STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 00 B. WING	02/07/2017

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00211102. Complaint IN00211102- Substatiated. Federal/State deficiencies related to allegations are cited at F 328. Survey dates: February 3, 6 and 7, 2017 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census bed type: SNF/NF: 120 Total: 120 Census payor type: Medicare: 8 Medicaid: 83 Other: 29 Total: 120 Sample: 5 This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on Februaty 10, 2017.	F 0000		

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

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F 0328 SS=D Bldg. 00	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional			

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	standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. Based on observation, interview and record review, the facility failed to ensure a resident was monitored during a respiratory treatment for 1 of 1 resident reviewed for respiratory needs (Resident D) and failed to ensure a resident's oxygen concentration amount was set as ordered and the portable oxygen tank was full for 1 of 4 residents being reviewed for oxygen use (Resident B). Findings include: 1. On 2/6/17 from 4:40 p.m. to 4:46 p.m., Resident D was observed continuously	F 0328	F328 1. Per clinical review and analysis, Residents D and B were not found to have been effected by these deficient practices. Regarding Resident D and the deficient practice involving lack of supervision during the administration of the nebulizer treatment, RN #1 was counseled and received disciplinary action (see attachment #1). Regarding Resident B and the deficient practice involving medication administration, RN #2 and C.N.A. #3 were verbally counseled. Additionally, as a Quality Improvement Measure,	03/03/2017

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	without a staff member in the room with her. At 4:40 p.m., Resident D was observed sitting in her wheelchair in her room facing the window with her back toward the door. She could not be seen from the hallway door in the position she was sitting in the room. She was receiving a respiratory breathing treatment by mask. At 4:44 p.m., the nebulizer machine shut off by itself and Resident D removed the nebulizer mask from her face and set it in her lap. At 4:46 p.m., RN #1 came into the resident's room and indicated she left the resident alone with the respiratory treatment running because she had a feeding pump alarming. On 2/6/17 at 4:48 p.m., RN #1 obtained the resident's vitals including her oxygen saturation and indicated her oxygen saturation was 90% and she needed to place her oxygen back on due to it was only 90% and it had to be above 90%. She indicated Resident D did not have a self medication assessment to allow her to administer the respiratory treatment to herself and she had dementia and there was no resident on the memory care unit, who could administer their own		Hooverwood is currently holding inservices on proper protocol for administering respiratory treatments for licensed nursing staff (see attachment #2). Furthermore, the contracted Respiratory Services and Medical Equipment company is holding inservices on proper policy and procedure for filling portable oxygen tanks (see attachment #3 and #3A) for all direct caregivers. 2. Hooverwood assembled a list of all residents receiving nebulizer and oxygen treatments and developed a monitoring tool (see attachment #4) to ensure compliance. Per this review, there were no other residents found to have been affected by this deficient practice. 3. Inservice's for Licensed Nurses, Q.M.A.'s and C.N.A.'s (see attachments #2, #3 and #3A) continue to take place in order to review this and all other deficient practices identified in the survey. Administration will utilize the monitoring tool (see attachment #4) to perform random daily (5 times per week) observations of residents receiving nebulizer and oxygen treatments and report results to Nursing Administration. The ongoing training and monitoring will decrease the potential of other residents being affected by these same deficient practices.	

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	medications. She indicated she could have shut the respiratory treatment off when the feeding pump alarmed then restarted it after she took care of the feeding pump alarm, but it was getting close to dinner time and she did not want to inconvenience the resident by making her wait. Resident D's record was reviewed on 2/7/16 at 1:35 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbances, coronary artery disease with stents, hypertension and bradycardia. The Physician Reconciliation orders dated February 2017, included, but were not limited to, 1/11/17--Albuterol Sulfate Nebulization Solution (a medication used to inhale into the lungs to help open the airways to make breathing easier) (2.5 milligrams/3 milliliters) 0.083% give one vial inhale orally by nebulizer three times a day for cough/congestion. The resident's record lacked an order and a self medication assessment to self administer her respiratory treatments. During an interview on 2/7/17 at 9:10 a.m., the Director of Nursing (DON) indicated RN #1 could not have been		4. Any deficient practices that are identified will be addressed through disciplinary action, policy development and/or inservice education. Any trends of deficient practices 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. 5. Date of Completion: March 3, 2017.	

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	monitoring Resident D for adverse reactions throughout the entire nebulizer treatment because she was left alone with the nebulizer treatment on. She indicated the resident did not have a self medication administration assessment or an order to administer the medication to herself. 2. Resident B's record was reviewed on 2/3/17 at 3:25 p.m. Diagnoses included, but were not limited to, dependence on supplemental oxygen, seizures, Chronic Pulmonary Obstructive Disease (COPD), and Alzheimer's disease. The resident had a Care Plan dated 6/28/16, which addressed the problem she required the use of oxygen related to COPD. Interventions/Approaches included, but were not limited to, "6/28/16...3. Apply oxygen as nursing measure or per doctors orders...." The resident had Physician Reconciliation Orders dated February 2017, including, but not limited to, 10/28/16--2.5 L (liters)/NC (nasal cannula) oxygen during the day and while awake to keep oxygen saturation greater than 90%. 10/28/16--3 L/NC oxygen at night to keep oxygen saturations greater than 90%.			

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	On 2/7/17 at 9:40 a.m., RN #2 and CNA #3 had just finished transferring Resident B with the Hoyer lift into he high back wheelchair. RN #2 indicated, at that time CNA #3 had just filled Resident B's portable oxygen tank. CNA #3 lifted the resident's portable oxygen tank with the resident sitting in her high back wheelchair, in front of the bathroom door with the bathroom light on, and turned the liter flow knob to setting number two indicating the resident would receive 2 liters of oxygen. She took the resident's nasal cannula and applied it to her nose, then went to the front of the the chair to continue getting the resident ready for breakfast. During that time, RN #2 was over at the resident's bedside picking up her belongings to straighten up the room and was not observing CNA #3 turning on and setting the portable oxygen tank liter flow. RN #2 was asked to observe the amount of oxygen set for the resident and she indicated CNA #3 must not have been finished setting her liter flow yet. She asked CNA #3 if she was finished with the oxygen liter flow and CNA #3 indicated yes. RN #2 indicated it was dark and the CNA must not have been able to see what liter flow she had placed the oxygen on. RN #2 turned the resident's oxygen liter flow up to 2.5 L per NC. When asked to check the			

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	amount of oxygen in the portable tank, RN #2 pulled the strap on the portable tank and the fill tank needle went to the red area indicating the portable tank was empty. The resident's nasal cannula had minimal oxygen, which could be felt coming out of it and none could be heard blowing out of the nasal cannula. During an interview on 2/7/17 at 3:10 p.m., the DON indicated CNA's were not to set the liter flow on oxygen tanks because oxygen was considered a medication and they were not allowed by law to administer a medication. A current policy titled "Aerolized Medication Therapy Hand Held Nebulizer" dated 4/23/14, provided by the DON on 2/7/17 at 9:10 a.m., indicated "...Procedure:..14. Administer therapy until medication is depleted, usually treatments take 10-15 minutes. The patient should inhale approximately 6-8 times per minute. 15. Monitor the patient's heart rate and level of consciousness before, during and immediately after the therapy. Stop therapy if the patient's heart rate increase by greater than 30% with the administration of the aerosol brochodilator...20. Return the medication to storage area. Do not leave medication in the patient's room..."			

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	A current competency checklist titled "Nurse Aide Competency Checklist" undated, provided by the DON on 2/7/17 at 3:10 p.m., indicated the CNA's responsibilities included, but were not limited to, "...Oxygen: Location of Oxygen room on units, Keep door closed when filling portables, Wipe liquid from tank, Demonstrates understanding of use of portables vs [versus] concentrator, Proper placement of nasal cannula, O2 [oxygen] tubing kept secure when not in use, Filling portable tanks (fill 2 x [times] / shift, when resident goes out & [and] when returns)...." A current policy titled "Medications and Treatments Policy" undated, provided by the DON on 2/7/17 at 4:15 p.m., indicated "Purpose: To provide correct administration of physician-ordered medications and treatments, following the standards of practice (medication, time, dose, frequency and route). Policy and Procedure:.. 2. Medication shall be administered only as prescribed by written order of the physician by licensed nursing personnel or a qualified medication aide (QMA). The QMA must be properly trained for each duty performed and must only perform duties that are within the QMA's Scope of Practice. 3...All personnel who			

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	administer medications are expected to know the side effect of the medications he/she administers...." This Federal tag relates to complaint IN00211102. 3.1-47(a)(6)			