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	09/02/2016

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

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 28, 29, 30 31, and September 1 and 2, 2016 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census bed type: SNF/NF: 129 Total: 129 Census payor type: Medicare: 6 Medicaid: 96 Other: 27 Total: 129 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on September 9, 2016.	F 0000		
F 0309	483.25			

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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SS=D Bldg. 00	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 interview and record review, the facility failed to coordinate hospice care and services to maintain the highest practical level of well being for 1 of 1 residents reviewed for hospice (Resident #100). Findings include: On 09/02/2016 at 9:19 a.m., the record for Resident #100 was reviewed. Diagnoses included, but were not limited to, acute renal failure, stage 3 chronic kidney disease, failure to thrive, hypotension, diabetes mellitus type 2, anxiety and deep vein thrombosis. On 09/02/2016 at 9:19 a.m., the (name of hospice company) hospice binder was reviewed for Resident #100. A document titled, "Hospice Facility Binder Order of Chart Assembly" indicated, "...Tab 5: Nursing home Activity log upon admission with revisions...Tab 6: Admission/Certification/Medication	F 0309	F309 1.Per review and analysis of Resident #100's Hospice plan of care, it was determined that this Resident was not affected by this deficient practice. Hooverwood's Executive Director and Director of Nursing had a conference call on 9/6/16 with this Hospice provider to further discuss this deficient practice. The Hospice provider had already fully investigated this matter and followed up with staff education and discipline with their involved personnel. **(See attachment #1)** Resident #100 was the only resident on this provider's caseload. 2.The Hospice binders, care plans, documentation, etc., were reviewed for all other Hospice Residents. Per this review, there were no other residents found to have been affected by this deficient practice.	09/30/2016

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	Profile (placed in sleeve) , Admission Order Indiana (Can never be thinned), Physician Order to Assess and admit (Can never be thinned), Comprehensive Assessment drug Profile/MD order (admission) (can never be thinned), Subsequent comprehensive Assessment Drug Profile/MD orders (Recertification or change in Level of care) (Must keep admission and most current in sleeve; previous drug profiles may go to facility medical records), Physician Certification of Terminal Illness Hospice Medicare/Medicaid Benefit (Recertification). Tab 7: Assessments (placed in sleeve), Initial RN Assessment, RN Comprehensive Assessment, Social Worker [SW] Assessment...RD [Registered Dietician] Assessment...HA [Hospice Aide] Assessment. Tab 8: Plan of care, Plan of care, Update to Plan of Care...IDG [Interdisciplinary Group] review...Care Coordination with MDS [Minimum Data Set]...Tab 9: Nurse, SW...RD, HHA [Hospice health aide]...." A current document titled, "YOUR HOSPICE TEAM AND SERVICES" undated, indicated, "...Hospice Nurse-The hospice nurse coordinates the individualized plan of care, provides specialized palliative care services and provides family teaching...."		1.On a weekly basis, the Unit Managers will be responsible for auditing the Hospice binders to assure that all necessary care plans, care coordination, communication, etc., are current and present in these binders. This weekly task will be added to the Unit Managers weekly auditing responsibilities **(See attachment #2)** An inservice for Licensed Nurses and C.N.A.'s will take place in order to review this and all other deficient practices identified in the annual survey **(See attachment #3, #3A)** 1.Any deficient practices identified by the Unit Managers during these weekly audits will be reported to Nursing Administration and immediately communicated to the Hospice providers. Any deficient practices that are determined to be the responsibility of Hooverwood's personnel 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 /	

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	The hospice binder for Resident #100 lacked any documentation in tabs 5, 6, 7 and 8. A current care plan dated 08/17/2016, indicated, " Hospice admission...Intervention 1. Maintain communication with hospice re: resident's condition and needs...3. Hospice staff to visit as indicated...8. Coordinate care/services...." During a phone interview on 09/02/2016 at 10:01 a.m., the hospice clinical manager [name of hospice company] indicated all hospice care and coordination information should be kept in the hospice binder and she did not know why it was not. She indicated the hospice nurses had all the resident care and coordination information on their laptops. She indicated she did not know how the facility staff would know what or how often the hospice agency provided services if it was not in the hospice binder. During an interview on 09/02/2016 at 10:19 a.m., the unit manager for 1 B indicated she called the hospice company yesterday to inquire when they were coming and what services they were providing for the resident. She indicated		QAPI Committee. 1.Date of Completion: September 30, 2016	

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	she had no information about what services the hospice agency was providing for the resident. During an interview on 09/02/2016 at 11:06 a.m., Hospice RN #4 indicated the plan of care should have been in the hospice binder upon admission. She indicated she would normally speak with the charge nurse at each visit and document this in her binder. She indicated the hospice aide plan of care and the coordination of care was supposed to be documented on the plan of care and kept in the hospice binder. She indicated the information regarding coordination of care should have been discussed upon admission regarding the plan of care, any visits and all coordination of services. A current policy titled, "Hospice Program" undated, provided by the Director of Nursing on 09/02/2016 at 2:00 p.m., indicated "...4. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the residents current status...."			

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	3.1-37(a)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure post fall interventions were followed through to prevent further potential falls for 1 of 4 residents reviewed for accidents (Resident #160) and the facility failed to ensure medication was not left at the bedside for 1 of 1 resident being reviewed for medications left at the bedside (Resident #164). Findings include: 1. During a staff interview RN #1 indicated Resident #160 fell within the last 30 days on 8/3/16 and 8/17/16. The following observation were made on these dates and times: On 8/31/16 at 4:11 p.m., the resident was laying in bed covered up with his blankets watching TV. There were four signs in his room indicating do not get up	F 0323	F323 1.Hooverwood's Inter-Disciplinary Team (IDT) will review and update Resident #160's current fall interventions to assure that the interventions are appropriate, in place, and consistent with his overall plan of care. Per consultation between Nursing staff and Occupational Therapy, it was determined that Dycem is no longer an appropriate or needed intervention for this resident. The medication found on Resident #164's nightstand was immediately discarded. Resident #164 was not affected by this deficient practice. 2.Hooverwood's IDT will be completing an audit of all residents' fall interventions to assure that the interventions are appropriate, in place, and consistent with their overall plan	09/30/2016

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	without asking for help. On 9/1/16 at 8:55 a.m., the resident was laying in bed with his eyes closed. His wheelchair was sitting next to the side of his bed. On 9/1/16 at 3:00 p.m., the resident was laying in bed watching TV with his wheelchair sitting next to the side of his bed. On 9/2/16 at 8:48 a.m., the resident was laying in bed with his eyes closed and his wheelchair was sitting next to his nightstand. Resident #160's record was reviewed on 9/2/16 at 8:50 a.m. Diagnoses included, but were not limited to, dementia, Congestive Heart Failure, and atrial fibrillation. The resident had a Care Plan dated 4/4/16, which addressed the problem he was at risk for injury secondary to falls as evidenced by history of falls related to syncopal episodes, debility and right sided weakness. Interventions included, but were not limited to, "...5/9/16--Educated to use call light...6/2/16--w/c [wheelchair] kept in hall...7/5/16--Three more signs put in room "Do Not Get Up Without Asking For Help" for resident to		of care. **(See attachment #4)** Any interventions found to be inappropriate or ineffective will be modified accordingly. Immediate rounds were conducted throughout facility after this deficient practice was identified by the surveyor. **(See attachment #4)** There were no other medications inappropriately being stored in other resident rooms. 1.In order to improve communication among all caregivers regarding fall interventions, Hooverwood's IDT will be developing Fall Intervention binders that will be located on each nursing station **(See attachment #5).** These binders will be current and will be available for nurses, C.N.A.'s, therapists, activity staff, etc., as a resource regarding the residents' specific and most up to date fall interventions. On a weekly basis, the Unit Managers, Nursing Supervisors, and / or Nursing Administration will make rounds in resident rooms to assure that medications are never inappropriately left if resident rooms**. (See attachment #4)** An inservice for Licensed Nurses and C.N.A.'s will take place in	

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	see...8/3/16--Dycem to w/c...." The annual MDS (Minimum Data Set) assessment dated 4/11/16, indicated the resident's BIMS (Brief Interview Mental Status) was 7, indicating he was severely impaired mentally. A Post Fall Assessment Summary dated 4/17/16 at 8:00 p.m., indicated the resident fell and the root cause analysis was self transfer. The new intervention was to remind him to contact staff. A Physician progress note dated 4/18/16, indicated the Physician was visiting the resident at the request of the staff for multiple falls and for laboratory followup. The note indicated the resident was very impulsive and had some right sided neglect, which caused him to fall almost everyday. He had lack of insight. He was on Aspirin (treats pain fever and inflammation) and was not a candidate for Warfarin (a medication that thins the blood) due to multiple falls. He was a very high risk for future falls. A Post Fall Assessment Summary dated 4/24/16 at 3:30 p.m., indicated the resident fell and the root cause analysis was self transfer while trying to go to the bathroom. The new intervention was to call for assistance.		order to review this and all other deficient practices identified in the annual survey. **(See attachment #3, #3A)** 1.On a monthly basis, these Fall Prevention binders will be audited by the Unit Managers to assure accuracy and appropriateness **(See attachment #6).** Any deficient practices identified by these audits and weekly rounds of resident rooms will be addressed through inservice education, disciplinary action, and / or policy development. 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. 1.Date of Completion: September 30, 2016	

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A Fall Analysis note dated 5/9/16 at 11:30 a.m., indicated the resident was found at his bedside and fell while self transferring trying to toilet himself. He indicated he was trying to go to the bathroom. The possible cause was toileting, cognitive impairment and impaired safety awareness. The new intervention was explaining to the resident to use his call light to call for assistance.

A Fall Analysis note dated 6/2/16 at 2:15 a.m., indicated the resident fell during a self transfer trying to toilet himself. He indicated he was trying to get in the wheelchair to go to the bathroom.

A Post Fall Assessment Summary dated 6/2/16, indicated the resident fell and the root cause analysis was self transfer. The new intervention was to remove his wheelchair from his room.

The quarterly MDS assessment dated 7/12/16, indicated the BIMS was not completed.

A Fall Analysis note dated 8/3/16 at 4:25 p.m., indicated the resident was found sitting on the floor between the bed and the wheelchair during a self transfer. He indicated he slid out of his wheelchair.

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	The cause of the fall was impaired safety awareness. A Post Fall Assessment Summary dated 8/3/16 at 4:25 a.m., indicated the resident had a fall and the root cause analysis was he slid out of his wheelchair. The new intervention was to apply dycem to his wheelchair. A Physician progress note dated 8/12/16, indicated the resident lacked insight. He had a resolving cerebrovascular accident with right hemiparesis and was improving in rehabilitation. He was on Aspirin and he was not a candidate for Warfarin due to multiple falls. He was a very high risk for future falls and he had dementia. A Fall Analysis note dated 8/17/16 at 6:45 a.m., indicated the resident was found sitting on the floor by the bed. He indicated he was going to the bathroom. He indicated he thought he could get to his chair. The cause of the fall was toileting and impaired safety awareness. A Post Fall Assessment Summary date 8/17/16 at 6:45 a.m., indicated the root cause analysis was the resident was getting up to go to the bathroom. The new intervention was to check on him at the change of shift.			

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	During an interview on 9/2/16 at 9:00 a.m., RN #1 indicated the resident's wheelchair was in his room. She indicated the staff placed his wheelchair in the hallway, but he would crawl out of bed and go look for his wheelchair because he wanted the wheelchair close to his bed. On 9/2/16 at 9:07 a.m., the resident was observed sitting on the edge of his bed finishing his breakfast. His wheelchair was sitting next to his nightstand. He indicated he wanted his wheelchair in his room and the staff had not tried to remove his wheelchair from his room, but if they had tried, he guess he would have to let them because he would not have a choice in the matter. There was no dycem in his wheelchair. During an interview at 9/2/16 at 9:53 a.m., RN #1 indicated the resident did not have dycem in his wheelchair, but she was not sure he was suppose to have it in his wheelchair. She indicated she would check with the Unit Manager and ask if he knew anything about the dycem in the resident's wheelchair. During an interview on 9/2/16 at 12:35 p.m., the Director of Nursing indicated there should have been a BIMS			

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	completed on the 7/12/16, quarterly MDS assessment. She indicated a resident with a BIMS of 7 cannot be educated or reminded to use the call light due to the resident being cognitively impaired. She indicated he wanted his wheelchair in his room and that intervention should have been taken off his Care Plan or a Care Plan should have been made for refusing to have his wheelchair taken out of his room. A current policy titled "Fall Prevention Program" dated 7/2014, provided by the DON on 9/2/16 at 2:52 p.m., indicated "I. Purpose: To reduce residents' risk of falling and to prevent and/or minimize injuries related to falls...III. Procedure:..An individual and immediate intervention will be implemented based on the result of the root cause analysis results...." A current policy titled "Fall Prevention and Post-Fall Protocol" dated July 2014, provided by the DON on 9/2/16 at 2:52 p.m., indicated "...III. Intervention: A. After each fall, a licensed nurse will determine the appropriate immediate intervention and will ensure that it is implemented....." 2. On 8/29/16 at 11:46 a.m., an Albuterol Sulfate vial (a medication used			

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	to open the lungs to make breathing easier) was observed sitting on Resident #164's night stand. Resident #164's call light was pushed to activate the light to call a staff member. On 8/29/16 at 11:53 a.m., LPN #2 came into Resident #164's room and indicated the Albuterol Sulfate vial was not suppose to be on the resident's nightstand because this resident was not on breathing treatments and medications were not to be left in the residents' rooms. She indicated she was not going to take the vial with her because the Unit Manager needed to see it laying on the nightstand. LPN #2 left the resident's room without the Albuterol Sulfate vial. On 8/29/16 at 11:55 a.m., LPN #2 came back into Resident #164's room with her chart and indicated she was not on a routine nebulizer treatment. She indicated she use to be on nebulizer treatments in the past. LPN #2 left the room and the Albuterol Sulfate vial was laying on the night stand. On 8/29/16 on 11:58 a.m., LPN #2 came back into the room and indicated she could not get the Unit Manager to come into the room, at that time because she was busy at that moment. She picked up the Albuterol Sulfate vial and the piece of			

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	paper it was laying on top of. The Director of Nursing (DON) was requested if she was able at that time to come to the resident's room. LPN #2 indicated she would get the DON. On 8/29/16 at 12:07 p.m., the DON came into the resident's room with LPN #2. LPN #2 placed the Albuterol Sulfate vial on the nightstand on top of the piece of paper it was originally laying on top of as it was found before. The DON indicated, at that time the Albuterol Sulfate vial should not have been in the resident's room. On 9/2/16 at 2:20 p.m., the Unit Manager of C-Wing unit indicated she had 15 residents on the unit that could independently move around and nine of those were residents that ambulated. She indicated she had 5 residents who wandered on the unit and two of them wandered all the time. The record review for Resident #164 was completed on 9/2/16 at 2:29 p.m. Diagnoses included, but were not limited to acute kidney disease and protein calorie malnutrition. A current policy titled "Medicine or Treatment Cabinets/Rooms, Schedule II Drugs, Emergency Medication" dated			

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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
	4/15/92, provided by the DON on 9/2/16 at 4:32 p.m., indicated "...III. Procedure:.. Drugs shall be stored in a clean and orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding...." 3.1-45(1)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to keep the medication error rate at less than 5% for 2 of 6 residents observed during medication pass. 2 errors were observed during 25 opportunities for errors in medication administration. This resulted in a medication error rate of 8.0% (Residents #39 and #40). Findings include: 1. On 09/01/2016 at 8:58 a.m., QMA #5 administered medications to Resident #39, which included Metoprolol Succinate (a medication to lower blood pressure) ER (extended release) 25 mg	F 0332	F332 1.Residents #39 & #40 were not found to have been affected by these deficient practices. The medication orders pertaining to this deficient practice were reviewed in detail with QMA #5 and disciplinary action was issued.**(See attachment #7)** 2.Hooverwood's consultant pharmacy will be conducting a medication administration observation with QMA #5 as a Quality Improvement Measure. **(See attachment #8)** These observations, by the pharmacy and by Nursing Administration,	09/30/2016

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	(milligrams) by mouth daily; to hold for systolic blood pressure less than 110. The resident's Medication Administration Record (MAR) dated August 2016, included, but was not limited to, the following order: Metoprolol Succinate ER 25 mg one tab by mouth every morning and hold for systolic blood pressure less than 110. Signed August 2016 physician orders included, but were not limited to, the following order: Metoprolol Succinate ER 25 mg one tab by mouth every morning and hold for systolic blood pressure less than 110. During an interview on 09/01/2016 at 9:00 a.m., at 11:15 a.m., QMA #5 indicated Resident #39 should have had her blood pressure taken prior to giving her medication. She indicated she missed the order on the medication sheet indicating to hold the blood pressure medication for a blood pressure less than 110 systolic before she gave the resident her morning medications. 2. On 09/01/2016 at 9:20 a.m., QMA #5 administered medication to Resident #40, which included Polyethylene Glycol (a medication to treat constipation) one cap, dissolved in 8 ounces of water by mouth		will continue monthly for other licensed nurses and QMA's. These ongoing observation will decrease the potential of other residents being affected by this same deficient practice. 1.An inservice for Licensed Nurses and C.N.A.'s will take place in order to review this and all other deficient practices identified in the annual survey. **(See attachment #3, #3A)** 1.Any deficient practices identified by the Pharmacy and / or Nursing Administration during these observations will be reported to Nursing Administration. 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: September 30, 2016	

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	daily. The resident's Medication Administration Record (MAR) dated August 2016, included, but was not limited to, the following order: Polyethylene Glycol, one cap, dissolved in 8 ounces of water by mouth daily. Signed August 2016 physician orders included, but was not limited to, the following order: Polyethylene Glycol, one cap, dissolved in 8 ounces of water by mouth daily. During an interview on 09/01/2016 at 9:20 a.m., QMA #5 indicated she had ran out of apple juice, and did not have enough to mix the full 8 ounces of apple juice with the Polyethylene Glycol powder. She indicated she would normally mix the medication in 8 ounces of water. 3.1-25(b)(9)			
F 0371 SS=F Bldg. 00	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			

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	under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food items were labeled and dated and expired items were discarded. This deficient practice had the potential to affect 127 of 129 residents who received food from the kitchen. Findings include: During a kitchen tour on 8/28/16 at 6:13 p.m., the Kitchen Manager was in attendance and the following observations were made: 1. In the dry storage area, a bag of elbow macaroni was opened and not dated. 2. In the walk in cooler the following observations were made: a. 1 bag of fresh broccoli without a date received by or a use by date. b. 1 plastic container of scrambled eggs was not labeled with a date prepared or a use by date. c. 15 cartons of 2% milk without an expiration date. 3. In the walk in freezer, 1 bag of frozen sweet potato fries without a date received by or a use by date. During tour of the kitchenettes on	F 0371	F371 1.The bag of elbow macaroni, bag of broccoli, container of scrambled eggs, 15 cartons of milk, bag of frozen sweet potato fries (main kitchen) , the 8 cartons of milk (2B kitchenette), 32 cartons of milk (2A kitchenette), and 4 cartons of expired milk (2A kitchenette) were all immediately discarded. The Food Service Director immediately contacted the milk vendor who confirmed that all the undated milk cartons were fresh milk that had not yet been expired. The vendor's internal investigation identified that the shipment of undated milk cartons was the result of a mechanical defect on their processing line. There were no residents identified as being affected by this deficient practice. 2.The undated and expired milk cartons and undated foods were immediately discarded in order to minimize the potential for any other residents being affected by this same deficient practice. 3.A daily compliance log will be developed and maintained in the main kitchen and in all kitchenettes that will document	09/30/2016

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	8/28/16 at 7:10 p.m., the Dietary Manager was in attendance and the following observations were made: 1. The second floor kitchenette on unit 2B was observed to have 8 cartons of 2% milk without an expiration date. 2. The second floor kitchenette on unit 2A was observed to have 32 cartons of 2% milk without an expiration date and 4 cartons of 2% milk with an expiration date of 8/27/16. During an interview on 8/28/16 at 6:30 p.m., the Kitchen Manager indicated all food items should be labeled and dated with a received by date and a use by date. During an interview on 8/28/16 at 7:20 p.m., the Dietary Manager indicated the facility staff should have noticed the milk cartons did not have an expiration date. A facility policy, titled "Receiving And Storage Of Food Items" dated January 2009, received from the Dietary Manager on 9/2/16 at 3:00 p.m., indicated "...Items not stored in original containers are wrapped or covered appropriately and are labeled as to contents...All food items that are not in original container are labeled with contents and date opened...."		the compliance of dating all opened food items and milk expiration dates **(See attachment #9).** The Food Service staff will be responsible for completing these logs on a daily basis. The Food Services Department will be having an inservice in order to review these deficient practices. **(See attachment #10, #10A)** Those Food Service employees identified to have responsible for these deficient practices received disciplinary action **(See attachment #11, #11A)** 1.The Dietitian, Food Service Manager, and Food Service Director will be responsible for monitoring these logs daily to assure accurate compliance. 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. 1.Date of Completion:	

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	3.1-21(i)(3)		September 30, 2016	
F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation and record review, the facility failed to ensure medications were stored safely and medications without secure closures were disposed of properly. This deficient practice affected 6 of 8 medication carts. Findings include: 1. During an observation of the 2 B medication storage areas on 09/02/2016 at 2:07 p.m., with RN #6 in attendance the following was observed: One medication cart had a medication card without secure closures. This included a medication card containing Oxycodone (a narcotic medication to treat pain) with the back of the card taped with clear tape. One open bottle of of Polyethylene Glycol (a laxative) lacked an open date. 2. The east and west medication carts were found to have multiple loose pills in the drawers. 3. During an observation of the 2 A medication storage areas on 09/02/2016 at 2:33 p.m., with RN #1 in attendance the following was observed:	F 0431	F431 1.On 2B, the narcotic, laxative, and loose pills were all destroyed. On 2A, the narcotic, anti-anxiety medication and loose pills were destroyed. On C, the narcotic and loose pills were destroyed, the ear drops, vitamins, Tums and 4 bottles of laxatives were discarded. All medications that needed to be replaced were done so at the facility's expense. There were no residents found to have been affected by this deficient practice. 2.Due to an immediate audit of all nursing units and medication carts, other residents were not identified as having the potential of being affected by this same deficient practice. 3.The contracted pharmacy will continue to inspect the medication carts on a monthly basis **(See attachment #8)** and report their findings to Nursing Administration. In addition, the Unit Managers, Nursing Supervisors, and Nursing Administration will inspect the medication carts on a weekly basis and document any deficient practices on a monitoring log	09/30/2016

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	One open bottle of Roxanol (a narcotic medication to treat pain) lacked an open date. One open bottle of Lorazepam (an anti-anxiety medication) lacked an open date and was leaking into an outer container. The medication carts were found to have multiple loose pills in the drawers. 4. During an observation of the 1 C medication storage areas on 09/02/2016 at 3:33 p.m., with LPN #7 and LPN #8 in attendance the following was observed: One open bottle of Morphine Sulfate (a narcotic medication to treat pain) lacked an open date. One open bottle of Ciprodex (antibiotic ear drops) was discontinued on 07/20/2016, and had not been removed from the medication cart. One open bottle of Vitamin E (a supplement) capsules lacked an open date. One open bottle of Tums chewable's (an anti-acid) lacked an open date. Four open bottles of Polyethylene Glycol		**(See attachment #12).** 1.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. 2.Date of Completion: September 30, 2016	

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	(a laxative) lacked open dates. The medication carts were found to have multiple loose pills in the drawers. A current policy titled "Medicine or Treatment Cabinets/Rooms, Schedule II Drugs, Emergency Medication" dated 4/15/92, provided by the Director of Nursing on 9/2/16 at 4:32 p.m., indicated "...III Procedure:..Drugs shall be stored in a clean and orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding...Discontinued, outdated or deteriorated medication shall not be used and are to be disposed of in compliance with federal, state, and local law." 3.1-25(o)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, and interview the facility failed to ensure a clean, sanitary, and home like environment related to 13 of 188 resident rooms and furniture, 4	F 0465	F465 1.The handrails outside of rooms #115-117 **(see**	09/30/2016

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	residents with wheel chair arm rests needing repair (Residents #7, #40, #79 and #94), hallway walls and handrails (Rooms #116, #121, #125, #127, #130, #132 hall 1C, rooms #106, #107, #117, #118 hall 1B, and rooms #204, #206, and #212 hall 2B). . Findings include: 1. During the initial tour on 8/28/2016 at 6:10 p.m., the following were observed: a.) Hand rails outside rooms #115-117, #117-119, #111-113, #114-116, #118-120, #119 to the end of the hallway and #114 to the lounge on Hall 1 B were chipped, peeling, splintered and cracked. b.) Residents #7 and #40's, wheel chair side arm right and left rests were peeling, chipped and the fabric was ripped and torn. c.) Residents #94 and #79, wheel chair left side rests were peeling, chipped and the fabric was ripped and torn. 2. During the resident room observations on 8/29/2016 and 8/30/2016, the following was observed: a.) Room #125 on hall 1C on 8/29/2016 at 3:38 p.m., the baseboard around the		**attachment #13**), 117-119 **(See attachment #13A**), 111-113 **(See attachment #13B)**, 114-116 **(See attachment #13C)** , 118-120 **(See attachment #13D)** , 119-end of hallway **(See attachment #13E)**, 114-to lounge **(See attachment #13F)** on Hall 1B were all repaired by Hooverwood's Maintenance Department in order to eliminate any chipping, peeling, splinters or cracking. Repair work included sanding, staining and finishing. The wheelchair arm rests belonging to Residents #7 **(See attachment #14),** #40 **(See attachment #14A)** , #94 **(See attachment #14B)**, and #79 **(See attachment #14C)** were all repaired and / or replaced by Hooverwood's Occupational Therapy Department in order to eliminate any peeling, chipping, or ripped / torn fabric. The baseboard around the bedroom wall in room C125 **(See attachment #15)** was replaced and the edges were repaired. The bathroom and bedroom walls were also repaired in order to eliminate the gouged, marred, chipped and peeling areas. **(See attachment #15A and #15B)** The bottom bedroom and bathroom wall molding in room B206 was repaired and the bedroom wall was repaired to	

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	bedroom wall was incomplete and the edges were splintered, the bathroom and bedroom walls were gouged, marred, chipped and peeling. b.) Room #206 on hall 2B on 8/30/2016 at 9:25 a.m., the bottom molding in the bedroom and bathroom were damaged and the bedroom wall was gouged, marred, chipped and peeling. c.) Room #117 on hall 1B on 8/30/2016 at 12:20 p.m., the sink fixtures were limed and rusty, bathroom door marred, chipped and peeling and the bathroom and bedroom walls were marred, chipped and peeling. d.) Room #132 on hall 1C on 8/30/2016 at 3:48 p.m., the bathroom and bedroom walls were marred, chipped and peeling. e.) Room #130 on hall 1C on 8/29/2016 at 11:40 a.m., the bathroom and bedroom walls were marred, chipped and peeling. f.) Room #106 on hall 1B on 8/29/2016 at 2:59 p.m., the bedroom wallpaper was gouged and ripped, debris was observed around the baseboards in the bathroom area, the sink had rusted metal on the fixtures, the furniture closet and chest of drawers was chipped, peeling and cracked and the bathroom walls were		eliminate the gouged, marred, chipped and peeling areas. **(See attachment #16 and #16A)** The sink fixtures in room B117 were replaced (**See attachment #17**), the marred bathroom door was repaired **(See attachment #17A),** and the bathroom and bedroom walls were repaired **(See attachment #17B and #17C**) in order to eliminate the marred, shipped and peeling areas. The bathroom and bedroom walls in room C132 were repaired in order to eliminate the marred, chipped and peeling areas **(See attachment #18 and #18A).** The bathroom and bedroom walls in room C130 were repaired in order to eliminate the marred, chipped and peeling areas **(See attachment #19 and #19A).** The bedroom wallpaper in room B106 was repaired **(See attachment #20**), the debris around the baseboard in the bathroom was removed **(See attachment #20A)**, the sink fixtures were replaced **(See attachment #20B**), the furniture closet,**(See attachment #20C**)and chest of drawers were all repaired **(See attachment #20D)** and the bathroom walls **(See attachment #20E)** were repaired in order to eliminate the	

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	gouged, marred, chipped and peeling. g.) Room #204 on hall 2B on 8/30/2016 at 10:59 a.m., the bathroom sink had a pink solution dripping on the walls and the hand washing dispenser was broken. h.) Room #116 on hall 1C on 8/29/2016 at 1:09 p.m., the light fixture was broken, the wall socket was loose from the wall, and the wall paneling and tiles were missing from the room floor and wall. j.) Room #121 on hall 1C on 8/30/2016 at 4:24 p.m., the bathroom and bedroom walls were marred, chipped and peeling. k.) Room #107 hall 1B on 8/29/2016 at 2:54 p.m., the bathroom floors and walls were marred, chipped, gouged and peeling. Baseboards around and beneath the sink were torn and the entry overhead light did not work. l.) Room #118 hall 1B on 8/30/2016 at 12:23 p.m., the bathroom and bedroom walls were marred, chipped and peeling, the furniture closet and chest of drawers were chipped, sink fixtures were limed and rusty and the archway to the bedroom was chipped and marred. j.) Room #212 hall 2B on 8/30/2016 at 10:03 a.m., the wooden trim along the		marred, chipped and peeling areas. The bathroom sink area in Room B204 was cleaned and the handwashing dispenser was repaired **(See attachment #21 and #21A).** The light fixture in room C116 was replaced **(See attachment #22),** the wall socket was tightened **(See attachment #22A),** and the wall paneling and tiles were replaced / repaired **(See attachment #22B and #22C).** The bathroom **(See attachment #23)** and bedroom **(See attachment #23A)**walls in C121 were repaired in order to eliminate the marred, chipped and peeling areas. The bathroom floors **(See attachment #24)** and walls **(See attachment #24A)**in room B107 were repaired in order to eliminate the chipped, gouged and peeling areas. The baseboards around and beneath the sink were repaired **(See attachment #24B)** and the entry overhead light was repaired **(See attachment #24C).** The bathroom **(See attachment #25)** and bedroom **(See attachment #25A)** walls in room B118 were repaired in order to	

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	middle of the bedroom wall was broken, chipped and peeling, the entry light was not working and the bedroom walls were marred chipped and peeling. During the environmental tour with the Executive Director, the Environmental Service Director and the Maintenance Director on 9/1/2016 at 10:15 a.m., the following was observed: 1.) Room #127 on Hall 1C the bedroom and bathroom walls were marred, chipped and peeling. 2.) Room #107 hall 1B the entry overhead light into room still did not work. 3.) The bathroom toilet seat cover in room #119 on the 1A unit was rusted and broken. 4.) Room #212 hall 2B the entry overhead light into the room still did not work. During an interview on 9/1/2016 11:10 a.m., the Director of Environmental Services indicated the facility had a reporting system for all the staff to notify the Maintenance Department if the facility needed repairs. The Director of Environmental Services indicated he was		eliminate the marred, chipped, and peeling areas, the furniture closet **(See attachment #24B)** and chest of drawers **(See attachment #25C**) were repaired, and the sink fixtures were replaced **(See attachment #25D),** and the archway to the bedroom **(See attachment #25E)** was repaired to eliminate the chipped and marred areas. The wooden trim **(See attachment #26)** along the middle of the wall in room B212 was repaired in order to eliminate the broken, chipped and peeling areas. The entry light was repaired **(See attachment #26A)** and the bedroom walls **(See attachment #26B)** were repaired in order to eliminate the marred, chipped and peeling areas. The bedroom **(See attachment #27)** and bathroom **(See attachment #27A**) walls in Room C127 were repaired in order to eliminate the marred, chipped and peeling areas. The entry overhead light in room B107 was repaired **(See attachment #24C).** The bathroom toilet seat cover in Room A119 was replaced **(See attachment #28**). The overhead light in Room B212 was repaired **(See attachment #29).**	

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	09/02/2016

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	not aware of the facility needing these repairs. Current policy "Reporting of Maintenance Repairs " received from the ED, on 9/1/2016 at 3:00 p.m., indicated "Staff are to document any need for repairs in resident rooms, corridors, lounges, etc., in the maintenance log located at every nurse's station ...Any repairs that are in need of immediate attention will be called to the Maintenance Department...." 3.1-19(f)		2.Environmental Rounds were conducted throughout the entire facility to assure that all other rooms were in compliance. All necessary repairs were completed by the Maintenance Department. Hooverwood is currently going through a facility-wide renovation and construction project that will be introducing brand new and modern rooms to our facility. As a result of the facility rounds and repair work completed, there were no other residents identified having the potential of being affected by this same deficient practice. 3.On a monthly basis, Environmental Rounds will be completed by the Maintenance Director, Environmental Services Director and Executive Director. Any areas that require repair or replacement will be immediately addressed. On a daily basis, the Maintenance Staff will continue to monitor the Maintenance Logs **(See attachment #30)** located on all the nursing units. Any repairs requested will be addressed by the Maintenance Staff. The Maintenance Director will follow up on repaired areas to assure they were completed with quality work and within a timely manner. An inservice for Licensed Nurses and C.N.A.'s will take place in	

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			order to review this and all other deficient practices identified in the annual survey **(See attachment #3).** Nursing staff will be reminded to utilize the Maintenance Logs to report any repair needs in resident rooms, lounges, corridors, etc. Nursing staff will also be reminded to call the Maintenance Department if immediate repairs are needed. 1.Any deficient practices that are identified during monthly rounds or daily reviews of the Maintenance Logs 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. 2.Date of Completion: September 30, 2016	