

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
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NAME OF PROVIDER OR SUPPLIER HOOVERWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, 21, 22 and 25, 2014.</p> <p>Facility number: 000001 Provider number: 155001 AIM number: 100275310</p> <p>Survey team: Gloria Bond, R.N.-- Team Coordinator Tammy Alley, R.N. Janet Stanton, R.N. Michelle Hosteter, R.N. Sandra Nolder, R.N. (8/18, 8/22 and 8/25/2014)</p> <p>Census bed type: SNF/NF--158 Total--158</p> <p>Census payor type: Medicare--14 Medicaid--110 Other--34 Total--158</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by</p>	F000000		
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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.

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F000157 SS=D	<p>Tammy Alley RN on August 28, 2014.</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> <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 record review and interview, the facility failed to ensure the physician was notified of hypoglycemic episodes</p>	F000157	<p>F157</p> <p>1.Asa result of this deficient practice, two facility-wide quality</p>	09/19/2014
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	<p>and weight changes for 1 of 3 residents reviewed for physician notification. (Resident # 14)</p> <p>Findings include:</p> <p>a. The record for Resident # 14 was reviewed on 8/21/14 at 9:04 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, and hypertension.</p> <p>Physician orders for May 2014 indicated orders for Accuchecks twice daily at 6 a.m., and 6 p.m.</p> <p>The Accucheck record for May 2014 indicated blood glucose levels of: 5/11/14: 6 a.m., 25, 34, 63, 58, the physician was notified and treatment was given. 5/13/14: 6 a.m., 47, with a recheck of 127 5/16/14: 6 a.m., no results 5/17/14: 6 a.m., no results</p> <p>During an interview on 8/21/14 at 11:05 a.m., with Unit Manager RN # 13, she indicated blood glucose levels below 70 should be notified to the physician.</p> <p>During an interview on 8/22/14 at 1:46 p.m., with ADON # 14, she indicated the physician was not notified of the 5/13/14 low blood glucose. She also indicated</p>		<p>improvement initiatives have and continue to be implemented. These initiatives include a new policy & procedure for the care of Hypoglycemia and Hyperglycemia and a new policy and procedure for the monitoring of resident weights. (see attachment 1,2)</p> <p>2. In order to identify any other residents having the potential of being affected by these same deficient practices, the Unit Managers completed an audit of all residents who have physician orders for notification of abnormal CBG results. In addition, the Dietitian has reviewed all residents with orders for daily or weekly weights in preparation for the implementation of the new weight monitoring standard.</p> <p>3. The new policies for Hypoglycemia and Hyperglycemia clearly defines licensed nurse responsibilities for CBG testing, assessment, interventions, and physician & family notification. New forms and protocols have been developed, inserviced, and implemented. (see attachment 3)</p> <p>The new Weight Program policy includes new documentation forms that will assist the nursing staff and Dietitian in tracking the weights, interventions and physician and responsible party</p>				

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	<p>the blood glucose was 63 on 5/16/14 at 6 a.m., and the physician was not notified. She indicated it was the facility expectation the physician would be notified of the blood glucose levels or 47 and 63.</p> <p>During an interview with the Administrator and ADON # 14, on 8/22/14 at 2:40 p.m., the Administrator indicated during a mock survey it had been identified that diabetic care was a concern and the facility was in the process of inservicing a new policy with dates scheduled for 9/2-9/10/14. ADON #14 indicated Resident # 14 had not been previously identified as a concern and there had not been a facility wide audit of diabetic records for compliance.</p> <p>A policy titled "Care of a Person with Diabetes Mellitus" dated 3/01 was provided by the DON on 8/25/14 at 2 p.m., and deemed as current. The policy indicated: "...all abnormal...finger stick blood sugars will be reported to the physician and recorded in the patient record..."</p> <p>b. The resident was admitted on 4/7/14 with orders for a daily weight (wt) and to notify the physician on a wt change of 4 pounds from baseline.</p>		<p>notification. (see attachment 4). In an effort to increase the consistency and accuracy of monthly weights, specific personnel have been designated to complete and document all of the monthly weights in the facility.</p> <p>4. The Unit Managers will be responsible for monitoring the CBG tracking forms on a daily basis and will also be responsible for completing monthly audits. The Unit Managers and the Dietitian will be responsible for monitoring the weight documentation and notifications daily and the Dietitian will complete monthly audits. Any deficient practices identified in the daily or monthly reviews of documentation will be addressed immediately through disciplinary action, policy development and/or mandated inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI / QAPI Committee.</p> <p>1. Date of Completion: 9/19/2014</p>		

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F000241 SS=D	<p>The Treatment Administration Record (TAR) for the month of April 2014 indicated a wt of 120 on 4/9/14 and a wt of 112 on 4/10/14. On 4/28/14 wt was 123 and on 4/29/14 it was 112.</p> <p>There was no documentation the physician was notified of the wt change.</p> <p>During an interview with the Unit Manager RN # 1 on 8/22/14 at 1:46 p.m., she indicated the physician was not notified of the 4 pound wt change.</p> <p>3.1-5(a)(2)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to maintain the dignity of residents in 2 of 5 units in the facility. (Residents #196, #170 and #139).</p> <p>Findings include:</p> <p>1. The record review for Resident #196</p>	F000241	<p>F241</p> <p>1. As a result of this deficient practice, a facility-wide, mandatory inservice on the topic of "Resident Dignity" will be presented by the Social Service Department. (see attachment 5) Due to ongoing monitoring of Residents #196, #170, and #139, it is not believed</p>	09/19/2014

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	<p>was completed at 11:00 A.M. on 8/25/14. Diagnoses included, but were not limited to, dementia with behavior disturbances, cardiovascular disease, and hypothyroidism.</p> <p>During an observation on 8/21/14 at 2:15 p.m., Resident #196 was walking down the hallway, sat down on couch and pulled down her pants and laid the pants on the floor next to the couch. Resident #18 was walking down hallway by couch, saw her disrobing, and became upset and was yelling and told her to put her pants up. Resident #196 went into her room with just her brief on. At 2:25 p.m., Resident #196 came out and sat on the recliner and started to take off her disposable underwear and pulled them down to her ankles.</p> <p>The Behavior Committee documentation indicated, "...4/7/14...Removing her clothing and was even in one of the males room naked...4/10/14 and 4/12/14-disrobing in the hallway...Possible modifications to current behavior treatment: chalk and chalkboard to write on (used to be a teacher) work papers (family to bring in) ...5/4/14- wandering and removing clothes at 3:20 p.m. and 9:20 p.m....5/17/14-removing clothes in hallway...possible modifications to</p>		<p>that these residents were affected or are exhibiting any ill effectsas a result of this this deficient practice. The employees responsible for these deficient practices were counseledand received disciplinary documentation. (seeattachment 6)</p> <p>2. Asa result our facility-wide, mandatory inservice that will include a review ofthese cited observations, role-playing, etc., as well as ongoing monitoring ofemployee performance and conduct, it is believed that the potential for otherresidents to be affected by this same deficient practice will be minimized. In addition, the Environmental ServiceDepartment conducted a separate departmental inservice on the topics ofcommunication, dignity, and customer services. (see attachment 7)</p> <p>3. Ongoinginservice education and the monitoring of employee conduct / performance ofeffective communication, proper feeding procedures, and the care of dementiareidents will continue to take place to assure that this same deficientpractice does not recur. Specificallyrelating to proper feeding procedures, the Infection Prevention Nurse andWeekend Administrators who already monitor infection control / hand washingduring meals, will also be assuring that employees</p>				

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	<p>current behavior treatment: bring resident to room to dress...6/6/14- found sitting in dining room with no clothes on...possible modifications to current behavior treatment: redirect resident and remove from situation...."</p> <p>The nurses notes indicated, "...5/24/14...12 p.m. was found naked sleeping in other resident recliner chair while male resident was fully clothed sleeping in bed snoring...3 p.m. found in another male residents room sitting on his bed naked from waist down with her brief put on her arms as if it were a shirt. The male resident looked at writer and said 'nothing happened' male was holding onto his wheelchair on side of the bed the nurse and CNA placed male resident in wheelchair and into the hallway and CNA redressed Resident #196 and walked her out of the room."</p> <p>There was no documentation indicating staff attempting to maintain the resident's dignity in response to her disrobing behaviors.</p> <p>2. On 8/25/14 at 10:43 A.M., Housekeeper #10 was observed to come into one of the "pod" lounge/dining room areas on the Alzheimer's/secured unit, with a broom and dust pan. Without saying anything to Resident #170, she pulled his wheelchair backwards about 3</p>		<p>do not stand while feeding residents. This compliance standard has been added to the "Meal Service QI Checklist" which is completed several days a week while monitoring infection prevention observations during meal times. (see attachment 8)</p> <p>4. Department Heads, Unit Managers, Nursing Supervisors, the Infection Prevention Nurse, and Weekend Administrators will be responsible for monitoring these deficient practices. Any deficient practices identified will be addressed immediately through disciplinary action, policy development and or mandated inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI /QAPI Committee.</p> <p>5. Date of Completion: 9/19/2014</p>				

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	<p>feet, away from the table where he was sitting. The resident asked her "Are you going to take me back to my room?" The Housekeeper did not look at the resident or respond to him. As she was sweeping up some food crumbs from the floor, the resident said "That works pretty good, doesn't it?" Again, the Housekeeper did not respond to him at all. After finishing, the Housekeeper left the area.</p> <p>The clinical record for Resident #170 was reviewed on 8/25/14 at 10:42 A.M. Diagnoses included, but were not limited to, lower back pain, and senile dementia--Alzheimer's type without behavioral disturbance.</p> <p>3. On 8/21/2014 at 1:00 P.M., Resident #139's record was reviewed. Diagnoses included but were not limited to, diabetes, high blood pressure, depression, anxiety, dementia, and neuropathy (pain caused by an abnormality anywhere in a nerve pathway).</p> <p>During an observation on 8/21/2014 at 1:05 P.M., the resident was observed with no socks on her feet. The resident's daughter was observed inquiring about the lack of socks.</p> <p>During a dining observation on 8/21/2014 at 5:31 P.M., QMA (Qualified Medication Aide) #8 was observed</p>			

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F000248 SS=D	<p>standing up and feeding the resident. At the same time QMA #8 was observed talking to an unidentified staff person who was in the area across the room.</p> <p>During a dining observation on 8/22/2014 at 9:20 A.M., CNA #9 was observed standing up and feeding Resident #139.</p> <p>During an interview on 8/22/2014 at 9:38 A.M., the Unit Manager #15 indicated staff was to sit down when feeding a resident because that was a dignity issue.</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review the facility failed to provide activities for residents with dementia for 2 of 2 residents reviewed on the dementia unit for activity participation. (Residents #18 and #185)</p> <p>Findings include:</p>	F000248	F248 1. As a result of these deficient practices, the Activity Director addressed these concerns in an inservice with the entire Activity Department and developed a Performance Improvement Plan. (see attachment 9) The activity assistant responsible for these deficient practices has been counseled and has received	09/19/2014			

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	<p>1. The record review for Resident #18 was completed at 11:15 a.m., on 8/21/14. Diagnoses included, but were not limited to, dementia, depression and high blood pressure.</p> <p>During continuous observations on 8/20, 8/21 and 8/22/14 from 9-11 a.m., and 8/20 and 8/22/14 from 1-3 p.m., Resident #18 had not participated in any activities.</p> <p>There was a craft activity going on on 8/22/14 at 3:00 P.M., and the resident was observed sitting in her recliner at that time.</p> <p>The activity documentation for Resident #18 indicated, "...8/5/14 resident had engaged in 1:1 activities of bird visit and fish visits. There was no 1:1 (one on one) documentation found for the month of June, July or August.</p> <p>The activity calendar documentation for Resident #18 indicated refusal of activities on 8/20 in morning, 8/21 refused in morning and nothing documented in the afternoon. On 8/22, indicated the resident sat in the morning with Betty Boop doll and refused afternoon activities.</p> <p>2. On 8/22/14 at 2:30 P.M., the record</p>		<p>disciplinarydocumentation. (see attachment 10) Resident#185 has transferred to the 2B resident unit. This transfer was already being considered during the annualsurvey. The resident's overall conditionand needs will be more appropriately met on a different resident unit. TheSeptember activity calendar for the C-wing has been updated in accordance withthe Performance Improvement Plan. (seeattachment 11) The revised calendaremphasizes additional daily activities, smaller group activities, and a varietyof 1:1 resident activities and interventions. Thecare plan for Residents #18 and #195 have been reviewed and updated by theActivity Director to assure that it appropriately meets the resident'sinterests. (see attachment 12) Additional 1:1 activities will be implementedfor this resident as she often refuses small or larger group activities on theunit.</p> <p>1.Asa result of this plan of correction and Quality Improvement Plan, the potentialfor other residents to be affected by this same deficient practice will be minimized.</p> <p>2.TheActivity Director will be closely monitoring the C wing activities, theperformance of the assigned Activity Assistant, the duration of 1:1 activities,and the</p>		

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	<p>review for Resident # 185 was completed. Diagnoses included, but were not limited to, dementia, high blood pressure and heart disease.</p> <p>During an observation at 9:15 a.m., on 8/21/14, Resident #185 was sitting in front of the television with CNN news on during the time frame of 9:15 a.m., through 11 a.m. There was a sing along activity in the Activity Room of the dementia unit at 10:15 a.m., that Resident #185 was not offered to attend.</p> <p>During an observation at 1:00 p.m., on 8/21/14, Resident #185 was sitting in front of the television with a soap opera "Days of Our Lives" playing on the television.</p> <p>At 1:35 p.m., an Activity Assistant turned the channel to the Movie Channel. The Activity Calendar indicated at 2:15 p.m., there was a birthday party activity going on in the main dining room. The resident was not taken to that activity. Resident #185 was observed at 2:30 p.m., sitting in her wheelchair in front of television with the movie channel on. The resident was picking at her pants and not looking at the television.</p> <p>The activity documentation indicated on 8/20/14, the resident refused the activity</p>		<p>necessary documentation of the attendance, care plans, and progressnotes. All monthly calendars for theentire facility will be submitted to the Activity Director for review andapproval prior to posting. The ActivityDirector will conduct weekly observations as well as monthly documentationaudits to assure ongoing compliance.</p> <p>3. Anydeficient practices identified by the Activity Director will be addressedimmediately through disciplinary action, policy development and / or mandatedinservice education. Any trends ofdeficient practice will be reported to the Quality Improvement / QAPI Committeeon a monthly basis. This monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee.</p> <p>4. Dateof Completion: 9/19/2014</p>		

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	<p>of a movie in the morning, and had a hand massage in the afternoon. 8/21/14 was documented as refusal for activities in the morning of Catholic mass and in the afternoon indicated she attended the Birthday Party.</p> <p>During an observation on 8/22/14 at 9:45 A.M., Activity Assistant #11 came and asked LPN#7 who could go to the Bingo activity. Resident #185 was taken by Activity Assistant #11 to Bingo. In an observation at 11:04 A.M., the resident was observed with her head down, and the Bingo card she had was empty with no chips on it. There were no staff observed sitting and helping at the table. The other residents at that table, as well as several other tables, had several red chips on their bingo card.</p> <p>The Activity book for Resident #185 indicated the resident had a hand massage and bird visit on 7/7/14 and had a fish visit on 8/8/14.</p> <p>The activity calendar for August for the dementia unit indicated : Two scheduled activities on all days except : 8/3, 8/4, 8/5, 8/20, and 8/28.</p> <p>The one on one documentation for June 2014 indicated the length of a one on one (1:1) visits varied from 3-5 minutes on 4</p>			

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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	
	<p>visits and 10 minutes on another visit. The July 2014 documentation indicated an average from 2-5 minutes on 19 visits out of 21 visits.</p> <p>During an interview on 8/25/14 at 1:45 P.M., the Activities Director (AD) indicated she would ask the residents with dementia if they wanted to go to an activity. The resident could say no or they would take them by the hand and take them to the activity . She indicated if a resident did not want to stay at an activity, the staff would document this as a refusal. The AD indicated she had been aware that the 1:1 activities were short in duration for June and July and that she had talked this over with Activity Aide #11, the duration should be at least 10-15 minutes. The AD indicated the CNA's are in charge to provide music or movie or other activities if the resident's do not want to participate in the activities for large groups. The Unit Manager for C wing is the one in charge of overseeing the CNA and their performance of these activities. The AD indicated these would not be documented on the activity calendar.</p> <p>3.1-33(a)(1)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow the physician's order for blood pressures and weights for 2 out of 40 residents reviewed for physician orders. (Residents #70 and #14).</p> <p>Findings include:</p> <p>1. On 8/20/2014 at 3:48 P.M., Resident #70's record was reviewed. Diagnoses included, but was not limited to, shortness of breath, congestive heart failure, coronary artery disease, peripheral edema (swelling) and chronic renal (kidney)insufficiency.</p> <p>The August physician's order recapulation indicated, but was not limited to, the medication, "carvedilol tab 3.125 mg [milligram] [anti high blood pressure medication] 1 tablet by mouth twice daily (hold for SBP [systolic blood pressure] < 100)...."</p> <p>The August MAR (Medication Administration Record) lacked blood pressure recordings before the morning</p>	F000282	<p>F282</p> <p>1.Asa result of the staff's failure to obtain blood pressure recordings forresident #70 prior to receiving blood pressure medication, the involved nursingstaff has been counseled on this deficient practice. In addition, this deficient practice alongwith all the deficient practices from the survey, will be reviewed with allnursing personnel at staff meetings on 9/5, 9/6 & 9/10/14.</p> <p>(seeattachment 13)</p> <p>Asa result of the staff's failure to notify the physician of Resident #14'sweight changes, a new Weight Program policy has been implemented. This policy includes new documentation formsthat will assist the nursing staff and Dietitian in tracking the weights,interventions and physician and responsible party notification. (see attachment 2,4) TheDietitian and Unit Managers will be responsible for monitoring this trackingsystem daily to assure physician notification has taken place.</p> <p>1.Dueto these two quality improvements, the potential for other residents to beaffected by this same deficient practice will</p>	09/19/2014

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	<p>medication dose on August 5, 6, 7 and 8 as ordered by the physician. No blood pressure recordings were recorded before the evening medication dose on August 2, 5, 8 and 11 as ordered by the physician.</p> <p>During an interview on 8/22/2014 at 11:30 A.M., the Unit Manager #12 indicated she was unable to find any other documentation on the missing blood pressure readings.</p>		<p>be minimized. Nevertheless, the Unit Managers completed an audit of physician orders requiring blood pressure documentation prior to medication in order to determine the overall level of compliance for this deficient practice.</p> <p>2. On a monthly basis, the Unit Managers will be responsible for auditing blood pressure recordings for medications on their unit and a new audit form has been developed and implemented. (see attachment 14) The Unit Managers and the Dietitian will be responsible for daily monitoring of weight documentation and physician notifications and the Dietitian will complete monthly audits.</p> <p>3. Any deficient practices identified in the daily or monthly reviews of documentation will be addressed immediately through disciplinary action, policy development and or mandated in-service education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless otherwise determined by the QI / QAPI Committee.</p> <p>4. Date of Completion: 9/19/2014</p>		

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F000309 SS=D	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to respond to behaviors in a timely and appropriate manner for 3 out of 3 residents reviewed for behaviors on the dementia unit. (Residents #18, #196 and #170).</p> <p>Findings include:</p> <p>1. The record review for Resident #18 was completed at 11:15 A.M. on 8/21/14. Diagnoses included, but were not limited to, dementia, depression and high blood pressure.</p> <p>During an observation at 12:05 P.M., on 8/18/14, Resident # 18 screamed at Resident #196 as the resident sat on the green chair and was putting her shoes on and off. No staff came to intervene when Resident #18 screamed at Resident # 196. Staff were walking by and Resident #18 was yelling at Resident #196 to get up off the couch, CNA #5 told Resident #18 she wasn't being very</p>	F000309	<p>F309 1.TheSocial Service Department will be completing mandatory, facility-wide inservicethat will include the topics of "Resident Dignity" and "Responding to ResidentBehaviors." (see attachment 5) Thesespecific deficient practices will be reviewed and role playing scenarios willoccur. In addition, the BehaviorIncident Report form and the Behavior Monitoring form (see attachment 15) that are already being utilized effectively andinclude recommended interventions for behaviors, will be reviewed during thisinservice. RegardingResident #196, Social Services has requested resident's family to purchaseother clothing options for the resident to wear which may reduce the resident'stendency to disrobe. Residents #18 and#196 will be reviewed at the next Behavior Committee in order to determine anyadditional interventions that may reduce their behaviors.</p> <p>1.Hooverwood'sBehavior Committee which meets monthly</p>	09/19/2014			

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	<p>nice, nothing else was done to redirect Resident #18.</p> <p>On 8/21/14 at 1:00 p.m., LPN #7 indicated the resident tends to escalate about this time of day every day, she indicated it gets worse as the afternoon goes on.</p> <p>During an observation at 1:30 p.m. on 8/21/14, Resident #18 was starting to sing and yell more loudly as people walked by. The resident no longer had her Betty Boop doll. She was sitting on the couch as staff and residents were observed going by. As Resident #196 walked by she waved her hand at her and looked at her with an angry face. The staff were walking back and forth in front of Resident # 18 as she was yelling loudly, but they did not attempt to redirect or calm the resident.</p> <p>During an observation on 8/21/14 at 2:15 p.m., Resident #196 was walking around the hallway and pulled down her pants and Resident #18 became upset and was yelling and told her to put her pants up. At 2:30 p.m., Resident #18 talked to Resident #111 in a negative tone. Resident # 111 called her stupid and put out his hand to shake hands and Resident # 18 shook his hand, shaking it rapidly up and down. There were no staff in the</p>		<p>and includes a Geriatric Psychiatrist, will continue to review all resident's behavior and strive to identify non-pharmacologic interventions in order to reduce the potential of other residents being affected by this same deficient practice.</p> <p>2. Social Services, Nursing Administration, Nursing Supervisors, Unit Managers and Weekend Administrators will monitor resident behaviors on a daily basis to assure that staff intervention is timely and effective.</p> <p>3. Any deficient practices identified in the daily observations will be addressed immediately through disciplinary action, policy development and or mandated inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI / QAPI Committee.</p> <p>4. Date of Completion: 9/19/2014</p>		

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	<p>area to intervene.</p> <p>During an observation at 11:45 A.M., on 8/22/14, Resident #18 was walking down the hallway crying. She continued to walk up and down hallway with her walker until lunch time. There were several staff observed walking past Resident #18 as she was crying, but the staff did not attempt to assist the resident or address her in any way.</p> <p>Behavior monitoring documentation from March through August 2014, indicated some of the behaviors of Resident #18 were: yelling, refusal of care, hitting, crying, grabbing others/ADL (activities of daily living) care/sleeping. The interventions were as follows : #1-offer reassurance, #2-listen to soothing music, #3-re-approach at a later time, #4- go for a walk, break tasks into steps, #5- non verbal reassurance #6- read to resident #7- remove from situation #8- take to activity #9- call family #10- fold laundry. There was a column in which staff check whether interventions were effective or not effective.</p> <p>There was no documentation found to establish a root cause for the resident's behaviors of yelling at other resident's and refusals of care.</p>						

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	<p>2. The record review for Resident #196 was completed at 11:00 A.M., on 8/25/14. Diagnoses included, but were not limited to, dementia with behavior disturbances, cardiovascular disease , and hypothyroidism.</p> <p>During an observation on 8/21/14 at 2:15 p.m., Resident #196 was walking down the hallway and sat down in the recliner and pulled down her pants and laid the pants on the floor by the couch. Resident #18 who was walking by the couch and recliner area became upset and was yelling and told her to put her pants up. Resident #196 went into her room with just her disposable underwear on. At 2:25 p.m., Resident #196 came out and sat on recliner and started to take off her brief and had them down to her ankles.</p> <p>The Behavior Committee documentation indicated, "...4/7/14...Removing her clothing and was even in one of the males room naked...4/10/14 and 4/12/14-disrobing in the hallway...Possible modifications to current behavior treatment: chalk and chalkboard to write on (used to be a teacher) work papers (family to bring in) ...5/4/14- wandering and removing clothes at 3:20 p.m. and 9:20 p.m....5/17/14-removing clothes in hallway...possible modifications to</p>						

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	<p>current behavior treatment: bring resident to room to dress...6/6/14- found sitting in dining room with no clothes on...possible modifications to current behavior treatment: redirect resident and remove from situation...."</p> <p>The nurses notes indicated, "...5/24/14...12 p.m. was found naked sleeping in other resident recliner chair while male resident was fully clothed sleeping in bed snoring...3 p.m. found in another male residents room sitting on his bed naked from waist down with her brief put on her arms as if it were a shirt. The male resident looked at writer and said ' nothing happened' male was holding onto his wheelchair on side of the bed the nurse and CNA placed male resident in wheelchair and into the hallway and CNA redressed Resident #196 and walked her out of the room" The behavior documentation from the incident indicated, "...resident lying flat on her back with no pants or brief was actually over her arms like it was a shirt. Male resident was sitting on the edge of the bed screaming help...."</p> <p>The behavior incident reports dated May through August 2014 had no documented attempts to implement the possible modifications to behavior treatment mentioned in Behavior Committee</p>			

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F000329 SS=D	<p>documentation from April through June 2014.</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 observation, interview and record review, the facility failed to ensure blood pressures were taken as ordered for one resident on blood pressure medication with blood pressure parameters and failed to ensure specific behaviors were identified and quantitatively monitored to support the use of a psychotropic medication on a resident with the diagnosis of dementia.</p>	F000329	<p>F329</p> <p>1. As a result of the staff's failure to obtain blood pressure recordings for resident #70 prior to receiving blood pressure medication, the involved nursing staff has been counseled on this deficient practice. In addition, this deficient practice along with all the deficient practices from the survey, will be reviewed with all nursing personnel at staff meetings on</p>	09/19/2014

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	<p>This affected 2 of 5 residents reviewed for Unnecessary Medications. (Resident #70 and #196).</p> <p>Findings include:</p> <p>1. On 8/20/2014 at 3:48 P.M., Resident #70's record was reviewed. Diagnoses included, but was not limited to, shortness of breath, congestive heart failure, coronary artery disease, peripheral edema (swelling) and chronic renal (kidney) insufficiency.</p> <p>The August physician's order recapitulation indicated, but was not limited to, the medication, "carvedilol tab 3.125 mg [milligram] [anti high blood pressure medication] 1 tablet by mouth twice daily (hold for SBP [systolic blood pressure] < 100)...."</p> <p>The August MAR (Medication Administration Record) lacked blood pressure recordings before the morning medication dose on August 5, 6, 7 and 8 as ordered by the physician. No blood pressure recordings were recorded before the evening medication dose on August 2, 5, 8 and 11 as ordered by the physician.</p> <p>During an interview on 8/22/2014 at 11:30 A.M., the Unit Manager indicated</p>		<p>9/5, 9/6 & 9/10/14. (see attachment 13) Regarding Resident #196, this deficient practice has been communicated to the Geriatric Psychiatrist and will be reviewed with Hooverwood's Behavior Committee. This deficient practice and documentation requirements for behaviors and interventions will be reviewed at the mandatory inservice conducted by the Social Service Department. (see attachment 5) 1. Nursing Administration completed an audit of physician orders requiring blood pressure recording prior to medication in order to determine the overall level of compliance for this deficient practice. In addition, Social Services will continue to audit the documentation of all residents taking antipsychotic medications to determine if necessary documentation is being completed. These quality improvement measures will minimize the potential of any other residents from being affected by this same deficient practice.</p> <p>2. On a monthly basis, the Unit Managers will be responsible for auditing blood pressure recordings for medications on their unit and will utilize a new tracking form that has been developed and implemented. (see attachment 14) The Social Service</p>		

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F000371 SS=E	<p>she was unable to find any other documentation on the missing blood pressure readings.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to maintain baking sheets and steam table pans in a dry and sanitary condition, and in a manner to prevent bacterial growth and cross contamination of food; in 1 of</p>	F000371	<p>Department, on a quarterly basis, will be responsible for assuring that all necessary behavior documentation is being completed for residents who are taking antipsychotic medications.</p> <p>3. Any deficient practices identified in the monthly or quarterly reviews of documentation will be addressed immediately through disciplinary action, policy development and or mandated inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure.</p> <p>4. Date of Completion: 9/19/2014</p> <p>F371 1. As a result of this deficient practice, all kitchen staff members who are responsible for pot and pan cleaning will be re-trained regarding this regulation. (see attachment</p>	09/19/2014

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	<p>1 main kitchens, and for 157 of 158 residents who received food from the kitchen.</p> <p>Findings include:</p> <p>The kitchen sanitation observation task was completed on 8/18/19 at 9:33 A.M., with the Director of Food Services in attendance.</p> <p>The following was observed in the "Pot and Pan" washing area: Multiple large flat baking sheets, and multiple steam table "well" pans were observed to be stacked upside down on racks in a cart next to the sink area. The baking sheets and well pans were nested together in an inverted position that did not allow air circulation between the inside of one pan or sheet, and the bottom on the one it was covering. The top three baking sheets and well pans in several stacks were checked. The interior surface of all were wet and dripping water. One baking sheet, which was second from the top in one stack, had some greasy food debris on the inside surface.</p> <p>During an interview at that time, the Director of Food Services indicated pots and pans were washed in this area, placed on the shelves above the sink until dry, and then stacked on this cart He</p>		<p>16) Additional drying racks will be utilized on both the meat and dairysides of the kitchen in order for these items to dry sufficiently before replacing them in the storage area. The employee responsible for this deficient practice is no longer employed at facility. There were no residents found to have been affected by this deficient practice.</p> <p>2. Due to these quality improvement measures, the potential for other residents to be affected by this same deficient practice will be minimized.</p> <p>3. A new operational procedure has been implemented as a result of this deficient practice. The evening porter will be responsible for organizing the pots and pans in the drying area to allow for the items to dry overnight. In the morning, the day porter will be responsible for storing these dried items in the clean storage cabinet.</p> <p>The kitchen supervisor will monitor ongoing compliance of this practice by checking the meat and dairy clean storage cabinets to assure that all service items are clean and dry. The supervisor will check these cabinets twice daily and document findings on a monitoring log. (see attachment 17)</p> <p>4. Any deficient practices identified in these daily</p>				

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	<p>indicated there was not a lot of shelf room to place the sheets and pans to dry. He indicated all of the baking sheets and pans on the cart were clean, but he did not know when they had been washed.</p> <p>Also during an interview at that time, Dietary Porter #1 indicated he had not washed them that day, that the pans had probably been washed the day before.</p> <p>During an interview on 8/19/14 at 12:40 P.M., the Administrator indicated he had discussed the wet pan issue with the Director of Food Services and Dietary Porter #1. Each had provided a signed statement related to the issue, which included, but was not limited to the following:</p> <p>Director of Food Services: "...I was concerned that [Dietary Porter #1] was nervous and did not provide ...accurate information... I determined that those sheet pans... that juices and grapefruits were stored on. THESE PANS NEVER CAME IN CONTACT WITH FOOD OR BEVERAGE ITEMS DURING BREAKFAST MEALS. These pans were placed on the shelf for air drying. Due to the large supply of sheet pans in the kitchen, these specific pans would not be utilized until approximately 2-3 meals later."</p>		<p>inspections will be addressed immediately through disciplinary action, policy development and or mandated inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI / QAPI Committee.</p> <p>5. Date of Completion: 9/19/2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
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NAME OF PROVIDER OR SUPPLIER HOOVERWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260
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	<p>Dietary Porter #1: "I did clean the pans immediately following the breakfast meal and put them on the shelf to let them air dry. These pans never came into contact with beverage or food items."</p> <p>The Administrator was accompanied into the kitchen, and joined by the Director of Food Services, to observe the storage cart with the sheets and pans. The cart was located in the "Pot & Pan" area, as identified by the Director of Food Services. The Director of Food Services again indicated the pans were washed and air dried on the shelves above the sinks, then stacked upside down, in an inverted position, on the storage cart until used. The Administrator indicated there had been too many pans stored on the cart, and many had been taken out of service. He indicated the pans would probably not be used for 2-3 days.</p> <p>On 8/18/14 at 11:07 A.M., the Director of Food Services provided an undated "Dietary Food Handling Policy," which included the following:</p> <p>"Procedure: ...23. All pots, pans, utensils and cutting boards are washed and sanitized after each use, following three compartment sink methods and air dried before storing...."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-21(i)(2)				