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	08/26/2015

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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: August 19, 20, 21, 24, 25 and 26 2015. Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census bed type: SNF/NF: 148 Total: 148 Census payor type: Medicare: 11 Medicaid: 97 Other: 40 Total: 148 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		
F 0250 SS=G Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	psychosocial well-being of each resident. Based on interview and record review, the facility failed to implement a plan of care for ongoing and repetitive behaviors for 1 of 1 residents reviewed who displayed aggressive behaviors toward other residents. Resident #173 displayed aggressive behaviors and "pulled" Resident #176 out of a chair and resident # 176 suffered a fractured shoulder. Findings include: On 8/26/15 at 12:06 p.m., the record for Resident #173 was reviewed. Diagnoses included, but were not limited to, dementia and seizures. A "Fall Analysis note" dated 7/31/15, indicated Resident #173 was found sitting on the floor next to another resident. The resident statement indicated the resident was unable to verbalize details. However, the resident had been saying/yelling "let's go" all day to individuals as she grabbed and pulled at the staff as well as residents. The Nurses Notes indicated: On 7/24/15 at 10:35 p.m., the resident demonstrated the behavior this shift of wandering aimlessly, grabbing other resident's and saying incoherent speech like " let's go" "Come low" "Common lay	F 0250	1.The plan of care for Resident #173 hasbeen reviewed and updated according to her change in overall condition. Resident #173 returned from an inpatientAdult Psychiatric stay at Hancock Regional Hospital on August 31, 2015. Hooverwood personnel attended a dischargeplanning meeting at the hospital on August 28, 2015 to review the plan of care,resident safety, the ISDH survey, etc. Further discussions took place with Hooverwood's Medical Director andGeriatric Nurse Practitioner, the Geriatric Psychiatrist, and Hooverwoodpersonnel to discuss Resident #173's overall plan of care upon her return. Further necessary interventions to assure the safety of all residents were thoroughly discussed and included private duty care,medications, seating & positioning, etc. 2.The other residents residing on the nursing unit where Resident #173 resides have been identified as having thepotential of being affected by this same deficient practice. In order to keep these residents as safe aspossible Hooverwood has provided private duty care for Resident #173 throughthe "Senior Helpers" agency. This 1:1supervision and care of Resident #173, along with further medicationinterventions, will	09/21/2015

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	down" "Can lady let's down" Staff frequently redirected resident to no avail. The resident displayed no signs and symptoms of pain. The resident was very restless throughout the shift. Staff tried to offer fluids, toileting, snacks, distraction, and sitting 1-1 with patient, but the resident was still restless. This resident was frequently agitated and annoyed the other residents on the unit. On 7/26/15 at 8 p.m., the resident continued to wander in and out of other resident's rooms and saying "let's go come on" to the residents and staff who were near by. The resident was still grabbing at people, but was not as aggressive as she had been. On 7/28/15 at 3 p.m., the resident was very talkative and was grabbing at anyone's clothing that was near by and their hands and was saying " hey come here with me." The resident was easily redirected even though she could be aggressive at times. On 7/28/15 at 8 p.m., the resident was wandering in and out of other resident's rooms and saying "hey come on let's go" and was pulling and grabbing on anyone she could see. The behavior was not easily redirected.		minimize the potential for other residents being affectedby this same deficient practice. Todate, there have been no further aggressive behaviors between Resident #173 andother residents on the nursing unit. Resident #173's ongoing medical care continues to be closely monitoredby the Geriatric Psychiatrist and Medical Director. 1.Resident aggressive behaviors that potential to harm other residents will be handled aggressively byHooverwood's Interdisciplinary Team. Such measures will include the ongoing reporting Resident to Residentaggressive incidents to ISDH, private duty care, medication changes, andinpatient psychiatric stays, as appropriate. TheGeriatric Nurse Practitioner will conduct inservices on 9/17/15 for nursing andsocial services personnel on the topic of "Resident Aggressive Behaviors." Theinservice will review this deficiency and discuss the immediate and necessaryinterventions to assure resident safety. Inservice sign-in sheets and content will be submitted to ISDH upon thecompletion of the inservices on 9/17/15. 2.All incidents of Resident aggressivebehavior will be thoroughly reviewed by Hooverwood's InterdisciplinaryTeam. The	

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	On 7/28/15 during the 11 p.m.-7 a.m., the resident was actively wandering on the unit yelling "help me" "come here" "let's go" did not get any sleep. On 7/30/15 during the 7-3 shift, the nurse indicated throughout the shift the resident had been grabby, constantly saying "come here!" somewhat aggressive in her attitude. The behavior had not been easily altered. On 7/31/15 at 2:45 p.m., the resident was found on the floor with another resident. The behavior of wandering and grabbing/pulling others, including staff and residents, was continuous throughout the shift. On 8/1/15 at 3 p.m., the resident wandered in and out of resident's rooms and was grabbing on other residents arms and clothing as well as nursing arms and clothing very aggressively, the behavior was not easily altered. On 8/2/15 at 10:25 p.m., the resident remained increasingly confused, grabbing staff and other residents and was not easily redirected as she would return to the behavior. On 8/3/15 at 9 p.m., the resident continued to wander in and out of		involved resident's care planwill be reviewed and updated and all necessary interventions will beimplemented immediately to assure resident safety. Anydeficient practices identified in the daily review of resident aggressivebehaviors will be addressed immediately through disciplinary action, policydevelopment and / or inservice education. Any trends of deficient practice will be reported to the Quality Improvement/ QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous qualityimprovement measure unless determined otherwise by the QI / QAPI Committee. 3.Date of Completion: September 21, 2015 ***Hooverwood requests an Informal Dispute Resolution for this deficiency due to the factresident #176 incident which involved an injury was not witnessed by Hooverwoodpersonnel.	

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	resident's rooms saying " come on let's go" pulling and grabbing at anyone who was around her. The resident became very aggressive when others would not go with her, she was not easily redirected. On 8/5/15 at 2:40 p.m., the resident began to wander the hallways in and out of rooms and grabbed the arm of a female resident. She was asked to release the other resident's hand. The nursing staff had to physically remove Resident #173's hand from the other resident. Resident #173 then grabbed the staff's hand and said "let's go." The resident would not remain still long at all. On 8/6/15 at 6:51 a.m., the resident was very anxious the majority of the shift and continued to walk around knocking plants on the floor, hitting the writer with a bathroom key and pulled on this writers clothing. The resident calmed down around 1:30 a.m. and fell asleep on the couch. At 2:30 a.m., the resident awakened and was toileted and placed in her bed. At 3:30 a.m., the resident got out of bed and it was reported per another unknown resident's statement that the resident pulled another resident (Resident #176) off of the recliner trying to make the resident walk. Resident # 176 suffered a fractured left distal radius (lower left arm) and a 1.5 x 0.8			

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	laceration. Behavior Incident Report indicated : On 7/23/15 at 4, 5, 6, 7, 8 and 9 p.m., the resident had behaviors of: intrusive wandering, grabbing others, and this was a result of frustration, confusion and dementia with behavioral disturbances. The staff tried interventions of going for a walk with the resident, and removed the resident from the situation and neither of these interventions were effective. The comments section indicated Resident #173 was very aggressive with staff and other residents today. The resident was grabbing at staff and trying to make them go with her and was not easily redirected at all. Resident #173 kept walking on peoples feet and touching them, this made the other residents upset and aggressive towards Resident #173. The nursing staff tried to keep the resident away from the other residents, but she was not easily redirected. On 7/23/15 at 8 p.m., in the middle of the pod dining room area Resident #173 was pulling on residents, grabbing others, and displayed intrusive wandering. The potential cause of the behaviors were frustration and confusion. The staff tried interventions such as; removing the resident from the situation and took the resident to her room and these were			

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	effective. The comments section indicated she was pulling another resident down the hallway and was not easily redirected. On 7/25/15 at 12 p.m., the resident was biting and grabbing others. The cause of the behavior was unknown. The interventions tried by staff: Go for a walk with the resident was marked as not effective. Removing the resident from the situation was effective. The comments section indicated: This resident was pulling on another resident's arm and each time staff separated them, this resident either grabbed or pulled on other residents. She was not easily redirected. The staff stayed 1 on 1 with her and sat with her, but she returned to those behaviors when left alone. This resident was found on the couch sitting with another resident, she was pulling her arm stating, "come on let's go" and biting the other resident's left hand. No apparent injury noted to the other resident. The residents were both separated. On 7/25/15, the nurse indicated "all 3-11 p.m. shift!!!!" the resident displayed intrusive wandering, repetitive questions, grabbing others, pulling on staff clothes trying to get them to go with her, grabbing other resident's hand and arms			

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	telling them to go with her, and was not easily redirected. This happened in the hallway, the resident's room, other resident's room and in pod (small areas of unit) areas. On 8/26/15 at 3:00 p.m., the Executive Director (ED) indicated he had provided all of the documentation related to behaviors for Resident #173 for the month of July through August 2015. The documentation included Social Services "Behavior Monitoring" dated July 2015, start date 7/23/15. The documentation indicated a behavior of grabbing on staff and other residents, pulling on staff and residents. The interventions were as follows: 1. Remove resident from situation. 2. Offer reassurance. 3. Go for a walk with the resident 4. Alert staff to residents behavior. 5. Show resident where her room is if she is tired. The date boxes for 7/23, 7/25, 7/27, 7/28, 7/29, 7/30 and 7/31/15 indicated the behavior was happening often. Staff documented they tried interventions and they were not effective. A document titled Behavior Committee Review dated 8/20/15, listed the residents behaviors and indicated the current psychotropic medications: 8/4/15,			

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	Depakote (a medication to help stabilize moods)125 milligrams every morning and 250 milligrams every evening. The non pharmaceutical interventions tried was one on one with resident and redirecting. Possible modifications/recommendations for current behavior treatment: sent to psychiatric unit on 8/6/15, an antipsychotic medication of Zyprexa 5 milligrams added and a medication review to be done. During an interview on 8/26/15 at 11:35 a.m., with the ED, he indicated the nurse who was providing one on one with Resident #173 on 8/6/15, had left the room of Resident #173 because she was asleep. He indicated the incident with the residents happened after the nurse had left the room. He indicated typically one on one was done with the staff or assigned person staying in the room with the individual at all times. 3.1-34(a)			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.			

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	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to correctly identify and accurately assess the residents status regarding Hospice for 2 of 2 resident reviewed for Hospice (Residents # 124 and #179). Findings include: 1. The Clinical record for Resident #124 was reviewed on 8/21/2015 at 2:45 p.m. Diagnoses included, but were not limited to, general weakness, metastatic	F 0278	1.Residents #124 and #179 were not foundto have been affected by this deficient documentation practice. The MDS assessments for these two residentswere corrected by the MDS nurse on 8/24/15 and were transmitted and accepted on8/26/15. 2.The MDS nurses conducted an audit of allresidents receiving Hospice care in order to determine if these other residentshave the potential of being affected by this same deficient practice. Any	09/21/2015

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	melanoma with metastasis to the brain, anxiety, and depression. A Physician's order, dated 5/26/2015, indicated Hospice Recertification for second 90-day period, with diagnosis of metastatic melanoma to liver and brain and the resident had a prognosis of six months or less. A Significant Change Minimum Data Set Assessment (MDS), dated 2/20/2015, indicated Resident #124 was on Hospice and did not have a prognosis of six months or less. A Quarterly Assessment MDS dated 5/23/2015, indicated Resident #124 was on Hospice and did not have a prognosis of six months or less. 2. The clinical record for Resident #179 was reviewed on 8/21/2015 at 2:45 p.m. Diagnoses included, but were not limited to, unspecified heart disease and apraxia following cerebral infarction. A Physician's order dated 7/15/2015, indicated, "The Medical Director / Hospice Team Physician listed above certifies that the patients prognosis is six months or less if the disease runs its normal course." The resident was admitted to Hospice care on 7/7/2015,		corrections to these MDS assessments weremade accordingly. 1.The Director of Medical Records conductedan inservice on 9/8/15 to review this deficient practice with the MDS nurses. **(See Attachment #1)** As a quality improvement measure, the MDSnurses will be required to closely review the Hospice medical record prior tocompleting the MDS assessment to assure that this deficient practice does notoccur. The Director of Medical Recordswill also closely monitor this issue moving forward and conduct her own audits. In addition, Hooverwood's MDS Consultant whovisits bi-monthly will also monitor this deficient practice during herconsultation visits. The MDS Nurseresponsible for the insufficient coding received counseling and disciplinaryaction. 1.Any deficient practices identified bythe Director of Medical Records and / or the MDS Consultant's ongoing audits willbe addressed immediately through disciplinary action, policy development and /or inservice education. Any trends ofdeficient practice will be reported to the Quality Improvement / QAPI Committeeon a monthly basis. This monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI /	

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	with a diagnosis of unspecified heart disease. A Significant Change MDS dated 7/12/2015, indicated Resident #179 was on Hospice and did not have a prognosis of six months or less. During an interview with the MDS Coordinator, RN #6, on 8/24/2015 at 10:40 a.m., regarding the Hospice status of Residents #124 and #179, she indicated that Hospice was noted on the MDS, but Resident #124 and #179 did not have a prognosis of less than six months indicated on the MDS. 3.1-31(a) 3.1-31(d)(3)		QAPI Committee. 1.Date of Completion: September 21, 2015	
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident was provided incontinent care in a timely manner for 1 of 1 residents being reviewed for incontinence care. (Resident #202)	F 0312	1.Regarding Resident #202, her plan ofcare for incontinence was reviewed and was found to be appropriate. C.N.A. #11 was counseled regarding thisdeficient practice and received disciplinary action. Inservice **(See Attachment #2)** have and	09/21/2015

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	Findings include: Resident #202's record was reviewed on 8/24/15 at 10:02 a.m. Diagnoses included, but were not limited to, vascular dementia, severe protein-calorie nutrition, bed sores on buttocks, peripheral venous insufficiency and Congested Heart Failure. The "Activities of Daily Living (ADL) Flowsheet Record" dated August 2015, indicated the resident was incontinent of her bladder for every shift from August 7 through 23, 2015. A current document titled "CNA Assignment Sheets 6:45 a.m.-3:00 p.m." undated, provided by RN #13 on 8/26/15 at 10:19 a.m., indicated "... Total care, Toilet before & [and] after meals-incontinent...." The resident had a Care Plan dated 8/13/15, which addressed the problem she had an alteration in bowel and bladder elimination as evidenced by bowel and bladder incontinence related to impaired mobility and cognition with a dementia diagnosis. Interventions included "8/13/15--Provide total assist of two persons with toileting needs in am, before and after meals, at bedtime, with each bedcheck... provide prompt		continue to be conducted to remind andre-educate staff regarding the importance of checking residents forincontinence and providing prompt peri-care after any incontinent episodes. 2.Inservices were conducted for nursingpersonnel to review this deficient practice and to remind and re-educate staffthe importance of this care issue. Throughongoing staff supervision and observation by Licensed Nurses, there were noother residents identified to have been affected by this same deficientpractice. 1.As a quality improvement measure,additional qualified staff have been assigned to assist the 2B unit with themeal service and feeding of residents. With the additional personnel assigned to this unit during meals, theC.N.A.'s are more readily available to assist residents with their incontinentneeds, per their plan of care. Theadditional staff assigned to the 2B unit during meal services has also beensuccessful in decreasing overall length of time required for meal service. 1.Any deficient practice regardingincontinent care will be addressed immediately through disciplinary action,policy development and / or inservice	

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	peri-care after incontinent episodes...." During a continuous observation on 8/24/15 from 9:58 a.m., through 1:46 p.m., the following observations were made: On 8/24/15 at 9:58 a.m., Resident #202 was sitting in her wheelchair in the common area waiting for a musical activity to begin. On 8/24/15 at 10:16 a.m., the resident was sitting in the common area listening to a musical activity. On 8/24/15 at 11:15 a.m., the musical activity concluded and the resident continued to sit in the common area in the dining room. On 8/24/15 at 11:25 a.m., an unidentified activity staff member attempted to place the resident at a dining room table and she indicated she wanted to go back to her room. The activity staff member told the resident to wait a minute and she would take her back to her room. She sat the resident's wheelchair up against the wall in the hallway. On 8/24/15 at 11:42 a.m., LPN #9 asked the resident if she wanted to eat lunch in her room or wanted to eat lunch in the		education. Any trends of deficient practice will bereported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI /QAPI Committee. 1.Date of Completion: September 21, 2015	

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	dining room. The resident indicated she wanted to eat in the dining room. LPN #9 sat her at a dining room table to eat lunch. On 8/24/15 at 12:09 p.m., the resident was waiting for her lunch tray to arrive in the dining room. On 8/24/15 at 12:30 p.m., the resident received her lunch tray. On 8/24/15 at 12:56 p.m., the resident had been assisted with her lunch. She had just finished her lunch and remained at the table. On 8/24/15 at 1:07 p.m., the resident was brought down to her room by CNA's #11 and #12. On 8/24/15 at 1:12 p.m., the resident was transferred to bed by CNA #11 and CNA #12 with the hoyer lift. On 8/24/15 at 1:22 p.m., CNA #11 prepared the supplies to provide peri-care for the resident. CNA #11 removed Resident #202's brief, which was slightly saturated with urine. CNA #11 provided peri-care for the resident and applied a clean brief. During an interview on 08/24/15 at 1:54			

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	p.m., CNA #11 indicated she got the resident up at 7:40 a.m. on that day, so she could eat breakfast. She indicated she repositioned Resident #202 at 9:00 a.m. and 10:00 a.m. 3.1-41(2)			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to follow their policy and procedures regarding wound care to prevent the possibility of wound infections for 2 of 3 residents observed for pressure ulcer dressing changes. (Residents #151 and #202). The facility also failed to implement pressure ulcer prevention interventions for 1 of 3 residents being reviewed for pressure ulcers. (Resident #202) This deficient practice resulted in Resident #202 developing a Stage III pressure ulcer (Full thickness tissue loss. Subcutaneous	F 0314	1.Regarding Residents #202 and #151, theLicensed Nurses who were responsible for providing wound care dressing changeswere counseled and received disciplinary action for their deficient practicesand failure to follow Hooverwood's policy. RegardingResident #202, the C.N.A. that was responsible for providing the necessary offloading and the appropriate ulcer prevention interventions (boots) wascounseled and received disciplinary action for this deficient practices.	09/21/2015

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	fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but, but does not obscure the depth of tissue loss. May include undermining and tunneling.) to her left upper buttock. Findings include: 1. Resident #202's record was reviewed on 8/24/15 at 10:02 a.m. Diagnoses included, but were not limited to, vascular dementia, severe protein-calorie nutrition, bed sores on buttocks, peripheral venous insufficiency and Congestive Heart Failure. The resident's physician's recapititulation orders dated August 2015, included, but were not limited to, the following orders: 8/7/15--Left buttock/Mid sacrum area apply santyl (a medication used to remove dead tissue from a wound) and a foam dressing-change daily 8/7/15--Off-loading boots to bilateral heels/foot The "Activities of Daily Living (ADL) Flowsheet Record" dated August 2015, indicated the resident was dependent for turning and repositioning herself for every shift from August 7 through August 23, 2015.		Bothresidents' (#202 & #151) wounds, as of 9/10/15 are deemed "Healed" by theMedical Director. 2.In order to minimize the potential forother residents to be affected by these same deficient practices, an inservicewill be conducted for Licensed Nurses on wound care by 9/21/15. Inservice sign-in sheets and content will besubmitted to ISDH upon completion. Return demonstration on a mannequin will occur in addition to thecompletion of a skills check list **(SeeAttachment #3)** for this policy. Inaddition, Hooverwood's wound care policy **(SeeAttachment #4)** will be reviewed and updated as necessary. Aninservice **(See Attachment #2)** fornursing personnel will be conducted and will review / re-educate staff on ulcerprevention interventions including off-loading and the utilization of wouldprevention supplies (cushions, boots, air mattresses, etc.) 1.Hooverwood's Wound Care Nurse and / orDirector of Nursing will be observing routine dressing change techniquecompleted by Licensed Nurses on an ongoing basis. Specifically, these nurses will observe aminimum of five dressing changes per week and	

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	The resident had a Care Plan dated 8/10/15, which addressed the problem she had an alteration in skin integrity as evidenced by pressure ulcers to her buttocks and heels and a rash under her breasts and buttocks. She was at risk for skin breakdown related to decreased mobility and frequently in bed. Approaches included "8/10/15--... Turn/reposition every 2 hours...." The resident had a Care Plan dated 8/13/15, which addressed the problem she had an alteration in skin integrity as evidenced by impaired mobility, cognition, bowel and bladder incontinence related to diagnoses of dementia, pressure ulcers, which were present on admission: an unstageable pressure ulcer to the left great toe and left heel, a Stage I to the coccyx, a Stage III pressure ulcer to the right and left buttocks and a rash surrounding the opened areas to her buttocks. Interventions included, "8/13/15--... Off loading boots to both heels/feet...." A current document titled "CNA Assignment Sheets 6:45 a.m.-3:00 p.m." undated, provided by RN #13 on 8/26/15 at 10:19 a.m., indicated "...Offload/Reposition every 2 hours." During a continuous observation on		will assure that each nursingunit receives one observation per week. An“off-loading” quality improvement program will be implemented that providesdaily facility notifications / “chimes” for the off-loading provided to ourresidents. Notifications will occurthroughout the day, on a regularly scheduled basis, between 9:00 a.m. and 9:00p.m. After 9:00 p.m., residents will continue to be off loaded as appropriate,during bed checks. The Unit Manager / Licensed Nurse / Nursing Supervisor willbe responsible for assuring that necessary off-loading is being provided. This new program will be inserviced tonursing personnel by 9/21/15. Inservicesign-in sheets will be submitted to ISDH upon completion. Inaddition, Nursing Administration will be updating / revising Hooverwood’s “SkinIntegrity Policy” **(See Attachment #5)** in order to reflectthe current procedures and protocols followed by the nursing department. This policy will address turning,off-loading, and other aspects for maintaining skin integrity. 1.Any deficient practices identified by theWound Nurse or Director of Nursing during observations of wound care will	

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	8/24/15 from 9:58 a.m., through 1:46 p.m., the following observations were made: On 8/24/15 at 9:58 a.m., Resident #202 was observed sitting in her wheelchair in the common area waiting for a musical activity to begin. She had wool heel protectors (a wool fleece lined boot that was opened in the front and layed underneath the lower extremities from mid calf to under the foot to the top of the toes. The boot had velcro wool padded straps in the front, which went across the shin to hold the boot in place) in place while her feet were sitting on the footrests of her wheelchair. On 8/24/15 at 10:16 a.m., the resident was sitting in her wheelchair in the common area listening to a musical activity. On 8/24/15 at 11:15 a.m., the musical activity had concluded and the resident continued to sit in the common area in the dining room. On 8/24/15 at 11:25 a.m., an unidentified activity staff member attempted to place the resident at a dining room table, but she indicated she wanted to go back to her room. The activity staff member told the resident to wait a minute and she		be addressedimmediately through disciplinary action, policy development and / or inserviceeducation. Any deficient practices identified by the Unit Managers or NursingSupervisors regarding off-loading or other wound prevention devices will beaddressed immediately through disciplinary action, policy development and / orinservice education. Any trends of deficient practice will be reported to theQuality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI /QAPI Committee. 1.Date of Completion: September 21, 2015 ***Hooverwoodrequest an Informal Dispute Resolution regarding this deficiency. As it isbelieved that the surveyor's observation of a lack of offloading for resident#202 on one isolated occasion would directly contribute to a Stage 3 pressureulcer.	

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	would take her back to her room. She sat the resident's wheelchair back up against the wall in the hallway. On 8/24/15 at 11:42 a.m., LPN #9 asked the resident if she was going to eat lunch in her room or if she wanted to eat lunch in the dining room and the resident indicated she wanted to eat in the dining room. LPN #9 sat her at a dining room table to eat lunch. On 8/24/15 at 12:09 p.m., the resident was waiting for her lunch tray to arrive at her table. On 8/24/15 at 12:30 p.m., the resident received her lunch tray. On 8/24/15 at 12:56 p.m., the resident had been assisted with her lunch. She had just finished her lunch and remained at the table. On 8/24/15 at 1:07 p.m., the resident was brought down to her room by CNA's #11 and #12. On 8/24/15 at 1:12 p.m., the resident was transferred to bed by CNA #11 and CNA #12 with the hoer lift. On 8/24/15 at 1:22 p.m., CNA #11 began peri care. LPN #9 came into the			

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	resident's room and indicated she was going to give the resident her pain medication, then she would change her dressing to her pressure wounds. On 8/24/15 at 1:46 p.m., LPN #9 came into the resident's room and medicated her with pain medication. She indicated at that time she would return in 30 minutes to complete her dressing change. During an interview on 08/24/15 at 1:54 p.m., CNA #11 indicated she got the resident up at 7:40 a.m., on that day, so she could eat breakfast. She indicated she repositioned Resident #202 at 9:00 a.m. and 10:00 a.m., by using her hoer lift sling and moving her in her seat. She indicated she turned and repositioned her residents every 2 hours. On 8/24/15 at 2:17 p.m., LPN #9 came into Resident #202's room to change her dressing and QMA #12 was going to assist her. LPN #9 and QMA #12 both washed their hands. QMA #12 donned clean gloves and assisted the resident to turn onto her right side. LPN #9 laid a towel down on the bed behind the resident along side her buttocks and back. She prepared her supplies. She sanitized her hands and donned clean gloves. LPN #9 removed the old dressing from the resident's sacral area, then she removed			

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	her gloves. The resident's sacral area was observed to have wounds on each side (left and right) with yellow tissue in the center of the wounds with a large amount of redness surrounding the wounds extending onto the buttocks area and in between the wounds. The right wound was in a lower location than the left. The left wound had 75% yellow tissue in the center of the wound and the right wound had 25% yellow tissue in the center of the wound. LPN #9 sanitized her hands and donned clean gloves. She took a Normal Saline (NS) bullet and squeezed NS across the right wound first in a sweeping motion, then she squeezed the NS across the left wound in a sweeping motion possibly contaminating the right wound with the irrigating solution and debris from the left wound, which was sitting above the right wound with the resident laying on her right side. She used the towel laying on the bed and patted the two wounds dry. She removed her gloves and sanitized her hands, then donned clean gloves. She used sterile applicators and applied Santyl to the left wound in a circular motion starting from the inside of the wound outward, then she used a new sterile applicator and applied Santyl to the right wound in a circular motion from			

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	the inside of the wound outward. LPN #9 removed her gloves and sanitized her hands. She picked up the Allevyn foam dressing package and dropped it on the floor as she was trying to open the package. She picked the dressing package up off the floor. She opened the package, took the foam dressing out of the package and dated and initialed the dressing and began to apply clean gloves to apply the dressing to the resident's wound. At that point LPN #9 was stopped during the dressing change procedure. She indicated at that time, she needed to get a new dressing to apply to the resident's wound. LPN #9 indicated at that time she thought she could use the dressing she had dropped on the floor because the dressing was in a sterile package. She removed her gloves, got a new foam dressing, donned new gloves and applied the foam dressing to the resident's sacral area. On 8/24/15 at 2:36 p.m., QMA #12 was observed removing the resident's wool boots (heel protectors) while LPN #9 prepared her dressing supplies to complete the treatments to Resident #202's left great toe and left heel. QMA #12 indicated at that time the resident did not have the correct boot on her left foot. The resident had an eschar area to the tip			

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	of her left great toe and to her left heel. During an interview on 8/24/15 at 2:57 p.m., LPN #9 indicated she should have cleansed the resident's wounds individually, changed her gloves and washed or sanitized her hands and changed her gloves in between wounds. She indicated she should have gotten a new dressing instead of trying to use the dressing that fell on the floor to place it on the resident's wound. On 8/25/15 at 1:38 p.m., the resident was observed laying in bed with a waffle boot on her left foot and a wool boot on her right foot. During an interview on 8/25/15 at 1:42 p.m., CNA #11 indicated the resident was to have the harder plastic boot (waffle boot) on her left foot and the softer cloth boot (wool boot) on her right foot. She indicated the waffle boot was in her closet and it was placed on the resident's left foot that morning. During an interview on 8/25/15 at 2:26 p.m., RN #13 indicated the resident should have a wool boot on the right foot and a waffle boot on the left foot to prevent pressure on her left heel. She indicated the resident was to be turned and repositioned every two hours and she			

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	should have been repositioned in her wheelchair before lunch on 8/24/15. The following "Wound/Skin Healing Records" dated 8/25/15, indicated the resident was admitted to the facility with the following pressure wounds: The left great toe pressure wound was an unstageable wound (Full thickness tissue loss, in which the base of the ulcer is covered by slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist, and light in color; may be stringy) and/or eschar (Thick, leathery necrotic or divitalized tissue, frequently black or brown in color) in the ulcer bed.) The wound measured 0.8 x 1.2 cm (centimeters) and the wound bed was eschar. The wound had no drainage or odor. The surrounding skin color was normal the skin color. The right buttock pressure wound was a Stage III wound. The wound measured 2.2 x 3.0 x < (less than) 0.2 cm and the wound bed was slough. The wound had no drainage or odor. The surrounding skin color was normal for the skin color The left heel pressure wound was an unstageable wound. The wound measured 3.5 x 2.5 cm. The wound bed had eschar. The surrounding skin color was normal for the skin color.			

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The coccyx pressure wound was a Stage III wound. The wound measured 1.2 x 1.0 x <0.2 cm. The wound bed had slough. The surrounding skin color was normal for the skin color.

The following "Wound/Skin Healing Records" dated 8/25/15, indicated the resident had a Stage III pressure wound to the left upper buttock with an onset date of 8/25/15. The wound measured 0.4 x 0.2 x <0.2 cm. The wound bed had slough. The surrounding skin color was normal for the skin color.

During an interview on 8/26/15 at 11:19 a.m., RN #14 indicated the resident's left upper buttock wound was found on wound rounds on 8/25/15 and it was considered a facility acquired wound.

During an interview on 8/26/15 at 1:00 p.m., the Director of Nursing indicated LPN #9 should have used gauze dressings to dry the residents wounds instead of the towel and she indicated wounds were to be cleansed individually.

2.) The clinical record of Resident #151 was reviewed on 8/25/2015 at 10:45 a.m. Diagnoses included, but were not limited to, decompensated Congestive Heart Failure (CHF), hyponatremia,

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	hypokalemia, and hypothyroiamrtension. A Physician order dated 8/10/2015, indicated Santyl (medication to remove dead tissue from a wound), to sacral wound, cover with foam dressing, change daily. During an observation on 8/24/2015 at 11:02 a.m., LPN #7 was observed performing a dressing change to Resident #151's sacral area. LPN #7 removed the dressing applied on 8/23/2015 and reapplied resident #151's new dressing without changing gloves or washing her hands per facility policy and procedure. The resident's wound was observed to measure 0.1 cm x less than 0.2 cm x no depth. During an interview with Unit Manager (RN #8), she indicated LPN #7 should have changed her gloves and washed her hands after she removed the dressing applied on 8/23/2015. She then indicated LPN #7 should have reapplied new gloves before applying the new dressing on 8/24/2015, for Resident #151. A current policy titled "Wound Care Policy and Procedure" dated 6/4/12, provided by the Director of Nursing on 8/25/15 at 3:05 p.m., indicated "Purpose: To provide guidelines for correct			

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	technique in completing wound care... 11. Clean the wound according to the physician's order, working from the center to the outside of the wound. 12. Remove gloves and discard into the bag for contaminated items. 13. Wash your hands. 14. Apply a pair of clean gloves. 15. Apply clean dressing with medication / ointment according to the physician's order... NOTE: If measuring and/or changing the dressings on more than one wound site on the resident's body, a clean measuring tool as well as clean gloves must be used for each individual site to avoid the potential for cross contamination of the wounds." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to maintain a safe environment for residents	F 0323	1.Resident #173 returned to facility on8/31/15 following an inpatient adult psychiatric stay at Hancock RegionalHospital. In	09/21/2015

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	when a resident (Resident #173) was displaying unsafe and aggressive behavior for 1 of 1 resident reviewed for supervision to prevent accidents Resident # 173 displayed aggressive and unsafe behavior toward residents and Resident # 176 was "pulled" from a chair and had a Left forearm fracture. (Resident # 176) Findings include: 1. On 8/25/15 at 3:00 p.m., the record for Resident #176 was reviewed. Diagnoses included, but were not limited to, dementia and heart failure. The MDS (Minimum Data Set) Assessment dated 7/8/15, indicated the resident required physical assistance of another person to walk. During an observation on 8/25/15 at 2:32 p.m., Resident #176 was sitting in the recliner with her eyes closed, her left lower forearm was noted to be in a soft cast, and a yellow/brown colored bruise was observed above her left eyebrow. During an interview on 8/25/15 at 2:34 p.m., LPN #3 indicated there had been an unwitnessed incident with another resident on the overnight shift a few weeks ago. LPN #3 indicated a staff		order to prepare forResident #173's return to facility and to assure the safety of this residentand all other residents on the nursing unit, Hooverwood personnel attended adischarge planning meeting at Hancock Regional Hospital on 8/28/15. During this meeting, plan of care, residentsafety, interventions, etc. were thoroughly discussed. Even though Resident #173's overall conditionhas declined and she is no longer ambulating, wandering, reaching out, etc.Hooverwood continues to provide her with private duty agency caregivers thatare only assigned to this resident. 2.The other residents residing on thenursing unit where Resident #173 resides have been identified as having thepotential of being affected by this same deficient practice. In order to keep these residents as safe aspossible Hooverwood has provided private duty agency care for Resident #173through an agency. This 1:1 supervisionand care of Resident #173, along with further medication interventions, willminimize the potential for other residents being affected by this samedeficient practice. To date, there havebeen no further aggressive behaviors between Resident #173 and other residentson the nursing unit. Resident #173'songoing medical care continues to be closely	

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	member had heard a "boom boom" and Resident #176 liked to sleep in a recliner and apparently another resident wanted to get her up and have her come with her and Resident #176 was found on the floor and was complaining of left lower arm pain. A "Fall Analysis note" dated 8/6/15 at 3:20 a.m., for Resident #176 indicated the resident had an unwitnessed event and was found in the dining room sitting on the floor. Resident #176 was found sitting upright on the floor actively bleeding from a laceration over her left eyebrow and was unable to state what happened. Another resident stated that another resident had pulled Resident #176 up from the recliner stating "come on let's go". The resident's statement indicated: When Resident #173 came near Resident #176, she would begin yelling "get her away from me, she hurt me and I'm scared of her." The document indicated the resident had a laceration of 1.5 centimeters (cm) x 0.8 cm and complaints of left shoulder pain. There was documentation under the monitoring portion of document that was struck out, it had indicated removed other resident from area and 1:1 with writer. The possible root cause of fall indicated: impaired safety awareness. Other: resident to resident incident. The		monitored by the GeriatricPsychiatrist and Medical Director. Resident#176's injury is medically stable and she not exhibiting any pain, discomfortor secondary effects from the injury. Resident #173 has minimal potential for contact with Resident #176 orother residents due to her 1:1 supervision and overall decline in condition. 1.Resident aggressive behaviors that havethe potential to harm other residents will be handled aggressively byHooverwood's Interdisciplinary Team. Such measures will include ongoing reporting Resident to Residentaggressive incidents to ISDH, private duty care, medication changes, andinpatient psychiatric stays, as appropriate. Incidentsof resident aggressive behaviors will continue to be reviewed by Hooverwood'sInterdisciplinary Team and Hooverwood's Behavior Committee under thesupervision of the Geriatric Psychiatrist. Any new incidents, escalating behaviors, or trends of incidents will beaddressed with private duty care, appropriate medication changes, inpatienthospitalization, activity interventions, counseling, etc.	

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	immediate new interventions: Other: removed other resident from the area. Supervisor notified and Resident #176 was sent out to the emergency room. The nurses notes for Resident #176 dated 8/6/15 at 9:40 a.m., indicated the report from the hospital was called and the resident had a left distal radius (lower left arm) fracture. The resident had a plantar cast (hand and shoulder). 2. On 8/26/15 at 12:06 p.m., the record for Resident #173 was reviewed. Diagnoses included, but were not limited to, dementia and seizures. A "Fall Analysis note" dated 7/31/15, indicated Resident #173 was found sitting on the floor next to another resident, The resident statement indicated the resident was unable to verbalize details, However has been saying/yelling "let's go" all day to individuals as she grabbed and pulled at the staff as well as residents. The Nurses Notes indicated: On 7/24/15 at 10:35 p.m., the resident demonstrated the behavior this shift of wandering aimlessly, grabbing other resident's and saying incoherent speech like " let's go" "Come low" "Common lay down" "Can lady let's down" Staff		TheGeriatric Nurse Practitioner will conduct an inservice on 9/17/15 for nursing andsocial services personnel on the topic of Resident Aggressive Behaviors. Theinservice will review this deficiency and discuss the immediate and necessaryinterventions to assure resident safety. Inservice documentation and content will be submitted to ISDH uponcompletion. 2.All incidents of Resident aggressivebehavior will be thoroughly reviewed by Hooverwood's InterdisciplinaryTeam. The involved resident's care planwill be reviewed and updated and all necessary interventions will beimplemented immediately to assure resident safety. In review of these resident to residentincidents, analysis will include physician / family notification, accuratedocumentation, attempts to provide non-medication interventions, assessment forpain, ISDH reporting of incident, etc. Anydeficient practices identified in the daily review of resident aggressivebehaviors will be addressed immediately through	

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	frequently redirected resident to no avail. The resident displayed no signs and symptoms of pain. The resident was very restless throughout the shift. Staff tried to offer fluids, toileting, snacks, distraction, and sitting 1-1 with patient, but the resident was still restless. This resident was frequently agitated and annoyed the other residents in the unit. On 7/26/15 at 8 p.m., the resident continued to wander in and out of other resident's rooms and saying "let's go come on" to the residents and staff who were near by. The resident was still grabbing at people, but was not as aggressive as she had been. On 7/28/15 at 3 p.m., the resident was very talkative and was grabbing at anyone's clothing and hands that was near by and was saying " hey come here with me." The resident was easily redirected even though she could be aggressive at times. On 7/28/15 at 8 p.m., the resident was wandering in and out of other resident's rooms and saying "hey come one let's go" and was pulling and grabbing on anyone she could see. The behavior was not easily redirected. On 7/28/15 during the 11 p.m.-7 a.m., the		disciplinary action, policydevelopment and / or inservice education. Any trends of deficient practice will be reported to the Quality Improvement/ QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous qualityimprovement measure unless determined otherwise by the QI / QAPI Committee. 3.Date of Completion: September 21, 2015 ***Hooverwoodrequest an Informal Dispute Resolution for this deficiency due to the factresident #176 incident which involved an injury was not witnessed by Hooverwoodpersonnel.	

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	resident was actively wandering on the unit yelling "help me" "come here" "let's go" and did not get any sleep. On 7/30/15 during the 7-3 shift the nurse indicated throughout the shift the resident had been grabby, constantly saying " come here!" somewhat aggressive in her attitude. The behavior had not been easily altered. On 7/31/15 at 2:45 p.m., the resident was found on the floor with another resident. The behavior of wandering and grabbing/pulling others, including staff and residents, was continuous throughout the shift. On 8/1/15 at 3 p.m., the resident wandered in and out of resident's rooms and was grabbing on other residents arms and clothing as well as nursing arms and clothing very aggressively, the behavior was not easily altered. On 8/2/15 at 10:25 p.m., the resident remained increasingly confused, grabbing staff and other residents and was not easily redirected as she would return to the behavior. On 8/3/15 at 9 p.m., the resident continued to wander in and out of resident's rooms saying "come on let's			

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	go" pulling and grabbing at anyone who was around her. The resident became very aggressive when others would not go with her, she was not easily redirected. On 8/5/15 at 2:40 p.m., the resident began to wander the hallways in and out of rooms and grabbed the arm of a female resident. She was asked to release the other resident's hand. The nursing staff had to physically remove Resident #173's hand from the other resident. Resident #173 then grabbed the staff's hand and said "let's go." The resident would not remain still long at all. On 8/6/15 at 6:51 a.m., the resident was very anxious the majority of the shift and continued to walk around knocking plants on the floor, hitting writer with a bathroom key and pulled on this writers clothing. The resident calmed down around 1:30 a.m. and fell asleep on the couch. At 2:30 a.m., the resident awakened and was toileted and placed in her bed. At 3:30 a.m., the resident got out of bed and it was reported per another unknown resident's statement the resident pulled another resident (Resident #176) off of the recliner trying to make the resident walk. Behavior Incident Report indicated : On 7/23/15 at 4,5,6,7,8 and 9 p.m., the			

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	resident had behaviors of: intrusive wandering, grabbing others, and this was a result of frustration, confusion and dementia with behavioral disturbances. The staff tried interventions of going for a walk with the resident, and to remove the resident from the situation and neither of these interventions were effective. The comments section indicated Resident #173 was very aggressive with staff and other residents today. The resident was grabbing at staff and trying to make them go with her and was not easily redirected at all. Resident #173 kept walking on peoples feet and touching them, this made the other residents upset and aggressive towards Resident #173. The nursing staff tried to keep the resident away from the other residents, but she was not easily redirected. On 7/23/15 at 8 p.m., in the middle of the pod dining room area Resident #173 was pulling on residents, grabbing others, and displayed intrusive wandering. The potential cause of the behaviors were frustration and confusion. The staff tried interventions such as; removing the resident from the situation and took the resident to her room and these were effective. The comments section indicated she was pulling another resident down the hallway and was not easily redirected.			

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	On 7/25/15 at 12 p.m., the resident was biting and grabbing others. The cause of behavior was unknown. The interventions tried by staff: Go for a walk with the resident was marked as not effective. Removing the resident from the situation was effective. The comments section indicated: This resident was pulling on another resident's arm and each time the staff separated them, this resident either grabbed or pulled on other residents. She was not easily redirected. The staff stayed 1 on 1 with her and sat with her, but she returned to those behaviors when left alone. This resident was found on the couch sitting with another resident, she was pulling her arm stating, "come on let's go" and biting the other resident's left hand. No apparent injury noted to the other resident. The residents were both separated. On 7/25/15, the nurse indicated "all 3-11 p.m. shift!!!!" the resident displayed intrusive wandering, repetitive questions, grabbing others, pulling on staff clothes trying to get them to go with her, grabbing other resident's hand and arms telling them to go with her, and was not easily redirected. This happened in the hallway, the resident's room, other resident's room and in the pod (small			

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	areas of unit) areas. On 8/26/15 at 3:00 p.m., the Executive Director (ED) indicated he had provided all of the documentation related to behaviors for Resident #173 for the month of July through August 2015. The documentation included Social Services "Behavior Monitoring" dated July 2015, start date 7/23/15. The documentation indicated a behavior of grabbing on staff and other residents, pulling on staff and residents. The interventions were as follows: 1. Remove resident from situation. 2. Offer reassurance. 3. Go for a walk with the resident 4. Alert staff to residents behavior. 5. Show resident were her room is if she is tired. The date boxes for 7/23, 7/25, 7/27, 7/28, 7/29, 7/30 and 7/31/15 indicated the behavior was happening often. Staff documented they tried interventions and they were not effective. A document titled Behavior Committee Review dated 8/20/15, listed the residents behaviors and indicated the current psychotropic medications: 8/4/15, Depakote (a medication to help stabilize moods)125 milligrams every morning and 250 milligrams every evening. The non pharmaceutical interventions tried			

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	was one on one with resident and redirecting,. Possible modifications/recommendations for current behavior treatment: sent to psychiatric unit on 8/6/15, an antipsychotic medication of Zyprexa 5 milligrams added and a medication review to be done. During an interview on 8/26/15 at 11:35 a.m., with the ED, he indicated the nurse who was providing one on one with Resident #173 on 8/6/15, had left the room of Resident #173 because she was asleep. He indicated the incident with the residents happened after the nurse had left the room. He indicated typically one on one was done with the staff or assigned person staying in the room with the individual at all times. 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose			

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	should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to quantitatively and completely measure specific targeted behaviors to support the use of the psychotropic medications these residents were receiving in order to determine the effectiveness and track the progress towards a therapeutic goal for 2 of 5 residents reviewed for unnecessary medications. (Residents #6 and #17) Findings include: 1. Resident #6's record was reviewed on 8/25/15 at 9:30 a.m. Diagnoses included, but were not limited to, depression, chronic anxiety and delusions. The resident's physician recapititulation orders dated August 2015, included, but were not limited to, the following orders: 12/12/08--Complete the behavior	F 0329	1.The current medications were immediatelyreviewed by the Medical Director and Geriatric Psychiatrist for Residents #6& #17. Both medications and theiruse were found to be appropriate per the physicians. Regarding Resident #17, the GeriatricPsychiatrist reviewed the gradual dose reduction on 9/9/15 and no changes weredeemed necessary due to clinical contraindication. Regarding Resident #6, the Medical Directorhas written a clinical contraindication for a gradual dose reduction citingthat the medication use is for palliative care. 2.Any resident in facility who hasphysician orders for psychoactive medications were identified as having thepotential to be affected by this same deficient practice. An updated “Behavior	09/21/2015

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	intervention form before giving an as needed medication for behaviors. 6/30/14--Lorazepam (an antianxiety medication) 0.5 mg (milligrams) take one tablet by mouth every evening. 6/30/14--Lorazepam 0.5 mg take one-half tablet (0.25 mg) by mouth twice daily as needed. 12/1/14--Quetiapine (an anti-psychotic medication) 50 mg take one tablet by mouth at bedtime for delusions. 1/12/15--Mirtazapine (an antidepressant medication) 15 mg take one tablet by mouth at bedtime for depression. A physician progress note dated 12/15/14, indicated the resident's Gradual Dose Reduction (GDR) for her Quetiepine was performed and unsuccessful due to she required a low dose of Quetiapine for her symptomatic shortness of breath (mostly at night), which was delusional in quality. The physician indicated she had anxiety at night involving feelings of shortness of breath, which required a tiny dose of Quetiapine at night and he did not want any further GDR on her. He indicated this was pallative care for her. He indicated she had a chronic problem of insomnia and she was on long term benzodiazepines, which was most helpful for her chronic intermittent anxiety, manifesting as shortness of breath, which		Monitoring Policy", **(See Attachment #6)** staff inservices, arevised / combined form **(See Attachment#7)** to improve communication between nursing and social services, andweekly audits **(See Attachment #8)** willtogether minimize the risk for other residents being affected by this samedeficient practice. 1.The Social Service and NursingDepartments have developed a new Behavior Monitoring Form **(See Attachment #7)** that will replace two current forms (BehaviorMonitoring Form & Behavior / Intervention Monthly Flow Record). This new "universal form" will include theresident's prescribed psychoactive medications, diagnoses, target symptoms,non-medication interventions, etc. Thepharmacy will be including potential medication side effects on the MedicationAdministration Record. Any noted side effects will be communicated to thePhysician / Nurse Practitioner. The goal of this new form will be to improvecommunication between Social Services and Nursing Personnel to more accuratelycapture resident behaviors and effective interventions for the residents' bestinterest. A form for each resident whoreceives psychoactive medications will be	

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	was very real to her, but her oxygen saturations were normal when she was short of breath. A "Psychoactive Medication Monthly Flow Record" dated May 2015, indicated the resident's behavior being monitored for the following medications were as follows: Mirtazapine was increased agitation and decreased appetite--19 out of 93 boxes on this form for the three shifts for this behavior were blank, Repetitive Health complaints--8 of 93 boxes on this form for the three shifts for this behavior were blank. Lorazepam was increased agitation--12 of 93 boxes on this form for the three shifts for this behavior were blank and increased tearfulness--18 of 93 boxes on this form for the three shifts for this behavior were blank. No behavior monitoring records were found in the resident's record for the month of May 2015, for the Quetiapine medication. A "Behavior/Intervention Monthly Flow Record" and "Psychoactive Medication Monthly Flow Record" dated June 2015, indicated the resident's behavior being monitored for the following medications were as follows: Mirtazapine was increased agitation--19		maintained in a binder and located ateach nurse's station. Aninservice to introduce this updated policy, new Behavior Form, and weeklyaudits will take place for social service and nursing personnel by9/21/15. Inservice documentation andcontent will be submitted to ISDH upon completion. 1.In order to maintain continuedcompliance with this deficient practice, the Social Service Department willaudit **(See Attachment #8)** thesebinders and forms on a weekly basis and will report their findings on a weeklybasis during Clinical Interdisciplinary Team meetings. In addition, significant findings will bereported at the monthly Quality Improvement Committee meetings and monthlyBehavior Committee Meetings. Anydeficient practices identified in the weekly audits will be addressedimmediately through disciplinary action, policy development and / or inserviceeducation. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. This monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee.	

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	out of 90 boxes on this form for the three shifts for this behavior were blank and decreased appetite--18 of 90 boxes on this form for the three shifts for this behavior were blank. Lorazepam was increased anxiety--10 of 90 boxes on this form for the three shifts for this behavior were blank. No behavior monitoring records were found in the resident's record for the month of June 2015, for the Quetiapine medication. A "Behavior/Intervention Monthly Flow Record" and "Psychoactive Medication Monthly Flow Record" dated July 2015, indicated the resident's behavior being monitored for the following medications were as follows: Mirtazapine was Agitation--19 out of 93 boxes on this form for the three shifts for this behavior were blank, Repetitive Health complaints--22 of 93 boxes on this form for the three shifts for this behavior were blank and Self Isolation--44 of 93 boxes on this form for the three shifts for this behavior were blank. Lorazepam was increased anxiety--84 of 93 boxes on this form for the three shifts for this behavior were blank and complaints of feeling nervous--86 of 93 boxes on this form for the three shifts for this behavior were blank. Quetiapine was paranoia--84 of 93 boxes		2.Date of Completion: September 21, 2015	

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	on this form for the three shifts for this behavior were blank and delusions--86 of 93 boxes on this form for the three shifts for this behavior were blank. A "Behavior/Intervention Monthly Flow Record" dated August 2015, indicated the resident's behavior being monitored for the following medications were as follows: Mirtazapine was Self Isolation--31 out of 93 boxes on this form for the three shifts for this behavior were blank. Lorazepam was increased anxiety and crying--34 of 93 boxes on this form for the three shifts for this behavior were blank. Quetiapine was delusions with anxiety--52 of 93 boxes on this form for the three shifts for this behavior were blank. During an interview on 8/26/15 at 2:54 p.m., LPN #16 and the SSD (Social Service Director were in attendance. LPN #16 indicated Resident #6's delusions were she felt she was short of breath when she really was not, her oxygen saturations would be normal and she would not be having nasal flaring. LPN #16 indicated she did not have the specific targeted delusional or paranoia symptoms documented on the July or August 2015, behavior monitoring logs. She indicated she could not find the			

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	Quetiapine behavior monitoring logs for May and June 2015. LPN #16 indicated if there is a blank on the "Behavior/Intervention Monthly Flow Record" or "Psychoactive Medication Monthly Flow Record" that indicated the resident's behavior did not get monitored for that shift. 2. The clinical record of Resident #17 was reviewed on 8/25/15 at 2:00 p.m. Diagnoses include, but not limited to, schizo-attention disorder, hypertension, hyperlipidemia, osteoarthritis, edema, dementia, saddle embolus, diabetes. Olazapine (an antipsychotic) 10 mg daily was prescribed for this behavior in July, 2014. Behavior of sadness and wanting to go home was to be monitored by staff on the Behavior/Intervention Monthly Flow Records located in the Treatment Administration record (TAR). A Behavior Monthly Flow Record dated May, 2015 indicated the resident's behavior being monitored for the following medications were as follows: Olazapine was sadness and wanting to go home- 10 of 93 boxes on this form for the three shifts were blank. A Behavior Monthly Flow Record dated June, 2015 indicated the resident's behavior being monitored for the following medications were as follows:			

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	Olazapine was sadness and wanting to go home- 11 of 90 boxes on this form for the three shifts were blank. A Behavior Monthly Flow Record dated July, 2015 indicated the resident's behavior being monitored for the following medications were as follows: Olazapine was sadness and wanting to go home- 23 of 93 boxes on this form for the three shifts were blank. A Behavior Monthly Flow Record dated August, 2015 indicated the resident's behavior being monitored for the following medications were as follows: Olazapine was sadness and wanting to go home- 2 of 75 boxes on this form for the three shifts were blank. During an interview with Social Services Director and Assistant Director of Nursing (ADON) on 8/26/15 at 11:15 a.m., the ADON indicated the behavior monitoring sheet was not complete and the expectation was to have nursing staff monitor the specific behavior and complete the log. A review of the policy titled " Behavior Monitoring Form" dated 7/1/14, received from the ADON on 8/26/15 at 11:15 a.m., indicated "Purpose of the Behavior Monitoring Form is to determine and			

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	implement the most effective individualized behavioral interventions for each resident... 2. Behavior Monitoring forms will be found on each nursing unit. Every shift, the Social Worker and/or Nurse will document on the Behavior Monitoring Form 1) the number of times an identified behavior occurred, 2) the interventions used and 3) the effectiveness of the interventions...." 3.1-48 (a)(3)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food was covered, labeled and dated in the refrigerators, freezer and the open kitchen area, food was disposed of after the date of expiration, and food was served following temperature-taking procedures in 1 of 1 kitchens and 4 of 5 kitchenettes in the facility. This deficient practice had the potential to affect 148 of 148 residents receiving food from the kitchen.	F 0371	1.There were no residents identified tohave been directly affected by these deficient practices. All food items that were observed not being covered,labeled, or dated in refrigerators, freezers, open kitchen areas, activitykitchen refrigerator, etc., were all immediately discarded. Any food items present with an expired datewere immediately discarded. The kitchenemployee responsible for serving the food prior to taking temperature readingswas	09/21/2015

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	Findings include: During the tour of the kitchen on 8/19/2015 at 10:00 a.m., with the Dietary Manager, the following observations were made: 1.) The open kitchen area was observed to have expired, open, uncovered and not dated items: containers of thickener powder, corn starch and bread crumbs were opened and not dated cookie sprinkles open and not dated pasta package open and not dated can of beans not dated challah bread package open and not dated and with visible mold rye bread package expired 2.) The general freezer was observed to have a block of cheese open and not dated. 3.) The reach in freezer was observed to have 6 trays of cookie dough opened and not dated. 4.) The tray line reach in refrigerator had a cranberry juice container open and not dated. 5.) The produce walk in refrigerator had		immediately counseled and received disciplinary action. The coffee makers and microwaves in thekitchenettes on 1B and 2B were immediately sanitized. 2.Due to the immediate corrective actionsthat took place (discarding food items, sanitizing coffee makers andmicrowaves, staff education regarding food temperatures, etc.) there were noother residents identified as having the potential to be affected by this samedeficient practice. 1.The cleaning policy **(See Attachment #9)** has been reviewed with nursing, food service,and environmental services personnel for the ongoing cleaning of equipment inthe 5 nursing unit kitchenettes. Nursing personnel was inserviced on thispolicy on 9/5/15. **(See Attachment #9A)** Nursing, Food Services and EnvironmentalServices employees will all be responsible for assuring this deficient practicedoes not re-occur. The Supervisors ofthese department will be responsible for assuring these cleaning practices arebeing completed per policy. TheActivity Director has developed an updated policy **(See Attachment #10)** for the regulatory compliance of the activityrefrigerator and kitchen. The activitystaff were inserviced	

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	a package of shredded cheese open and not dated. During the second visit of the kitchen area on 8/19/2015 at 10:50 a.m., with the Dietary Manager the following was observed: 1.) The refrigerator/ freezer located in the activities room was observed to have open and not dated items: chocolate syrup container 3 bottles of red wine whipped cream container pitcher of lemonade ice cream sherbet 2.) The kitchenette located on the first floor, B unit, was observed to have a dirty coffee maker and microwave oven. 3.) The kitchenette located on the second floor, B unit, was observed to have a dirty coffee maker and microwave oven. During the third visit of the kitchen area on 8/19/2015 at 12:30 p.m., with the Dietary Manager, the kitchen staff were observed serving food from the first floor kitchenette, unit C, with out first checking the temperature of the food. During an interview on 8/19/2015 at		on this updated policy **(See Attachment #11)** on 9/7/15 and a daily log was updated **(See Attachment #12)** to document thedaily compliance of the policy. TheFood Service Manager conducted an inservice **(See Attachment #13)** on 9/1/15 with the kitchen employees to reviewthese deficient practices including taking food temperatures prior to serving,covering and labeling food, etc. Thefood service manager has developed new job responsibilities for the"Nourishment Position" that will include daily cleaning of the refrigerators,etc. A daily log to monitor continuedcompliance of food covering, labeling, dating, etc. **(See Attachment #14)** was developed and implemented. 1.Any deficient practices identified bythe Activity Director, Food Service Manager, Unit Managers / NursingSupervisors, Environmental Services Managers, etc., will be addressedimmediately through disciplinary action, policy development and / or inserviceeducation. Any trends of deficient practice will be reported to the QualityImprovement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI	

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	12:55 p.m., with the Dietary Manager, she indicated all open items should have been dated, expired items should have been discarded, and the staff should have taken food temperatures prior to serving the luncheon meal. The "PROPER THEMPERATURE-TAKING PROCEDURES", dated 5/8/2015, received on 8/25/2015 at 11:04 a.m., from the Dietary Manager, indicated " PURPOSE: To assure that proper procedures are followed in the taking of food temperature prior to service... log temperature for each food tested ...." The "PRODUCTION, PURCHASING, STORAGE", dated 6/14, received on 8/25/2015 at 11:04 a.m., from the Dietary Manager, indicated "... Cover, label, and date unused portions and open packages... Remove from storage any items for which the expiration date has expired ...." 3.1-21(i)(2) 3.1-21(i)(3)		/QAPI Committee. 2.Date of Completion: September 21, 2015	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt			

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	and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications had an open date on them for 2 of 7 medication carts reviewed for medication storage. Findings include: On 8/26/2015 at 10:40 a.m., 1 of the 2	F 0431	1.The two medications (eye drops &allergy medication) observed to have no open date were immediatelydiscarded. As a result, the resident whowould be receiving these medications would not be affected by this deficientpractice. There were no residents tohave been affected by this deficient practice. 2.As a result of the immediate	09/21/2015

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	medication carts had a bottle of eye drops with no open date on it. LPN #4 indicated she could not find the open date. On 8/26/15 at 10:54 a.m., one medication cart for unit 2B was observed to have a bottle of Flonase (an allergy medication) 50 micrograms nasal spray with no open date written on it. LPN #5 indicated she could not find an open date on it. On 8/26/15 at 12:45 p.m., the Director of Nursing indicated there should be an open date on nasal sprays and eye drops as they have a time frame after opening before they were to be disposed of. She indicated without the open date the staff would not be able to know when to dispose of the medication properly. She indicated the pharmacy guidelines were the time frames they follow for the disposal of medications after the open date. 3.1-25(g)(1)		discardingof the eye drops and allergy medication, as well as an audit of all othermedication carts in the facility, the risk for other residents having thepotential of being affected by this same deficient practice was minimized. 1.License Nurses and QMA's attended aninservice **(See Attachment #15)** to discussthis deficient practice on 9/5/15. Theunit managers, pharmacy personnel, and nursing supervisors will continue tomonitor this deficient practice to assure ongoing compliance throughout thefacility. Any deficient practices identified by the pharmacy personnel will becommunicated through the pharmacy report. Any deficient practices identified by nursing supervisors or unitmanagers will be communicated on the 24 hour report sheet and addressedimmediately. 1.Any further deficient practicesidentified by the unit managers, pharmacy personnel, and nursing supervisorswill be addressed immediately through disciplinary action, policy developmentor inservice education. In addition, anymedications found without an open date will be discarded and reordered at thefacility's expense. Any trends ofdeficient practices will be reported to the Quality Improvement /	

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			QAPICommittee on a monthly basis. Thismonitoring will continue ongoing as a continuous quality improvement measureunless determined otherwise by the QI / QAPI Committee. 2.Date of completion: September 21, 2015	
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash			

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	their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview and record review, the facility failed to ensure new employees received Tuberculosis (TB) screening in the prescribed time frame. This deficient practice affected 2 of 5 new employees screened for TB testing. (EMP #1, EMP #2) Findings include: During a review of employee records on 8/20/15 at 2:00 p.m., the employee record of EMP #1 indicated a hire date of 6/15/15. The first step of the Mantoux skin test was completed on 6/9/15. The second step of the Mantoux skin test was completed on 7/16/15. The second step was completed outside the recommended 1-3 week period after the first Mantoux was read as negative. During a review of employee records on 8/20/15 at 2:00 P.M., the employee record of EMP #2 indicated a hire date of 6/15/15. The first step of the Mantoux skin test was completed on 6/1/15. The second step of the Mantoux skin test was	F 0441	1.There were no residents identified asbeing affected by this deficient practice. Per an audit of all employees' TB testing records, there were noemployees identified as having TB or posing any risk to our residents as aresult of this deficient practice. 2.As a result of an audit of allemployees' TB testing records, and all Hooverwood employees testing negativefor TB, there were no other residents identified as having the potential ofbeing affected by this same deficient practice. Anyother current employee that did not receive the second step TB test inaccordance with Hooverwood's policy will be required to restart the TB testingprocess in the immediate future. Thosefew employees who are not currently working due to leave of absence, etc., willbe required to restart the TB testing process prior to returning to work. 1.Nursing Administration and Human Resourceshas developed a new policy **(See Attachment #16)** and tracking form **(See**	09/21/2015

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	completed on 7/10/15. The second step was completed outside the recommended 1-3 week period after the first Mantoux was read as negative. During an interview with the Human Resources Director on 8/20/15 at 2:45 p.m., she indicated the TB skin test was not performed at the prescribed time frame. A review of the policy titled "Employee Health ", dated 10/09, received from the Human Resources Director on 8/20/15 at 2:45 p.m., indicated " Purpose: to prevent the spread of transmittable infectious disease to [name of facility] residents and employees... The baseline testing shall employ the two step method, as required, with the second test completed within one (1) to three (3) weeks after the first step test is completed.... " 3.1-18(k)		**Attachment #17)** for assuring thatall second step TB testing will consistently be done in accordance withHooverwood's policy. Any Hooverwoodemployee that does not cooperate in receiving the second step TB test inaccordance with Hooverwood's policy will be taken off the work schedule and notpermitted to work until their TB testing is in compliance. 2.On a quarterly basis, the employee TBrecords will be audited by Nursing Administration and / or Human Resources toassure ongoing compliance. Any furtherdeficient practices identified by Nursing Administration or Human Resourceswill be addressed immediately through disciplinary action, policy developmentor inservice education. Any trends ofdeficient practices will be reported to the Quality Improvement / QAPI Committeeon a monthly basis. This monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 1.Date of Completion: September 21, 2015	