

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00190518 and IN00189935.</p> <p>Complaint IN00190518 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00189935- Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: February 4, 5, 8, 9, 10, and 11, 2016</p> <p>Facility number: 009569 Provider number: 155628 AIM number: 200139920</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 5 Medicaid: 56 Other: 7 Total: 68</p> <p>These deficiencies reflect State findings</p>	F 0000		
------------------------	---	--------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 0157 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on February 19, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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).</p> <p>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.</p>						

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a physician of a resident's refusal for an administration of an anticoagulant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #62)</p> <p>Findings include:</p> <p>The clinical record for Resident #62 was reviewed on 2/8/16 at 8:30 a.m. The diagnosis for Resident #62 included, but was not limited to fracture of the right pelvis.</p> <p>A physician ordered dated, 12/24/15, indicated Resident #62 was to be administered an injection of 0.4 milliliters of Lovenox (anticoagulant medication used to prevent blood clots) in the evening for pelvic fracture.</p> <p>The January 2016 Medication Administration Record (MAR) indicated Resident #62 refused the administration of her Lovenox the following dates:</p> <p>1/2/16, 1/3/16, 1/5/16, 1/6/16, 1/7/16, 1/8/16, 1/9/16, 1/11/16, 1/12/16, 1/14/16, 1/15/16, 1/16/16, 1/17/16, 1/19/16,</p>	F 0157	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> 1) Immediate actions taken for those residents identified: Resident #62 physician and family/responsible party were notified of residents repeat refusals of administration of anticoagulant medication as prescribed. An order was received to discontinue the medication at that time. Resident #62 has had no adverse effects noted. 2) How the facility identified other residents: All residents residing in the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: An audit was conducted of the February medication records, for current residents residing in the facility, to ensure that physicians and</p>	03/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1/20/16, 1/21/16, 1/22/16, 1/23/16, 1/25/16, 1/26/16, 1/27/16, 1/28/16, 1/29/16, 1/30/16, and 1/31/16</p> <p>There was no documentation the physician was notified Resident #62 refused the Lovenox administrations in January.</p> <p>The February 2016 MAR indicated Resident #62 refused the administration of her Lovenox the following dates: 2/2/16, 2/3/16, 2/4/16, 2/5/16, and 2/6/16</p> <p>There was no documentation the physician was notified Resident #62 refused the Lovenox administrations in February.</p> <p>An interview was conducted with the Director of Nursing (DON) #2 on 2/11/16 at 9:50 a.m. He indicated the physician was not notified for Resident #62's January or Februarys refused Lovenox administrations. He indicated the type of medication Resident #62 was on the physician should have been notified immediately.</p> <p>A physician notification policy was provided by the DON #2 on 2/11/16 at 11:44 a.m. It indicated, "Purpose: To</p>		<p>families/responsible parties were notified of repeat medication refusals. Nursing staff were inserviced regarding notification of repeat refusals to take prescribed medications to attending physician and family/responsible party in a timely, efficient and effective manner per facility policy. Weekly medication administration record audits will be conducted, for random residents on each hall to ensure that physicians and families/responsible parties are notified of repeat medication refusals. The Director of Nursing/ designee will be responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance. 5) Date of compliance: 3/12/2016</p>	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0225 SS=D Bldg. 00	<p>ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner...Policy: 1. Physician and family/responsible party notification is to include, but is not limited to:..Repeated refusals to take prescribed medication...2. Physician and Family/Responsible Party notification will be documented in the progress notes, it should contain information regarding the resident condition, physician notification, and any physician orders obtained."</p> <p>3.1-5(a)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to have evidence an alleged abuse violation was thoroughly investigated prior to allowing the alleged perpetrator to return to work for 2 of 3 incidents reviewed for abuse. (Resident #40 and #52)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #40 was reviewed on 2/4/16 at 2:00 p.m. The diagnoses for Resident #40 included, but were not limited to, depression and dementia.</p> <p>The 12/9/15 MDS (minimum data set)</p>	F 0225	<p>facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. The Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i> Immediate actions taken for those residents identified: Resident #40 has had no adverse effects noted. Resident #52 has had no adverse effects noted. Statements were obtained</p>	03/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2016
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>assessment indicated Resident #40 had a BIMS (brief interview for mental status) score of 15, highest possible score indicating Resident #40 was cognitively in tact.</p> <p>An interview was conducted with Resident #40 on 2/4/16 at 2:33 p.m. She indicated a staff member abused her. She indicated an aide shoved her into bed instead of pivoting her. She indicated this happened in October, 2015 and was shocked by the aide's actions.</p> <p>The 2/9/16 Follow Up incident report was provided by the Administrator on 2/9/16 at 1:03 p.m. It indicated Resident #40 reported that during October, 2015 a (gender and race) aide shoved her into the bed instead of pivoting her and she was shocked by that. It indicated the facility investigation revealed that Resident #40 stated this did occur in her old room on another hall in the evening..."Resident stated he did not pivot her when putting her to bed and shoved her instead. Resident stated she was not afraid of him...Resident stated she had no further incident in facility and felt safe." It indicated the incident was not reported to the facility at the time of concern in October, 2015 and that CNA #9, the alleged perpetrator, was contacted by the Administrator and suspended from the</p>		<p>regarding allegations of abuse involving C.N.A #9. 2) How the facility identified other residents: All residents residing in the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: An audit was conducted of Facility staff were inserviced regarding abuse policy and investigation procedures including obtaining evidence an alleged abuse violation was thoroughly investigated, per facility policy, prior to allowing the alleged perpetrator to return to work. Statements from alleged perpetrator, other staff members and residents, will be obtained as indicated, prior to alleged perpetrator returning to work. On going audits will be conducted The administrator/designee will be responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance. 5) Date of compliance: 3/12/16</p>		

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>schedule until the investigation was completed. The 2/9/16 follow up portion of the incident report indicated, "Other alert and oriented residents on the same assignment were interviewed and no other issues were identified. Social Services has followed up with resident to ensure that she feels safe and secure in her environment. Resident has been participating in activities and therapy and has shown no signs of psychosocial stressors. Resident denied having any issues in her current stay at facility. Upon completion of investigation, employee was returned to duty. Therapy will observe a stand pivot transfer with staff person to ensure they are utilizing correct procedure."</p> <p>The complete investigative file for the above incident was provided by the Administrator on 2/10/16 at 11:05 a.m. It included CNA #9's current certification, resident interviews with no concerns, CNA #9's time sheet indicating he worked with Resident #40 the evenings of 10/17/15, 10/18/15, and 10/28/15. The file did not include a written statement from CNA #9 or any other verification CNA #9's statement was received, nor did it include any interviews with other staff members.</p> <p>An interview was conducted with the</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administrator on 2/10/16 at 11:30 a.m. She indicated the facility did receive a written statement from CNA #9, and would have to find it. She indicated she asked 2 other nurses if they'd heard of any concerns with CNA #9, but did not document these interviews. She indicated she did not interview other CNA's and did not get any written statements from staff.</p> <p>An interview was conducted with the Administrator on 2/10/16 at 12:27 p.m. She indicated CNA #9's written statement could not be located. She indicated he was told to leave the written statement before he left work the weekend of 2/6/16 and 2/7/16. She indicated CNA #9 came back to work the 3:00 p.m. to 11:00 p.m. shift on 2/6/16. She indicated she got a verbal statement from CNA #9 over the phone on 2/4/16 when she told him he was suspended. She indicated she was told he would never do anything like that (shove her.) She indicated she did not document her phone conversation with CNA #9 and asked if she should have. She indicated her conversations with the 2 nurses were not really part of her investigation, and just wanted to know.</p> <p>During an interview with the Administrator on 2/10/16 at 1:09 p.m.,</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>she indicated CNA #9 did not leave a written statement when he worked over the weekend and would bring it in the following day (2/11/16).</p> <p>An interview was conducted with the Administrator, Nurse Consultant, and Social Services Consultant, and Social Services Director on 2/10/16 at 2:01 p.m. The Administrator indicated CNA #9 never did leave his written statement regarding the allegation by Resident #40. The Administrator indicated she always got an alleged perpetrator's written statement prior to coming to work, but did not this time. She indicated she was always told to get a written statement and not to just write down what was verbally said because they could always come back and say they didn't say that. She indicated the investigation was completed the evening of 2/5/16 and decided to let CNA #9 come back to work because none of the other residents had any issues with him, and could not see where he'd done anything wrong. She indicated CNA #9's statement was missing from the investigation as well as staff interviews. She indicated the facility did not typically get staff interviews, but always gets statements from the accused.</p> <p>The Abuse, Neglect, and Misappropriation of Resident Property</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>policy was provided by the Nurse Consultant on 2/4/16 at 11:31 p.m. It indicated, "The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress."</p> <p>2. The clinical record for Resident #52 was reviewed on 2/9/16 at 8:30 a.m. The diagnosis for Resident #52 included, but was not limited to: major depressive disorder. Resident #52 had a BIMS (brief interview for mental status) score of 12, cognitively intact as of the 11/12/15, Annual Minimum Data Set (MDS) assessment.</p> <p>An interview was conducted with Resident #52 on 2/5/16 at 9:36 a.m. He indicated Certified Nursing Assistant (CNA) #9 who works in the evening was vulgar and mean. Resident #52 indicated CNA #9 had wiped his bottom roughly one evening. Resident #52 indicated at that time, he had told CNA #9 that he was too rough, and CNA #9 responded with a explicit swear word toward him.</p> <p>An interview was conducted with the Administrator on 2/5/16 at 9:49 a.m., regarding the abuse allegation reported by Resident #52. She indicated she would start an investigation and submit a report to the Indiana State Department of</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Health. The Administrator did indicate Resident #52 had a history of false allegations toward male caregivers.</p> <p>The completed investigation file was provided by the Administrator on 2/10/16 at 12:17 p.m. It included an incident report submitted to the Indiana State Department of Health, a written statement from Resident #52, a look back report titled, "Personal Hygiene" for Resident #52, a punch detail report included staff members that had worked on 2/3/16, and 4 written statements from interviewable residents. The resident interviews was conducted on 2/5/16, by the staff. 1 of 4 resident's interviewed indicated a response of "yes (name of resident)" when asked, "Have you observed anyone else being harmed?" Resident #100 had a BIMS score of 15 (cognitively intact) which is the highest possible score. Resident #100 was Resident #52's roommate. Resident #100 indicated "The curtain was drawn - I didn't see but (name of resident) was adamant that one of the male nurse not touch him - He was cussing at the nurse. The next night I asked the CNA - don't bring that guy in here. The CNA said he wasn't working so that was good." On 2/5/16 the staff had also interviewed Resident #52. It indicated "Writer interviewed (name of resident) regarding</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>treatment from a male CNA. He states this occurred the night before last, 2/3/16, at about 8:30 p.m. when he was going to bed. (name of resident) stated that the staff member, (name of CNA), was mean and nasty and called me names I didn't like. He states his roommate heard him. (name of resident) states that the next day his roommate asked a different CNA please don't bring him (name of CNA) back cause he's nasty ---man".</p> <p>The investigation did not include a written statement from CNA #9, nor did it include staff interviews.</p> <p>An interview was conducted with the Administrator on 2/10/16 at 1:09 p.m. She indicated Social Services had conducted the investigation regarding this abuse allegation she had not. The Administrator indicated she had not spoken to CNA #9 about this abuse allegation.</p> <p>An interview was conducted with the Social Service Consultant and the Social Services Director on 2/10/16 at 1:30 p.m. The Social Services Consultant indicated the resident interviews were conducted by social services, but they had not interviewed CNA #9 or staff members.</p> <p>An interview was conducted with the</p>			

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 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 0226 SS=D Bldg. 00	<p>Social Services Consultant, Social Services Director, Nurse Consultant, and the Administrator on 2/10/16 at 2:01 p.m. The Nurse Consultant indicated this abuse allegation was completed. The Administrator indicated she had not gotten a verbal or written statement from CNA #9 nor had she gotten staff interviews regarding this abuse allegation. The Administrator indicated during investigations she does not normally get staff interviews, but always gets written statements from the accused. She indicated CNA #9's suspension had been lifted, and CNA #9 had worked on 2/6/16 and 2/7/16. The Administrator indicated the conclusion to this abuse allegation was CNA #9 had not worked on the evening of 2/3/16, when Resident #52 indicated the occurrence occurred. She also indicated Resident #52 does not like male care givers that have accents, and CNA #9 had not been assigned to Resident #52 for a long period of time.</p> <p>3.1-28(d) 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review,</p>	F 0226				03/12/2016	

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 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the facility failed to have evidence an alleged abuse violation was thoroughly investigated, per facility policy, prior to allowing the alleged perpetrator to return to work, for 2 of 3 incidents reviewed for abuse and to obtain a criminal background check for 2 of 10 employee personal files reviewed. (Resident #40, Resident #52, Resident #100, CNA #7, and CNA #8)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #40 was reviewed on 2/4/16 at 2:00 p.m. The diagnoses for Resident #40 included, but were not limited to, depression and dementia.</p> <p>The 12/9/15 MDS (minimum data set) assessment indicated Resident #40 had a BIMS (brief interview for mental status) score of 15, highest possible score indicating Resident #40 was cognitively in tact.</p> <p>An interview was conducted with Resident #40 on 2/4/16 at 2:33 p.m. She indicated a staff member abused her. She indicated an aide shoved her into bed instead of pivoting her. She indicated this happened in October, 2015 and was shocked by the aide's actions.</p>		<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #40 has had no adverse effects noted.</p> <p>Resident #52 has had no adverse effects noted.</p> <p>Statements were obtained regarding allegations of abuse involving C.N.A #9.</p> <p>Criminal Background checks were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The 2/9/16 Follow Up incident report was provided by the Administrator on 2/9/16 at 1:03 p.m. It indicated Resident #40 reported that during October, 2015 a (gender and race) aide shoved her into the bed instead of pivoting her and she was shocked by that. It indicated the facility investigation revealed that Resident #40 stated this did occur in her old room on another hall in the evening..."Resident stated he did not pivot her when putting her to bed and shoved her instead. Resident stated she was not afraid of him...Resident stated she had no further incident in facility and felt safe." It indicated the incident was not reported at the time of concern in October, 2015 and that CNA #9, the alleged perpetrator, was contacted by the Administrator and suspended from the schedule until the investigation was completed. The 2/9/16 follow up portion of the incident report indicated, "Other alert and oriented residents on the same assignment were interviewed and no other issues were identified. Social Services has followed up with resident to ensure that she feels safe and secure in her environment. Resident has been participating in activities and therapy and has shown no signs of psychosocial stressors. Resident denied having any issues in her current stay at facility. Upon completion of investigation, employee was returned to</p>		<p>obtained for C.N.A#7 and C.N.A#8, no concerns noted.</p> <p>2) How the facility identified other residents:</p> <p>All residents residing in the facility have the potential to be affected by the alleged deficient practice.</p> <p>3) Measures put into place/ System changes:</p> <p>An audit was conducted of</p> <p>An audit of all current employee files was conducted to ensure that criminal background checks have been obtained.</p> <p>Facility staff were inserviced regarding abuse policy and investigation procedures including obtaining evidence an alleged abuse violation was thoroughly investigated, per facility policy, prior to allowing the alleged perpetrator to return to work. Statements from alleged perpetrator, other staff members and residents, will be obtained as indicated, prior to</p>				

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 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>duty . Therapy will observe a stand pivot transfer with staff person to ensure they are utilizing correct procedure."</p> <p>The complete investigative file for the above incident was provided by the Administrator on 2/10/16 at 11:05 a.m. It included CNA #9's current certification, resident interviews with no concerns, CNA #9's time sheet indicating he worked with Resident #40 the evenings of 10/17/15, 10/18/15, and 10/28/15. The file did not include a written statement from CNA #9 or any other verification CNA #9's statement was received, nor did it include any interviews with other staff members.</p> <p>An interview was conducted with the Administrator on 2/10/16 at 11:30 a.m. She indicated the facility did receive a written statement from CNA #9, and would have to find it. She indicated she asked 2 other nurses if they'd heard of any concerns with CNA #9, but did not document these interviews. She indicated she did not interview other CNA's and did not get any written statements from staff.</p> <p>An interview was conducted with the Administrator on 2/10/16 at 12:27 p.m. She indicated CNA #9's written statement could not be located. She indicated he</p>		<p>alleged perpetrator returning to work.</p> <p>Facility staff were inserviced regarding obtaining criminal background check per facility policy.</p> <p>Ongoing audits will be conducted</p> <p>An audit will be completed weekly to ensure that newly hired employees have criminal background checks completed per facility policy.</p> <p>The administrator/designee will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by</p>				

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was told to leave the written statement before he left work the weekend of 2/6/16 and 2/7/16. She indicated CNA #9 came back to work the 3:00 p.m. to 11:00 p.m. shift on 2/6/16. She indicated she got a verbal statement from CNA #9 over the phone on 2/4/16 when she told him he was suspended. She indicated she was told he would never do anything like that (shove her.) She indicated she did not document her phone conversation with CNA #9 and asked if she should have. She indicated her conversations with the 2 nurses were not really part of her investigation, and just wanted to know.</p> <p>During an interview with the Administrator on 2/10/16 at 1:09 p.m., she indicated CNA #9 did not leave a written statement when he worked over the weekend and would bring it in the following day (2/11/16).</p> <p>An interview was conducted with the Administrator, Nurse Consultant, and Social Services Consultant, and Social Services Director on 2/10/16 at 2:01 p.m. The Administrator indicated CNA #9 never did leave his written statement regarding the allegation by Resident #40. The Administrator indicated she always got an alleged perpetrator's written statement prior to coming to work, but</p>		<p>Quality Assurance.</p> <p>5) Date of compliance: 3/12/16</p>	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>did not this time. She indicated she was always told to get a written statement and not to just write down what was verbally said because they could always come back and say they didn't say that. She indicated the investigation was completed the evening of 2/5/16 and decided to let CNA #9 come back to work because none of the other residents had any issues with him, and could not see where he'd done anything wrong. She indicated CNA #9's statement was missing from the investigation as well as staff interviews. She indicated the facility did not typically get staff interviews, but always gets statements from the accused.</p> <p>The Abuse, Neglect, and Misappropriation of Resident Property policy was provided by the Nurse Consultant on 2/4/16 at 11:31 p.m. It indicated, "The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress."</p> <p>2. The clinical record for Resident #52 was reviewed on 2/9/16 at 8:30 a.m. The diagnosis for Resident #52 included, but was not limited to: major depressive disorder. Resident #52 had a BIMS (brief interview for mental status) score of 12, cognitively intact as of the 11/12/15, Annual Minimum Data Set (MDS)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>assessment.</p> <p>An interview was conducted with Resident #52 on 2/5/16 at 9:36 a.m. He indicated Certified Nursing Assistant (CNA) #9 who works in the evening was vulgar and mean. Resident #52 indicated CNA #9 had wiped his bottom roughly one evening. Resident #52 indicated at that time, he had told CNA #9 that he was too rough, and CNA #9 responded with a explicit swear word toward him.</p> <p>An interview was conducted with the Administrator on 2/5/16 at 9:49 a.m., regarding the abuse allegation reported by Resident #52. She indicated she would start an investigation and submit a report to the Indiana State Department of Health. The Administrator did indicate Resident #52 had a history of false allegations toward male caregivers.</p> <p>The completed investigation file was provided by the Administrator on 2/10/16 at 12:17 p.m. It included an incident report submitted to the Indiana State Department of Health, a written statement from Resident #52, a look back report titled, "Personal Hygiene" for Resident #52, a punch detail report included staff members that had worked on 2/3/16, and 4 written statements from interviewable residents. The resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>interviews was conducted on 2/5/16, by the staff. 1 of 4 resident's interviewed indicated a response of "yes (name of resident)" when asked, "Have you observed anyone else being harmed?" Resident #100 had a BIMS score of 15 (cognitively intact) which is the highest possible score. Resident #100 was Resident #52's roommate. Resident #100 indicated "The curtain was drawn - I didn't see but (name of resident) was adamant that one of the male nurse not touch him - He was cussing at the nurse. The next night I asked the CNA - don't bring that guy in here. The CNA said he wasn't working so that was good." On 2/5/16 the staff had also interviewed Resident #52. It indicated "Writer interviewed (name of resident) regarding treatment from a male CNA. He states this occurred the night before last, 2/3/16, at about 8:30 p.m. when he was going to bed. (name of resident) stated that the staff member, (name of CNA), was mean and nasty and called me names I didn't like. He states his roommate heard him. (name of resident) states that the next day his roommate asked a different CNA please don't bring him (name of CNA) back cause he's nasty ---man".</p> <p>The investigation did not include a written statement from CNA #9 nor did it include staff interviews.</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An interview was conducted with the Administrator on 2/10/16 at 1:09 p.m. She indicated Social Services had conducted the investigation regarding this abuse allegation she had not. The Administrator indicated she had not spoken to CNA #9 about this abuse allegation.</p> <p>An interview was conducted with the Social Service Consultant and the Director of Social Services on 2/10/16 at 1:30 p.m. The Social Services Consultant indicated the resident interviews were conducted by social services, but they had not interviewed CNA #9 or staff members.</p> <p>An interview was conducted with the Social Services Consultant, Social Services Director, Nurse Consultant and the Administrator on 2/10/16 at 1:45 p.m. The Nurse Consultant indicated this abuse allegation was completed. The Administrator indicated she had not gotten a verbal or written statement from CNA #9 nor had she gotten staff interviews regarding this abuse allegation. The Administrator indicated during investigations she does not normally get staff interviews, but always gets written statements from the accused. She indicated CNA #9's suspension had</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>been lifted, and CNA #9 had worked on 2/6/16 and 2/7/16. The Administrator indicated the conclusion to this abuse allegation was CNA #9 had not worked on the evening of 2/3/16, when Resident #52 indicated the occurrence occurred. She also indicated Resident #52 does not like male care givers that have accents, and CNA #9 had not been assigned to Resident #52 for a long period of time.</p> <p>3. The Employee Records form and 10 employee personnel files were reviewed on 2/11/16 at 2:00 p.m. The record indicated Certified Nursing Assistant (CNA #7) start date was 10/25/15 and Certified Nursing Assistant (CNA #8) start date was 12/12/15.</p> <p>The personnel files for CNA #7 and CNA #8 did not include criminal background checks.</p> <p>An interview was conducted with the Administrator 2/11/16 on 2:45 p.m. She indicated she could not locate criminal background checks for CNA #7 and CNA #8.</p> <p>A time detail work schedules was provided by the Administrator on 2/11/16 at 3:15 p.m. for CNA #7 and CNA #8. It indicated CNA #7 has worked a total of 509 hours, since his start date and CNA</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0323 SS=D Bldg. 00	<p>#8 has worked a total of 287.25 hours, since her start date.</p> <p>An Abuse policy was provided by the Nurse Consultant on 2/4/16 at 11:31 a.m. It indicated "Policy Interpretation and Implementation... 3. The facility will do a "criminal record check" on all unlicensed staff according to the Indiana law."</p> <p>3.1--28(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to properly transfer a resident via mechanical lift, per facility policy, and to use the appropriate mechanical lift, which resulted in an assisted fall, for 2 of 3 residents reviewed for transfers. (Resident #50 and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 2/11/16 at 11:00 a.m. The diagnoses for Resident #C included, but were not limited to, idiopathic</p>	F 0323	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i> Immediate actions taken for those residents identified: Resident C has had no adverse</p>	03/12/2016

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 02/11/2016
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>peripheral autonomic neuropathy.</p> <p>The 1/21/16 activities of daily living care plan for Resident #C indicated she needed a total mechanical lift and staff assistance for transfers.</p> <p>An observation was made on 2/11/16 at 11:32 a.m. of Resident #C being transferred via mechanical lift, from her bed into her wheel chair, with the assistance of CNA #10 and LPN #11. CNA #10 pushed the mechanical lift under Resident #C's bed, affixed the sling to the lift, and began to lift Resident #C. The mechanical lift was not locked prior to beginning to lift Resident #C. LPN #11 locked the wheels while Resident #C was being raised from her bed. During the raising of Resident #C, the lift only raised a little at a time, with a pause in between risings. The lifting of Resident #C was not in a continuous lifting motion. LPN #11 asked CNA #10 about the intervals during lifting, to which CNA #10 responded that the lift did that when there was weight in it, but it continuously lifted when no one is in it. Resident #C was lowered into her wheel chair. During the lowering, the front wheels of Resident #C's wheel chair were an inch off the ground and the back of the wheel chair was resting on the antitippers (devices attached to the frame of the</p>		<p>effects noted. C.N.A # 10 and LPN #11 were in serviced regarding the Transfer/Positioning Total Mechanical lifts policy which includes locking brakes during the lift procedure. The Hoyer lift was checked for proper function per maintenance. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: An audit of the mechanical lifts was conducted to ensure proper function. All residents requiring mechanical lift transfer were audited and care plan/kardex updated to Ensure that appropriate lift is indicated. Nursing staff were in serviced regarding the Transfer/Positioning Total Mechanical lift policy which Includes locking brakes during the lift procedure. Nursing staff were in serviced regarding proper use of lift as deemed appropriate per resident Transfers assessment. Appropriate lift will be care planned and added to Kardex. Visual observations of staff assisting residents with transfers via total mechanical lifts, will be Conducted on both units, on varying shifts on varying days, 2 x a week. 4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 3, monthly x2 then quarterly x1. Further monitoring</p>		

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>wheel chair to prevent the wheel chair from tipping over and injuring the user). The lift made a loud, grinding noise upon lowering Resident #C.</p> <p>An interview was conducted with LPN #11 at 2/11/16 at 11:45 a.m. She indicated she'd only assisted with a transfer of Resident #C two or three times previously. She indicated this was the first time she'd seen a complete transfer of Resident #C. She indicated she hurried up and locked the wheel chair, but when she saw the antitippers bearing the weight, she figured that was just the way a transfer went with her since Resident #C was unable to sit up straight.</p> <p>An interview was conducted with CNA #10 on 2/11/16 at 11:50 a.m. She acknowledged Resident #C's antitippers were bearing her weight while lowering her into the wheel chair and indicated that was the purpose of antitippers, so the wheel chair didn't fall backwards.</p> <p>An interview was conducted with Occupational Therapist (OT) #12 on 2/11/16 at 12:11 p.m. She indicated, when transferring a resident from bed into a wheel chair, via mechanical lift, one should always lock the lift prior to raising the resident.</p>		will be determined by Quality assurance. 5) March 12, 2016	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An interview was conducted with OT #12 and Therapy Technician (TT) #13 on 2/11/16 at 12:33 p.m. OT #12 indicated she was familiar with Resident #C and did not know why staff would need to rest her wheel chair on the antitippers during a transfer. OT #12 indicated perhaps staff positioned her wheel chair too close to the mechanical lift during the transfer. Both OT #12 and TT #13 indicated they had no idea why a mechanical lift would make a grinding noise when lowering. TT #13 indicated it could be a problem if Resident #C's antitippers gave out.</p> <p>An interview was conducted with the Director of Nursing (DON) #2 on 02/11/16 at 1:09 p.m. He indicated he did not know why the lift would make a grinding noise and would have maintenance staff look at it.</p> <p>The Transfer/Positioning Total Mechanical Lift policy was provided by the DON #2 on 2/11/16 at 1:39 p.m. It indicated, "The base spreader provides stability and locking brakes ensure safety during the lifting procedure....Always lock the brakes during transfer for safety."</p> <p>2. The clinical record for Resident #50</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was reviewed on 2/10/16 at 10:30 a.m. The diagnoses for Resident #50 included, but were not limited to, hemiplegia and abnormalities of gait and mobility.</p> <p>An Occupational Therapy Therapy Progress Report, signed 11/12/15, indicated, "...Instructed patient and caregivers regarding stand-lift transfers and safety related to L LE (left lower extremity). Patient's L shoe has been misplaced and patient is unsafe to complete transfers without shoe donned due to instability in ankle joint and inability to maintain foot position on L LE during transfers with non-skid surface.</p> <p>During an interview with the Therapy Manager, on 2/10/16 at 1:26 p.m., the Therapy Manager indicated Resident #50, upon her admission, was deemed safe to utilize the stand up lift after she was assessed by their department. One of her diabetic shoes went missing after the assessment and her ankle would roll/turn due to lack of support, making it unsafe for her to continue to use the stand up lift, so she needed to be transferred via the Hoyer (mechanical) lift.</p> <p>On 2/10/16 at 2:04 p.m., the Therapy Manager indicated facility staff was instructed on 11/11/15 to use the Hoyer</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>lift for all transfers for Resident #50 due to the instability of her left ankle.</p> <p>A Physical Therapy Progress Report, dated 11/27/15, indicated, "Resident unable to safely use standing lift dt [due to] increasing L ankle inversion/plantar flexion, now using Hoyer lift..."</p> <p>The Admission MDS (minimum data set) assessment, dated 11/2/15, indicated Resident #50 was total dependence with 2 plus person assist for transfers.</p> <p>A Progress Note, dated 11/27/2015 at 10:09 p.m., indicated, "Resident was being transferred to bed with a stand up lift when her legs gave way and she was lowered to the floor. Resident was checked and there was no injuries noted. V/S [sic]within normal limits. MD [medical doctor] and DON [Director of Nursing] notified and the fire Dept [sic] was called to pick her up from the floor. Family could not be reached as the numbers do not belong to persons assigned. Bariatric hoyer has been ordered for future transfer."</p> <p>A Progress Note, dated 11/30/2015 at 8:58 a.m., indicated, "...Attendees present:: Administrator, director of nursing, therapy manager, social services, and nurse managers present. Summary of</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the fall: Resident was being transferred utilizing the stand up lift. Residents leg gave out, and resident was lowered to the floor. Resident was assessed by licensed nurse, and no injury was observed. MD notified [sic], resident is own responsible party, facility did attempt to contact family but numbers were not good. Root cause of fall: Resident is weak, and knee gave out. Intervention and care plan updated: Resident was previously identified as being at risk for falls, and care plan implemented, with interventions present per care plan. Resident is also on therapy to improve strength and endurance. In an effort to prevent reoccurrence [sic], a bariatric [sic] hoier was ordered to assist with transfers. Care plan reviewed and updated, will continue to observe...."</p> <p>At 9:45 a.m., on 2/11/16, Director of Nursing (DON) #2, indicated he was unsure of why staff used the stand lift, on 11/27/15, when Resident #50 needed the Hoyer lift to be transferred. DON #2 further indicated according to the notes, it appeared that Resident #50's legs gave out so she probably wouldn't have had an assisted fall if the Hoyer lift with used.</p> <p>3.1-45(a)(2)</p> <p>This federal tag relates to Complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2016
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0329 SS=D Bldg. 00	<p>#IN00189935.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure a resident had an indication for the initiation of an anti-psychotic for 1 of 5 residents reviewed for unnecessary medication (Resident #20).</p> <p>Findings include:</p>	F 0329	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared</i></p>	03/12/2016	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The clinical record for Resident #20 was reviewed on 2/8/16 at 2:30 p.m. The diagnoses for Resident #20 included, but were not limited to, dementia with behavioral disturbances, insomnia, delusional disorders, and depression.</p> <p>The February 2016 Physician's Orders indicated an order for Zyprexa (anti-psychotic) 5 milligrams daily. The order was initiated on 8/25/15.</p> <p>A psychiatric Follow-Up Assessment, dated 7/13/15, indicated, "...Doing well on Zoloft (anti-depressant) appears happy...continue current Rx (medications)."</p> <p>A Behavior Sheet, dated 7/16/15, indicated, "...Resident called 911 twice today requesting that the police go to her old address for emergencies. Police responded both times to find no issues, and then notified facility of the calls. Writer spoke with resident, and asked why she was calling. She stated that she was ready to go home, and when she lived at home the police would drive by frequently to check on her safety, and she wanted then to go ahead and start doing it again. Writer explained that 911 should only be called in an emergency, and that she would not call them again. Family and physician notified. Will continue to</p>		<p><i>and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i></p> <p>Resident # 20's Zyprexa was reduced on 2/12/16. Resident #20's behavior plan Reviewed and updated as necessary. 2) How the facility identified other residents: All resident's receiving an antipsychotic medication has the potential to be affected. 3) Measures put into place/ System changes: All residents receiving anti-psychotic medications will be reviewed during the monthly Psychoactive medication/gradual dose reduction meeting on 3.8/16. Staff in-serviced over behavior management and psychoactive medication/gradual dose reduction policy and procedure. 4) How the corrective actions will be monitored: Resident's receiving antipsychotic medications will continue to be reviewed quarterly in the psychoactive medication/gradual dose reduction meeting. Interdisciplinary team will review all new orders during clinical meeting to ensure antipsychotic drugs are not given unless necessary to treat a specific condition as diagnosed and documented in the clinical records. All findings of audits will be reviewed in QA meeting</p>	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>observe...."</p> <p>A Behavior Management Team Review document, dated 7/20/15, indicated, "Summarize The Behavioral Occurrences-Resident called 911 7/16/15. Stated that there was a problem at her house. 911 was contacted and told that resident had dementia. Resident asks [sic] staff daily about her money and about going home..Psychopharmacological Medications Review-Zoloft 75 mg (milligrams)...Team Recommendations-Resident appears "happier". Contantly [sic] asked about her money and about going home. Can sometimes be redirected by talking about her past experiences of dancing and work. Social services attempting to get her to have her hair done by the beautician but she claims she 'can't afford it" (she can). Daughter would like staff to encourage resident to go to church services on occasion [sic]. Greenhouse will continue to see for psychotherapy. Continue on behavior management for 60 days to observe..."</p> <p>A Physician Narrative Progress Note, dated 7/29/15, did not indicate any changes to Resident #20's "management [medication/treatment] at this point."</p>		<p>monthly for six months. 5) March 12, 2016</p>	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A psychiatric Follow-Up Assessment, dated 10/17/15, indicated, "...Current Psychoactive Medications-Zoloft...continue current Rx [medications]." Zyprexa or an indication for it's use was not documented by the Psychiatrist during the visit.</p> <p>A Physician Progress Note, dated 11/4/15, indicated "...Psych-appropriate...." Zyprexa or indication for it's use was not documented by the Medical Doctor during the visit.</p> <p>No other documentation, including behaviors, MD/NP (medical doctor/nurse practitioner) notes, progress notes, related to the initiation of Zyprexa was located in the clinical record.</p> <p>During an interview with RN #3, on 2/10/16 at 11:45 a.m., she indicated she had not noticed a change or improvement in Resident #20's demeanor or behaviors since this summer.</p> <p>On 2/10/16 at 11:49 a.m., Director of Nursing #2 indicated Resident #20's demeanor or behaviors fluctuated and he hadn't noticed a change or improvement with Resident #20 demeanor or behaviors since this summer.</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview with the Social Service Consultant (SSC), on 2/10/16 at 1:08 p.m., the SSC indicated behaviors were tracked by behavior sheets and it appeared that Resident #20 only had one behavior around the time of the initiation of Zyprexa on 8/25/15, as noted above. The SSC further indicated she will continue to look into why the Zyprexa was initiated on 8/25/15.</p> <p>At 11:00 a.m., on 2/10/16, the SSC indicated the facility was unable to locate any indication for the initiation of Zyprexa after contacting the Psychiatrist and Medical Doctor's offices and reviewing the clinical record. The SSC further indicated the one behavior in July would not warrant an initiation of the anti-psychotic medication in August and the Medical Doctor had initiated an order for a gradual dose reduction for the Zyprexa.</p> <p>A policy titled, Psychoactive Medications/Gradual Dose Reduction Policy, dated 6/2013, was received from the Nurse Consultant on 2/11/16 at 12:41 p.m. The policy indicated, "...It is the policy of this facility that a resident will receive psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status...1. Residents receiving</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0412 SS=D Bldg. 00	<p>psychoactive medications will have their medical record reviewed for appropriate diagnosis...."</p> <p>3.1-48(a)(4)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility to follow up on a dental recommendation for teeth extraction for 1 of 3 residents reviewed for dental. (Resident #35)</p> <p>Findings include:</p> <p>The clinical record for Resident #35 was reviewed on 2/9/16 at 10:30 a.m. The diagnoses for Resident #35 included, but were not limited to, hemiplegia, adjustment disorder with mixed anxiety and depressed mood and epilepsy.</p> <p>During an observation and interview with Resident #35, on 2/4/16 at 2:39 p.m.,</p>	F 0412	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i> Resident # 35 is scheduled to see an oral surgeon on March 7, 2016. 2) How the facility identified other residents: All</p>	03/12/2016

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident #35 was observed with missing teeth on the top and bottom. Resident #35 indicated she had some teeth pulled awhile ago and was supposed to get dentures, but hasn't heard of anything further.</p> <p>A dental progress note from the dentist, dated 1/27/15, indicated, "...Patient was written a oral surgery referral, to have teeth extracted...."</p> <p>A Oral Surgery Referral, dated 1/27/15, indicated, "...Extraction of all the remaining upper teeth and lower roots 27 & 28...."</p> <p>A dental progress note from the dentist, dated 3/27/15, indicated, "...DDS [Dentist] wrote referral for all upper teeth to be extracted my oms [name of oral surgeon office]."</p> <p>A Progress Note, dated 6/26/15, indicated, "Narrative: 6/25/15- Resident was seen by Dentist at the facility. Referral made to [name of oral surgeon office]."</p> <p>A Progress Note, dated 7/15/15, indicated, "Narrative: 8/3/15 - Resident has oral surgery appointment." No documentation from the 8/3/15 oral surgery appointment was located in the clinical record.</p> <p>A Social Service Update Assessment and</p>		<p>resident's receiving dental services have the potential to be affected. 3) Measures put into place/ System changes: Staff in-serviced regarding procedure for dental visits and ensuring all recommendations are addressed. All notes completed by the dental provider will be reviewed by IDT in clinical meeting the day following the visit. Any referrals for outside dental services will be made by nursing and progress noted will be entered to indicate that the recommendation was addressed. 4) How the corrective actions will be monitored: Any dental recommendations for the teeth extractions will be logged and tracked in clinical meeting until completed. All findings of audits will be reviewed in QA meeting monthly x 6 months.</p> <p>5) March 12, 2016</p>	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0425 SS=D Bldg. 00	<p>Plan, dated 10/9/15, indicated, "...Resident does not have dentures however is in the process of having teeth pulled and denture fitting." A Social Service Update Assessment and Plan, dated 1/9/16, indicated, "...Residents [sic] hearing and vision are adequate and resident does not require the use of hearing devices, dentures, or corrective lenses." A Dental Care Plan, dated 10/16/15, indicated an intervention of, "...Refer me to the dentist as needed...."</p> <p>During an interview with the Social Services Director (SSD) on 2/9/16 at 10:04 a.m., the SSD indicated Resident #35's teeth were not extracted on 8/3/15 due to a paperwork error and there was no follow up after that appointment to ensure Resident #35's teeth were extracted as recommended. The SSD further indicated she was unsure why it took till June for the recommendation to be addressed from the 1/27/15 dental visit to make an appointment for the teeth extraction.</p> <p>3.1-24(b)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to maintain an adequate supply of medications to 2 of 8 residents observed for medication administration. (Resident #11 and Resident #102)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #102 was reviewed on 2/8/16 at 8:30 a.m. The diagnosis for Resident #102 included, but was not limited to acute hepatitis C.</p> <p>A physician order dated, 1/22/16, indicated 30 milliliters of Lactulose was to be administered to Resident #102 orally two times a day.</p>	F 0425	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident #102 and # 11 Medication was ordered, doctor and family was notified of medication being missed. 2) How the facility identified other residents: All residents</i></p>	03/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A random observation was made of a medication observation was made for Resident #102 on 2/8/16 at 9:51 a.m. LPN #6 pulled Resident #102's medications, but could not locate her Lactulose. LPN #6 at this time indicated medications can be ordered from the pharmacy by using the computer on the medication cart when the supply of medication is low. She indicated Resident #102's Lactulose had not been reordered at this time. LPN #6 indicated she would notify the pharmacy by telephone to get the medication immediately.</p> <p>A progress note dated, 2/8/16 at 10:07 a.m., indicated "medication not found".</p> <p>A progress note dated, 2/8/16 at 11:04 a.m., indicated "Lactulose not found called pharmacy and ordered for stat (immediate) delivery. Notified (name of provider) NP (nurse practitioner) of medication not given. No new ordered noted. Patient made aware of medication not given."</p> <p>2.) The clinical record for Resident #11 was reviewed on 2/4/16 at 9:00 a.m. The diagnosis for Resident #11 included, but was not limited to constipation.</p> <p>A physician order dated, 7/2/14, indicated</p>		<p>residing in facility have the potential to be affected. 3) Measures put into place/ System changes: 100% audit was conducted to insure all medications ordered were completed. All nursing staff was in-serviced on how and when to order medication. 4) How the corrective actions will be monitored: Weekly audits done by DON or designee 5 x weekly to insure the medications are on hand. The results will be reviewed weekly x 4 then monthly x2. Results will be taken to QA.</p> <p>5) March 12, 2016</p>	

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>artificial tears solution 0.4% was to be administered one time a day. Resident #11 was to be administered 1 drop in both eyes for her dry eyes.</p> <p>A physician order dated, 12/14/13, indicated 17 grams of polyethylene powder was to be administered to Resident #11 by mouth once a day for constipation.</p> <p>A random observation was made of a medication administration for Resident #11 on 2/9/16 at 9:40 a.m. RN #5 pulled Resident #11's medications, but was unable to locate Resident #11's artificial tears and polyethylene powder. He would not be able to administer Resident #11's artificial tears or polyethylene powder. RN#5 indicated the artificial tears and polyethylene powder had not been reordered. Staff should have reordered medication when the medication gets low or 2-3 pills are left if the medication was in a pill form. He would need to contact the pharmacy and have the medication sent "stat" (immediately).</p> <p>An observation was made at 2/9/16 at 10:00 a.m. RN#5 notified the pharmacy Resident #11's artificial tears and polyethylene powder was needed to be sent immediately.</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0441 SS=E Bldg. 00	<p>An interview was conducted with the Director of Nursing (DON) #2. He indicated medications in powered or liquid form should be ordered when they are low, but not after the medication is completely gone. It takes about 24 hours to get medication from the pharmacy.</p> <p>3.1-25(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure a glucometer (a machine that test blood sugars) was disinfected as recommended by the manufacture's instructions for 1 of 1 random observations. This had the potential to affect 4 residents that received blood sugar checks on 1 of 2 medication carts on the North hall. (Resident #9, Resident #31, Resident #101, and Resident #103)</p> <p>Findings include:</p> <p>A random observation was made of a blood sugar check for Resident #101 on 12/8/16 at 11:50 a.m. LPN #6 donned gloves and immediately removed the glucometer out of a zipped plastic bag. She proceeded to prepare with a alcohol wipe, lancet (device to prick finger), and a cotton ball. LPN #6 did not disinfect the glucometer prior to checking Resident #101's blood sugar. LPN #6 located Resident #101 and pricked his</p>	F 0441	<p>The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p>Immediate actions taken for those residents identified All nurses and QMA were in-service on the cleaning and storage of glucometer machines. 2)</p> <p>How the facility identified other residents: All residents with accu-checks have the potential to be affected. 3) Measures put into place/ System changes: A random audits will be done to ensure the nurses and qma's are properly disinfecting the glucometer 4) How the corrective actions will be</p>	03/12/2016

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 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>finger. After the completion of the blood sugar check, LPN #6 began to disinfect the glucometer. The glucometer was placed on the medication cart. LPN #6 pulled out a cloth from a container that indicated it was a bleach wipe. The container indicated the (name of the manufacture) and the disinfection instructions. LPN #6 used the bleach cloth and wiped the glucometer front and back once and immediately threw away the cloth. She removed a second bleach cloth and wiped the front and back of the glucometer and immediately disposed of the cloth. The glucometer was not wet at this time. LPN #6 placed the glucometer in a new plastic bag and immediately placed the bag and the bleach wipe container inside her medication cart. The glucometer was not wet in the bag, nor did the bag contain a bleach cloth. LPN #6 indicated she did not have anymore resident's blood sugars to check.</p> <p>At this time, LPN #6 was asked to read the disinfection instructions on the container. It indicated "[name of manufacture] Bleach wipe..Directions for use: It is a violation of Federal Law to use this product in a manner inconsistent with its labeling. Disinfection:..A 30 second contact time is required to kill HBV (hepatitis B) and HCV (hepatitis C). A 3 minute contact time is required to</p>		<p>monitored: The DON or designee will observe 5 residents weekly x 4 weeks then monthly x 2. Results Will be taken to QA. 5) March 12, 2016</p>				

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>kill Clostridium difficile (bacteria infection) spores. A 5 minute contact time is required to kill HIV (virus infection) and other organisms listed on the label. Reapply as necessary to ensure that the surface remains wet for entire contact time. Allow surface to air dry and discard used wipe and empty canister."</p> <p>After reading the manufacturer's disinfection instructions, LPN #6 indicated the bleach residue from the wet cloth, left on the glucometer after having been wiped with the cloth, continues to disinfect in the plastic bag. LPN #6 indicated it takes up to 5 minutes to disinfect.</p> <p>On 2/8/16 at 12:35 p.m., a random observation was made of the Director of Nursing (DON) #1 inservicing LPN #6 on proper glucometer disinfection procedures. DON #1 donned gloves and removed a bleach cloth from the bleach container. She wiped the glucometer front and back and discarded the bleach cloth. She immediately removed a 2nd bleach wipe and wiped the glucometer front and back. She than immediately wrapped the 2nd bleach cloth around the glucometer and placed it in a grey closed container with a 5 minute sand timer that was attached. After the sand in the timer had ran out the DON removed the</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>glucometer and discarded the wet cloth. The glucometer then was placed in a zipped plastic bag. The DON indicated at this time the glucometer is ready to be used and does not need to be cleaned prior to use.</p> <p>An interview was conducted with LPN #6 on 2/8/16 at 1:10 p.m. She indicated she was unaware the bleach cloth was supposed to be wrapped around the glucometer and left in the grey container using the sand timer for 5 minutes. LPN #6 indicated the only blood sugar she checked that day was Resident #101's.</p> <p>A list of residents who receive blood sugar checks was provided by the Administrator on 2/9/16 at 9:11 a.m. It indicated Resident #9, Resident #31, Resident #101, and Resident #103 receive blood sugar checks with the glucometers on LPN #6's medication cart.</p> <p>A glucometer cleaning policy was provided by the Administrator on 2/8/16 at 3:30 p.m. It indicated "Purpose: To prevent cross contamination when using a glucometer between residents...General Procedure: 1. Healthcare professionals shall perform hand hygiene prior to handling the glucometer. 2. Healthcare professionals shall apply gloves before cleaning glucometer. Contact with blood</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0465 SS=F Bldg. 00	<p>presents a potential infection risk. 3. Clean/disinfect glucometer after each use by wiping the outside of the glucometer with disinfectant bleach wipe. Use a clean bleach disinfectant wipe, wrap the glucometer in the wipe, place in a container, and let sit for at least 5 minutes (may use the boxes and timers provided by the manufacturer). 4. Remove the bleach wipe and place into clean container (Note: the container you cleaned the glucometer in would now be considered clean and may be used)..."</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed maintain bathroom doors and a wheelchair in good repair for 7 of 40 residents reviewed for homelike environment (Resident #4, #32, #39, #41, #62, #64, #71). The facility also failed to ensure the kitchen's dry storage was maintained in a cleanly fashion. This had the potential to affect 64 of 64 residents who received meals from the kitchen.</p> <p>Findings include:</p>	F 0465	<p>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for</p>	03/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2016
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1. During an observation of Resident #4, #62, & #64's bathroom, on 2/4/16 at 1:46 p.m., multiple arm length, fingernail high gouges with missing paint were observed on the bathroom door. A rust color was observed where gouges were missing paint.</p> <p>On 2/11/16 at 10:30 a.m., the same observation was made of Resident #4, #62, & #64's bathroom, as above, with the Maintenance Director. The Maintenance Director indicated at this time, when the door have gouges as observed, the doors were usually sanded down, painted and plastic sheeting was placed over the doors to prevent a reoccurrence.</p> <p>2. During an observation of #32, #41, & #71's bathroom, on 2/4/16 at 2:29 p.m., a dark gray residue was observed near the sink and black half circles were observed around the toilet. Multiple arm length, fingernail high gouges with missing paint were observed on the bathroom door. A rust color was observed where the gouges were missing paint. Black debris was observed in the area between the floor and the door frame.</p> <p>On 2/11/16 at 10:35 a.m., the same observation of #32, #41, & #71's</p>		<p>those residents identified: All reported rooms were repaired. Dry storage area was cleaned.</p> <p>2) How the facility identified other residents: All residents have the potential to be affected.</p> <p>3) Measures put into place/ System changes: A room audit was completed and Monthly thereafter. An audit tool will be used to monitor the dry storage area.</p> <p>4) How the corrective actions will be monitored: Maintenance/designee will check 5 rooms per week x 4 weeks then monthly to ensure each room is good repair. The dietary Manager /designees will monitor dry storage area weekly for 3 months for compliance. Results will be reviewed at Quality Assurance meetings.</p> <p>5) March 12, 2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>bathroom was made with the Maintenance Director. The Maintenance Director indicated he would be able to clean the residue, black marks, and black debris with a heavy duty cleaner. The Maintenance Director further indicated when the door had gouges as observed, the doors were usually sanded down, painted and plastic sheeting was placed over the doors to prevent a reoccurrence.</p> <p>3. During an observation of Resident #39's room, on 2/4/16 at 2:20 p.m., a fist size piece of tile was missing near the head of Resident #39's bed. Resident #39's wheelchair cushion was noted to have a worn area with peeled black coating hanging near where the Resident's legs would rest. The top of back of Resident #39's wheelchair was cracked in several areas.</p> <p>On 2/11/16 at 10:45 a.m., the same observations of Resident #39's room and wheelchair were made with the Maintenance Director. The Maintenance Director indicated at this time the tile can be replaced and he can speak to therapy about the wheelchair.</p> <p>During an interview with the Administrator, on 2/11/16 at 11:00 a.m., the concerns listed above were addressed with the Administrator. The</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administrator indicated a couple weeks prior a contractor was in the building to document concerns to be repaired until the facility moved into their new location. The Administrator indicated she was unsure when the repairs would take place, but will find out.</p> <p>A document with a handwritten note, "Rounds [symbol for with] [name of contractor], dated 1/24/16 was received from the Administrator on 2/11/16 at 12:01 p.m. The Administrator indicated the highlighted rooms were the rooms that were identified as needing repairs. Resident #39's room was highlighted with a note indicating, "wants rm [room] painted" and Residents #41, #62, #71's rooms were highlighted but there was no indication of the repair needed. Residents #4, #32, #64's room were not highlighted indicating no repairs were to be completed.</p> <p>During an interview with the Administrator, on 2/11/16 at 12:03 p.m., the Administrator further indicated the facility replaced Resident #39's wheelchair. She also indicated the facility does quarterly audits of Resident's wheelchairs and it was a couple of months since the last audit was completed.</p>			

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 02/11/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An email dated, 2/11/16 at 1:13 p.m., was received from the Administrator, on 2/11/16 at 1:38 p.m. The email was received from the contractor's work order system. It indicated, "...Description...Resident room repairs [;] repairs to be completed: Floor tiles repaired as needed...Bathroom doors repaired/painted as needed (due to scratches or chipped laminate)...Status: Open [,] Priority: High...Created date: 2/11/16 at 12:14 p.m. CT [central time]...." There was no date to indicate when the repairs were to be completed in the document.</p> <p>4. During a tour of the kitchen with the Dietary Manager, on 2/4/16 at 10:50 a.m., multiple areas of black debris was noted under the dry storage rack containing but not limited to paper goods and plastic silverware. Fist sized areas of a dark liquid and 2 plastic spoons were also observed under the rack. Under the rack on the opposite wall, a white granular substance with black debris was noted spanning from one end of the rack to the middle of the rack.</p> <p>On 2/11/16 at 12:45 p.m., the dry storage area was observed the with Dietary Manager. Black debris and plastic spoons were observed under the racks, as described above. Two napkins were also</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>noted under the same rack with a red substance on them. Under the rack on the opposite wall, containing but not limited to paper goods and thickner product, multiple areas of black debris was observed under the rack.</p> <p>During an interview with the Dietary Manager, on 2/11/16 at 12:50 p.m., he indicated he was not sure why the area under the racks was not free from debris, since he recently cleaned under the racks himself.</p> <p>The AM/PM Dietary Aide-Cleaning Schedule for February 2016, was received from the Administrator on 2/11/16 at 1:30 p.m. It indicated, "...Sweep & Mop after Lunch" was completed daily. There was no other indication on the checklist/Cleaning Schedule the kitchen was swept or mopped other times throughout the day.</p> <p>A policy titled, Nutritional Services Policy and Procedure Manual, dated 6/2012, was received from the Administrator on 2/11/16 at 1:30 p.m. The policy indicated, "...5) The Dietary Manager shall routinely check that cleaning is being done to meet the regulation standards...."</p> <p>3.1-19(f)</p>			

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 02/11/2016
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0496 SS=D Bldg. 00	<p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on interview and record review, the facility failed to ensure 2 of 28 actively employed CNAs (certified nursing assistant) had an active license</p>	F 0496	<p>The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or</p>	03/12/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/11/2016	
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>when worked. (CNA #1, CNA #2).</p> <p>Findings include:</p> <p>The Employee Records form and 28 CNA licenses were reviewed on 2/8/16 at 10:00 a.m. The Employee Records form indicated the following start dates: CNA #1=9/24/14, CNA #2=6/11/15.</p> <p>CNA #1's license indicated her license expired on 2/1/16 and was renewed on 2/7/16. The Time Detail provided by the Administrator, on 2/9/16 at 9:11 a.m., indicated she worked 6.5 hours during the timeframe of 2/1/16-2/6/16.</p> <p>CNA #2's license indicated her license expired on 1/21/16 and was not was renewed at the time of review. The Time Detail provided by the Administrator, on 2/9/16 at 9:11 a.m., indicated she worked 120.75 hours during the timeframe from 1/22/16-2/7/16.</p> <p>During an interview with the Administrator, on 2/11/16 at 9:09 a.m., the Administrator indicated staff were expected to have active licenses when they worked and the expired CNA licenses were overlooked.</p> <p>3.1-14(q)(5)</p>		<p><i>execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</i></p> <p><i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified: No resident were affected. CNA # 1 and 2 licenses were renewed.</p> <p>2) How the facility identified other residents: All resident's residing in the facility have the potential to be affected.</p> <p>3) Measures put into place/ System changes: An audit of all c.n.a licenses was conducted to ensure that they were current. HR was in-service on the policy for maintaining the licensure of all c.n.a.'s An audit will conducted weekly x 4 weekly then monthly x 2, then quarterly ongoing audits will be conducted. The Administrator/designee will be responsible for oversight.</p> <p>4) How the corrective actions will be monitored: The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p> <p>5) March 12, 2016</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0502 SS=D Bldg. 00	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure a lab was drawn, as ordered, for 1 of 5 residents reviewed for unnecessary medications. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record for Resident #2 was reviewed on 2/9/16 at 9:20 a.m. The diagnoses for Resident #2 included, but were not limited to, mixed hyperlipidemia.</p> <p>The February, 2016 Physician's Orders for Resident #2 indicated she received two medications related to her mixed hyperlipidemia (Lovaza twice daily and Pravastatin once daily).</p> <p>A 1/4/16 care plan indicated Resident #2 had high cholesterol with an intervention, initiated 1/4/16, to get her labs as ordered.</p> <p>The 11/4/15 Physician's Order indicated an FLP (fasting lipid profile) lab was to</p>	F 0502	<p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i></p> <p>The laboratory was contacted in regards to the lab that was ordered for resident #2. The lab was drawn on 2/10/16 The physician and family were notified of the omission of lab. 2) How the facility identified other residents: All residents have the potential to be affected.</p> <p>3) Measures put into place/ System changes: A complete audit will be done. All orders will be read in the clinical meeting 5 x weekly to ensure labs are drawn. 4) How the corrective actions will be</p>	03/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>be drawn on Monday 1/18/16.</p> <p>No FLP lab was located in the clinical record.</p> <p>An interview was conducted with DON (Director of Nursing) #2 on 2/10/16 at 9:47 a.m. He indicated there was no FLP lab drawn after the 1/18/16 order, so he called the doctor. He indicated the purpose of the lab was to monitor her hyperlipidemia.</p> <p>The 2/9/16, 3:46 p.m. progress note indicated, "NP (Nurse Practitioner) (name of NP) made aware of missing lab draw on 1/18/16, new order to redraw on 2/10/16."</p> <p>3.1-49(a)</p>		<p>monitored: The DON /designees will monitor bi-weekly for 3 months, then monthly for 3 months for compliance. Results will be reviewed at Quality Assurance meetings.</p> <p>5) March 12, 2016</p>	