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	03/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00257038. Complaint IN00257038 - Substantiated. Federal/state deficiencies related to the allegations are cited at F684 and F689. Survey dates: March 27 and 28, 2018 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 10 Medicaid: 83 Other: 22 Total: 115 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on April 4, 2018.	F 0000	F0000 Facility requests that this plan of correction be considered its credible allegation of compliance effective April 27, 2018. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is submitted timely and in accordance with State and Federal guidelines. Any additional documents can be made available for your review. Facility respectfully requests desk review. If you have any questions, please feel free to contact me at 317-251-2261. Respectfully, David Glass, HFA, Administrator ="" b=""> ="" b="">	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility lacked non-pressure skin condition assessments to determine the progress of a hematoma and two lacerations from a fall for 1 of 1 resident reviewed for assessment of non-pressure wounds (Resident C). Finding includes: The record review for Resident C was completed on 3/28/18 at 11:54 a.m. Diagnoses included, but were not limited to, heart failure, cognitive communication deficit, and Parkinson's disease. A progress note dated 2/3/18 at 10:25 a.m., indicated the resident was found by a CNA when she was screaming for help in her room. Two nurses assessed the resident. She hit the back of her head and had a hematoma 4 x 4 cm (centimeters) with 2 small cuts, there was active bleeding from the lacerations, a dressing was compressed against the area and ice was applied and she was given her as needed Tramadol (a non-narcotic pain medication). The doctor was notified and indicated not to send the resident to the hospital. A document titled "Resident Skin Incident Report" dated 2/3/18 at 10:25 a.m., indicated the resident had a laceration and a hematoma. There were two small lacerations on top of the large hematoma to the back of the resident's head (Occipital) The hematoma measured 4.0 x 4.0 cm. One laceration on the hematoma measured 1.5 cm and the other measured one measured 1.0 cm. The cause of the incident was a fall on 2/3/18, caused by the resident attempting to self transfer. The	F 0684	F 684 = D It is the intent of this facility to ensure the necessary care and services are provided to in accordance with professional standards of practice, the comprehensive care plan, and resident's choices. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · Resident C was assessed and free of injury. 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? · All other resident non-pressure skin conditions have been reviewed without findings. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? · Nursing staff educated by DON/ Designee on policy /procedure for the appropriate documentation of non-pressure skin conditions, care plans, and C.N.A assignment sheets have been reviewed to accurately reflect resident's plan of care. 4. How corrective actions will be monitored to ensure the	04/27/2018

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	resident indicated she was transferring herself from the recliner to her wheelchair and fell. The resident's record lacked further non-pressure skin condition reports or documentation to measure and assess the hematoma and the lacerations. On 3/28/18 at 12:15 p.m., the DON (Director of Nursing) was observed assessing the resident's occipital area of her head. At that time, the resident indicated the back of her head continued to have a knot on it and it remained tender from her fall. There was no knot that could be felt on her head. While her head was being palpated, she indicated it was tender. During an interview on 3/28/18 at 1:41 p.m., RN 1, with the DON in attendance, indicated she had the first measurements, but she did not have any measurements for progressive healing after the initial measurement. The DON indicated there should have been charting completed to monitor the hematoma and lacerations for progressive healing. During an interview on 3/28/18 at 2:30 p.m., the ADON (Assistant Director of Nursing) indicated she did not have any further skin records for Resident C's hematoma and lacerations to her head after the first set of measurements. A current policy titled "Non-pressure Skin Conditions" dated 11/28/16 with a revision date of 11/28/17, contained the following, "Policy: A licensed nurse will assess and document all non-pressure skin conditions weekly. Definition: A non-pressure skin condition is one that does not meet the criteria of pressure ulcers or venous, arterial, or diabetic ulcers, Stage I-IV. Examples of		deficient practice will not recur? · Audits have been developed to monitor the non- pressure skin sheets by DON/ Designee weekly x 4, and monthly x 3 and will be reviewed in the QAPI meeting by the DON monthly, or until such time as committee determines substantial compliance has been achieved. 5. By what date the systematic changes will be completed? April 27, 2018	

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	non-pressure ulcer skin conditions include, but are not limited to...bruises...lacerations... Procedure:..4. To document the healing process, the nurse looks at the non-pressure skin area, and documents the condition of the skin area each week. 5. Skin sheets will be reviewed weekly...." This Federal tag relates to Complaint IN00257038. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident's neurological assessments were completed according to the facility policy and procedure after two falls for 1 of 3 residents reviewed for accidents (Resident D). Finding includes: The record for Resident D was reviewed on 3/28/18 at 4:00 p.m. Diagnoses included, but were not limited to, heart failure, retention of urine, encounter for palliative care, dementia without behavioral disturbance and cognitive communication deficit. A "Post Fall Analysis V2" report dated 3/6/18 at 12:00 a.m., indicated the resident fell without any	F 0689	F 689 – D It is the intent of this facility to ensure that the resident environment remains as free as hazards as possible; and that each resident receives adequate supervision and assistive devices to prevent accidents. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? · Resident # D remains in facility with intact neurological examination. 2. How will other residents having the potential to be affected	04/27/2018

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	treatment. It was believed the resident was trying to toilet herself because she was incontinent of her bowels. The cause of the fall was transferring self. A "Post Fall Analysis V2" report dated 3/19/18 at 1:36 p.m., indicated the resident fell without an apparent injury. She was found on the floor on the second West pod. She was attempting to get up from her wheelchair to go to her room. There were no 15 minute, 30 minute or 1 hour interval neurological checks located in the residents record for the fall on 3/6/18 and 3/19/18. During an interview on 3/28/18 at 5:15 p.m., the DON (Director of Nursing) indicated there should have been neurological checks for q (every)15 mins x 4, q 30 mins x 4 then q 1 hours x 4. A current policy titled "Neurological Assessment" dated 5/17/15, provided by the DON on 3/28/18 at 5:30 p.m., contained the following information, "PURPOSE: The purpose of the neurological assessment is to ensure adequate monitoring of a resident with head trauma and to identify any acute neurological change that could be indicative of a serious head injury. The documentation of a resident's neurological status involves the assessment of several key areas, including vital signs, pupil and eye response, level of consciousness, speech and motor response. Policy: Following any time of head trauma, suspected head trauma or following an unwitnessed fall, a Neurological Assessment (see attached) will be conducted at the following intervals: Every 15 minutes x 1 hour, then Every 30 minutes x 1 2 hours then Every hour x 4 hours, then		by the same deficient practice be identified and what corrective actions will be taken? · All other residents at risk, therefore education executed immediately regarding the importance of completing neurological assessment according to facility policy. 3. What measures will be put into place, or what systematic changes will be made to ensure that the deficient practice does not recur? · Licensed nursing staff was educated by DON on 4-10 and 4-11-2018 regarding policy and procedure required for skin conditions and progress toward healing. Licensed staff received further education from ADON on 4/17 and 4/18/ 2018 regarding both fall and skin systems. Both educational opportunities complete with post test. 4. How corrective actions will be monitored to ensure the deficient practice will not recur? · Fall audit tool will be reviewed by Director or Nursing or Designee weekly x3, monthly x2 and then, quarterly, or until such time as QAPI committee determines substantial compliance has been achieved. 5. By what date the systematic changes will be completed? · April 27, 2018	

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	Every shift for a total of 72 hours...." This Federal tag relates to Complaint IN00257038. 3.1-45(a)(2)			