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 06/12/2014

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 the Investigation of Complaints IN00150002, IN00150431, and IN00150445. Complaint IN00150002 substantiated. Federal/State deficiencies related to the allegations are cited at F279. Complaint IN00150431 substantiated. Federal/State deficiencies related to the allegations are cited at F272 and F314. Complaint IN00150445 substantiated. Federal/State deficiencies related to the allegations are cited at F157, F272, F279, F309, and F514. Survey date: June 6, 9, 10, 11, and 12 2014 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Team: Chuck Stevenson RN Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 2	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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	Medicaid: 71 Other: 5 Total: 78 Sample: 4 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on June 18, 2014 by Cheryl Fielden, RN.			
F000157 SS=D	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). The facility must also promptly notify the resident and, if known, the resident's legal			

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	representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified for repeated non-verbal expressions of pain during treatment, including wound dressing changes, as expressed by grimacing, groaning, moaning, facial expressions, and body posture, and who repeatedly refused regularly scheduled physician ordered medications. 1 resident of 3 (Resident #D) reviewed for physician notification in a sample of 4. Findings include: The record of Resident #D was reviewed on 6/10/14 at 1:00 P.M. Diagnoses included, but were not limited to, unstageable pressure ulcers at admission, dementia, cognitive communication deficit (difficulty in thinking or communicating), dysphagia (difficulty swallowing), anemia, hypertension, and contractures of the lower extremities.	F000157	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 of 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 by the provisions of State and Federal Law.1. Resident D had PAINAD completed with MD notification of results and adjustments made to medication regimen.2. All residents with a BIMS less than 8 were reassessed utilizing the PAINAD. Any residents with unaddressed pain symptoms were referred to MD for interventions.3. Licensed nurses will be inserviced on completing PAINAD assessements and recognizing non-verbal signs/symptoms of pain with cognitively impaired residents. MD notification will be done for further intervention based on assessments and resident findings.4. DON/designee will	07/12/2014

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	A significant change Minimum Data Set assessment dated 5/23/14 indicated Resident #D was severely cognitively impaired (severe difficulty in thinking or communicating), did not ambulate, required extensive to total assist with all activities of daily living, required extensive assist of 2 staff for bed mobility, and was incontinent of bowel and bladder. Progress notes for Resident #D indicated: 5/03/14 3:48 P.M. "...facial grimacing noted. Brow is wrinkled. Resident is moaning...Level of pain is difficult to assess." 5/04/14 4:01 P.M. "...difficult to rate pain as resident is not able to verbalize..." 5/05/14 2:39 P.M. "...complains of pain at site of wound. Facial grimacing noted. Resident is moaning. Resident does not verbalize pain with descriptions." 5/06/14 2:09 P.M. "Resident refused to open mouth for medications." 5/06/14 4:08 P.M. "...Resident unable to rate pain..." 5/06/14 6:28 P.M. "...Resident refused all evening meds (medications), writer attempted to give more than 3 times." 5/06/14 10:21 P.M. "...Resident refused all evening medications, writer attempted to give several times..." 5/09/14 4:03 P.M. "...Resident unable to rate pain. Resident has difficulty taking		audit 3 PAIN/PAINAD assessments in residents with BIMS less than 8 per week for accuracy and MD notification of any unrelieved pain. Results of these audits will be done weekly x 4, monthly x 2, then quarterly x 1 for a total of 6 months as part of the Quality Assurance.5. Date of compliance: July 12, 2014	

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	medications..." 5/12/14 3:59 P.M. "...Facial grimacing noted. Has been grunting." 5/13/14 1:25 P.M. "...Medications refused..." 5/13/14 3:33 P.M. "...Resident has been frowning. Resident is moaning. Has been grunting..." 5/14/14 2:18 P.M. "...Resident is moaning. Has been grunting. Has been resistive to care." 5/18/14 3:26 P.M. "...Resident in a fetal position most of shift...Resident unable to communicate pain. Wincing and moaning with movement..." 5/22/14 1:16 P.M. "...Resident has jaws clenched. Mouth is turned down. Resident is moaning. Has been grunting. States constantly in pain..." 5/26/14 3:50 P.M. "...Resident is moaning. Has been grunting. Resident is unable to rate pain." 5/29/14 3:52 P.M. "...Resident is moaning. Has been resistant to care." 5/31/14 12:50 P.M. "...Resident unable to verbalize pain scale. Resident moans intermittently with treatment, resists with tense muscular movements. Facial grimacing noted. Resident is moaning. Has been grunting..." Resident #D's record did not contain any documentation of physician notification, requests for additional pain medication or			

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	alteration in medication scheduling, or communication with nursing management related to the above documented incidents of non-verbal expression of pain and refusal of scheduled medications. A facility policy titled "Physician/Family/Responsible Party Notification for Change in Condition" dated 8/2013 received from the Director of Nursing on 6/11/14 at 9:25 A.M. indicated: "Purpose: To ensure that medical problems are communicated to the attending physician and family/responsible party in a timely, efficient and effective manor. Responsibility: All Licensed Nursing Personnel. Policy: 1. Physician and family/responsible party notification is to include, but is not limited to: Repeated refusals to take prescribed medications...Abnormal complaints of pain... 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."			

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	This federal tag relates to Complaint IN00150445. 3.1-5(a)(1)			
F000272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in			

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	assessment. Based on record review and interview, the facility failed to ensure comprehensive and accurate assessments were performed and documented for a non-verbal resident who experienced pain during treatment, including wound dressing changes, and a resident who was without pressure sores who developed stage lll and stage lV pressure sores. 2 residents (Residents #C and #D) of 3 reviewed for assessments in a population of 4. Findings include: 1. The record of Resident #D was reviewed on 6/10/14 at 1:00 P.M. Diagnoses included, but were not limited to, unstageable pressure ulcers at admission, dementia, cognitive communication deficit (difficulty in thinking or communicating), dysphagia (difficulty swallowing), anemia, hypertension, and contractures of the lower extremities. A significant change Minimum Data Set assessment dated 5/23/14 indicated Resident #D was severely cognitively impaired (severe difficulty in thinking or communicating), did not ambulate, required extensive to total assist with all activities of daily living, required	F000272	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 of 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 by the provisions of State and Federal Law.1. Resident D had PAINAD completed with MD notification of results and adjustments made to medication regimen.Resident C had complete body skin assessment on readmission to facility which identified all skin issues.2. Full in house skin sweep completed and addressed any findings.Completed audit on weekly skin assessments to identify any missing or late completion.All residents with BIMS less than 8 were reassessed utilizing the PAINAD. Any residents with unaddressed pain symptoms were referred to MD for intervention.3. Licensed nurses will be inserviced on completing PAINAD assessments and recognizing non-verbal signs/symptoms of pain with cognitively impaired residents. MD notification will be done for further intervention based on assessment and resident findings.All nursing staff will be inserviced on proper procedure for doing weekly skin	07/12/2014

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	extensive assist of 2 staff for bed mobility, and was incontinent of bowel and bladder. Progress notes for Resident #D indicated: 5/03/14 3:48 P.M. "...facial grimacing noted. Brow is wrinkled. Resident is moaning...Level of pain is difficult to assess." 5/04/14 4:01 P.M. "...difficult to rate pain as resident is not able to verbalize..." 5/05/14 2:39 P/.M. "...complains of pain at site of wound. Facial grimacing noted. Resident is moaning. Resident does not verbalize pain with descriptions." 5/06/14 4:08 P.M. "...Resident unable to rate pain..." 5/09/14 4:03 P.M. "...Resident unable to rate pain..."5/12/14 3:59 p.m. "...Facial grimacing noted. Has been grunting." 5/13/14 3:33 P.M. "...Resident has been frowning. Resident is moaning. Has been grunting..." 5/14/14 2:18 P.M. "...Resident is moaning. Has been grunting. Has been resistive to care." 5/18/14 3:26 P.M. "...Resident in a fetal position most of shift...Resident unable to communicate pain. Wincing and moaning with movement..." 5/22/14 1:16 P.M. "...Resident has jaws clenched. Mouth is turned down. Resident is moaning. Has been grunting. States constantly in pain..."		assessments and documenting accurately.Wound nurse/designee is to validate 3 weekly licensed nurse skin assessments; and 3 CNA weekly skin checks per week. Inconsistent findings will be addressed with licensed nurse/CNA via progressive discipline which could be up to and including termination.LPN #1 has been terminated.4. DON/wound nurse will audit 3 PAIN/PAINAD assessments in resident with BIMS less than 8 per week for accuracy and MD notification of any unrelieved pain. Audits will be done weekly x 4, monthly x 2, then quarterly x 1 for a total of 6 months as part of Quality Assurance.5. Date of compliance: July 12, 2014	

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	5/26/14 3:50 P.M. "...Resident is moaning. Has been grunting. Resident is unable to rate pain." 5/29/14 3:52 P.M. "...Resident is moaning. Has been resistant to care." 5/31/14 12:50 P.M. "...Resident unable to verbalize pain scale. Resident moans intermittently with treatment, resists with tense muscular movements. Facial grimacing noted. Resident is moaning. Has been grunting..." Resident #D's record did not contain any documentation of physician notification, requests for additional pain medication or alteration in medication scheduling, or communication with nursing management related to the above documented incidents of non-verbal expression of pain. Resident #D had a health care plan dated 5/08/14 which indicated: "Focus: (Resident #D) is at risk for pain related to wounds. Goal: Resident will not have uncontrolled pain through next review. Interventions: Administer pain medication as indicated. Observe for non-verbal signs of pain such as grimacing or other facial expressions. Reposition every 2 hours and PRN (as needed) to provide comfort."			

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	A "Pain Monitoring Tool (PAINAD)" assessment, the facility's pain assessment tool for non-verbal residents, was completed 6/10/14 and indicated Resident #D had a pain rating of 6, indicating moderate pain. Resident #D's record contained no "Pain Monitoring Tool (PAINAD)" pain assessment prior to that date. During an interview with the Director of Nursing (D.O.N.) on 6/12/14 at 10:30 A.M. she indicated no "Pain Monitoring Tool (PAINAD)" assessment had been completed for Resident #D prior to 6/10/14, as indicated by facility policy. 2. The record of Resident #C was reviewed on 6/09/14 at 2:00 P.M. Diagnoses included, but were not limited to, senile dementia, hemiplegia (paralysis of one side of the body) due to cerebrovascular disease, hypertension, diabetes mellitus, and chronic kidney disease. A quarterly Minimum Data Set (M.D.S.) assessment dated 3/25/14 indicated Resident #C was cognitively impaired (difficulty thinking or communicating), did not ambulate, was incontinent of bowel and bladder, and required extensive to total assistance with activities of daily living.			

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	"Weekly Skin Observation" assessment documentation records for Resident #C contained categories for documenting Skin Tears, Open Areas, Bruises, Surgical Wounds, Dry Cracked Lips, Rashes, Burns, and Dry Mucous Membranes. These assessments indicated the following: 4/29/14 All categories marked "No." 5/06/14 "Open Areas" marked "Yes" with the note "Ammonium Lactate 12% lotion apply to bilateral lower extremities topically two times a day for dry skin." All other categories marked "No." 5/13/14 "Open Areas" marked "Yes" with the note "Resident has redden (sic) area to scrotum." All other categories marked "No." 5/23/14 All categories marked "No." 5/27/14 Categories "Skin Tear" and "Dry Mucous Membranes" marked "Yes" with no accompanying narrative notes. All other categories marked "No." 5/30/14 Categories for "Skin Tears" and Surgical Wounds" not marked as assessed. All other categories marked "No."			

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	An interview with C.N.A. #2 conducted by the D.O.N. on 6/10/14 related to L.P.N. #1's assessment of Resident #C's skin indicated: "Employee (C.N.A. #2) stated she gave resident (Resident #C) a shower on 5/30/14 and notified nurse to come do a skin assessment. She stated she lifted the resident, and the nurse felt over his bottom, and viewed all other areas of skin..." During an interview on 6/09/14 at 3:15 P.M. with the Administrator, Nurse Consultant, and Resident #C's assigned nurse present, the Director of Nursing (D.O.N.) reviewed Resident #C's clinical record in it's entirety and indicated that prior to the identification of Stage lll and Stage lV pressure sores on 5/31/14, Resident #C's record contained no documentation of any open areas. During an interview on 6/11/14 at 4:15 P.M. with the Administrator, Nurse Consultant, and Corporate Director of Nursing present, the Director of Nursing (D.O.N.) indicated that all recent skin assessments for Resident #C had been completed by the same nurse, L.P.N. #1. The D.O.N. indicated that L.P.N. #1 had been educated and trained in facility policies and procedures related to skin			

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	assessment and documentation. She indicated L.P.N. #1 had not followed facility guidelines in assessing and documenting Resident #C's skin condition as noted in the "Weekly Skin Observation" above, and that these assessments did not accurately reflect Resident #C's skin condition. The D.O.N. also indicated that the assessment described in C.N.A. #2's statement above did not reflect an appropriate assessment based on facility policy and procedure. This federal tag relates to complaints IN00150431 and IN00150445. 3.1-31(a) 3.1-31(b)			
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			

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(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
	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 record review and interview, the facility failed to ensure health care plans were developed and implemented for a resident (Resident #D) with a gastrostomy tube (g-tube) and for a resident (Resident #B) with bilateral lower extremity amputations. 2 residents of 4 reviewed for health care plans in a sample of 4. Findings include: 1. The record of Resident #D was reviewed on 6/10/14 at 1:00 P.M. Diagnoses included, but were not limited to, unstageable pressure ulcers at admission, dementia, cognitive communication deficit (difficulty thinking or communicating), dysphagia (difficulty swallowing), anemia, hypertension, and contractures of the lower extremities. A significant change Minimum Data Set assessment dated 5/23/14 indicated Resident #D was severely cognitively impaired (severe difficulty thinking or communicating), did not ambulate, required extensive to total assist with all	F000279	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 of 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 by the provisions of State and Federal Law.1. Resident D had care plan developed for gastrostomy tube.Resident B no longer resides in facility.2. All residents with feeding tubes and amputations were audited for appropriate care plans.3. Review all resident care plans regarding feeding tubes and amputees.Admission/readmission resident care plans are to be reviewed by IDT in next clinical meeting for appropriate care plans regarding resident needs in reference to feeding tubes and amputations.Inservicing completed with IDT and nursing staff on initiating care plans for residents with feeding tubes and amputations.Audits will be completed during Clinical meeting following admission/readmission on next business day for adequate care plans completion	07/12/2014

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BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN 46205

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	activities of daily living, required extensive assist of 2 staff for bed mobility, and was incontinent of bowel and bladder. Progress notes for Resident #D indicated: 5/13/14 4:45 P.M. "(Name of Medical Director) came in to evaluate resident this a.m...contacted resident responsible party...enteral feeding (per feeding tube) discussed. Family wishes for G-Tube (gastrostomy tube) to be placed. (Medical Director) gave order..." 5/14/14 3:14 P.M. "Resident LOA (leave of absence) for feeding tube placement." 5/15/14 9:59 P.M. "Resident transferred from (acute care hospital) Resident has new G-Tube placement." Resident #D's record contained no health care plan related to care, assessment, utilization, or documentation of the g-tube, including use for medications or feedings. 2. The record of Resident #B was reviewed on 6/06/14 at 1:30 P.M. Diagnoses included, but were not limited to, congestive heart failure, hypertension, cervical spinal cord injury, peripheral vascular disease (potential for blood clots in the extremities), and cognitive communication deficit (difficulty thinking or communicating).		regarding feeding tube and amputations.MDS will review care plans to ensure all care concerns are identified on care plan of residents with feeding tubes and amputations.4. DON/designee will audit weekly x 4, monthly x 2, then quarterly x 1 for a total of 6 months as part of Quality Assurance.5. Date of compliance: July 12, 2014	

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	An initial Minimum Data Set (M.D.S.) assessment dated 4/15/14 indicated Resident #B was cognitively intact, required extensive assistance for bed mobility, total assistance with transfers, did not ambulate, and required staff assistance for other activities of daily living. A hospital "Admission H & P" (history and physical) note dated 4/04/14 for Resident #B indicated: "Right BKA (below the knee amputation) Left AKA (above knee amputation)" A facility "PT (physical therapy) Evaluation (symbol for "and") Plan of Treatment" dated 4/09/14 indicated: "HX/Complexities (history)...L (left) AKA, R (right) BKA..." Resident #B's record contained no health care plan to address safety, transfer, assistance, or other issues related to bilateral lower extremity amputations. During an interview on 6/10/14 at 3:30 P.M. the Director of Nursing indicated the facility had no specific policy related to the development of resident health care plans, and relied on the Resident			

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	Assessment Instrument for guidance. This federal tag relates to complaints IN00150002 and IN00150445. 3.1-35(a)			
F000309 SS=G	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 record review and interview, the facility failed to ensure a non-verbal resident did not experience pain during treatment, including wound dressing changes, as expressed by grimacing, groaning, moaning, facial expressions, and body posture. 1 resident of 3 (Resident #D) reviewed for pain in a sample of 4. Findings include: The record of Resident #D was reviewed on 6/10/14 at 1:00 P.M. Diagnoses included, but were not limited to, unstageable pressure ulcers at admission, dementia, cognitive communication deficit (difficulty thinking or	F000309	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 of 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 by the provisions of State and Federal Law.1. Resident D had PAINAD completed with MD notification of results and adjustments made to medication regimen.2. All residents with a BIMS less than 8 were reassessed utilizing the PAINAD. Any residents with unaddressed pain symptoms were referred to MD for intervention.3. Licensed nurses will be inserviced on completing	07/12/2014

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	communicating), dysphagia (difficulty swallowing), anemia, hypertension, and contractures of the lower extremities. A significant change Minimum Data Set assessment dated 5/23/14 indicated Resident #D was severely cognitively impaired (severe difficulting thinking or communicating), did not ambulate, required extensive to total assist with all activities of daily living, required extensive assist of 2 staff for bed mobility, and was incontinent of bowel and bladder. Progress notes for Resident #D indicated: 5/03/14 3:48 P.M. "...facial grimacing noted. Brow is wrinkled. Resident is moaning...Level of pain is difficult to assess." 5/04/14 4:01 P.M. "...difficult to rate pain as resident is not able to verbalize..." 5/05/14 2:39 P.M. "...complains of pain at site of wound. Facial grimacing noted. Resident is moaning. Resident does not verbalize pain with descriptions." 5/06/14 4:08 P.M. "...Resident unable to rate pain..." 5/09/14 4:03 P.M. "...Resident unable to		PAINAD assessments and recognizing non-verbal signs and symptoms of pain with cognitively impaired residents. MD notification will be done for further intervention based on assessments and resident findings.4. DON/designee will audit weekly x 4, monthly x 2, then quarterly x 1 for a total of 6 months as part of Quality Assurance.5. Date of complaince: July 12, 2014	

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	rate pain..."5/12/14 3:59 p.m. "...Facial grimacing noted. Has been grunting." 5/13/14 3:33 P.M. "...Resident has been frowning. Resident is moaning. Has been grunting..." 5/14/14 2:18 P.M. "...Resident is moaning. Has been grunting. Has been resistive to care." 5/18/14 3:26 P.M. "...Resident in a fetal position most of shift...Resident unable to communicate pain. Wincing and moaning with movement..." 5/22/14 1:16 P.M. "...Resident has jaws clenched. Mouth is turned down. Resident is moaning. Has been grunting. States constantly in pain..." 5/26/14 3:50 P.M. "...Resident is moaning. Has been grunting. Resident is unable to rate pain." 5/29/14 3:52 P.M. "...Resident is moaning. Has been resistant to care." 5/31/14 12:50 P.M. " Resident unable to verbalize pain scale. Resident moans intermittently with treatment, resists with tense muscular movements. Facial grimacing noted. Resident is moaning. Has been grunting..."			

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	Resident #D's record did not contain any documentation of physician notification, requests for additional pain medication or alteration in medication scheduling, or communication with nursing management related to the above documented incidents of non-verbal expression of pain. Resident #D had a health care plan dated 5/08/14 which indicated: "Focus: (Resident #D) is at risk for pain related to wounds. Goal: Resident will not have uncontrolled pain through next review. Interventions: Administer pain medication as indicated. Observe for non-verbal signs of pain such as grimacing or other facial expressions. Reposition every 2 hours and PRN (as needed) to provide comfort." Physician's orders for pain medications as documented in Resident #D's "Order Recap Report" for the period of 03/01/2014 through 06/30/2014 indicated: 4/30/14 "Hydrocodone-Acetaminophen 5-325 MG (milligrams) Give 1 tablet by			

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	mouth three times a day for pain related to pressure ulcer." This medication order was discontinued 6/10/14 due to "change in pain medications." 5/30/14 "Medicate resident at least 30 minutes prior to wound care." This order contained no additional instructions. During an interview 6/10/14 at 1:30 P.M. L.P.N. #3, Resident #D's assigned nurse, indicated she believed this order was intended to indicate Resident #D was to receive pain medication 30 minutes prior to wound dressing changes. She stated "She has wounds which are painfulul when we change dressings." During an interview on 6/10/14 at 3:50 P.M. with the D.O.N. and Nurse Consultant, both indicated the above order was not a valid physician's order in that it did not specify medication, specific time, or route of administration. They also indicated they had reviewed Resident #D's medication and treatment records for the period of 5/30/14 through 6/10/14 and could not determine if Resident #D had pain medication administered 30 minutes prior to wound treatment. 6/10/14 "Morphine Sulfate (Concentrate) Solution 20 MG/ML (milligrams per			

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	milliliter) Give 0.25 ml sublingually (under the tongue) every 6 hours related to pressure ulcer..." 6/10/14 "(Brand name of medication) Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet via G-Tube (gastrostomy tube) every 4 hours as needed for pain." Resident #D's medication orders did not contain any PRN (as needed) pain medication orders from admission on 4/29/14 through 6/10/14. A "Pain Monitoring Tool (PAINAD)" assessment, the facility's pain assessment tool for non-verbal residents, was completed 6/10/14 and indicated Resident #D had a pain rating of 6, indicating moderate pain. Resident #D's record contained no "Pain Monitoring Tool (PAINAD)" pain assessment prior to that date. During an interview with the D.O.N. on 6/12/14 at 10:30 a.m. she indicated no "Pain Monitoring Tool (PAINAD)" assessment had been completed for Resident #D prior to 6/10/14, as indicated by facility policy. A "Pain Evaluation" policy dated 3/2012 received from the D.O.N. on 6/11/14 at 9:25 A.M. indicated:			

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	"Purpose: 1. To establish guidelines to measure a resident's level of pain. 2. To provide optimal comfort through a pain control plan, which is established with the members of the health care team. Policy: 1. Residents will have a pain evaluation completed on admission, quarterly, and with significant change in pain status. 2. A resident with cognitive impairment that is unable to verbalize pain will have the PAINAD completed..." This federal tag relates to Complaint IN00150445. 3.1-37(a)			
F000314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview the facility failed to ensure a resident who was without pressure sores did not develop pressure sores, as evidenced by a	F000314	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute	07/12/2014

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	resident who developed who developed stage lll and stage lV pressure sores. 1 resident (Resident #C) of 3 reviewed for pressure sores in a population of 4. Findings include: The record of Resident #C was reviewed on 6/09/14 at 2:00 P.M. Diagnoses included, but were not limited to, senile dementia, hemiplegia (paralysis of one side of the body) due to cerebrovascular disease, hypertension, diabetes mellitus, and chronic kidney disease. A quarterly Minimum Data Set (M.D.S.) assessment dated 3/25/14 indicated Resident #C was cognitively impaired (difficulty thinking or communicating), did not ambulate, was incontinent of bowel and bladder, and required extensive to total assistance with activities of daily living. "Weekly Skin Observation" assessment documentation records for Resident #C contained categories for documenting Skin Tears, Open Areas, Bruises, Surgical Wounds, Dry Cracked Lips, Rashes, Burns, and Dry Mucous Membranes. These assessments indicated the following: 4/29/14 All categories marked "No."		admission of 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 by the provisions of State and Federal Law.1. Resident C had complete body skin assessment on readmission to facility which identified all skin issues.2. Full in house skin sweep completed and any findings were addressed per policy.Completed audit on weekly skin assessments to identify any missing or late completion.3. All nursing staff will be inserviced on proper procedure for doing weekly skin assessments and documenting accurately.Wound nurse/designee is to validate 2 weekly licensed nurse skin assessments; and 3 CNA weekly skin checks per week. Discrepancies in findings will be addressed with licensed nurse/CNA via progressive discipline which could be up to and including termination.LPN #1 has been terminated.4. DON/designee will audit weekly x 4, monthly x 2, then quarterly x 1 for a total of 6 months as part of Quality Assurance.5. Date of compliance: July 12, 2014	

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	5/06/14 "Open Areas" marked "Yes" with the note "Ammonium Lactate 12% lotion apply to bilateral lower extremities topically two times a day for dry skin." All other categories marked "No." 5/13/14 "Open Areas" marked "Yes" with the note "Resident has redden (sic) area to scrotum." All other categories marked "No." 5/23/14 All categories marked "No." 5/27/14 Categories "Skin Tear" and "Dry Mucous Membranes" marked "Yes" with no accompanying narrative notes. All other categories marked "No." 5/30/14 Categories for "Skin Tears" and Surgical Wounds" not marked as assessed. All other categories marked "No." An interview with C.N.A. #2 conducted by the D.O.N. on 6/10/14 related to L.P.N. #1's assessment of Resident #C's skin indicated: "Employee (C.N.A. #2) stated she gave resident (Resident #C) a shower on 5/30/14 and notified nurse to come do a skin assessment. She stated she lifted the resident, and the nurse felt over his			

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	bottom, and viewed all other areas of skin..." During an interview on 6/09/14 at 3:15 P.M. with the Administrator, Nurse Consultant, and Resident #C's assigned nurse present, the Director of Nursing (D.O.N.) reviewed Resident #C's clinical record in it's entirety and indicated that prior to the identification of Stage lll and Stage lV pressure sores on 5/31/14, Resident #C's record contained no documentation of any open areas. During an interview on 6/11/14 at 4:15 P.M. with the Administrator, Nurse Consultant, and Corporate Director of Nursing present, the Director of Nursing (D.O.N.) indicated that all recent skin assessments for Resident #C had been completed by the same nurse, L.P.N. #1. The D.O.N. indicated that L.P.N. #1 had been educated and trained in facility policies and procedures related to skin assessment and documentation. She indicated L.P.N. #1 had not followed facility guidelines in assessing and documenting Resident #C's skin condition as noted in the "Weely Skin Observation" above, and that these assessments did not accurately reflect Resident #C's skin condition. The D.O.N. also indicated that the assessment described in C.N.A. #2's statement above			

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	did not reflect an appropriate assessment based on facility policy and procedure. Progress Notes for Resident #C indicated: 2/17/14 4:00 P.M. "Writer assessed bilateral lower extremities and skin integrity noted clean/dry and intact." 2/18/14 3:48 P.M. "Writer assessed resident scrotum and bilateral buttocks, no open areas noted. Skin integrity noted clean, dry and intact..." 3/21/14 1:30 P.M. "Dietary note...No wounds or edema noted per skin assessment dated 3/18/14..." 4/09/14 2:25 P.M. "...no redness or open areas noted at this time..." 5/31/14 9:11 P.M. "...open areas to the right and left buttock folds with necrotic tissue. (Name of Medical Director) notified, order received for daily wound treatment with (brand name for an enzymatic debridding agent)..." An "Initial Pressure Ulcer Report" for Resident #C dated 5/31/14 at 11:19 P.M. indicated: "Date first Observed: 05/31/2014			

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	Was pressure ulcer present on admission? No. Document location, type, size and stage of pressure ulcer... Site: Left ischium (the lower part of the hip bone); Type: Pressure; Length: 4.5; Width 5.0; Depth: 0.2; Stage: lll (measurements in centimeters.) Right ischium; Type: Pressure; Length: 5.0; Width 3.0; Depth: 1.5; Stage: lV (measurements in centimeters.)" A health care plan for Resident #C dated as initiated 3/07/14 indicated "Focus: Potential for Pressure Ulcers related to history of ulcer(s), immobility." During an interview with the D.O.N. on 6/10/14 at 3:50 P.M., she indicated after Resident #C's pressure sores were identified on 5/31/14, a Low Air Loss pressure relieving mattress was ordered for Resident #C. Prior to that Resident #C had been on the facility's standard foam "pressure relieving" mattress. The D.O.N. also indicated that prior to 5/31/14 Resident #C had not received any prophylactic (preventative) treatment to			

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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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	prevent skin breakdown, including but not limited to, the application of barrier cream to the perineal and or buttocks area. A facility document titled "Wound Prevention Protocol" dated 4/2012 received from the D.O.N. on 6/11/14 at 9:25 A.M. indicated: "Purpose: Identify residents that are high risk for developing pressure areas...Relieve or remove pressure. To prevent tissue trauma... Policy: All skin surfaces should be exposed for a thorough examination by a licensed nurse...skin inspection should be done as a component of routine care...Resident specific interventions will be care planned...Weekly skin observations will be recorded in the resident's medical record...Inspect the entire body for any areas with redness or open areas..." This federal tag relates to Complaint IN00150431. 3.1-40(a)(1)			
F000514 SS=D	483.75(l)(1) RES			

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	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, the facility failed to ensure medical records were complete and accurate by not ensuring a physician's order was complete and accurate, and by not ensuring a resident's medication and treatment records accurately recorded medication administration and treatment times. 1 resident (Resident #D) of 3 reviewed for medical records in a sample of 4. Findings include: The record of Resident #D was reviewed on 6/10/14 at 1:00 P.M. Diagnoses included, but were not limited to, unstageable pressure ulcers at admission, dementia, cognitive communication deficit (difficulty thinking or communicating), dysphagia Difficulty swallowing), anemia, hypertension, and	F000514	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 of 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 by the provisions of State and Federal Law.1. Resident D had clarification of order in regards to pain management and timeliness of administration.2. All resident current orders reviewed for accuracy and completeness of physician order.Clarification of any resident's medication and treatment orders that did not accurately monitor medication administration and treatment times.3. Licensed nurses will be inserviced on accurately completing a physician order and entering into the medical	07/12/2014

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	contractures of the lower extremities. A significant change Minimum Data Set assessment dated 5/23/14 indicated Resident #D was severely cognitively impaired (severe difficulty thinking or communicating), did not ambulate, required extensive to total assist with all activities of daily living, required extensive assist of 2 staff for bed mobility, and was incontinent of bowel and bladder. Resident #D's medication administration record for May 2014 contained a physician's order dated 5/30/14 which indicated "Medicate resident at least 30 minutes prior to wound care." This order contained no additional instructions. During an interview 6/10/14 at 1:30 P.M. L.P.N. #3, Resident #D's assigned nurse, indicated she believed this order was intended to indicate Resident #D was to receive pain medication 30 minutes prior to wound dressing changes. She stated "She has wounds which are painful when we change dressings." During an interview on 6/10/14 at 3:50 P.M. with the Director of Nursing (D.O.N.) and Nurse Consultant, both indicated the above order was not a valid physician's order in that it did not specify		record.All new physician orders will be reviewed in next clinical meeting and clarification requested from MD as needed.4. DON will audit in clinical meeting daily and results of these audits will be reviewed monthly x 6 as part of Quality assurance.5. Date of complaince: July 12, 2014.	

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	medication, specific time, or route of administration. They also indicated they had reviewed Resident #D's medication and treatment records for the period of 5/30/14 through 6/10/14 and could not determine if Resident #D had pain medication administered 30 minutes prior to wound treatment. During an interview on 6/12/14 at 9:30 A.M. the D.O.N. indicated she had no additional information related to Resident #D's medical records. A facility policy titled "Administrative Physician's Orders" dated 1/2012 received from the D.O.N. on 6/11/14 at 9:25 A.M. indicated: "Purpose: To provide general guidelines when receiving, transcribing, notification, and care planning physician's orders. Performed by: Licensed Nursing. 1. When receiving physician's orders by telephone: a. Enter the order into the resident's chart under "phys order" tab and according to the instructions for the type of order that is received. Be sure to include a diagnosis or indication for the medication/treatment ordered.. If a diagnosis is not already in the resident's clinical record, ask the			

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	physician for a diagnosis. Include: 1. Route. 2. Dose. 3. Times. 4. If a treatment, be sure to put in the directions the specific area(s) to be treated." This federal tag relates to Complaint IN00150445. 3.1-50(a)(1) 3.1-50(a)(2)			