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	11/28/2017

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00245669. Complaint IN00245669-Federal/State deficiencies related to the allegations are cited at F759, F760, F761 and F842. Survey dates: November 27 and 28, 2017 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census bed type: SNF/NF: 122 Total: 122 Census payor type: Medicare: 14 Medicaid: 85 Other: 23 Total: 122 These deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on December 4, 2017.	F 0000	This 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 December 28, 2017.	

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

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F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 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 10 residents observed during medication passes. 2 errors were observed during 28 opportunities for errors in medication administration. This resulted in a medication error rate of 7.14% (Residents E and J) Findings include: 1. On 11/27/17 at 1:29 p.m., RN 1 was observed administering medications to Resident E, which included, but was not limited to, Baclofen (a medication used to relax muscles) 10 mg (milligrams) give one tablet by mouth twice daily in the morning and at noon. Resident E's Electronic Medication Administration Record (EMAR) dated	F 0759	It is the policy of this facility to minimize medication errors and maintain a medication error rate of no more than Five (5) Percent (%). 1. Physician and family of resident E notified of late administration of Baclofen. In addition, the physicians order was clarified as to medication administration time. Physician and family of resident J notified of late administration for Simbrinza. RN 1 was re-educated that if she notes that the pharmacy label and EMAR do not match, she needs to bring this to the Unit Manager and/or Nursing Administrations attention so that a reconciliation can be made. LPN 5 was re-educated on the need to pass medications timely and follow all recommended medication administration	12/28/2017

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	November 2017, included, but was not limited to, the following order: 7/31/17--Baclofen tablet 10 mg Give one tablet orally two times daily in the a.m. and at noon for muscle spasms. During an interview on 11/27/17 at 1:41 p.m., RN 1 indicated Resident E's Pharmacy label on her Baclofen medication card indicated it was to be given in the morning and at noon, but the order was placed in the computer EMAR system to "pop" (indicated to the licensed personnel the residents' medications were in the time frame to, which they were able to safely administer the medications to them) up at 2 p.m., so she could not administer the medication any sooner than 1:00 p.m.. Resident E's EMAR indicated her Baclofen was documented in the 2 p.m., box with RN 1's initials, indicating she had given the resident's medication at that time, which indicated the medication was administered late. 2. During an interview on 11/28/17 at 11:10 a.m., LPN 5 indicated she was late administering some of her residents' medications and Resident J was one of those residents. On 11/28/17 at 11:45 a.m., LPN 5 was		protocols associated with specific medications, such as, administering Simbrinza at least five (5) minutes apart from other topical ophthalmic medications and shaking the bottle well prior to use. 2. All residents have the potential to be affected by the alleged deficient practice. In-services for all licensed nurses and QMA's will take place on or before December 28, 2017 to review this and all other alleged deficient practices identified in this survey. Including, but not limited to: medication administration policy, administering medications timely, importance of the physician's order, pharmacy label and EMAR matching, proper narcotic count documentation, especially liquid medications, process for implementing change orders, proper medication administering protocols as outlined in the Nursing Drug Handbook, etc. (In-service material included and identified as Attachment 1) Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. 3. Monitoring tools have been developed and Nursing Administration and/or Unit	

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	observed administering medications to Resident J, which included, but were not limited to, Simbrinza (a eye drop medication used to lower high eye pressures) Opthalmic Suspension 0.1% (Brinzolamide)/0.2% (Brimonidine) Instill one drop into both eyes three times a day. At that time, LPN 5 was observed administering this medication without shaking the bottle prior to administration and administering other topical opthalmic medications three minutes prior to this medication. Resident J's Electronic Medication Administration Record (EMAR) dated November 2017, included, but was not limited to, the following order: 2/8/17--Simbrinza (Brinzolamide (decreases aqueous humor secretions) and Brimonidine (decreases aqueous humor production while increasing the drainage of the aqueous humor) medications combined) Opthalmic Suspension 0.1% (Brinzolamide)/0.2% (Brimonidine) Instill one drop into both eyes three times a day scheduled to be given on the EMAR at 8:00 a.m., 3:00 p.m. and 8:00 p.m. During an interview on 11/27/17 at 4:03 p.m., the DON (Director of Nursing) indicated the nurses have one hour before and one hour after a schedule medication		Managers and Nursing Supervisors will randomly audit the MARs and TARs of at least ten (10) residents, two (2) times weekly for at least sixty (60) days. In addition, Nursing Administration and/or Unit Managers and Nursing Supervisors will conduct medication pass observations with licensed nurses and QMAs monitoring that medication passes are conducted timely and that medications are administered correctly and per physician order and recommended dispensing guidelines as prescribed through the Nursing Drug Handbook. At least three (3) observations will be conducted weekly on various shifts with at least one of these observations to coincide with any resident on liquid PO Morphine, or other similar type liquid controlled medication. (QAA Monitoring Tool – MARs and TARs – Timely Medication Pass is included as Attachment 2) (QAA Monitoring Tool – Medication Pass Observation is included as Attachment 3). 4. Any alleged deficient practices that are identified will be addressed through re-education and if issues continue, through disciplinary action, additional policy development and/or in-service education. Any trends of the alleged deficient practices will be reported to the QAA Committee monthly. This	

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	time frame to administer the medication. She indicated that expectation was not written in the facility policy, but was something every nurse should have learned in nursing school and these nurses should have known that expectation. The Nursing Drug Handbook 34th Edition, dated 2017, indicated Simbrinza was to be administered at least 5 minutes apart from other topical opthalmic drugs and the bottle was to be shaken well prior to use. The onset (when the medication began working) of the medication was rapid. The peak (the highest concentration of the medication in the resident's bloodstream) for the medications were: Brimonidine--1-4 hours and Brinzolamide--2-3 hours. The duration (the length of time the medication was effective) was unknown and the half-life (how long it takes the body to get rid of half of the dose of the medication) for the medications were: Brimonidine--3 hours and Brinzolamide--111 days. A current policy titled "Medications and Treatments Policy" with a revised date of 08/2017, provided by the Administrator on 11/27/17 at 2:31 p.m., contained the following, "Purpose: To provide correct administration of physician-ordered		monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QAA Committee. If improvement is noted, the QAA Committee may decide to modify the frequency of audits / observations, but still maintain this practice. 5. Completion Date: December 28, 2017	

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	medications and treatments, following the standards of practice (medication, time, dose, frequency and route). Policy and Procedure:..2. Medication shall be administered only as prescribed by written order of the physician...." This Federal tag relates to Complains IN00245669. 3.1-48(c)(1)			
F 0760 SS=G 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 administer a controlled substance at the prescribed dose twice in a six hour time period to ensure a resident was free from significant medication errors for 1 of 12 residents reviewed regarding medication errors (Resident B). This deficient practice resulted in Resident B receiving	F 0760	It is the policy of this facility that all residents will be free of significant medication errors. 1. The physician and family were notified at the time of medication error. This incident was reported to the Indiana State Department of Health as a “Reportable Event”, by Hooverwood’s Administrator. The Nurse involved	12/28/2017

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	an accidental overdose of Morphine Sulfate Concentrate (a medication used to treat pain),which resulted in the resident requiring hospitalization, where her condition continued to decline and she expired. Finding Includes: On 11/27/17 at 9:50 a.m., an "Indiana State Department of Health Survey Report System" report dated 8/18/17, was provided by the Administrator. The report indicated on 8/14/17 at 3:30 p.m., RN 6 self reported to nursing administration she believed she gave the resident two incorrect dosage of pain medication. A nursing assessment was completed, which indicated the resident appeared less responsive than her baseline. The resident was a terminally ill cancer resident with a declining condition. She was transferred to the (Name of Hospital) Emergency room. RN 6 was suspended during the investigation. The report indicated on 8/18/17, the investigation indicated RN 6 failed to administer the physician ordered dosage of Morphine on two separate occasions. During the investigation meeting with RN 6 on 8/17/17, she admitted her mistake. As a result of the investigation, RN 6 was terminated effective immediately. The resident		in this incident was suspended pending investigation. A thorough investigation of the incident was conducted. Due to the seriousness of the incident, the investigation resulted in termination of the nurse's employment. 2. All residents have the potential to be affected by the alleged deficient practice. An audit of all residents on liquid PO Morphine was conducted by Nursing Administration, on August 21, 2017, to verify that the narcotic control administration sheet and medication administration record coincide. Licensed Nurses were reeducated on dosage calculation and the effects / side effects of morphine. In-services for all licensed nurses and QMA's will take place on or before December 28, 2017 to review this and all other alleged deficient practices identified in this survey. Including, but not limited to: medication administration policy, administering medications timely, importance of the physician's order, pharmacy label and EMAR matching, proper narcotic count documentation, especially liquid medications, process for implementing change orders, proper medication administering protocols as outlined in the	

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	remained in the hospital in a declining condition. A "Medication Event Report Form" dated 8/14/17, indicated the date of occurrence was 8/14/17 at 8:00 a.m. and 2:00 p.m. The report indicated the event reached the resident, more than one dose was effected and extra monitoring was required. The reactions the resident experienced from the incorrect doses were lethargy, sleepiness, slight drop in her BP and complaints of pain. RN 6's employee record was reviewed on 11/27/17 at 3:30 p.m., which included, but was not limited to the following information: A handwritten statement from RN 6 dated 8/17/17, indicated she was nearing the end of her shift during the narcotic count and she noticed a discrepancy in the amount of Morphine sulfate on this resident. She checked the EMAR (Electronic Medication Administration Record) and realized Resident B was to receive Morphine Sulfate 5 mg (milligrams) at 8 a.m. and 2 p.m., but after she took a closer look at the resident's routine Morphine order, she realized she had administered 5 ml (milliliters) instead of 0.25 ml, so she had administered an incorrect dose twice.		Nursing Drug Handbook, etc. (In-service material included and identified as Attachment 1) Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. 3. Monitoring tools have been developed and Nursing Administration and/or Unit Managers and Nursing Supervisors will randomly audit the MARs and TARs of at least ten (10) residents, two (2) times weekly for at least sixty (60) days. In addition, Nursing Administration and/or Unit Managers and Nursing Supervisors will conduct medication pass observations with licensed nurses and QMAs monitoring that medication passes are conducted timely and that medications are administered correctly and per physician order and recommended dispensing guidelines as prescribed through the Nursing Drug Handbook. At least three (3) observations will be conducted weekly on various shifts with at least one of these observations to coincide with any resident on liquid PO Morphine, or other similar type liquid controlled medication. (QAA Monitoring Tool – MARs and TARs – Timely Medication Pass is included as Attachment 2) (QAA Monitoring Tool –	

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	A typed statement from LPN 7 dated 8/17/17, indicated RN 6 came to her and indicated "I think I made a med error." She indicated during the shift to shift narcotic count Resident B's Morphine Sulfate Concentrate Solution count was supposed to be 29.75 ml and it was 20 ml, then she checked her Morphine order and realized instead of administering 5 mg, she had administered 5 ml twice on her shift. She indicated she went to assess Resident B at that time and when she called her name she opened her eyes sluggishly and upon further stimulating her by calling her name and rubbing her back, she responded verbally, but very sluggishly. A document dated 8/17/17, titled "Take off Payroll" indicated RN 6 was terminated on 8/17/17 and was not eligible for re-employment A document titled "Use of Syringes and Destruction of Used Syringes" signed by RN 6 on 1/12/17, indicated "It is the responsibility of every Licensed Nurse to follow the manufacturer's instructions regarding the use of syringes for medication administration. It is the responsibility of each Licensed Nurse to know how to use each syringe and how to properly destroy each syringe prior to using the syringe...."		Medication Pass Observation is included as Attachment 3). All liquid PO narcotic orders must be verified by 2 Licensed Nurses or a Licensed Nurse and a Nurse Practitioner, Physician or Pharmacist prior to administering medication. 4. Any alleged deficient practices that are identified will be addressed through re-education and if issues continue, through disciplinary action, additional policy development and/or in-service education. Any trends of the alleged deficient practices will be reported to the QAA Committee monthly. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QAA Committee. If improvement is noted, the QAA Committee may decide to modify the frequency of audits / observations, but still maintain this practice. 5. Completion Date: December 28, 2017	

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	The record review for Resident B was completed on 11/28/17 at 1:15 p.m. Diagnoses included, but were not limited to, dysphagia, chronic lymphocytic leukemia, and Morphine overdose accidental or unintentional. Resident B's Physician orders dated August 2017, included, but were not limited to, the following orders: 7/24/17--Morphine Sulfate solution 20 mg (milligrams)/1 ml (milliliter) Give 5 mg by mouth four times a day for dyspnea. (Discontinued on 8/14/17) 8/14/17--Naloxone HCL (a medication given to reverse the effects respiratory depression from an overdose of opiate medications) liquid 4 mg/0.1 ml Inject 0.4 mg/ml subcutaneously one time only for lethargy. 8/14/17--Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 0.25 mg sublingually four times a day for SOB (shortness of breath)/pain management. A print screen copy of medication administration log times dated 8/18/17 at 2:08 p.m., indicated RN 6 administered the Morphine Sulfate on 8/14/17 at 9:46 a.m. and 12:38 a.m., to Resident B.			

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	A progress note dated 8/14/17 at 4:58 p.m., indicated "Res [resident] given incorrect dose of morphine, M.D. notified, order received to monitor v/s [vital signs] q [every] 30 min [minutes] x [times] 24 hours. If changes in v/s or LOC [Level of Consciousness] to call MD back immediately... Res arouses easily, but is very sleepy...CURRENT V/S 100/55, 102 Pulse, resp [respirations] 14-16, unlabored, O2 sat [oxygen saturation] 96%. Res brought out to common area in w/c [wheelchair] for monitoring." A progress note dated 8/14/17 at 5:17 p.m., indicated "Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 5 mg orally four times a day for Dyspnea medication not administered." A progress note dated 8/14/17 at 6:40 p.m., indicated "Patient is sleepy and will open her eyes when her name is called and fall back to sleep. [Name of Physician] called about change of condition. Order received for Naloxone 0.4 mg/ml SC [Subcutaneously] and sent patient to [Name of Hospital] ER [Emergency Room] for evaluation. 911 ambulance called to for transportation...." A progress note dated 8/15/17 at 2:16 a.m., indicated "Forgoing [sic] nurse			

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	asked writer to correct scheduled morphine order in eMar. after verifying written order writer changed order in eMar to correct dosage to be given. Writer called [Name of Hospital] and spoke with ER charge nurse and was told that resident was admitted...." (Name of Hospital) "History and Physical" dated 8/17/17, indicated Resident B was brought to the hospital due to an accidental overdose of morphine. Her medications to lower her high blood pressure was held since admission due intermittent episodes of low blood pressure. She was being treated for acute hypoxic hypercapnic respiratory failure (respiratory failure resulted from inadequate gas exchange by the respiratory system) likely secondary (occurs after or as a result of the first condition) to morphine overdose, and encephalopathy (loss of brain function) likely secondary to morphine overdose. During an interview on 11/27/17 at 4:03 p.m., the DON (Director of Nursing) indicated the orders can be put in by the residents' Physician or by the nurses, but the Physician must sign off on the order in the computer. Sometimes the Physicians placed the orders in the computer. She indicated the current order for the liquid Morphine for this resident,			

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	when the errors occurred, was placed into the computer (created), confirmed, revised and signed off by the resident's Physician as "Morphine Sulfate (Concentrate) Solution 20 mg/ml *Controlled Drug* Give 5 mg orally four times day for Dyspnea." She indicated the problem with this order, which may have contributed to the medication errors were there was no mls documented by the ordered mg dosage to indicate how many mls were to be administered. She indicated (0.25 ml) should have been placed in the order to clarify the ml amount, but the Physician placed the order in the computer instead of a nurse. She indicated the the nurses were supposed to check over the orders even when the Physician placed them into the computer. The DON indicated RN indicated she mistook the 5 ml being ordered instead of 5 mg and that was what she administered to the resident twice. During an interview on 11/28/17 at 10:52 a.m., the Administrator indicated the "incident" RN 6 was terminated because she indicated she gave Resident B two doses of five mls (100 mg) of Morphine Sulfate Concentrate Solution instead of the prescribed amount.			

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	A current policy titled "Medications and Treatments Policy" with a revised date of 08/2017, provided by the Administrator on 11/27/17 at 2:31 p.m., contained the following, "Purpose: To provide correct administration of physician-ordered medications and treatments, following the standards of practice (medication, time, dose, frequency and route). Policy and Procedure:..2. Medication shall be administered only as prescribed by written order of the physician... 8... b. Narcotics: Medications should be observed carefully for accurate measurements (liquid, powders and tablets) prior to administration. If medication is measuring lower than what should be remaining per narcotic measurement count, then the Nursing Supervisor and Unit Manager need to be notified immediately to investigate why the measurement count is inaccurate. If medication is measuring lower than one order dose or more per lat narcotic measurement count then Nursing Supervisor, Unit Manager and Nursing Administration need to be notified immediately. c. Measurement tools that are provided for medication administration per pharmacy recommendation should be utilized and not altered in any way unless physician order specifies otherwise...."			

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	155001	A. BUILDING 00 B. WING	11/28/2017

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	This Federal tag relates to Complains IN00245669. 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(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 date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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.			

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	§483.45(h)(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 ensure a system of accurate reconciliation of controlled medications (Resident G) for 1 of 5 medication carts observed for medication storage review and failed to properly label medications after order changes for 4 of 5 medication carts observed for medication storage review (Residents G, F, H, K and L). Findings include: 1. On 11/27/17 at 11:49 a.m., LPN 2 was observed preparing Morphine Sulfate for Resident G in the syringe, which came with the Morphine. The Pharmacy label indicated the administration directions were Morphine Sulfate (Concentrate) solution (a narcotic medication used to treat pain) 20 mg (milligrams)/ml (milliliters) Take (0.25 ml) by mouth four times a day and every two hours as needed. Call the Physician if not effective. She was observed at 11:51	F 0761	It is the policy of this facility that all drug (medication), records, labeling, storage, opening and dating are done in accordance with professional standards of practice. 1. Resident G count correction completed. Notified pharmacy of overage. Change of direction sticker added to bottle for resident G. Medical Director (MD) and family notification of medication labeling error for resident F. MD and family notification of medication labeling error for resident H. MD and family notification of medication error for resident K. MD and family notification of medication error for resident L. LPN 2 was re-educated on the proper procedure for documenting liquid medications, especially those considered a narcotic, when first opening a new bottle – whereas the bottle will likely contain more medication than what is documented on the label. In some instances,	12/28/2017

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	a.m., administering (0.25 ml) Morphine Sulfate solution sublingually to Resident G in his room. At 11:55 a.m., after administering the Morphine LPN 2 came back to her medication cart and documented she removed (0.25 ml) of Morphine leaving a remaining amount of 29.75 ml in the bottle according to her documentation on the narcotic count sheet. The Morphine Sulfate bottle was observed with more than 30 ml remaining. Prior to LPN 2 administering the Morphine the bottle had approximately 35 ml. At that time LPN 2 indicated Resident G had to have his medications by G-tube or sublingual, since he had difficulty swallowing. She indicated at that time the bottle required a change of direction sticker, but she had not placed it on the bottle, since she just opened it. She removed the bottle from the locked narcotic drawer and placed a change of direction sticker on the label after she was asked about the Physician order and the Pharmacy label not being accurate. During an interview on 11/27/17 at 3:10 p.m., the DON (Director of Nursing) indicated when the nurses removed the first dose of liquid Morphine from the resident's bottle, they should have documented the actual amount of		including this one, pharmacy's place more liquid in the containers to account for spillage, etc. In addition, LPN 2 was re-educated on the importance of placing "change of direction stickers" on medications as they are received, not waiting as a medication error could have occurred, although in this instance, this nurse was aware that the physicians order had changed from "by mouth to sublingual or by G-tube". The pharmacy has been engaged to conduct an audit of all existing in-house residents to verify that the physician's order, pharmacy label and MAR/TAR/EMAR all match. This audit should be completed by December 22, 2017, and the results will be presented to nursing and medical records to make reconciliations so each record matches. 2. All residents have the potential to be affected by the alleged deficient practice. In-services for all licensed nurses and QMA's will take place on or before December 28, 2017 to review this and all other alleged deficient practices identified in this survey. Including, but not limited to: medication administration policy, administering medications timely, importance of the physician's order, pharmacy label and EMAR	

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	medication in the bottle, not leave the number as the preprinted 30 ml on the narcotic sheet. She indicated she had talked to Pharmacy about the liquid narcotic medications before and the Pharmacy indicated all liquid medications had overfill of medication in them to account for spillage. She indicated the nurses needed to account for the overfill amount in those bottles for the controlled substances On 11/27/17 at 3:30 p.m., with the DON in attendance, Resident G's Morphine Sulfate bottle was observed and she indicated it contained approximately 35 ml not 29.75 ml as documented on his Morphine narcotic count sign out sheet. She indicated LPN 2 should have started the narcotic count sheet with 35 ml when she opened the bottle. A reconciliation for the current Physician orders dated November 2017, was completed on 11/27/17 at 4:03 p.m., which included, but was not limited to, the following order: 11/16/17--Morphine Sulfate (Concentrate) Solution 20 mg/ml Give 0.25 ml sublingually four times a day for labored breathing. 2. On 11/27/17 4:52 p.m., LPN was observed preparing and administering		matching, proper narcotic count documentation, especially liquid medications, process for implementing change orders, proper medication administering protocols as outlined in the Nursing Drug Handbook, etc. (In-service material included and identified as Attachment 1). Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. The pharmacy has been engaged to conduct an audit of all existing in-house residents to verify that the physician's order, pharmacy label and MAR/TAR/EMAR all match. This audit should be completed by December 22, 2017, and the results will be presented to nursing and medical records to make reconciliations so each record matches. 3. Monitoring tools have been developed and Nursing Administration and/or Unit Managers and Nursing Supervisors will randomly audit the MARs and TARs of at least ten (10) residents, two (2) times weekly for at least sixty (60) days. In addition, Nursing Administration and/or Unit Managers and Nursing Supervisors will conduct medication pass observations with licensed nurses and QMAs	

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	Resident F's his medication. The Pharmacy label indicated "Tramadol [a medication used to treat pain] 50 mg [milligrams] Take one tablet by mouth three times a day as needed for pain." A reconciliation of the current Physician orders dated November 2017, was completed on 11/27/17 at 4:50 p.m., which included, but was not limited to, the following order: 10/24/17--Tramadol HCL tablet 50 mg Give 1 tablet by mouth every 8 hours as needed for pain During an interview on 11/27/17 at 4:55 p.m., the DON (Director of Nursing) indicated Resident F's orders on his Pharmacy label and his Physician orders did not match and that was a labeling error. 3. On 11/27/17 at 1:36 p.m., RN 1 was observed preparing and administering Resident H's medications to him. The Pharmacy label indicated "Norco [a narcotic medication to treat pain] 5/325 mg [milligrams] tablet Take one tablet by mouth four times a day for pain." During and interview on 11/27/17 at 1:41 a.m., RN 1 indicated Resident H's Norco was ordered for every six hours as needed for pain on is pharmacy label on the		monitoring that medication passes are conducted timely and that medications are administered correctly and per physician order and recommended dispensing guidelines as prescribed through the Nursing Drug Handbook. At least three (3) observations will be conducted weekly on various shifts with at least one of these observations to coincide with any resident on liquid PO Morphine, or other similar type liquid controlled medication. (QAA Monitoring Tool – MARs and TARs – Timely Medication Pass is included as Attachment 2) (QAA Monitoring Tool – Medication Pass Observation is included as Attachment 3). In addition, Medical Records has developed a monitoring tool and will begin conducting random audits to verify that the physician's order, pharmacy label and MAR/TAR/EMAR all match. These audits will begin following the initial pharmacy audit and reconciliation and medical records will audit at least ten (10) residents weekly, for at least sixty (60) days and then conduct random audits of at least five (5) residents weekly, monthly thereafter. (QAA Monitoring Tool – Physicians Order – Pharmacy Label – MAR/TAR/EMAR Reconciliation is included as	

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	Norco medication card, but the EMAR (Electronic Medication Administration Record) indicated he was to take them four times a day for pain. She indicated in order to correct the pharmacy label on the medication card, so it matched the order on the EMAR, she would have to write the new order change on his Norco label. RN 1 indicated she did not know anything about placing a change of direction order sticker on the label until pharmacy could sent a new medication card. She indicated she would call pharmacy for a new label to place on the Norco card and continue to give the medication as ordered in the EMAR until the new medication came from pharmacy. A reconciliation of the current Physician orders dated November 2017, was completed on 11/27/17 at 4:03 p.m., with the DON (Director of Nursing) in attendance, which included, but was not limited to, the following order: 8/8/16--Hydrocodone/APAP (Acetaminophen) 5/325 mg tablet Give one tablet orally four times a day for pain. 4. On 11/28/17 at 11:57 a.m., LPN 5 was observed preparing and observing Resident K's medications to her, which included, but were not limited to,		Attachment 4) 4. Any alleged deficient practices that are identified will be addressed through re-education and if issues continue, through disciplinary action, additional policy development and/or in-service education. Any trends of the alleged deficient practices will be reported to the QAA Committee monthly. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QAA Committee. If improvement is noted, the QAA Committee may decide to modify the frequency of audits / observations, but still maintain this practice. 5. Completion Date: December 28, 2017	

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	Aspirin. The pharmacy label indicated "Aspirin [a medication used to decrease a patient's risk for heart attack or stroke and decreases inflammation] 81 mg [milligrams] chewable tablet Chew one tablet by mouth once daily." At 12:00 p.m., after the resident took her medication, LPN 5 indicated she had not had her chew the aspirin because her directions on the EMAR did not tell her to do that, so the label and the EMAR did not match. A reconciliation of the current Physician orders dated November 2017, was completed on 11/28/17 at 4:45 p.m., which included, but was not limited to, the following order: 2/8/17--Aspirin 81 mg Chewable tablet Give one table orally one time daily for heart health During an interview on 11/27/17 at 4:55 p.m., the DON (Director of Nursing) indicated there was a labeling error with Resident K's Aspirin. 5. On 11/27/17 at 4:58 p.m., LPN 4 was observed preparing and observing Resident L's medication to him, which included, but was not limited to, Atorvastatin. The pharmacy label indicated "Atorvastatin [a medication used to lower the cholesterol level] 20			

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	mg [milligrams] Give one tablet by mouth at bedtime for HLD [hyperlipidemia]." Prior to the medication being administered LPN 4 indicated this medication was ordered to be administered in the evening according to the EMAR, but his pharmacy label indicated the medication was to be administered at bedtime. She indicated she would have called pharmacy and notified them the medication was ordered to be administered in the evening on the label, not at bedtime and wait for the new supply. She indicated she could have called pharmacy and got the order clarified, then passed it along in report. She would not use a change of direction sticker on the pharmacy label unless she received the change of order from the physician herself. A reconciliation of the current Physician orders dated November 2017, was completed on 11/27/17 at 5:25 p.m., with the DON (Director of Nursing) in attendance, which included, but was not limited to, the following order: 2/4/17--Atorvastatin 20 mg tablet Give one tablet by mouth every evening shift. At that time, the DON indicated the label indicated to administer the medication at bedtime, a change of direction sticker			

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	should have been placed on it and pharmacy should have been notified because this was a labeling error. A current policy titled "Controlled Medications" dated 1/17/15, provided by the Medical Records and Audit and Reimbursement Personnel on 11/28/17 at 5:15 p.m., contained the following, "Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling. storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. Procedures:...3. Preparation of the dosage form occurs according to the medication administration policy. 4. when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): a. Date and time of administration b. Amount administered c. Signature of the nurse administering the dose, completed after the medication is actually administered...." A current policy titled "Medication Labels" dated 1/17/15 with a effective date 5/1/15. provided by the Medical			

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	Records and Audit and Reimbursement Personnel on 11/28/17 at 5:15 p.m., contained the following. "Policy: Medications are labeled in accordance with state and federal laws. Only the dispensing pharmacy can modify or change prescription labels. Procedure:..2. Each prescription label includes:.. b. Specific directions for use, including route of administration....l. Accessory labels indicating storage requirements and special procedures. Example: 'Shake well' 'Take on empty stomach, one hour before or 2 hours after meals.' Container number and total number of containers (e.g., 1 of 3, 2 of 3, 3 of 3 when multiple containers are dispensed for one prescription/order...4. Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy...6. Medication labels are not altered, modified, or marked in any way by nursing personnel... Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacy may place a label on the medication container. a. If the physician's directions for use change or the label is inaccurate, the nurse may place a 'change of order-check chart or an equivalent label on the container indicating there is a change in directions for use, taking care not to cover important label information. b. When			

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	such a label appears on the container. the medication nurse checks the residents medication administration record (MAR) or the physician's order for current information. c. The dispensing pharmacy is informed prior to the next refill of the prescriptions so the new container will show an accurate label...." A current policy titled "Medications and Treatments Policy" with a revised date of 08/2017, provided by the Administrator on 11/27/17 at 2:31 p.m., contained the following, "Purpose: To provide correct administration of physician-ordered medications and treatments, following the standards of practice (medication, time, dose, frequency and route). Policy and Procedure:..2. Medication shall be administered only as prescribed by written order of the physician... 8... b. Narcotics: Medications should be observed carefully for accurate measurements (liquid, powders and tablets) prior to administration. If medication is measuring lower than what should be remaining per narcotic measurement count, then the Nursing Supervisor and Unit Manager need to be notified immediately to investigate why the measurement count is inaccurate. If medication is measuring lower than one order dose or more per lat narcotic measurement count then Nursing			

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	Supervisor, Unit Manager and Nursing Administration need to be notified immediately. c. Measurement tools that are provided for medication administration per pharmacy recommendation should be utilized and not altered in any way unless physician order specifies otherwise...." This Federal tag relates to Complains IN00245669. 3.1-25(b) 3.1-25(e)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;			

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	(iii) Readily accessible; and (iv) Systematically organized §483.70(i)(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 examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the			

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	resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview and record review, the facility failed to ensure the documentation for a Physician's order for medication accurate for 1 of 29 medication orders reviewed for accuracy (Resident E). Finding includes: On 11/27/17 at 1:29 p.m., RN 1 was observed administering medications to Resident E, which included, but was not limited to, Baclofen (a medication used to relax muscles) 10 mg (milligrams) give one tablet by mouth twice daily in the morning and at noon. Resident E's Electronic Medication Administration Record (EMAR) dated November 2017, included, but was not limited to, the following order: 7/31/17--Baclofen tablet 10 mg Give one tablet orally two times daily in the a.m. and at noon for muscle spasms.	F 0842	It is the policy of this facility to maintain the resident's record in accordance with professional standards. 1. Physician and family of resident E notified of late administration of Baclofen. In addition, the physicians order was clarified as to medication administration time. Physician and family of resident J notified of late administration for Simbrinza. RN 1 was re-educated that if she notes that the pharmacy label and EMAR do not match, she needs to bring this to the Unit Manager and/or Nursing Administrations attention so that a reconciliation can be made. 2. All residents have the potential to be affected by the alleged deficient practice. In-services for all licensed nurses and QMA's will take place on or before December 28, 2017 to review this and all other alleged	12/28/2017

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	11/28/2017

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
	During an interview on 11/27/17 at 1:41 p.m., RN 1 indicated Resident E's Pharmacy label on her Baclofen medication card indicated it was to be given in the morning and at noon, but the order was placed in the computer EMAR system to "pop" (indicated to the licensed personnel the residents' medications were in the time frame to, which they were able to safely administer the medications to them) up at 2 p.m., so she could not administer the medication any sooner than 1:00 p.m.. A reconciliation of the current Physician orders dated November 2017, was completed on 11/27/17 at 4:03 p.m., with the DON (Director of Nursing) in attendance, which included, but was not limited to, the following order: 7/31/17--Baclofen tablet 10 mg Give one tablet orally two times daily in the a.m. and at noon for muscle spasms.. At that time, the DON indicated the EMAR (Electronic Medication Administration Record) indicated the medication was to be given in the morning and at 2:00 p.m., but the Physician's order was written to be administered in the morning and at noon. She indicated this was a transcription error because when the medication pass times were entered by the nurse and were not entered for noon.		deficient practices identified in this survey. Including, but not limited to: medication administration policy, administering medications timely, importance of the physician's order, pharmacy label and EMAR matching, proper narcotic count documentation, especially liquid medications, process for implementing change orders, proper medication administering protocols as outlined in the Nursing Drug Handbook, etc. (In-service material included and identified as Attachment 1). Those nursing department employees identified to have been responsible for the alleged deficient practices received re-education. 3. Monitoring tools have been developed and Nursing Administration and/or Unit Managers and Nursing Supervisors will randomly audit the MARs and TARs of at least ten (10) residents, two (2) times weekly for at least sixty (60) days. In addition, Nursing Administration and/or Unit Managers and Nursing Supervisors will conduct medication pass observations with licensed nurses and QMAs monitoring that medication passes are conducted timely and that medications are administered correctly and per physician order and recommended dispensing	

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	This Federal tag relates to Complains IN00245669. 3.1-50(2)		guidelines as prescribed through the Nursing Drug Handbook. At least three (3) observations will be conducted weekly on various shifts with at least one of these observations to coincide with any resident on liquid PO Morphine, or other similar type liquid controlled medication. (QAA Monitoring Tool – MARs and TARs – Timely Medication Pass is included as Attachment 2) (QAA Monitoring Tool – Medication Pass Observation is included as Attachment 3) 4. Any alleged deficient practices that are identified will be addressed through re-education and if issues continue, through disciplinary action, additional policy development and/or in-service education. Any trends of the alleged deficient practices will be reported to the QAA Committee monthly. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QAA Committee. If improvement is noted, the QAA Committee may decide to modify the frequency of audits / observations, but still maintain this practice. 5. Completion Date: December 28, 2017	