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	10/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 the Investigation of Complaint IN00419026. Complaint IN00419026 - Federal/State deficiencies related to the allegations are cited at F760. Survey date: October 12, 2023 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census Bed Type: SNF/NF: 149 Total: 149 Census Payor Type: Medicare: 14 Medicaid: 97 Other: 38 Total: 149 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 19, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 11/13/23.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for 3 of 6 residents reviewed for medication administration. (Residents B, C and D)	F 0760	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/13/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	11/02/2023

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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	Findings include: 1. The record for Resident B was reviewed on 10/12/23 at 2:10 p.m. Diagnoses included, but were not limited to, vascular dementia, type 2 diabetes, and hypertension. A physician's order, with a start date of 12/3/22, indicated to give Humalog (also known as Lispro insulin) per sliding scale. A physician's order, with a start date of 2/18/23, indicated to give Lantus 6 units at bedtime every day. A nurses' note, dated 9/4/23 at 10:14 p.m., indicated the resident was given the wrong insulin at the beginning of the shift. The physician was contacted, and an order was given to hold the Lantus insulin that evening, to give 10 units of Humalog insulin, and to recheck the blood sugar in one hour. A facility document, titled "HOOVERWOOD IN-SERVICE," was provided by the Director of Nursing on 10/12/23 at 4:45 p.m. The form indicated the subject was insulin and an education video was reviewed by RN 3. The education also included a review of an insulin chart and a verbal return demonstration. The form was dated 9/4-9/7/23. RN 3 and another staff member were the only ones noted on the educational in-service form. The facility was not able to provide documentation to show other staff were educated on medication administration and medication errors after this medication error event.		**practice;** Resident B's Medication Administration Record was reviewed, a med pass was observed and no concerns noted Resident C's Medication Administration Record was reviewed, a med pass was observed and no concerns noted Resident D's Medication Administration Record was reviewed, a med pass was observed and no concerns noted **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Education to be provided via inservicing by 11/2/2023. Education to include Medication Administration Procedures by DNS/designee -All residents have potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education to be provided via inservicing by 11/2/2023. Education to include Medication Administration Procedures by	

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	During a telephone interview, on 10/12/23 at 4:32 p.m., RN 3 indicated she administered the wrong insulin to Resident B. She administered the long-acting insulin, Lispro, instead of the insulin Humalog. She did keep checking the Medication Administration Record and did not know why she had gotten confused. It was her first time with insulin, and she was a new nurse. She did not ask another nurse to recheck/verify the medication prior to administering it. She indicated when administering medications, she needed to ensure it was the correct resident, the correct medication, the correct dose, and the correct time of the medication administration. 2. The record for Resident C was reviewed on 10/12/23 at 5:15 p.m. Diagnoses included, but were not limited to, pneumonia, malignant neoplasm of female breast (breast cancer), and cerebral infarction (stroke). The hospital discharge order indicated to start taking Xeloda (capecitabine) 500 milligrams, take three (3) tablets by mouth two times a day. Days 1-14 of every 21-day cycle. The date of the order was 9/5/23. An order summary, dated 9/6/23, indicated Xeloda (an antineoplastic medication for cancer) oral tablet 500 milligrams was to be given by mouth twice a day for breast cancer for 14 days. The order had a hold date of 9/6/23 at 4:11 p.m., to 9/7/23 at 4:10 p.m. The reason for the hold order indicated per hospital orders. A physician's order, with a start date of 9/11/23 at 9:00 a.m., indicated to give Xeloda 500 mg by mouth two times a day for breast cancer for 14 days (total dose 1500 milligrams) twice a day. The order also included a hold date from 9/6/23 at 4:11		DNS/designee DNS/designee will observe Medication Administration Pass 5 x/ week for 4 weeks, then weekly for 3 months DNS/designee will review orders placed on hold to ensure accuracy, during the clinical meeting Facility to provide on going training and skills validations for Medication Administration, as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** The DNS/designee will be responsible for the completion of the Med Pass Audit Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	p.m., to 9/7/23 at 4:10 p.m., and a discontinue date of 9/9/23 at 6:19 p.m. A nursing note, dated 9/9/23 at 6:28 p.m., indicated "...Two tabs of Xeloda given today on day shift by floor nurse. Res A&O x 3 [resident alert and oriented to person, place, and time], no complaints voiced. Vitals taken and WNL [within normal limits] ...Staff to monitor for any s/s [signs and symptoms] of adverse reaction...." There was no documentation on the Medication Administration Record to show the administration of the medication was given on 9/9/23. A physician's order, with a start date of 9/13/23 at 6:00 p.m., indicated to give Xeloda 500 mg. Give three (3) tablets by mouth two times a day for breast cancer for 14 days, off for seven (7) days then restart. The order had a discontinue date of 9/15/23 at 8:52 a.m. A physician's order, with a start date of 9/15/23, indicated to give Xeloda 500 milligrams (mg), three tablets by mouth two times a day for breast cancer for 14 days, off for seven (7) days then restart. A facility document, titled "HOOVERWOOD EMPLOYEE COMMUNICATION FORM EDUCATION," was provided by the Director of Nursing on 10/12/23 at 4:45 p.m. The document indicated "...On 9/6/23 orders were clarified with a residents outside provider re: Xeloda. Med was to be held until 9/13/23. order was placed on hold... 9/6/23. The hold timed out by 9/9/23 then showing active. Floor nurse then gave med x 1 administration in error...Action...when receiving hold orders ensure time duration matches orders received from outside provider and/or Medical Director...." The document was signed by the			

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	Director of Nursing and the Assistant Director of Nursing on 9/11/23. There were no other employees noted on the form to have been included in the education. During an interview, on 10/12/23 at 4:48 p.m., the Director of Nursing indicated the cancer drug, Xeloda, came from the hospital. Resident C was not to start the medication and the facility placed the order on hold. The order fell off hold and showed up on the Medication Administration Record, but the resident was not to start the medication. 3. The record for Resident D was reviewed on 10/12/23 at 1:29 p.m. Diagnoses included, but were not limited to, pain in right foot, pain in left foot, and low back pain. A physician's order, dated 9/19/23, indicated to apply 12 microgram (mcg) fentanyl transdermal patch 72 hour, every 72 hours for pain related to intervertebral disc degeneration of the lumbar region. A nursing note, dated 10/1/23 at 9:20 p.m., indicated two (2) fentanyl 12 mcg patches were removed from the right side of Resident B's chest. A new patch was applied. The resident was alert and oriented and no adverse reaction were noted. A facility document, titled "HOOVERWOOD EMPLOYEE COMMUNICATION FORM," indicated LPN 2 would ensure the facility policy and procedure were followed in relation to medication administration and treatment orders. The form did not indicate if education was provided. The form was signed by the Director of Nursing and LPN 2 on 10/3/23.			

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	The facility was not able to provide any further education to staff related to medication administration or medication errors after this medication error event. During an interview, on 10/12/23 at 4:17 p.m., the Director of Nursing indicated when it was time to administer a new fentanyl (a narcotic) patch to Resident B, two fentanyl patches were found on the resident. LPN 2, who had placed the second narcotic patch, had been educated on the facilities medication policy and procedure. The facility did have an all staff meeting at the end of September and they discussed medications and medication administration with the nurses and QMAs. The facility did not conduct observations of medication pass or audits of medication pass or medication errors. During a telephone interview, on 10/12/23 at 4:31 p.m., LPN 2 indicated she did check Resident B for other fentanyl patches, she did not see or feel one on the resident. She was informed two patches were found on the resident and she was educated by the Director of Nursing and indicated "she rattled off education." LPN 2 indicated when administering medication, she was to check the medication, ensure it was the correct resident, the correct dose of medication, the correct time for the medication and when applying a medication patch (to the skin) rotate the site (put the medication patch in a different area from the last medication patch). During an interview, on 10/12/23 at 4:01 p.m., LPN 1 indicated when prepping medications for administration you need to check for the right resident, right medication, the right dose of medication and the right time for the administration of the medication, also check for			

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	medication patches on the resident's body before applying another medication patch. A current facility policy, titled "Medication Administration," dated as last revised 8/2022 and provided by the Director of Nursing on 10/12/23 at 5:36 p.m., indicated "...All medications will be administered utilizing the five (5) rights of medication passing...RIGHT PATIENT...RIGHT DRUG...RIGHT DOSE...RIGHT ROUTE...RIGHT TIME...." A current facility procedure, titled "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES," dated as effective 5/2016 and provided by the Director of Nursing on 10/12/23 at 5:36 p.m., indicated "...Purpose...To administer medication through the skin through proper placement of the patch and care of the application sites...Remove old patch from body...Cleanse area of old patch...Cleanse area where new patch will be placed...Label patch with date and nurse's initials...Apply new patch...." This Federal Tag relates to Complaint IN00419026. 3.1-48(a)(1)			
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00419026. Complaint IN00419026 - State deficiencies related to the allegations are cited at R301. Survey date: October 12, 2023 Facility number: 000001	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible	

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	Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 19, 2023.		allegation and requests desk review (paper compliance) on or after 11/13/23.	
R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review, the facility failed to have accurate labels on medications for 1 of 5 residents reviewed during medication administration. (Resident 4) Finding includes: During a medication administration observation, on 10/12/23 at 9:57 a.m., LPN 4 was observed preparing the medications to be administration to Resident 4. During the preparation of the medications, the following medications labels were found to be different then the medications prepared.	R 0301	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 4's Medication Labels were reviewed and are labeled correctly **How other residents having the potential to be affected by the same deficient practice will be**	11/13/2023

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	LPN 4 was observed preparing two tablets of hydrazaline (a blood pressure medication) 25 milligrams (mg). The label on the medication indicated to give three (3) tablets of hydrazaline 25 mg daily. LPN 4 was observed preparing one tablet of hydrazaline 50 mg. The label on the medication indicated to give one and one half tablet of the medication four times a day. LPN 4 was observed preparing one tablet of torsemide (a medication used to treat edema) 20 mg. The label on the medication indicated to give two tablets of torsemide 20 mg. LPN 4 was observed preparing eight tablets of prednisone (a steroid) 5 mg. The label on the medication package indicated to give one tablet every morning for osteoarthritis. During an interview, on 10/12/23 at 10:03 a.m., LPN 4 indicated the prednisone was changed to 40 mg that morning, and the hydrazaline and torsemide were recently changed. She did not put change of direction labels on the medications and she had them "right here" and pointed to the top drawer of the medication cart. The record for Resident 4 was reviewed on 10/12/23 at 2:36 p.m. Diagnoses included, but were not limited to, hypertension, rheumatoid arthritis, and muscle weakness. A physician's order, dated 10/10/23, indicated to give a half tablet of torsemide 40 mg twice a day. A physician's order, dated 10/10/23, indicated prednisone 20 mg. Give 40 mg by mouth every 24		**identified and what corrective action(s) will be taken;** Education to be provided via inservicing by 11/2/2023. Education to include Medication Labeling Procedures by Clinical Director/designee -All residents have potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education to be provided via inservicing by 11/2/2023. Education to include Medication Labeling Procedures by Clinical Director/designee Clinical Director/designee will observe Medication label's on the resident's Medication bottles 5 x/ week for 4 weeks, then weekly for 3 months Facility to provide on going training and skills validations for Medication Labeling, as needed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed**	

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	hours for five days. A physician's order, dated 3/29/23, indicated to give hydralazine oral tablet 75 mg by mouth four times a day. This order did not have a stop date. The order contained parameters to hold the medication if the blood pressure was less than 110/less than 60. A physician's order, dated 10/12/23, indicated to give hydralazine 75 mg by mouth four times a day. This order did not have a stop date. This medication contained parameters to hold the medication if the blood pressure was less than 110/less than 60. The medication was held after contacting the provider with the blood pressure result of 119/46. During an interview, on 10/12/23 at 10:55 a.m., the Director of Nursing indicated a change of direction was to be noted on the medication card and the pharmacy was to be notified to make the change. A current facility policy, titled "Medication Labeling," dated as revised 5/2022 and provided by the Director of Nursing on 10/12/23 at 10:54 a.m., indicated "...The facility shall maintain accurately labeled medications to assure safe and effective medication administration to the residents...Any medication that is incorrectly labeled shall be sent back to the pharmacy...." This State tag relates to Complaint IN00419026.		The Clinical Director/designee will be responsible for the completion of the Med Labeling Audit Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	