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	10/18/2017

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 10, 11, 12, 13, 16, 17 and 18, 2017 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census bed type: SNF/NF: 118 Total: 118 Census payor type: Medicare: 7 Medicaid: 82 Other: 29 Total: 118 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 27, 2017.	F 0000	The Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Hooverwood desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective November 16, 2017.	
F 0164 SS=D Bldg. 00	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS			

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

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	483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical			

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	examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.			
	Based on observation, interview and record review, the facility failed to maintain a residents' privacy while providing personal care for 3 of 3 residents observed for privacy (Residents 136, 35 and 33). Findings include: 1. During an observation of CNA 14 providing care to Resident 136 on 10/11/2017 at 11:03 a.m., LPN 10 knocked on the resident's door and without waiting for a response entered the room leaving the door open behind her. The door remained open to the hallway as Resident 136 attempted to stand with his pants unfastened and down around his thighs exposing his incontinent brief. The record for Resident 136 was reviewed on 10/12/17 at 3:52 p.m. Diagnoses included, but were not limited to, type 2 diabetes, dementia and hypertension. 2. During an interview on 10/11/2017 at 10:50 a.m., Resident 35 indicated staff frequently left the doors to his bedroom and bathroom open while they provided	F 0164	F164 It is the policy of Hooverwood to monitor each residents personal privacy to include, but not be limited to accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. 1.Social Service's met with Residents #136, #35 and #33 to provide psychosocial support. These residents were not found to have been affected by the alleged deficient practices. The policies and procedures relating to the alleged deficient practices were reviewed with all CNA's and licensed nurses as part of the comprehensive in-service. 2.Nursing Administration conducted facility wide observations to determine if other residents were affected by these alleged deficient practices. Per this review, there were no other residents found to have been affected	11/16/2017

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	him care. Resident 35 also indicated often after staff knocked on his door they failed to wait for a response before entering his room and they didn't close his door when they exited. The record for Resident 35 was reviewed on 10/12/17 at 04:06 p.m. Diagnoses included, but were not limited to, type 2 diabetes, heart failure and bipolar disorder. 3. During an interview with Resident 33, on 10/10/17 at 1:39 p.m., Resident 33 indicated staff does not close the door or blinds when they provide care. The record for Resident 33 was reviewed on 10/13/17. Diagnoses included, but were not limited to, hypothyroidism, type 2 Diabetes Mellitus without complications and hyperlipidemia. During an observation, on 10/13/17 from 3:24 p.m. to 03:28 p.m., the nurse's cart was parked in the common area in front of the main dining room, the computer was on and Resident 33's electronic medical record was open, to the evaluation tab, and easily viewed by anyone passing the area. During interview with RN 5, on 10/13/17 at 3:28 p.m., RN 5 indicated she just walked away from her computer and		by the alleged deficient practices. 3.In-services for licensed nurses and CNA's will take place on or before November 15, 2017 in order to review this and all other alleged deficient practices identified in the annual survey. Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. (In-service material included and identified as Attachment 1.) Nursing Administration developed a monitoring tool and will conduct random audits 2 times a day for 5 days a week for at least 30 days. If audits show noted improvements, audits will be performed 2 times a day for 3 days a week for at least 30 days and if continued improvement is noted, audits will be conducted randomly at least 2 times weekly thereafter. The ongoing training and observations will decrease the potential for other residents being affected by these same deficient practices. (QAA Monitoring Tool for Personal Privacy/Confidentiality of	

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	should not have left the medical record information unsecured. During an observation of a dressing change on, 10/16/17 at 10:59 a.m., LPN 6 began the dressing change with Resident 33's blinds open and door half open. LPN 6 left Resident 33's room to check the treatment order and upon returning left Resident 33's door open as she completed the treatment. A current policy titled, "Dignity and Resident Care", provided by the scheduler, on 10/17/17 at 12:15 p.m., indicated: "...Curtains and/or doors should be closed when staff are providing care in the resident's room...." A current policy titled, " HIPAA Privacy Policies", provided by the Administrator, on 10/17/17 at 11:15 a.m., indicated "...When you need to leave your work area, make sure the computer is logged off so others do not have access to it...." 3.1-3(o) 3.1-3(p)(2) 3.1-3(p)(3) 3.1-3(p)(4)		Records is included as Attachment 2.) 1.Any alleged deficient practice identified in the daily and monthly review 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 monthly. This monitoring will continue ongoing as a continuous quality improvement measure unless otherwise determined by the QA / QAPI Committee. 2.Date of Completion:November 16, 2017	

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F 0246 SS=D Bldg. 00	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to have the resident's call lights accessible for 3 out 40 of residents reviewed for accommodation of needs (Residents 4, 22 and 91). Findings include: 1. The record for Resident 4 was reviewed on 10/13/2017, at 11:22 a.m. Diagnoses included, but were not limited to, heart failure, respiratory failure with hypoxia and anxiety disorder. A care plan for Resident 4, received from	F 0246	F246 It is the policy of Hooverwood that all residents will be treated with respect and dignity and all residents have the right to receive services at Hooverwood with reasonable accommodation of resident needs and preferences including but not limited to having their call-light accessible. 1.The Resident's #4, #22 and #91 call lights were checked to determine if call light clips needed to be	11/16/2017

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	the Scheduler on 10/17/17, at 3:05 p.m., indicated, "...Resident 4 was at high risk for falls...Be sure Resident 4's call light was within reach and encourage the resident to use it for assistance as needed. The Resident needed prompt response to all requests for assistance...." On 10/12/2017, at 2:00 p.m., Resident 4 was observed in bed with the call light at the end of the bed wrapped up in a blanket, out of reach of Resident 4. During an interview on 10/17/2017, at 2:10 p.m., QMA (qualified medication aide) 1 indicated Resident 4 was able to and did use the call light. 2. The record for Resident 22 was reviewed on 10/12/2017, at 2:10 p.m. Diagnoses included, but were not limited to, Parkinson's Disease, hypertension and anemia. A care plan for Resident 22, received from the Scheduler on 10/17/17, at 3:00 p.m., indicated, "...Resident 22 had an ADL (activities of daily living) self-care deficit...encourage Resident 22 to use bell to call for assistance...." On 10/12/2017, at 2:58 p.m., Resident 22 was observed in bed, the call light was on the floor, out of reach of the Resident.		replaced and / or installed. Residents #4, #22 and #91 were not found to have been affected by the alleged deficient practices. The policies and procedures relating to the alleged deficient practices were reviewed with all CNA's and licensed nurses as part of the comprehensive in-service. 2.Immediate rounds were conducted throughout the facility to determine what call light clips need to be replaced and / or installed. In addition, making sure all call-lights are functioning properly and within residents reach. There were no other resident identified as having been affected by the alleged deficient practice. 1.In-services for licensed nurses and CNA's will take place on or before November 15, 2017 in order to review this and all other alleged deficient practices identified in the annual survey. Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. (In-service material included and identified as Attachment 1.)	

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	On 10/13/2017, at 2:03 p.m., Resident 22 was observed in bed, the call light was dangling down between the wall and the bed frame, out of reach of the Resident. During an interview, on 10/12/2017, at 3:01 p.m., CNA 3 indicated the call light for Resident 22 should have been placed within reach of the Resident. During an interview, on 10/13/17, at 2:03 p.m., CNA 2 indicated the call light should have been placed within reach of Resident 22. 3. The record for Resident 91 was reviewed on 10/12/17, at 2:10 p.m. Diagnoses included, but were not limited to, hypertension, difficulty walking and cognitive communication deficit. A care plan for Resident 91, received from the Scheduler on 10/17/17, at 3:00 p.m., indicated, "...Resident 91 was at risk for impaired skin integrity...place call light within reach...Resident 91 had the potential for alteration in urinary and bowel incontinence...place call light within reach and answer promptly when used...." On 10/13/2017, at 1:27 p.m., Resident 91's call light was observed hanging from		Nursing Administration developed a monitoring tool and will conduct an audit on every shift for 5 days a week for at least 30 days. If audits show noted improvement, audits will be performed on every shift 3 days a week for at least 30 days and if continued improvement is noted, audits will be conducted randomly at least 2 times weekly. The ongoing audit will decrease the potential of other residents being affected by this same alleged deficient practice. (QAA Monitoring Tool - Reasonable Accommodation of Needs/Preferences - Call-lights is included as Attachment 3.) 1.Any alleged deficient practice identified in the audits and monthly reviews 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 monthly. This monitoring will continue ongoing as a continuous quality improvement measure unless otherwise determined	

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	the wall, dangling to the floor, out of reach of the Resident. During an interview, on 10/13/2017, at 1:59 p.m., CNA 4 indicated the call light should have been placed in reach of Resident 91. A facility policy, received from the scheduler, on 10/17/17, at 12:15 p.m., indicated, "...Make sure all call lights were within reach...." 3.1-3(v)(1)		by the QA / QAPI Committee. 2.Date of Completion:November 16, 2017	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and			

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	(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to ensure a dressing change was completed in a manner to prevent possibility of wound contamination for 1 of wound care observation. (Resident 33) Findings include: During a wound treatment observation on 10/13/17 starting at 10:59 a.m., LPN 6 was observed to use her scissors to cut off an old Kerlix (rolled gauze) dressing from Resident 33's left heel and right ankle. After providing treatment LPN 6 then used the same scissors to cut a clean foam dressing and placed the foam dressing over Resident 33's right ankle pressure wound. A record review completed on 10/13/17 indicated Resident 33 had a stage 2 (a wound that has broken the skin due to prolonged pressure to the area) pressure wound on the right lateral (outside) ankle and a healing pressure wound on her left heel. The current doctor's ordered wound	F 0314	F314 It is the policy of Hooverwood that residents with pressure ulcers, as identified through the comprehensive assessment, receive care consistent with professional standards of practice. 1.The wound dressing for Resident #33 was immediately changed. LPN #6 was re-educated to correct treatment protocol. Resident #33 was not found to have affected by this alleged deficient practice. 2.During a QAPI review of the Wound Care Policy and Procedure, it was identified that the procedure required additional clarification and as such, the policy was revised and licensed nurses were in-serviced. Nursing Administration will be conducting observations of dressing changes. There were no other resident identified as being affected by this alleged deficient practice. 3.In-services for licensed nurses will take place on or	11/16/2017

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	treatment was to continue collagen/hydrogel (a mediation use to help heal open wounds) dressing order to right lateral malleolus (ankle) daily, cover with adhesive foam pad and continue until healed. Change daily. During and interview following the wound treatment LPN 6 indicated she should have cleaned her scissors with an antibacterial before cutting the clean foam dressing. A current policy titled "Wound Care Policy and Procedure" provided by the scheduler, on 10/17/17 at 12:15 p.m., indicated "...8. Using clean scissors remove the tape and dressing from the wound...9. Place the soiled scissors on one corner of the bag not touching any of the supplies...." 3.1-40(a)(2)		before November 15, 2017 in order to review this and all other alleged deficient practices identified in the annual survey. Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. (In-service material included and identified as Attachment 1.) Nursing administration developed a monitoring tool and will conduct 3 dressing change observations per week per unit for at least 30 days. If audits show noted improvement, audits will be conducted randomly at least 2 times weekly thereafter. The monitoring will decrease the potential for other residents being affected by this deficient practice. (QAA Monitoring Tool - Treatment to Prevent/Heal Pressure Sores is included as Attachment 4.) 1.Any alleged 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	

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			basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI / QAPI Committee. 2.Date of Completion:November 16, 2017	
F 0315 SS=D Bldg. 00	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review the facility failed to ensure an anchored catheter drainage bag was positioned in a manner to prevent the possibility of infection for 1 of 2 residents reviewed for infection control (Resident 160). Finding includes: 1. On 10/13/2017 at 11:25 a.m., CNA 13 was transporting Resident 160 down the hallway in her wheel chair, Resident 160's catheter bag was observed to be dragging on floor under the wheel chair. CNA 13 was informed Resident's catheter bag was not secured to her wheel chair and was dragging on the floor. At that time CNA 13 retrieved the catheter bag from the ground and indicated the clip used to secure the bag to the wheel chair was broken. CNA 13 began assisting Resident 160 back to her room while holding the catheter bag off of the ground. At that time RN 7 approached and CNA 13 informed her Resident 160's catheter bag was on the floor due to a	F 0315	F315 It is the policy of Hooverwood that any resident with an indwelling catheter as identified through the comprehensive assessment, receives care consistent with professional standards of practice. 1.The clip for Resident #160's the catheter bag was replaced. Resident #160 was not found to have been affected by this alleged deficient practice. 2.Nursing Administration assembled a list of all residents with catheters and developed a monitoring tool to ensure compliance. Per this review, there were no other residents found to have been affected by this deficient practice. 1.In-services for licensed nurses and CNA's will take place on or before November 15, 2017 in order to review this and all other alleged deficient practices identified in	11/16/2017

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	broken clip. During an interview on 10/17/2017 at 3:20 p.m., RN # 15 indicated Resident 160's catheter bag had not been replaced and she was unaware Resident's catheter bad had been on the ground. The record for Resident 160 was reviewed on 10/12/17 at 03:31 p.m. Diagnoses included, but were not limited to, hypertension, urinary tract infection and type 2 diabetes. A physician's order, dated 11/10/2017, indicated, "...Change Foley catheter on 11/9/17 one time only for urinary...." A current policy titled "Urinary Drainage Bag and Tubing Care" provided by the scheduler, on 10/17/17 at 12:15 p.m., indicated "...Purpose: To prevent urinary tract infection ...3. The drainage bag shall be attached ...so that it does not touch the floor. 3.1-18(a)		the annual survey. Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. (In-service material included and identified as Attachment 1.) Nursing Administration will utilize the monitoring tool to perform random checks of residents with catheters and replace clips if broken. The ongoing training and monitoring will decrease the potential of other residents being affected by these same deficient practices. (QAA Monitoring Tool - Catheter, Prevent UTI, Restore Bladder is included as Attachment 5.) 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	

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F 0371 SS=F Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Based on observation, interview and record review the facility failed to monitor the temperatures for 1 of 1 refrigerator, 2 of 2 freezers and 4 of 5 coolers. The facility also failed to cover open food and to labeled foods with open/received dates. This deficient	F 0371	F371 It is the policy of Hooverwood to procure, store, prepare and serve food in accordance with professional standards for food service safety. 1.The temperatures of the refrigerator, freezers, and	11/16/2017

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	practice had the potential to effect 116 of 118 residents who receive food from the kitchen. Findings include: During a kitchen tour with the Food Service Director, on 10/10/17 beginning at 10:20 a.m., the following were observed: 1. The Bakery Refrigerator temperature was not documented on the temperature log on 10/01, 10/06, 10/07, 10/08 and 10/09 of 2017. 2. The Bakery Freezer temperature was not documented on the temperature log on 10/01, 10/03, 10/04, 10/05, 10/06. 10/07, 10/08 and 10/09 of 2017. 3. The Meat Freezer temperature was not documented on the temperature log on 10/05 and 10/06 of 2017. 4. The Nourishment Cooler temperature was not documented on the temperature log on on 10/06/17. 5. The Dairy Cooler temperature was not documented on the temperature log on 10/06/17. 7. The Meat Cooler temperature was not documented on the temperature log on 10/06/17. 8. The Trayline Cooler temperature was not documented on the temperature log on 10/04 and 10/06/17.		coolers were checked. The box of frozen peas, box of frozen carrots and bag of toasted oats cereal were all immediately discarded. There were no residents identified as being affected by this alleged deficient practice. 2.The temperatures of all the refrigerator, freezers, and coolers were all immediately taken and the open / unlabeled foods were all immediately discarded in order to minimize the potential for any other residents being affected by this same alleged deficient practice. 3.In-services for all food service staff will take place on or before November 15, 2017 in order to review this and all other alleged deficient practices identified in the annual survey. Those food service employees identified to have been responsible for the alleged deficient practices received re-education. (In-service material included and identified as Attachment 6.) During a QAPI review of the current Refrigerator / Freezer Temperature Logs and the Unlabeled / Open Item Log, it was identified that forms needed updated. Updates	

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	9. One full 30 pound box of frozen peas was found open, in the freezer, and without an open date label. 10. One half full 30 pound box of frozen carrots was found open, in the freezer, and without an open date label. 11. One 35 ounce bag of toasted oats cereal, one third full, was found open on the shelf and without an open date label. At that time the Food Service Director indicated refrigerators, coolers and freezer temperatures should be checked daily and documented on the temperature log. A current policy titled, "Nourishment/Kitchen Refrigerators and Stoves and Employee Meal Refrigerators", provided by the Administrator, on 10/17/17 at 3:44 p.m., indicated "...8. Both the refrigerator and freezer temperatures shall be checked daily...and the information documented on the departmental Refrigerator and Freezer Log's...." A current policy titled "Food and Supply Storage Procedures" provided by the Administrator, on 10/10/17 at 12:12 p.m., indicated "...Cover, label and date unused portions and open packages...." 3.1-21(i)(3)		were completed November 1, 2017 and food service staff were in-serviced. These compliance log's will be maintained in the main kitchen and in all kitchenettes that will document the compliance of monitoring temperatures and dating all open food items. The Food Service staff will be responsible for completing these logs on a daily basis. (Refrigerator Temperature Log, Freezer Temperature Log and Unlabeled / Open Item Log is included as Attachment 7.) 1.The Dietitian, Food Service Manager, and Food Service Director will be responsible for monitoring these logs daily to assure accurate compliance. Any alleged 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.	

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			2.Date of Completion:November 16, 2017	
F 0431 SS=E Bldg. 00	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. 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			

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	date when applicable. (h) Storage of Drugs and Biologicals. (1) 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. (2) 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 dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to safely store medications in 1 of 4 medication carts and 1 of 4 medication rooms, failed to ensure expired medication was discarded appropriately in 3 of 4 medication rooms and 3 of 4 medication carts, failed to date perishable medications upon opening in 3 of 4 medication rooms and 1 of 4 carts, failed to secure medications in a locked storage area in 1 of 4 medication rooms and failed to ensure medication labels were legible in 2 of 4 medication rooms and 1 of 4 medication carts observed.(Resident 14, 108, 142, 1, 119, 156, 43, 22, 136, 51, 161, 35, 110, 15, 45 and 17.)	F 0431	F431 It is the policy of Hooverwood that all drug (medication) records, labeling, storage, opening and dating are done in accordance with professional standards of practice. 1.On 1A, the blood sugar medication and injector pen and dietary supplement was discarded. On C, the anti-anxiety medications were destroyed. The eye solution, injector pen, blood sugar medication bag, vitamin supplement, IV tubing, safety needle, hypodermic needle, box of breakfast essentials, and cough medication were	11/16/2017

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	Findings include: 1. During an observation of the unit 1A medication room, on 10/16/2017 at 1:49 p.m., with LPN 9 in attendance the following was found: One open 10 ml (milliliter) vial of Lantus (a medication to treat high blood sugar), ordered for Resident 14, without an open date in the medication refrigerator. One 3 ml Humalog injector pen (a medication to treat high blood sugar), ordered for Resident 14, with an open date of 09/17/17 in the medication refrigerator. Two 20 pack boxes of breakfast essentials light start (a dietary supplement) stored in an upper cabinet next to a 100 fluid ounce bottle of Tide laundry soap. 2. During an observation of the unit C medication room, on 10/16/2017 at 2:29 p.m., with LPN 6 in attendance the following was found: One open 2.5 ml bottle of Travatan ophthalmic solution (used to reduce pressure in the eye), ordered for Resident 108, with an expiration date of August 2017.		discarded. On 2A, the narcotic, anti-anxiety medication were destroyed. The blood sugar medication was discarded. On 2B, the allergy medication, eye solution, and anti-fungal medication were all discarded. The narcotic was destroyed. Maintenance immediately installed an automatic door closer on the C-wing medication room. There were no residents found to have been affected by this alleged deficient practice. 1.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. Maintenance installed an automatic door closure on the C-Wing Medicine Room Door and audited all other medicine room doors and did not find any others without the required automatic closure. 2.In-services for licensed nurses will take place on or before November 15, 2017 in order to review this and all other alleged deficient practices identified in the annual survey. Those nursing department employees	

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	One open 3 ml Novolog injection pen (a medication to treat high blood sugar), ordered for Resident 142, with an expiration date of 9/16/17, and stored in a bag labeled Levemir (a medication to treat high blood sugar). One open 30 ml bottle of Lorazepam (an anti-anxiety medication), ordered for Resident 1, with no open date. One open 30 ml bottle of Lorazepam, ordered for Resident 119, received on 8/29/16, without an open date and the expiration date covered by a label. One 100 capsule bottle of I caps (a vitamin supplement), ordered for Resident 119, with an expiration date of September 2017. One open 30 ml bottle of Lorazepam ordered, for Resident 156, with no open date. One small-bore extension set (used to extend IV tubing) with an expiration date of May 2015 One 1/2 inch 26 gauge safety needle (used to inject medications) with an expiration date of February 2017.		identified to have been responsible for the alleged deficient practices received re-education. (In-service material included and identified as Attachment 1.) Nursing administration developed a monitoring tool and will conduct 2 medication cart. treatment cart and medicine room observations per week per unit for at least 30 days. If audits show noted improvement, audits will be conducted randomly at least 2 times weekly thereafter. The monitoring will decrease the potential for other residents being affected by this deficient practice. (QAA Monitoring Tool - Drug Records, Label/Store Drugs & Biologicals is included as Attachment 8.) The contracted pharmacy will continue to inspect the medication carts on a monthly basis and report their findings to Nursing Administration. 1.Any alleged 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	

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	One 2 inch 20 gauge Hypodermic (beneath the skin) needle with an expiration date of 12/01/2014 During an interview, at that time, LPN 9 indicated expired medications should have been removed from stock then destroyed or sent back to the pharmacy. 3. During an observation of the unit C medication cart, on 10/17/2017 at 11:59 a.m., with RN 5 in attendance the following was found: One box of breakfast essentials light start stored next to an 8 ounce aerosol can of Air Wick air freshener. One open 30 ml bottle of Lorazepam, ordered for Resident 43, and received in February 2017 with an illegible label due to soilage and no open date. One open 473 ml bottle of guaifenesin (a cough medication), ordered for Resident 22, with an expiration date of 08/15/17. 4. During an observation of the unit 2A medication cart, on 10/17/2017 at 2:38 p.m., with LPN 11 in attendance the following was found: One 30 ml bottle of morphine sulfate (a narcotic pain medication), ordered for		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:November 16, 2017	

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	Resident 136, with an open date of 06/15/17. 5. During an observation of the unit 2A medication room, on 10/17/2017 at 2:48 p.m., with LPN 11 in attendance the following was found: One open 30 ml bottle of Lorazepam, ordered for Resident 51, with an open date of 12/28/16. One open 30 ml bottle of Lorazepam, ordered for Resident 161, without an open date and a manufacture's expiration date which was covered by a hand written label. One open 10 ml vial of Humulin R (a medication used to treat high blood sugar), ordered for Resident 35, with an open date of 09/12/17. 6. During an observation of the unit 2B medication cart, on 10/17/2017 at 3:28 p.m., with RN 12 in attendance the following was found: One 16 gram bottle of Flonase nasal spray (used to treat allergies), ordered for Resident 110, one 16 gram bottle of Flonase nasal spray, ordered for resident 15, one 15 ml bottle of timolol ophthalmic solution (used to reduce			

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	pressure in the eye), ordered for Resident 15 and one 6.6 ml bottle of ciclopirox (an anti-fungal medication), ordered for Resident 45, stored together in the same compartment. One 30 ml bottle of morphine sulfate, ordered for Resident 17, with an open date of 06/18/17. During an interview at that time RN 12 indicated the facility normally kept open bottles of morphine and lorazepam for five to seven months. 7. During an observation, on 10/13/17 from 3:24 p.m. to 03:28 p.m., the C-Wing medication room door, which is located off the common area and not adjacent to the nurses station, was found open and unattended. During an interview with RN 5, on 10/13/17 at 03:28 p.m. she indicated the med room door should have been closed. A current policy titled "Labeling of Medications" provided by the scheduler, on 10/17/17 at 12:15 p.m., indicated: "...All drugs shall be labeled in compliance with State and Federal Laws...5. The labels on all medications must be clean and legible...6. Containers which are...soiled...shall not be used ...."			

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	A current policy titled "Williams LTC Pharmacy Policy and Procedure" provided by the scheduler on 10/17/17 at 12:15 p.m., indicated, "...2. The facility is required to secure all medications in a locked storage area... 5. Eye drops are stored separate from ear drops...8. Potential harmful substances are stored in a locked area separately from the medications...a. Potential harmful substances may include, but are not limited to...cleaning supplies, and disinfectants...." A current policy titled "Williams LTC Expiration Dating Policy" provided by the scheduler, on 10/17/17 at 12:15 p.m.,indicated, "...Lorazepam Solution...opened...refrigerator-90 days ...Humulin R ...Novolog...Room Temp/Fridge; 28 days...." 3.1-25(o) 3.1-25(m) 3.1-25(j)			