STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING _____ B. WING _____	C 01/22/2025

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

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00445292, IN00446410, IN00446579, IN00449484 and IN00450262. Complaint IN00445292-Federal/State deficiencies related to the allegation was cited at F755. Complaint IN00446410-Federal/State deficiencies related to the allegation was cited at F550. Complaint IN00446579-Federal/State deficiencies related to the allegation was cited at F550. Complaint IN00449484-Federal/State deficiencies related to the allegation was cited at F689. Complaint IN00450262-Federal/State deficiencies related to the allegation was cited at F550. Survey dates: January 21 and 22, 2025 Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census bed type: SNF/NF: 143 Residential: 19 Total: 162 Census payor type: Medicare: 2 Medicaid: 97 Other: 44 Total: 143 These deficiencies reflect state findings cited in	F 000		

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

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F 000	Continued From page 1 accordance with 410 IAC 16.2-3.1. Quality review was completed on January 29, 2025.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 12 residents reviewed for resident rights. (Resident J and K). The deficient practice was corrected on 11/5/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: A document, titled "Indiana State Department of Health Survey Report System," dated 11/4/24, indicated Resident J had indicated CNA 1 was rough with her when she got her up on 10/31/24 at 9:01 a.m. A facility resident questionnaire document indicated on 10/31/24 at 9:01 a.m., Resident J indicated CNA 1 was grouchy with her. CNA 1 told the resident to "do this, do that." Resident J indicated "she hurt my feelings." A facility written statement, dated 10/31/24, indicated a telephone interview was conducted with CNA 1. CNA 1 indicated she was not mean, hateful or rough with the resident when she provided care for her. The CNA was suspended pending an investigation.	F 550	Past noncompliance: no plan of correction required.	

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F 550	Continued From page 3	F 550		

A facility written statement, dated 10/31/24, signed by LPN 2 indicated CNA 1 was asked to get Resident J out of bed. CNA 1 brought Resident J to the nurses' station to sit with LPN 2. While sitting at the desk, Resident J indicated to LPN 2 that CNA 1 was hateful, and CNA 1 ignored her.

A document, titled "Take off Payroll," dated 11/5/24, indicated CNA 1 was terminated for being "mean and nasty" with Resident J. The facility yielded on the side of safety to keep their residents safe from perceptions of abuse.

The clinical record for Resident J was reviewed on 1/21/25 at 12:43 p.m. The diagnoses included, but were not limited to, major depressive disorder, pain, anxiety disorder, frontotemporal neurocognitive disorder, moderate protein-calorie malnutrition, and difficulty walking.

Resident J was unable to be interviewed.

2. A document, titled "Indiana State Department of Health," dated 11/8/24, indicated Resident K reported she had a care concern with CNA 5 on 11/3/24.

A typed facility statement dated 11/3/24 at 8:02 p.m., CNA 5 indicated she took Resident K to the bathroom. Resident K wore a brief with a pull up over the brief. The resident turned on her light at around 10:30 a.m., indicating she was in pain. The CNA informed the nurse the resident was complaining of pain. During the last bed check, CNA 5 took the resident to the bathroom, and she observed the pullup was off. The nurse had removed the pullup because it was too tight with the brief and the resident was complaining of pain

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F 550	Continued From page 4	F 550		

in her private area. CNA 5 indicated the resident requested to have two briefs placed on her and CNA 5 informed the resident she was not able to. This was the only conversation she had with the resident.

A handwritten statement, dated 11/3/24, CNA 6 indicated when she went to Resident K's room to get her for dinner, the resident started crying and said she was tired of being mistreated. She did not want CNA 5 to take care of her again. Resident K indicated CNA 5 yelled at her roommate as well.

A handwritten statement, dated 11/3/24, LPN 7 indicated Resident K did not want CNA 5 to care for her anymore because CNA 5 yelled at her and told her she could not wear two briefs.

A typed statement, dated 11/6/24, Resident K indicated CNA 5 yelled at her because she had to go to the bathroom. She scolded her for being wet and wanting to wear two briefs.

A document, titled "Take off Payroll," dated 11/7/24, indicated CNA 5 was terminated on 11/7/24.

The clinical record for Resident K was reviewed on 1/21/25 at 11:36 a.m. The diagnoses included, but were not limited to, psychotic disorder with hallucinations, major depressive disorder, type II diabetes mellitus, dementia, and frontotemporal neurocognitive disorder.

On 1/21/25 at 3:03 p.m., Resident K was unable to be interviewed.

A current facility policy, titled "Resident Rights,"

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F 550	Continued From page 5 dated 10/18 and provided by the Director of Nursing (DON) on 1/21/25 at 12:45 p.m., indicated "...The facility shall use Resident's Rights (as identified by the Federal and State Guidelines) as the basis for their services to residents in providing care that meets the needs and rights of the residents...." The deficient practice was corrected by 11/5/24, after the facility implemented a systemic plan that included the following actions: resident interviews were conducted, facility staff were in-serviced, and CNA 1 and 5 were terminated. This citation relates to Complaints IN00446410, IN00446579, and IN00450262.	F 550		
F 689 SS=D	3.1-3(t) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure two staff members completed a Hoyer lift transfer to prevent an accident for 1 of 3 residents reviewed for accidents. (Resident J) The deficient practice was corrected on 11/11/24, prior to the start of the survey, and was therefore past noncompliance.	F 689	Past noncompliance: no plan of correction required.	

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Findings include:

A facility typed statement, dated 11/11/24, indicated the Director of Nursing (DON) spoke to CNA 9 regarding transferring Resident J with a Hoyer Lift (mechanical lift machine) without using a second person for the transfer. CNA 9 indicated she knew she was supposed to use a second person to transfer residents with the Hoyer lift. Because of the education CNA 9 had received related to transfers of residents with a Hoyer lift and choosing not to wait for a second person to transfer Resident J, CNA 9 was terminated from the facility.

The clinical record for Resident J was reviewed on 1/21/25 at 12:43 p.m. The diagnoses included, but were not limited to, major depressive disorder, pain, anxiety disorder, frontotemporal neurocognitive disorder, moderate protein-calorie malnutrition, and difficulty walking.

A nursing progress note, dated 11/9/24 at 11:22 a.m., indicated LPN 8 was notified Resident J was on the floor. CNA 8 indicated during a Hoyer lift transfer Resident J moved her hands and slid out of the Hoyer lift onto her recliner, then CNA 8 slid the resident onto the floor due to bad positioning on the recliner. Resident J had complaints of pain all over. The resident was given as needed pain medication.

An IDT (Interdisciplinary Team) progress note, dated 11/12/24 at 10:27 a.m., indicated Resident J was assisted to the floor by CNA 9 during a Hoyer lift transfer. The resident repositioned her hand which caused her to slide from the Hoyer lift onto the recliner. The resident's positioning was

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F 689	Continued From page 7	F 689		

bad in the recliner, so CNA 9 assisted the resident to the floor. The root cause of the fall was related to CNA 9 performing the Hoyer lift transfer without another staff member to assist with the transfer.

A document, titled "Employee Communication Form," dated 11/11/24, indicated CNA 9 was terminated, on 11/11/24, because she transferred a resident with a Hoyer lift without a second person as a spotter. She was educated to use two staff members with all mechanical lifts.

A document, titled "Take off Payroll," dated 11/11/24, indicated CNA 9 was terminated for a significant policy violation resulting in a resident falling from the Hoyer lift on 11/11/24.

A current facility policy, titled "Mechanical Lift-Hoyer," dated 5/2022 and provided from the DON on 1/22/25 at 11:39 a.m., indicated "...To provide guidelines regarding the safe transfer of residents...The staff shall safely transfer resident's using mechanical lifts...Ensure the second staff person is present for transfer...Instruct the resident to place arms and hands inside sling for duration of the lift...."

The deficient practice was corrected by 11/11/24, after the facility implemented a systemic plan that included the following actions: All staff members were in-serviced on ensuring two staff members were present for all Hoyer lift transfers and CNA 9 was terminated.

This citation relates to Complaint IN00449484.

3.1-45(a)(2)

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F 755	Continued From page 8	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a staff member followed the policy and procedure when administering	F 755	Past noncompliance: no plan of correction required.	

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narcotics to 2 of 7 residents reviewed for pharmaceutical services. (Residents C, D and H) The deficient practice was corrected on 10/15/24, prior to the start of the survey, and was therefore past noncompliance.

Findings include:

A document, titled "Intake Information," dated 10/14/24 at 2:36 p.m., indicated several residents reported they did not receive their medications from the evening before, on 10/13/24, from RN 10. The agency nurse, RN 10, was placed on the do not return to the facility list.

The following Electronic Medication Administration Record (EMAR) did not have the narcotic medication documented for the dates and times the narcotic count sheet indicated the medication was administered:

1. The clinical record for Resident C was reviewed on 1/22/25 at 2:30 p.m. The diagnoses included, but were not limited to, anxiety disorder, hypertension, and vitamin deficiency.

Resident C's physician's orders included, but were not limited to, the following:
Cyclobenzaprine HCL 10 mg by mouth every six hours as needed for muscle spasms.
Norco 5-325 mg by mouth every four hours as needed for moderate-severe pain.

The resident's Electronic Medication Administration Record (EMAR), dated 10/1/24 to 10/31/24, had no documentation to indicate the resident received any as needed doses of the medications on 10/11/24.

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A document, titled "Med Script," indicated the Norco was signed out on the narcotic sheet on 10/11/24 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., by RN 10.

2. The clinical record for Resident D was reviewed on 1/22/25 at 2:00 p.m. The diagnoses included, but were not limited to, aphasia, protein-calorie malnutrition, and vitamin deficiency.

Resident D's physician's orders included, but were not limited to, the following:
Oxycodone HCL 5 mg by G-tube every four hours as needed for severe pain.

The resident's Electronic Medication Administration Record (EMAR), dated 10/1/24 to 10/31/24, had no documentation to indicate he received any as needed doses of this medication on 10/11/24.

A document, titled "Med Script," indicated the Oxycodone was signed out on the narcotic sheet on 10/11/24 at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., by RN 10.

A handwritten document, dated 10/15/24 at 10/30 a.m., indicated Resident D and his caregiver had indicated RN 10 acted strange the whole day. Resident D indicated he had received Tylenol during that day and did not receive any Oxycodone.

During an interview, on 1/21/25 at 1:30 p.m., Resident D indicated there was a night a while back when an agency nurse did not give him his medications. She lied and said he took narcotics when he did not take them. He only took Tylenol

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F 755	Continued From page 11	F 755		

for pain.

3. The clinical record for Resident H was reviewed on 1/22/25 at 2:45 p.m. The diagnoses included, but were not limited to, depression, hypertension, and anemia.

Resident H's physician's orders included, but were not limited to, the following:
Oxycodone HCL 10 mg by mouth every four hours as needed for severe pain.

The resident's EMAR, dated 10/1/24 to 10/31/24, had no documentation to indicate the resident had received any as needed doses of this medication on 10/11/24.

A document, titled "Med Script," indicated the Oxycodone was signed out on the narcotic sheet on 10/11/24 at 8:00 a.m., 2:00 p.m., and 8:00 p.m., by RN 10.

A current facility policy, titled "Medication Administration," dated 8/2022 and provided by the Director of Nursing (DON) on 1/21/25 at 12:45 p.m., indicated "...To assure that medication and treatments are administered safely and correctly...Documentation of all medications given to the resident shall be documented by the person administering the medicine after the medication has been administered...IF YOU ARE GIVING A PRN NARCOTIC MEDICATION, YOU MUST DOCUMENT IN THE E-MAR AND ON THE NARCOTIC SHEET...."

The deficient practice was corrected by 10/15/24, after the facility implemented a systemic plan that included the following actions: all staff were in-serviced, a medication competency was

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F 755	Continued From page 12 scheduled to be completed by the pharmacy, and RN 10 was placed on the do not return to the facility list. This citation relates to Complaint IN00445292. 3.1-25(b)(3)	F 755		