 0761 SS=D Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accepted							
	§483.45(h)(1) In a Federal laws, the and biologicals in under proper temp	pe of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments perature controls, and rized personnel to have s.						
	separately locked, compartments for listed in Schedule Drug Abuse Preve 1976 and other dr	e facility must provide , permanently affixed storage of controlled drugs Il of the Comprehensive ention and Control Act of rugs subject to abuse, acility uses single unit						

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12/12/2018 PRINTED: FORM APPROVED OMB NO. 0938-039

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 B. WING 155721

COMPLETED 11/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. F 0761 F761 12/02/2018 Based on observation and interview the facility Strict authorized access to drugs failed to assure medications were stored in locked and biologicals affects all compartments for 1 of 1 medication room residents. This includes utilization observered of a medication room with a functioning lock that is only Findings include: accessible by clinical staff entrusted with key as appropriate. Medication room lock has been On 11/02/2018 at 12:10 p.m., the door to the medication room was observed to be ajar with the repaired. door latch resting on the inside of the door frame. There were no licensed nurses present in the Strict authorized access to drugs nursing station or in the medication room. and biologicals affects all residents. Medication room lock On 11/02/2018 at 12:20 p.m., LPN (licensed has been repaired. practical nurse) 1 was observed entering the medication room. She did not need to use her key Medication room lock has been to unlock the medication room door due to the repaired, and the key has been door being ajar and the latch resting on the inside identified and included on key ring of the door frame. supplied to charge nurse during each shift. The Director of Nursing During an interview on 11/02/2018 at 12:20 p.m., and Assistant Director of Nursing LPN 1 indicated that the medication room door will use an audit tool to monitor does not shut completely at times and needs to be compliance. pulled shut in order for it to lock. The door must not have gotten shut completely when the last The Director of Nursing and nurse left the room. Assistant Director of Nursing will use an audit tool to monitor 3.1-25(m)compliance daily for six months. Weekly monitoring will continue indefinitely thereafter. The audits will be reviewed monthly by the QAPI committee and corporate risk management to ensure 95% compliance. If this benchmark is

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not met, an action plan will be developed and implemented to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BUILDING B. WING	<u> </u>		COMPLETED 11/02/2018			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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		
F 0880 SS=D Bldg. 00	infection prevention designed to provide comfortable environment and communicable discussions. See Section 1. Sec	on & Control Control stablish and maintain an an and control program le a safe, sanitary and comment and to help prevent and transmission of leases and infections. In prevention and control stablish an infection introl program (IPCP) that minimum, the following In the following In the following investigating, and insight and communicable sidents, staff, volunteers, individuals providing contractual arrangement cility assessment ing to §483.70(e) and in national standards; Item standards, policies, in the program, which must be limited to: I weillance designed to communicable diseases or ney can spread to other		ensure compliance.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICI	ΞS
CENTERS FOR MEDICARE & MEDICAID SERVICE	S

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 11/02/2018				
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
PREFIX (EACH DEFICIENCE	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PR	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
precautions to be of infections; (iv)When and how for a resident; inclu (A) The type and of depending upon the organism involved (B) A requirement the least restrictive under the circumstar must prohibit emplocommunicable displesions from direct their food, if direct disease; and (vi)The hand hygie followed by staff in contact. §483.80(a)(4) A sy incidents identified and the corrective facility. §483.80(e) Linens Personnel must have transport linens so of infection. §483.80(f) Annual The facility will cor its IPCP and updanecessary. Based on interview failed to maintain a	that the isolation should be possible for the resident tances. Inces under which the facility loyees with a pease or infected skin a contact with residents or contact will transmit the ene procedures to be envolved in direct resident for recording and under the facility's IPCP actions taken by the facility store, process, and the ast to prevent the spread for the their program, as and record review, the facility method to track and analyze in the facility each month for 1 and facility each month facility each each each each each each each each	F 088		F880 Accurate infection tracking, analysis, and prevention affective residents. This includes consistent utilization of the		12/02/2018

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				III TIPLE CO	NCTRICTION	(V2) D 1 777	CLIDATEN	
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		<u>00</u>	COMPLETED		
		155721	B. W	B. WING			11/02/2018	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
					46TH ST			
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN	IAPOLIS, IN 46226			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					facility's existing infection con-	trol		
	An infection contro	l binder was reviewed on			binder and its various			
	11/2/18 11:03 a.m.	It indicated monthly mapping			components. Infection contro	l		
	and monitoring of i	nfections in the facility. The			binder updated to accurately			
	binder did not inclu	de a color coded map or			reflect resident infections and			
	monitoring method	of the facility's infections in			antibiotic use.			
	July 2018.							
					Accurate infection tracking,			
	An interview was c	onducted with the Director of			analysis, and prevention affect	ts all		
	Nursing (DON) on	11/2/18 at 11:21 a.m. She			residents. Infection control bit			
		was utilized to track and			updated to accurately reflect			
	analyze infections. The infection control binder				resident infections and antibio	tic		
	should include each month with the following: a				use.			
		oded, a document "Line List of						
	_	ocument "Antibiotic Use			Pertinent charting and physici	an		
		the infections in the facility.			orders will be reviewed daily a			
	-	ed and was not done.			morning QA meeting to identif			
	July 2010 was iiiiss	ed and was not done.			residents with newly diagnose	-		
	An "Infaction Prove	ention Program Overview" was				u		
		ON on 11/2/18 at 1:14 p.m. It			infections and new antibiotic			
		-			orders. Infection control binds			
		s. The goals of the Infection			be updated simultaneously by			
	_	n are to: A. Decrease the risk of			Director of Nursing and Assist			
		ts and personnel. B. Monitor			Director of Nursing as indicate	ea.		
		ifection and implement			The Director of Nursing and	•••		
	* * *	measures. C. Identify and			Assistant Director of Nursing	WIII		
	^	lating to infection prevention			use an audit tool to monitor			
	-	ain compliance with state and			compliance.			
	_	relating to infection						
		be of the Infection Prevention			The Director of Nursing and			
	-	tion Prevention Program is			Assistant Director of Nursing v	will		
	•	hat it addresses detection,			use an audit tool to monitor			
	-	trol of infections among			compliance daily for six month			
	_	nnel. The scope of services			Weekly monitoring will continu			
	-	dent population, and			indefinitely thereafter. The au			
	_	f the healthcare facility. The			will be reviewed monthly by th	ie		
		the Program are: A.			QAPI committee and corporat	е		
	Surveillance of Infe	ections with implementations of			risk management to ensure 10	00%		
	control measures ar	nd prevention of infections.			compliance. If this benchmarl	k is		
	There is on-going n	nonitoring for infections			not met, an action plan will be			
	among residents an	d personnel and subsequent			developed and implemented t			

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NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		1				COMPLETED	
	100721	B. WI			1 1/02/2	2010	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
			TAG	DEFICIENCY)		DATE	
Prevention of spread accomplished by us other barriers, appro	d of infections is e of standard precautions and opriate treatment and			ensure compliance.			
3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and		F 99	999	annual tuberculin skin testing organized ongoing in-service education and training affects employees, including CNA 18 QMA 20, Dietary Staff 21, and LPN 24. Identified employee records were reviewed, and employees brought up to date tuberculin skin testing. Employees were also in-service individually on the following to 1. Residents' rights 2. Prevention and control of infection 3. Fire prevention 4. Safety and accident prevention 5. Needs of specialized populations served 6. Care of cognitively impair residents Importance of accurate record-keeping reviewed with	and all with ced pics:	12/02/2018	
	PROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY OR documentation of ir Prevention of spread accomplished by us other barriers, appro follow-up, and emp illness" 3.1-18(b)(1) 3.1-18(b)(1) 3.1-18(b)(1) 3.1-19 Personnel (k) There shall be at education and traini advance for all pers include, but not be la (1) Residents' rights (2) Prevention and (3) Fire prevention. (4) Safety and accid (5) Needs of special (6) Care of cognitiv (1) The frequency at education and traini accordance with the facility personnel as personnel, this shall hours of inservice p hours of inservice p nonnursing personn required inservice h who have regular co have a minimum of dementia-specific tr initial employment, personnel assigned dementia special ca annually thereafter to	IDENTIFICATION NUMBER 155721 ROVIDER OR SUPPLIER ICE MANOR HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION documentation of infections that occur. Prevention of spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employees work restrictions for illness" 3.1-18(b)(1) 3.1-18(b)(1) 3.1-18(b)(1) 3.1-19 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for	IDENTIFICATION NUMBER 155721 A. BU B. WI PROVIDER OR SUPPLIER ICE MANOR HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION documentation of infections that occur. Prevention of spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employees work restrictions for illness" 3.1-18(b)(1) 3.1-18(b)(1) F 99 (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. 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Prevention of spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employees work restrictions for illness" 3.1-18(b)(1) 3.1-18(b)(1) F 9999	A BUILDING 156721 ROVIDER OR SUPPLIER ICE MANOR HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR IS CUBENTIFYING INFORMATION) documentation of infections that occur. Prevention of spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employees work restrictions for illness" 3.1-18(b)(1) 3.1-18(b)(1) 3.1-18(b)(1) F 9999 F9999 F9999 F9999 F9999 F9999 F9999 F9999 F9999 FP9999 FP9999 FP9999 FP9999 FP9999 FP9999 FP999 FP9999 FP999 FP9999 FP9999 FP9999 FP9999 FP9999 FP9999 FP9999 FP9999 FP9999 FP9999	A BUILDING 00 COMPLET 11/02/2 ROVIDER OR SUPPLIER ROE MANOR HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MIST BE PRECEDED BY FILL. REGULATORY OR IS CIDENTIFYING INFORMATION documentation of infections that occur. Prevention of spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employees work restrictions for illness" 3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. 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(1) in addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thrity (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
	155721 B.V		B. W	B. WING 11/02/2018			2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				46TH ST			
LAWREN	ICE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	n understanding of the current			corporate HR consultant.		
		r residents with dementia.					
		ination shall be required for			Accurate and timely new-hire		
		facility within one (1) month			annual tuberculin skin testing	and	
		t. The examination shall			organized ongoing in-service		
		skin test, using the Mantoux			education and training affects		
), administered by person			employees. All employee rec		
		on of training from a			were reviewed, and employee		
		ed course of instruction in			brought up to date with tubero		
		lin skin testing, reading, and			skin testing. Employees were		
		previously positive reaction			also in-serviced individually or	n the	
		The result shall be recorded			following topics:		
		duration with the date given,			Residents' rights		
		hom administered. The			Prevention and control of		
	tuberculin skin test must be read prior to the				infection		
		vork. The facility must assure			Fire prevention		
	the following:				Safety and accident		
	(1) At the time of employment, or within one (1)				prevention		
		loyment, and at least annually			Needs of specialized		
		es and nonpaid personnel of			populations served		
		reened for tuberculosis. For			6. Care of cognitively impair	ed	
	health care workers who have not had a				residents		
	documented negative tuberculin skin test result				Importance of accurate		
	during the preceding twelve (12) months, the			record-keeping reviewed with HR			
	baseline tuberculin skin testing should employ the			coordinator during time of survey			
	two-step method. If the first step is negative, a			and this information was reinforced			
	second test should be performed one (1) to three				on subsequent occasions by		
	(3) weeks after the first step.				corporate HR consultant.		
	(3) The facility shall maintain a health record of					.,,	
	each employee that includes:				Corporate in-service program		
	(A) a report of the preemployment physical				be implemented to ensure two		
	examination.				hours of in-service for clinical		
	(u) In addition to the required inservice hours in				and six hours of in-service for		
	subsection (l), staff who have regular contact with				non-clinical staff completed ea		
	residents shall have minimum of six (6) hours of				calendar year. Calendar with		
	dementia-specific training within six (6) months of initial employment, or within thirty (30) days for				in-service dates will be develo	-	
		•			and implemented by Director		
		to the Alzheimer's and			Nursing and Assistant Directo		
	_	re unit, and three (3) hours			Nursing. New staff will receive		
I	annually thereafter to meet the needs or				I training upon hire and will reco	PIVE	

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED			
155721		B. WING 11/02/20			/2018			
		<u> </u>		CTD PPT	ADDRESS SET STATE OF			
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
LANAGEN	IOE MANIOD LIEAL	THO A DE OFNITED			46TH ST			
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN	APOLIS, IN 46226			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	preferences, or both	n, of cognitively impaired			subsequent training according	to		
	residents and to gai	n understanding of the current			in-service calendar. New stat	f will		
	standards of care fo	or residents with dementia.			also receive a two-step tuberc	ulin		
					skin test upon hire, with the fire			
	This state rule was	not met as evidenced by:			step completed within one mo	nth		
					prior to employment. The sec	ond		
		and record review, the facility			step will be completed one to			
	failed to provide sta	aff members with new-hire and			three weeks after the first as			
	annual tuberculin sl	kin testing, resident rights and			required. Tuberculin skin testi	ng		
	_	or 4 of 10 employee personal			will be completed annually			
	files reviewed. (Cer	rtified Nursing Assistant			thereafter. The Director of Nu	rsing		
	(CNA)18, Qualified	d Medication Aide (QMA) 20,			and Assistant Director of Nurs	ing		
	Dietary Staff 21 and	d License Practical Nurse (LPN		will monitor compliance with an				
	24)				audit tool.			
	Findings include:				The Director of Nursing and			
					Assistant Director of Nursing v	vill		
	1a. The Employee I	Records were reviewed on			use an audit tool to monitor			
	11/2/18 at 10:30 a.r	n. The Employee Records form			compliance weekly for six			
	indicated CNA 18's	s start date was 12/16/17, and he			months. Monthly monitoring w	/ill		
	was a full time emp	ployee.			continue indefinitely thereafter			
					The audits will be reviewed			
	The personnel file for CNA 18 did not include new				monthly by the QAPI committe	ee		
	hire dementia training within 6 months of CNA				and corporate risk manageme			
	18's hire date.				ensure 100% compliance. If the	nis		
					benchmark is not met, an action	on		
	1b. The Employee Records were reviewed on				plan will be developed and			
	10/2/18 at 10:30 a.m. The Employee Records form				implemented to ensure			
	-	tide 21's start date was 9/23/13,			compliance.			
	and she was a full to	ime employee.						
	_	for Dietary Aide 21 did not						
		dent rights or dementia						
	in-servicing training	g.						
	1c. The Employee Records were reviewed on							
		m. The Employee Records form						
	indicated LPN 24's start date was 9/20/07, and she							
	was a part time emp	ployee.						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER					COMPLETED	
	155721 B. WING			11/02/	2018			
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	T	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TC	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	The personnel file for LPN 24 did not include annual resident rights or dementia in-servicing training.							
		Records were reviewed on						
		m. The Employee Records form						
	indicated QMA 20s start date was 7/25/84, and he was a full time employee.							
	The personnel file for QMA 20 indicated the last tuberculin skin testing was completed 8/27/17.							
	2b. The Employee Records were reviewed on 11/2/18 at 10:30 a.m. The Employee Records form indicated CNA 18's start date was 12/16/17, and he was a full time employee.							
	The personnel file for CNA 18 indicated CNA 18 had a tuberculin skin testing on 8/22/17. It did not include an annual or new hire tuberculin skin testing.							
	2c. The Employee Records were reviewed on 10/2/18 at 10:30 a.m. The Employee Records form indicated Dietary Aide 21's start date was 9/23/13, and she was a full time employee.							
	the last tuberculin s completed on 10/10	For Dietary Aide 21 indicated kin testing assessment was 0/13. The file did not include kin testing for Dietary Aide 21.						
	10/2/18 at 10:30 a.r	Records were reviewed on m. The Employee Records form start date was 9/20/07, and she bloyee.						
		For LPN 24 indicated LPN 24's kin testing was given on not read.						

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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 COMPLETED 00 B. WING 11/02/2018 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE An interview was conducted with the Regional Business Office Manager on 11/2/18 at 2:47 p.m. She indicated she was unable to provide any other documentation for the completion of tuberculin skin testing, resident rights, or dementia training to the staff. A "In-Service Training Program" policy was provided by the Administrator on 11/2/18 at 3:15 p.m. It indicated "...Our facility has developed an effective in-service training program. Policy Interpretation and Implementation 1. Our staff development program is divided into two classifications, one being orientation and the other in-service training (staff development)...3. Our in-service training program (staff development) is planned and conducted for the development and improvement of skills of all our personnel..." A tuberculosis screening employees policy was provided by the Administer on 11/2/18 at 3:15 p.m. It indicated ".. Each employee will be screened for tuberculosis ("TB") infection and disease. Employees with active TB diseases shall not be permitted to work until TB disease is successfully treated and the employee is free from the communicate disease according to the written statement of a licensed physician...All employees.. A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by a person having

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documentation of training from a

department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED			
		155721	B. WI	NG		11/02/	/2018	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (2			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY) DA			
in millimeters of induration with: i. The date given, date read, and identity of person administering test. ii. The tuberculin skin test must be read prior to the employee starting work. iii. For employees who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first stepThe facility will conduct an annual tuberculin skin test on all employees and nonpaid personnel with a history of negative results"								

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