STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN46205	

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F0000	This visit was for the Investigation of Complaint IN00101962. Complaint IN00101962 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F309. Unrelated deficiencies cited. Survey dates: January 17 & 18, 2012 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Survey team: Rita Mullen, RN, TC Michelle Hosteter, RN Census bed type: SNF/NF: 90 Total: 90 Census payor type: Medicare: 11 Medicaid: 72 Other: 7 Total: 90 Sample: 3 These deficiencies also reflect state	F0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	findings in accordance with 410 IAC 16.2. Quality review 1/24/12 by Suzanne Williams, RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician of a Resident's change of condition, an	F0157	1. Resident #C no longer resides at the facility.2. All residents have the potential to be affected.3. A. Nurses have been re-educated	02/17/2012

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	increased pulse rate of 145 beats per minute (normal rate 60 to 80 beats per minute) on two different occasions. This impacted 1 of 3 residents reviewed for physician notification in a sample of 3. (Resident C) Findings include: The clinical record of Resident C was reviewed on 1/17/12 at 1:30 P.M. Diagnoses included, but were not limited to, chronic airway obstruction, tachycardia (rapid heart rate) history of laryngeal cancer and dyspnea (shortness of breath). A hospital discharge order, dated 12/23/11, indicated "...Tachycardia - HR (heart rate) 120s -130s on admission down to 109 today - note patient has a history of sinus tachycardia - on previous admissions, likely secondary to dehydration in addition to breathing treatments. Patient given fluids initially and some improvement seen. Note patient is afebrial (no fever), elevated but resolving..., was given a beta agonist (regulates heart rate), does not appear in pain - other than some localized discomfort at the trach (tracheostomy) site noted on admission, he is in sinus rhythm, thus the tachycardia - could be secondary		on the requirements of notification to MD and responsible party of a change in condition. B. Changes in condition of residents are reviewed at the morning meeting to ensure all appropriate actions related to the change have been implemented, as well as ensuring the MD and responsible party were notified timely. C. The DON/designee will review residents with a change of condition daily for two weeks; then three times a week for two weeks; then once a week for two weeks or until 100% compliance is reached.4. The notification of change of condition will be brought to the next scheduled Quality Assurance Committee meeting and all recommendations made will be followed.5. Correction Date: 2-17-12	

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	to anxiety from the difficulty breathing." Discharge vital signs: blood pressure - 92/61, heart rate 109 - 119, respirations 22, O2 saturation 100% on 4 liters of oxygen per tracheostomy. A hospital discharge order, dated 12/27/11, indicated the Resident's discharge vital signs were: blood pressure - 102/55, heart rate 70, O2 saturation (Sat) 99% on 28% trach collar and humidified air. A Nursing Enteral (care of feeding tube site) note, dated 12/29/11 at 14:35 (2:35 P.M.), indicated a blood pressure of 101/58, pulse 88, respirations 18 and O2 Sat 97%. A Nursing Tracheostomy care note, dated 12/30/11 at 05:08 (5:08 A.M.) indicated a blood pressure of 116/62, pulse 121, respirations 18 and O2 Sat 99%. A Nursing Enteral note, dated 12/31/11 at 02:56 (2:56 A.M.), indicated a blood pressure of 130/72, pulse 145, respirations 20, O2 saturation 99%. The physician was not notified of the increased pulse rate. A Nursing Enteral note, dated 12/31/11 at 10:20 (10:20 A.M.), indicated a blood pressure of 145/76, pulse 70, respirations			

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	18 and O2 saturation 97% with 28% humidity and 4 liters of oxygen. A Nursing Tracheostomy care note, dated 12/31/11 at 10:29 (10:29 A.M.), indicated a blood pressure of 130/72, pulse 145, respirations 20 and O2 saturation 99%. The physician was not notified of the increased pulse rate. During an interview with the Director of Nursing, on 1/17/12 at 10:00 A.M., she indicated the physician was not notified of the increased pulse rate. During an interview with the Corporate Nurse Consultant, on 1/17/12 at 11:45 A.M., she indicate the increased pulse rate should have been reported to the physician. This federal tag relates to complaint IN00101962. 3.1-5(a)(2)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure that the QMA (Qualified Medication Aide) received	F0282	1. Resident #C no longer resides at the facility.2. All residents have the potential to be affected.3. A. All QMA's have been re-educated	02/17/2012

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	appropriate approval from a nurse before giving PRN (as needed) medication to 1 of 3 residents reviewed for medications in a sample of 3. [Resident C] Findings include: Record review for Resident C was completed on 1/17/12 at 1:30 P.M. Resident C's diagnoses included, but were not limited to, chronic airway obstruction, history of laryngeal cancer and tachycardia. Resident C was receiving a PRN medication for anxiety. The resident had an order dated 12/17/11 for Lorazepam 1 mg by mouth to be given three times a day as needed. The EMAR (Electronic Medication Administration Record) for December 2011 indicated that on December 30th, the resident had received the PRN Lorazepam 1 mg at 1705 (5:05 P.M.) from QMA #3, the number 1, and the letter E were in the column under medication pass as well. In an interview with the Corporate Nurse Consultant (CNC) on 1/18/12 at 11:45 A.M., she indicated the EMARs had numbers and letters designating specific things. She indicated in regard to the EMAR for Resident C in December 2011,		related to the necessity of following their scope of practice requirements related to provision of PRN medications. The nurses were re-educated related to their requirements of ensuring that PRN medications have been assessed for appropriateness prior to the QMA giving the medication, as well as documenting its effectiveness after administration. B. The Don/designee will monitor the MAR daily for two weeks to ensure PRN's have been signed off by a nurse when administered by a QMA, as well as ensuring effectiveness is documented; then the DON/designee will montor three times a week for two weeks as described above; then the DON/designee will monitor monthly for two months or until 100% compliance is reached.4. The compliance findings will be presented to the Quality Assurance Committee and all recommendations will be followed.5. Correction date : 2-17-12	

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	the number one in the column designated the reason for giving medication, which indicated anxiety. The letter E was indicating the follow up which was done after the PRN dose was given and that it was effective. The CNC indicated the medication was given by QMA #3, who also did the follow-up evaluation of the effectiveness of the medication. The CNC indicated QMA #3 should not be doing the follow up regarding a medication. She indicated there was no documentation in the EMAR or anywhere else in resident's medical record indicating that a nurse had been notified of the PRN medication being given. The Indiana Law and Rules on Qualified Medication Aides indicated 410 IAC 16.2-3.1-25 Sec. 25 (a)(8) "...Per required need (PRN) medications may be administered only upon authorization of a licensed nurse or physician. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of contact..." 3.1-35(g)(2)			

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F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to assess and provide necessary care to a resident with a tracheostomy and complaints of breathing difficulty and having a rapid heart rate, resulting in the resident becoming unresponsive, having to have CPR (cardiopulmonary resuscitation) preformed and EMS (emergency medical service) called for transport to a hospital. This impacted 1 of 3 residents reviewed for care and treatment in a sample of 3. (Resident C) Finding include: The clinical record of Resident C was reviewed on 1/17/12 at 1:30 P.M. Diagnoses included, but were not limited to, chronic airway obstruction, tachycardia (rapid heart rate), history of laryngeal cancer and dyspnea (shortness of breath). A hospital discharge order, dated 12/23/11, indicated "...Tachycardia - HR (heart rate) 120s -130s on admission down to 109 today - note patient has a history of sinus tachycardia - on previous	F0309	1. Resident #C no longer resides at the facility.2. All residents have the potential to be affected.3. The nurses will be re-educated on the need for thorough assessments for their residents during their tour of duty. In addition the nurses will be reminded that the physician must be contacted for any evidence of an assessment that indicates a change in condition. the physician's response will be documented. The responsible party of the resident will also be contacted regarding the change.Changes of condition for any resident(s) and appropriate assessment will be reviewed at the morning meeting. The DON/designee will monitor for complete documentation daily for two weeks; then three times a week for two weeks and with 100% compliance, will monitor for an additional month.4. The DON will report to the Quality Assurance Committee her findings related to assessments conducted by the nursing staff. Recommendations made by the committee will be followed.5. Correction date: 2-17-12	02/17/2012

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	admissions, likely secondary to dehydration in addition to breathing treatments. Patient given fluids initially and some improvement seen. Note patient is afebrial (no fever), elevated but resolving..., was given a beta agonist (regulates heart rate), does not appear in pain - other than some localized discomfort at the teach site noted on admission, he is in sinus rhythm, thus the tachycardia - could be secondary to anxiety from the difficulty breathing." Discharge vital signs: blood pressure - 92/61, heart rate 109 - 119, respirations 22, O2 saturation 100% on 4 liters of oxygen per tracheotomy. A hospital discharge note, dated 12/27/11, indicated "...Hospital course: 1. the patient had suctioning performed and was given duonebs and humidified air, and the pt. (patient) felt better with his breathing. The pt. was also given acetylcysteine (a mucolytic) via nebs which helped loosen secretions. The patient was to continue receiving duonebs (bronchodilator) and acetylcysteine via nebs, and humidified air and suctioning at regular intervals. There may be a component of anxiety as well in which the pt. feels even more dyspneic (short of breath), and so he was given lorazepam (an anti-anxiety medication) prn....If this recurrs, pt. needs aggressive suctioning of trach, and can try			

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	duonebs (breathing treatment) and acetylcysteine via neb." Hospital discharge orders, dated 12/27/11, included, but were not limited to, Albut 2.5 mg (milligram)/Ipra 0.5 mg neb solution (bronchodilator), one 3 ml (milliliter) vial via nebulization BID (twice a day) PRN (as needed) and Albuterol HFA inhaler, inhale 2 puffs PO (by mouth) every 4 hours prn, shortness of breath. Review of the resident's care plans indicated a plan of care for chronic airway obstruction and tracheostomy care had not been developed. A Nursing note, dated 12/31/11 at 18:12 (6:12 P.M.), indicated "while writer went to check on her residents, found resident face down on floor beside his bed resident had complain to me earlier when I came through the door he could not breathe this writer told him to please inform nurse until I clock in. report nurse stated that resident was having some anxiety during the day shift before I came in she gave him an anxiety pill to calm him. After finding resident unresponsive to me I call (sic) CNA [certified nursing assistant] to watch over resident while I got materials to check resident further and another nurse we could not get a pulse at this time			

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	resident was given CPR initiated and 911 was called also resident sister [name of sister] was notified resident was transported to [name of hospital] unit manager aware also [name of doctor] made aware of resident status." An investigative report received from the Administrator on 1/17/12 at 11:00 A.M., not dated, indicated the incident occurred on 12/31/11 at 4:00 P.M. Brief description of incident: "Resident complained of not being able to breath and requested suctioning. His CNA requested twice per the resident that his (sic) wanted to be suctioned. [name of nurse] told the CNA she had just suctioned the resident five minutes prior and wasn't doing it again. After the change of shift occurred, the evening nurse was going to check [name of resident] and found him face down on the floor beside his bed." A review of the Nursing notes indicated the last time the resident received tracheostomy care was on 12/31/11 at 10:29 (10:29 A.M.): vital signs: 130/72, 145, 20, 98.2, O2 99%. Respiratory assessment: breath sounds clear and unlabored. Condition of site: site clean dry and intact. Trach care: half and half (half water and half hydrogen peroxide). Sputum: greenish, yellow in color.			

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	Patient tolerated: tolerates well. Oxygen use: 4 lpms (4 liters per minute). A review of the Medication Administration Record (eMAR), dated for the month of December 2011, indicated Resident C received a Lorazapam 1 mg (milligram) (an anti anxiety medication) on 12/31/11 at 02:48 (2:48 A.M.) from LPN #7. This was 12 hours prior to the Resident complaining of difficulty breathing at change of shift at 3:00 P.M. The Resident did not receive the Albut 2.5 mg/Ipra 0.5 mg neb solution, one 3 ml vial via nebulization BID PRN or Albuterol HFA inhaler, inhale 2 puffs PO every 4 hours prn, for shortness of breath. A Nursing Tracheostomy care note, dated 12/30/11 at 05:08 (5:08 A.M.) indicated a blood pressure of 116/62, pulse 121, respirations 18 and O2 Sat 99%. A Nursing Enteral note, dated 12/31/11 at 02:56 (2:56 A.M.), indicated a blood pressure of 130/72, pulse 145, respirations 20, O2 saturation 99%. The physician was not notified of the increased pulse rate. A Nursing Tracheostomy care note, dated 12/31/11 at 10:29 (10:29 A.M.), indicated a blood pressure of 130/72, pulse 145, respirations 20 and O2 saturation 99%.			

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	The physician was not notified of the increased pulse rate. During an interview with the Director of Nursing, on 1/17/12 at 10:00 A.M., she indicated the physician was not notified of the increased pulse rate. During an interview with the Corporate Nurse Consultant, on 1/17/12 at 11:45 A.M., she indicate the increased pulse rate should have been reported to the physician. A review of the Physician's Orders Audit Report, dated for 12/29/11 to 12/31/11, indicated a physician's order for "Tracheotomy care every shift and when needed to promote a patent air way. Respiratory failure; dyspnea, stridor, tachypnea." LPN #7 was recorded as having given tracheostomy care on 12/31/11 at 1:00 P.M. and documented at 1:24 P.M. This was an hour prior to Resident C complaining of difficulty breathing at 2:00 P.M. During an interview with LPN #2, on 1/18/12 at 3:00 P.M., she indicated she saw Resident C talking on the phone in the dining room when she came into the building. Resident C told LPN #2 he wanted to be suctioned. I told him to ask his nurse. He said he didn't know where			

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	his nurse was. He didn't look like he was having breathing difficulty while talking on the phone. I put my things in my locker and went to get report and told LPN #7 Resident C said he was having trouble breathing. LPN #7 indicated he was like that earlier and was upset because his sister left, he had been given trach care, suctioned and PRN lorazepam; she indicated he was alright. After report Resident C was sitting in a chair in the hallway, I asked if he was OK, and he wanted to go outside. I told him no and asked him to lay down. His sister had called and wanted him to lay down. He agreed and I told him I would be back shortly. I was going to give him another lorazepam. It was 10 - 15 minutes at most when I went back, he was face down on the floor unresponsive. CNA #1 was coming out of a room and I called him into the room. We turned the resident over and I got another nurse and he started CPR while I called 911. Resident C could transfer himself, he was independent and didn't use a wheelchair. Vital signs were not taken when he was complaining of breathing difficulty. During an interview with CNA #1, on 1/18/12 at 3:20 P.M., he indicated Resident C had told him around 2:00 P.M. he was having a problem breathing. CNA #1 told LPN #7 Resident C wanted to be			

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NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN46205	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	suctioned he had said he was having a problem breathing. LPN #7 told him Resident C had been suctioned five minutes ago and wasn't doing it again. He seemed short of breath, LPN #7 said Resident C was working himself up. The oncoming nurse, LPN #2, found him face down on the floor. Another nurse and I got him on the flat board and started CPR while LPN #2 got the crash cart. EMTs arrived shortly after and asked for proof of full code before they provided care. A hospital death summary, dated 1/4/12, indicated Disposition: Patient is deceased. Discharge diagnoses: anoxic brain injury due to cardiac arrest, cardiac arrest outside the hospital, history of laryngeal cancer, chronic obstructive pulmonary disease with emphysema and hypertension. Hospital course: The patient was initially on the critical care service through 1/3/2012. After rewarming and off sedation, he remained GCS (Glasgow coma scale) of 3 with pupils fixed and dilated and no gag reflex. The family at that time understood that he had a very poor prognosis, and that it would be highly unlikely for him to regain any meaningful brain function. They withdrew care, and he was transferred to my service for palliative intent. I assumed care the evening of 1/4/2012, and the patient expired a few hours later at 9:30			

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	P.M. on 1/4/2012. A Facility Policy for "Tracheostomy Suctioning", dated 9/2005, received from LPN #5, on 1/18/12 at 2:30 P.M., indicated the following: "23. Assess the need for suctioning every (2) hours and/or as needed." This federal tag relates to complaint IN00101962 3.1-37(a)			