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 02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00163089. Complaint IN00163089-Unsubstantiated due to lack of evidence. Survey dates: January 28, 29, 30, February 2, 3, 4, and 5, 2015 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Survey team: Karina Gates, Generalist-TC Beth Walsh, RN Tom Stauss, RN Angie Stallsworth, RN Census bed type: SNF/NF: 76 Total: 76 Census payor type: Medicare: 7 Medicaid: 62 Other: 7 Total: 76	F000000		

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

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

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	155628		02/05/2015

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 12, 2015 by Cheryl Fielden, RN.			
F000278 SS=A	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on interview and record review,	F000278	The facility request paper	03/06/2015

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	the facility failed to accurately document a nutritional assessment on the quarterly Minimum Data Set (MDS) assessment for 1 of 1 resident's reviewed for a feeding tube. (Resident #73) Findings include: The clinical record for Resident #73 was reviewed on 2/2/15 at 9:00 a.m. The diagnoses for Resident #73 included, but were not limited to, stroke, hemiplegia, nutritional deficiency, gastrointestinal bleed, and anemia. The Quarterly Minimum Data Set (MDS) assessment dated on 12/31/14 was reviewed. The nutritional assessment for Resident #73 indicated this resident had a feeding tube and was receiving 51% or more calories through a tube feeding. During an interview with Unit Manager #2 on 2/2/15 at 10:00 a.m., indicated Resident #73 does not have a feeding tube nor has he had one in the past year. An interview was conducted on 2/2/15 at 10:13 a.m., with the MDS Coordinator. She indicated Resident #73's nutritional assessment on the Quarterly MDS assessment dated on 12/31/14 was incorrect, and this resident's diet was pureed.		compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution 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 provisons of the Federal and State Law. 1. MDS assessment dated 12-31-14 for resident #73 has been modified as indicated. 2. All residents residing in the facility have the potential to be affected. 3. Resident MDS's were reviewed for accuracy of nutritional status and corrected as indicated. Facility staff that completed sections of the MDS will be inserviced regarding assessment must accurately reflect the resident's status. An audit will be completed in weekly Nutrition at Risk meeting to ensure that nutritional assessments reflect the residents status and are accurately documented on the MDS. 4. DON/designee will monitor the audits weekly x 4, monthly x 2 and then quarterly x 1. All results will be reviewed at the Quality Assurance meeting and determine further monitoring. 5. Date of compliance: 3-6-15	

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	3.1-3.1(g)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to ensure care plans were developed for proper positioning and use of a hip splint, urinary incontinence, and anticoagulant medication use for 3 of 24 residents reviewed for care plans. (Residents #41, #73, and #84) Findings include: 1. The clinical record for Resident #41	F000279	The facility request paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution 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 provisons of the Federal and State Law. 1. Resident #41's plan of care was	03/06/2015

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	was reviewed on 1/29/15, at 9:00 a.m. The diagnoses for Resident #41 included, but were not limited to, lower leg joint pain and history of cerebral vascular accident with left side hemiplegia. The 11/11/14 Quarterly MDS (minimum data set) assessment for Resident #41 indicated she was totally dependent on one person for locomotion (ability to move from one place to another) on and off the unit. It indicated she had a limitation in range of motion, with a lower extremity impairment on one side. The 11/28/14 Therapy Communication to Nursing form indicated Resident #41 required a hip splint for proper positioning, when in her wheel chair. It indicated she needed a hip splint, because her right hip turned in, when she was in her wheel chair. The goal of having a hip splint was to maintain good hip positioning, when in her wheelchair. An observation of Resident #41 was made on 1/29/15, at 9:50 a.m. She was sitting in her wheel chair in the television area of the dining room. Her right leg was not positioned correctly on the right leg rest of her wheel chair. Her right foot was on the pedal, but her calf was pressed against the side of the leg rest, rather than on the leg rest.		reviewed and updated to include use of hip splint. Resident #84's plan of care was reviewed and updated to include use of anticoagulant as ordered. 2. All residents noted with urinary incontinence, utilizing splints and/or receiving anticoagulant therapy have the potential to be affected. 3. A comprehensive care plan audit was completed for all residents noted with urinary incontinence, utilizing splints and/or receiving anticoagulant therapy. Licensed nursing staff will be inserviced on developing care plans for residents noted with urinary incontinence, utilizing splints and/or receiving anticoagulant therapy. An audit will be completed in clinical meeting on when bowel/bladder assessments indicate urinary incontinence, to ensure that urinary incontinece is addressed in the residents plan of care. An audit will be completed in the clinical meeting when new orders for splints and/or for coagulant therapy are read, to check for appropriate care plans in place. 4. DON/designee will audit weekly x 4, monthly x 2 then quarterly x 1. All results will be reviewed at Quality Assurance meeting and will determine further monitoring. 5. Date of compliance: 3-6-15	

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	An observation of Resident #41 was made on 2/5/15, at 10:27 a.m. She was sitting in her wheel chair in the television area of the dining room. Her left leg was on the pedal. Her right leg was on the floor. She was wearing a hip splint (device used to keep the hips aligned). The hip splint consisted of a bar between the right and left thigh area. The bar was positioned on an angle, rather than straight across, as one foot was on the pedal and the other on the floor. The right leg rest/pedal was sticking outward to the right, as opposed to straight forward in a locked position. CNA (Certified Nursing Assistant) #5 walked past Resident #41, and did not address Resident #41's positioning. CNA #5 was informed of Resident #41's right leg position. CNA #5 went back into the television area of the dining room, repositioned her right leg on the pedal, tried to lock the pedal, and indicated it would not lock. CNA #5 assisted Resident #41 into the therapy department. A therapist was able to lock Resident #41's wheel chair pedal. The therapist and CNA #5 repositioned Resident #41 in her wheel chair, by lifting her twice, so her back was against the back of her chair. An interview was conducted with Unit			

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	Manager #2 on 2/5/15, at 10:41 a.m. He indicated Resident #41 had abductors to keep her legs positioned correctly, so her knees didn't turn in and rub, and for proper alignment. He indicated, "The foot pedals should be locked. You'll know if they are, because there will be a click, or you can move it, and make sure it's locked." An interview was conducted with the DON (Director of Nursing) on 2/5/15, at 12:08 p.m. She indicated there was no care plan regarding Resident #41's use of a hip splint. 2. Resident #84's record was reviewed on 1/30/15 at 12:17 p.m. The resident's diagnoses included, but were not limited to, diabetes type II, depressive disorder, senile psychotic disorder, hypertension, dementia, and muscle weakness. A 9/1/14 MDS assessment indicated Resident #84 was "Occasionally incontinent" of urine. An 11/28/14 MDS assessment indicated the resident was "Frequently incontinent" and required "Extensive assistance" from staff for toileting. A 9/4/14 Braden Scale Pressure Sore Risk assessment indicated Resident #84 was "Very Moist". This indicated the resident's skin was moist from			

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	incontinence episodes. An 11/21/14 Bowel and Bladder quarterly review indicated a toileting program was "effective" for Resident #84. It also stated "Resident (#84) is a check and change when he allows." This indicated the staff would check the resident for incontinence and change his incontinent brief if necessary. On 2/2/15 at 9:28 a.m., during an interview, Resident #84's assigned unit nurse identified the resident as "resistive to toileting at times". She indicated the resident wears incontinence briefs. On 2/3/15 at 2:11 p.m., during an interview, the MDS Coordinator indicated a trial toileting program was done for Resident #84 upon admission to the facility, but a urinary incontinence care plan was not created for Resident #84. She indicated the resident was incontinent of urine upon admission and at the 11/28/14 MDS quarterly assessment, but during the "look back" period to categorize the resident's continent status (7 days), the resident was categorized as occasionally incontinent on a 9/1/14 MDS admission assessment. She stated the resident "has not had a change in continence status" since admission to the facility.			

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	On 2/3/15 at 3:06 p.m., during an interview, the DON indicated Resident #84 did not qualify for the toileting program due to his cognitive status. She stated nursing staff should offer toileting to Resident #84 to ensure the resident maintains the highest level of continence status. On 2/4/15 at 9:06 a.m., the DON indicated the facility does not have a urinary incontinence care plan in place for Resident #84. She indicated the check and change reference above is one which should have been added to a care plan for urinary incontinence. 3. The clinical record for Resident #73 was reviewed on 2/2/15 at 9:00 a.m. The diagnoses for Resident #73 included, but were not limited to, stroke, hemiplegia, nutritional deficiency, gastrointestinal bleed, and anemia. A physician's order, dated on 2/2/15, indicated to administer total 7 milligrams of an anticoagulant by mouth daily. During a review Resident #73's care plans, no care plan regarding his anticoagulant medication use was found. An interview was conducted on 2/2/15 at 11:09 a.m., with Unit Manager #2. He			

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	indicated, he could not locate a care plan for Resident #73's anticoagulant medication. During an interview with the Director of Nursing (DON) on 2/2/15 at 12:10 p.m., she indicated the facility had been monitoring the anticoagulant medication by lab results. 3.1-35(a)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident with a hip splint was properly positioned in her wheel chair for 1 of 2 residents reviewed for positioning. (Resident #41) Findings include: The clinical record for Resident #41 was reviewed on 1/29/15, at 9:00 a.m. The diagnoses for Resident #41 included, but were not limited to, lower leg joint pain and history of cerebral vascular accident	F000309	The facility request paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution 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 provisons of the Federal and State Law. 1. Resident #41 was repositioned as indicated, resident specific inservice/training initiated. Will continue to be observed for	03/06/2015

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	with left side hemiplegia. The 11/11/14 Quarterly MDS (minimum data set) assessment for Resident #41 indicated she was totally dependent on one person for locomotion (ability to move from one place to another) on and off the unit. It indicated she had a limitation in range of motion, with a lower extremity impairment on one side. The 11/28/14 Therapy Communication to Nursing form indicated Resident #41 required a hip splint for proper positioning, when in her wheel chair. It indicated she needed a hip splint, because her right hip turned in, when she was in her wheel chair. The goal of having a hip splint was to maintain good hip positioning, when in her wheelchair. An observation of Resident #41 was made on 1/29/15, at 9:50 a.m. She was sitting in her wheel chair in the television area of the dining room. Her right leg was not positioned correctly on the right leg rest of her wheel chair. Her right foot was on the pedal, but her calf was pressed against the side of the leg rest, rather than on the leg rest. An observation of Resident #41 was made on 2/5/15, at 10:27 a.m. She was sitting in her wheel chair in the television		proper positioning and has had no adverse effects noted. 2. All residents that utilize splints have the potential to be affected. 3. Residents utilizing splints were reviewed for proper positioning with use of splints. Licensed nursing staff will be inserviced on use of, and positioning of residents who utilize splints. An audit will be completed in the clinical meeting when new orders for splints are read, to ensure proper positioning with splint has been initiated as indicated. Resident observation/audits will be completed 3 x weekly per clinical management team to ensure residents are properly positioned with use of splints. 4. DON/designee will audit weekly x 4, monthly x 2 and then quarterly x 1. results will be reviewed at the Quality Assurance meeting and determine further monitoring. 5. Date of compliance: 3-6-15	

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	area of the dining room. Her left leg was on the pedal. Her right leg was on the floor. She was wearing a hip splint (device used to keep the hips aligned). The hip splint consisted of a bar between the right and left thigh area. The bar was positioned on an angle, rather than straight across, as one foot was on the pedal and the other on the floor. The right leg rest/pedal was sticking outward to the right, as opposed to straight forward in a locked position. CNA (Certified Nursing Assistant) #5 walked past Resident #41, and did not address Resident #41's positioning. CNA #5 was informed of Resident #41's right leg position. CNA #5 went back into the television area of the dining room, repositioned her right leg on the pedal, tried to lock the pedal, and indicated it would not lock. CNA #5 assisted Resident #41 into the therapy department. A therapist was able to lock Resident #41's wheel chair pedal. The therapist and CNA #5 repositioned Resident #41 in her wheel chair, by lifting her twice, so her back was against the back of her chair. An interview was conducted with Unit Manager #2 on 2/5/15, at 10:41 a.m. He indicated Resident #41 had abductors to keep her legs positioned correctly, so her knees didn't turn in and rub, and for			

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	proper alignment. He indicated, "The foot pedals should be locked. You'll know if they are, because there will be a click, or you can move it, and make sure it's locked." 3.1-37(a)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to perform catheter care according to standards of nursing practice and facility policy for 1 of 2 residents reviewed for urinary catheter care. (Resident #103) Findings include: Resident #103's record was reviewed on 2/4/15 at 2:31 p.m. The resident's diagnoses included, but were not limited to, 3rd degree burns, gastrostomy, depression, and chronic pain.	F000315	The facility request paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution 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 provisons of the Federal and State Law. 1. Resident #103 was assessed, physician notified of current status. No decline in status noted, no new orders received. 1:1 inservice conducted with CNA #3.	03/06/2015

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

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	A care plan, dated 12/9/14, for Resident #103 indicated the resident had an indwelling urinary catheter. On 2/5/15 at 10:38 a.m., during an observation, CNA #3 performed catheter care for Resident #103. During the procedure, the CNA wiped the catheter tubing, with a soapy washcloth, from an area near the connection point of the urine collection system upwards toward the resident's urethral meatus (opening). On 2/5/15 at 10:47 a.m., during an interview, CNA #3 indicated the procedure was performed as she usually does and according to facility policy. On 2/5/15 at 11:24 a.m., during an interview, the DON indicated staff should clean a resident's catheter tubing consistent with facility policy related to catheter care. She indicated the policy states to clean the tubing from the urethral meatus (opening) outward and away from the penis. On 2/5/15 at 1:08 p.m., RN #4 indicated Resident #103 was being treated for a urinary tract infection. She stated he was receiving antibiotic therapy, which began 1/29/15, for the infection. On 2/5/15 at 1:25 p.m., during an		2. All residents with urinary catheters have the potential to be affected. 3. Residents with urinary catheters have been revieiwed. Licensed nursing staff will be inserviced on proper catheter care. CNA's will complete a skills validation for catheter care. Skills observation/audits will be completed 3 x week per clinical management team to ensure residents are receiving proper catheter care. 4. DON/designee will audit weekly x 4, monthly x 2 and then quarterly x 1. All results will be reviewed at the Quality Assurance meeting and determine further monitoring. 5. Date of compliance: 3-6-15	

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 02/05/2015
NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205	

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	interview, CNA #3 indicated she performed the catheter care task incorrectly by cleaning the catheter tubing towards Res #103 's urinary meatus rather than cleaning it away from his urinary meatus according to facility policy. A facility policy, undated and titled "Perineal Care", indicated "...if resident has a catheter, check for leakage, secretions or irritations. Gently wipe four inches of catheter from meatus out..." The policy listed the rationale for wiping from the meatus out as "...Washes pathogens away from the meatus..." 3.1-41(a)(2)			
F000514 SS=A	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review,	F000514	The facility request paper compliance for this citation. This	03/06/2015

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	the facility failed to ensure documentation regarding splint use was completed for 1 of 2 residents reviewed for positioning. (Resident #3) Findings include: The clinical record for Resident #3 was reviewed on 2/2/15 at 8:30 a.m. The diagnoses for Resident #3 included, but were not limited to, Cerebral Palsy, contracture ankle/foot joint, and contracture of hand joint. An Occupational therapy order on 1/4/15 indicated, " patient will don right hand modified resting hand splint (green) daily x 6 hours to prevent worsening contractures one time a day." During the clinical record review no documentation was found regarding Resident #3's daily hand splint use. An interview was conducted on 2/4/15 at 11:00 a.m., with the Minimum Data Set (MDS) Coordinator. She indicated the information had been entered in the system incorrectly, so the staff had not been documenting when Resident #3's hand splint was on or off her right hand. At this time, a review of this task was reviewed, and there was no documentation entered since the		Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution 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 provisons of the Federal and State Law. 1. Documentation related to splint use for #3 has been initiated and is being entered into the clinical record. Resident #3 has had no adverse effects noted. 2. All residents utilizing splints have the potential to be affected. 3. Physician orders and point of care tasks for residents currently utilizing splints were reviewed to ensure documentation is in place. Licensed staff will be inserviced related to required documentation regarding splint use. An audit will be completed in the clinical meeting when new orders for splints are read, to ensure documentation has been initated as indicated. An audit of documentation for residents utilizing splints will be completed in clinical meeting to ensure that application and removal of the splint is noted in the clinical record. 4. DON/designee will audit weekly x 4, monthly x 2 and then quarterly x 1. Results of the audit will be reviewed at the Quality Assurance meeting and further monitoring will be	

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	Occupational therapy order date of 1/4/15. 3.1-50(a)(2)		determined. 5. Date of compliance: 3-6-15	