STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE MANOR HEALTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00234663 and IN00235475. Complaint IN00234663- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00235475- Substantiated. Deficiencies related to the allegations are cited at F279, F323, and F514. Survey date: July 17 and 18, 2017 Facility number: 000383 Provider number: 155721 AIM number: 100289610 Census bed type: SNF/NF: 40 Total: 40 Census payor type: Medicare: 4 Medicaid: 36 Total: 40 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.3-1.	F 0000		

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

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	Quality review completed on July 21, 2017			
F 0279 SS=D Bldg. 00	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's			

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	exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to ensure a resident (Resident C) had care plans consistent with an Minimum Data Set (M.D.S.) assessment indicating a requirement for 2 or more staff during care to ensure safety, and were updated appropriately to reflect changing needs. 1 of 3 residents reviewed for care plans. Findings include:	F 0279	F 279 1.Resident C's care plan and C.N.A. assignment sheet has been updated to indicate resident requires 2-person assist for transferring, personal hygiene and mobility. 2.All residents have the potential to be affected. All residents' care plans were reviewed for accuracy by the	08/01/2017

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	The record of Resident C was reviewed on 7/18/17 at 9:45 A.M. Diagnoses included, but were not limited to, dementia, psychosis, a history of stroke, diabetes mellitus, hypertension, and mood disorder. An annual Minimum Data Set (M.D.S.) assessment dated 5/27/17 indicated Resident C was cognitively impaired, with a Basic Interview for Mental Status score of 5 out of a possible 15; required extensive assistance of 2 or more staff members for bed mobility, transfers, and personal hygiene; was totally dependent on 2 or more staff members for bathing; ambulated only with extensive assist from 2 or more staff members; and was incontinent of bowel and bladder. A physician's progress note dated 4/07/17 indicated "History of Present Illness...Gradual functional decline...used to be an assist X1 (one person) for transfers, now (mechanical) lift..." A care plan initiated 7/20/16 indicated Resident C was dependent on staff for bathing, dressing, and grooming related to weakness, loss of balance and cognitive loss. The care plan does not include the requirement for 2 or more staff during care as documented in the		DNS/designee to ensure care plans were accurate and were consistent with the MDS in relation to the provision of ADLs. 3.All licensed staff were in serviced by regional clinical and operations staff on July 28-31 regarding Comprehensive Care Plans Policy, including accuracy of the MDS and accuracy of the care plans. Resident care plan and most recent MDS for ADLs will be reviewed quarterly and when a significant change occurs, during morning IDT clinical meeting and weekly care plan meetings to ensure the care plan is an accurate reflection of the most current comprehensive assessment. 4.To ensure compliance, the DNS/Designee is responsible for the completion of the care plan/MDS audit QAPI tool weekly times 4 weeks, monthly times 6 months. The results of these audits will be reviewed by the QAPI committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	M.D.S. of 5/27/17, and was not updated following Resident C's accident with injury of 7/11/17. A care plan initiated 5/01/17 indicated Resident C as needing assistance "of one to two persons" to perform activities of daily living (ADLs); care plan "Interventions" indicate ADLs include dressing, grooming, and bathing, mobility, toileting, transfers, and turning and repositioning. . The care plan does not include the requirement for 2 or more staff during care as documented in the M.D.S. of 5/27/17, and was not updated following Resident C's accident with injury of 7/11/17. During an interview on 7/18/17 at 11:45 A.M., with the Administrator and Social Service Director present, the DON indicated that Resident C's care plans should reflect the most recent M.D.S. assessment, including the requirement for 2 or more staff members present during care to ensure safety, and that Resident C's care plans should have been updated following the accident with injury of 7/11/17. . A facility policy titled "Care Plans-Comprehensive" dated 9/2014 and received from the DON on 7/18/17 at 2:15 P.M., indicated "Our facility's Care			

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	Planning/Interdisciplinary Team...develops and maintains a comprehensive care plan for each resident...the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS...The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans...When there has been a significant change in the resident's condition..." This Federal tag relates to Complaint IN00235475. 3.1-35(a)			
F 0323 SS=G Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to			

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	use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on record review, interview, and observation, the facility failed to ensure a resident (Resident C) was protected from injury when a CNA acted alone to provided care for a resident who required 2 or more staff for personal care. This resulted in the resident falling from bed during care and receiving a laceration above his right eye which required an Emergency Room visit where 9 sutures were required to close the wound. 1 of 3 residents reviewed for falls. Findings include: The record of Resident C was reviewed on 7/18/17 at 9:45 A.M. Diagnoses included, but were not limited to, dementia, psychosis, a history of stroke,	F 0323	F 323 1.Resident C's care plan and C.N.A. assignment sheet has been updated to indicate the resident is a 2-person assist for bed mobility, transfers and personal hygiene. 2.All residents have the potential to be affected by this deficient practice. The DNS/Designee reviewed and updated as needed, all care plans and C.N.A. assignment sheets to ensure accuracy regarding assistance with bed mobility, transfers and personal hygiene 3.All nursing staff were in serviced by regional clinical and operations staff on July 28-31 regarding Safety and Supervision of Residents Policy - Accident Hazards, including the provision	08/01/2017

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	diabetes mellitus, hypertension, and mood disorder. An annual Minimum Data Set (M.D.S.) assessment dated 5/27/17 indicated Resident C was cognitively impaired, with a Basic Interview for Mental Status score of 5 out of a possible 15; required extensive assistance of 2 or more staff members for bed mobility, transfers, and personal hygiene; was totally dependent on 2 or more staff members for bathing; ambulated only with extensive assist from 2 or more staff members; and was incontinent of bowel and bladder. Care plans for Resident C included, but were not limited to: "Resident needs assistance of one to two person to perform ADL's (activities of daily living) R/T dx. (related to diagnosis) dementia, left hemiparesis and weakness...Goal...Resident will be able to participate in ADL's...Interventions...Turning and positioning: Resident requires extensive assistance for bed mobility such as turning and positioning..." "(Resident C) has a potential for falls R/T weakness, loss of balance and confusion...Goal... (Resident C)...will not sustain serious injury from falls...Interventions...Check for positioning in w/c (wheelchair) and bed..." "(Resident C) is dependent on		of personal care at the bedside. DNS/Designee will complete rounds each shift to ensure the accurate provision of care is provided to each resident for transfers, personal hygiene and mobility per plan of care. 4.To ensure compliance, the DNS/Designee is responsible for the completion of the provision of care audit QAPI tool weekly times 4 weeks, monthly times 6 months. The results of these audits will be reviewed by the QAPI committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	staff for his bathing, dressing and grooming skills R/T weakness, loss of balance and cognitive loss...Goal: (Resident C) will be appropriately bathed, dressed and groomed...Interventions...Honor his preferences for daily care..." "(Resident C) is incontinent due to weakness, loss of balance and severe confusion due to his dementia...Goal: (resident C) will be kept clean, dry, and comfortable...Interventions...Assist with skin care after each incontinent episode..." A physician's progress note dated 4/07/17 indicated "History of Present Illness...Gradual functional decline...used to be an assist X1 (one person) for transfers, now (mechanical) lift..." A physician's order dated 7/11/17 at 3:45 P.M., indicated "Send to (acute care hospital) eval (evaluate) et Tx (and treat) RT (related to) fall." An "Interdisciplinary Post-Fall Assessment" signed by the DON and SSD, indicated "Date of current fall: 7/11/17...Description of fall: Res (resident) was too close to edge of bed and fell to the floor...Injury...Transfer to acute care...laceration to (symbol for "right") eyebrow..."			

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An "Incident/Accident Report" signed by the DON indicated "...Res was being cleaned by CNA (CNA #1) when he got too close to edge of bed and fell to floor (sic)..."

On 7/18/17 at 10:00 A.M., the Social Services Director (SSD) indicated that on 7/11/17 at approximately 3:30 P.M., she and the Director of Nursing (DON) were called to Resident C's room. Resident C was on the floor and had suffered a wound to his head above his right eye. CNA #1 had been providing care following Resident C's return from the hospital when he slipped off his low air loss mattress and fell to the floor. The Resident was assessed, 911 was called, and the resident was sent to the hospital for evaluation and treatment. The SSD noted CNA #1 was working alone at the time of the incident.

Resident C was observed on 7/18/17 at 3:15 P.M., with RN #2. The resident was unresponsive to questions. The RN indicated she had been on duty at the time of Resident C's injury, and had assisted in his care and transfer to the hospital, but had not been present at the time of the accident. She removed the dressing over Resident C's left eye for observation. There was an approximately

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	5 centimeter arch shaped wound above the resident's right eye, secured with 9 sutures. There was dried blood on the wound. RN #2 indicated that cleaning the dried blood from the wound would cause fresh bleeding and it was being left undisturbed to facilitate healing. The dressing was replaced. During an interview on 7/18/17 at 11:45 A.M., with the Administrator and SSD present, the DON indicated that when she was called to Resident C's room on 7/11/17, she found him on the floor, and actively bleeding from a wound above his right eye. She indicated she applied pressure to the wound to help control the bleeding, and maintained pressure until the emergency medical technicians arrived and assumed care. The DON indicated CNA #1 had been providing care alone, and that this was in conflict with the resident's assessed need for 2 or more staff during care to ensure safety, and that this represented a violation of facility policy. A facility policy titled "Safety and Supervision of Residents" dated 2001 and revised December 2007, was received from the DON on 7/18/17 at 2:15 P.M. It indicated: "Facility-Oriented Approach to Safety...Employees shall be trained and inserviced on potential accident			

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	hazards...and to try to prevent avoidable accidents...Resident-Oriented Approach to Safety...Staff shall use various sources to identify risk factors for residents, including...the MDS..." This Federal tag relates to Complaint IN00235475. 3.1-45(a)(2)			
F 0514 SS=D Bldg. 00	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;			

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	(iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure accurate and complete clinical records were maintained for a resident (Resident C) who suffered an accident with injury requiring emergent transfer to an acute care hospital and subsequent treatment. 1 of 3 residents reviewed for medical records. Findings include: The record of Resident C was reviewed on 7/18/17 at 9:45 A.M. Diagnoses included, but were not limited to, dementia, psychosis, a history of stroke, diabetes mellitus, hypertension, and mood disorder. An annual Minimum Data Set (M.D.S.) assessment dated 5/27/17 indicated Resident C was cognitively impaired, with a Basic Interview for Mental Status	F 0514	F 514 1.Resident C's medical record has been updated with a late entry describing the resident's fall, return from the hospital, and new physician's orders. 2.All residents have the potential to be affected by this deficient practice. The medical records of residents who experienced a significant change within the last thirty days were reviewed by the DNS/Designee to ensure medical records adhered to the Charting and Documentation Policy. Licensed nursing staff were in serviced by regional clinical and operations staff on July 28-31 regarding the Charting and Documentation Policy, including documentation with a resident's significant change and/or event. 3.DNS/Designee will review the medical record of residents who experience a significant change in condition to ensure the medical record reflects the necessary	08/01/2017

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	score of 5 out of a possible 15; required extensive assistance of 2 or more staff members for bed mobility, transfers, and personal hygiene; was totally dependent on 2 or more staff members for bathing; ambulated only with extensive assist from 2 or more staff members; and was incontinent of bowel and bladder. A nurse's note dated 6/20/17 at 9:57 P.M., indicated Resident C was discharged to an acute care hospital. There was no nurse's note indicating his return. A physician's order dated 7/11/17 at 3:45 P.M., indicated "Send to (acute care hospital) eval (evaluate) et Tx (and treat) RT (related to) fall." Resident C's nurse's notes did not contain any documentation related to: His return from the acute care hospital on 7/11/17 at approximately 3:00 P.M., including, but not limited to, his treatment at the hospital, any new orders, an assessment of his condition on return, and notification of family or physician. Any documentation related to his fall from bed, any assessment of his injuries, and actions taken subsequent to the injury, or his discharge to the hospital by emergency medical services.		documentation per policy. 4.To ensure compliance, the DNS/Designee is responsible for the completion of the documentation audit QAPI tool weekly times 4 weeks, monthly times 6 months. The results of these audits will be reviewed by the QAPI committee overseen by the administrator. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	A nurse's note dated 7/11/17 at 8:50 P.M., indicated Resident C had returned to the facility from an acute care hospital. It noted the resident had a dressing above his right eye. It did not contain any description or assessment of the injury. During an interview on 7/18/17 at 11:45 A.M., with the Administrator and Social Services Director (SSD) present, the DON indicated that Resident C had returned to the facility from an acute care hospital stay on 7/11/17 "just before" his accident at approximately 3:30 P.M. She indicated documentation should have included an assessment on return from the hospital stay initiated 6/20/17, documentation of the details surrounding his fall from bed with injuries, an assessment of his condition including documentation of his injuries, and details of his discharge to the hospital for treatment of his injuries. A facility policy titled "Charting and Documentation" dated 2001 and revised April 2008, received from the DON 7/18/17 at 2:25 P.M., indicated "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record...All incidents, accidents, or changes in the resident's condition must be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 00 B. WING	07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	documented..." This Federal tag relates to Complaint IN00235475. 3.1-50(a)(10 3.1-50 (a)(2)			