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	07/17/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00412984 and Complaint IN00412833. Complaint IN00412984 - No deficiencies related to the allegations are cited. Complaint IN00412833 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: July 14 and 17, 2023 Facility number: 000001 Provider number: 155001 Census Bed Type: SNF/NF: 145 Total: 145 Census Payor Type: Medicare: 9 Medicaid: 97 Other: 39 Total: 145 Thiss deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 21, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 8/9/2023	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	08/07/2023

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

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	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. Based on observation, interview and record review, the facility failed to protect a resident from injury during a transfer when the CNA did not follow transfer instructions for 1 of 3 residents reviewed for accidents. (Resident 2) Resident 2 sustained a fracture to her femur when she was lowered to the floor. Finding includes: An incident report filed with the Indiana Department of Health indicated Resident 2 sustained a fall, on 06/05/23 at approximately 2:00 p.m., when she became weak during a transfer. The Nurse Practitioner assessed the resident, and a STAT (immediate) x-ray was ordered. The x-ray showed an acute right transverse distal femur fracture (a fracture to the leg bone between the hip and the knee). Per the report, Resident 2 was sent out to the hospital and had to have surgery and rehabilitation therapy before returning to the facility. During an observation, on 07/17/23 at 9:00 a.m., Resident 2 was observed sitting up in bed and leaning slightly to her left. She had a palm protector in her right hand and her right arm was propped up with a pillow. Resident 2 was eating her meal with her left hand. An interview was attempted, but Resident 2 was nonverbal. The record for Resident 2 was reviewed on 07/14/23 at 11:01 a.m. Diagnoses included, but were not limited to, history of falling, difficulty	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident 2 transfer status has been reviewed, care plan and assignment sheet has been updated, as needed **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - Education to be provided via inservicing by 8/9/23. Education to include the transferring of residents program -All residents have potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Education to be provided via inservicing by 8/9/23. Education to include the transferring of residents program - Facility will implement daily rounds provided each business day by	08/09/2023

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	walking, and hemiplegia and hemiparesis affecting the right side (weakness and paralysis on the right side of the body). A nurses' note, dated 06/05/2023 at 3:04 p.m., indicated "...Nurse called to residents room due to resident falling on the floor in her bathroom. Writer went into room and observed the resident on the floor with her right leg folded under her. Nurse assessed resident for injuries from fall, stabilized resident's right leg and took vital signs T.97.2, P.89 R.16 B/P 188/83. Resident assisted off the floor by nurse and CNA and into her wheelchair and then into her bed...." A care plan, undated, indicated Resident 2 was a high risk for falling and to have 2 staff members for weight bearing assist with all transfers using a gait belt. The care plan indicated to use 2 people to assist with toileting. The physician's orders were reviewed and did not include orders on use of a full body mechanical lift or transfers using 2 people and a gait belt. A current CNA assignment sheet, provided by the Assistant Director of Nursing on 07/14/23 at 11:20 a.m., indicated "...High fall risk...2 person assist with gait belt/wheelchair...Extensive assist...Rt (right) side hemiparesis...." During an interview, on 07/14/23 at 11:14 a.m., CNA 1 indicated Resident 2 could be transferred by a full body lift with two (2) staff or by gait belt with two (2) staff. She did transfer Resident 2, in the bathroom, by herself and did not use a gait belt. She indicated the proper way to transfer Resident 2 was documented on the CNA assignment sheet, but she did not have her assignment sheet with her that day, she was in a		Management, to ensure residents are being transferred per their plan of care. -All residents transfer status has been reviewed, assignment sheets and Care Plans updated as needed - Facility to provide on going training and skills validations for transfers, as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the Transfer CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	hurry. She was aware the resident required two (2) people and a gait belt for transfers. It was not the first time she had worked with the resident, prior to the incident. CNA 1 indicated when she was transferring Resident 2 in the bathroom, the resident had her good hand on the assist bar. CNA 1 placed her weak hand on the bar, and when she stood Resident 2 up, the resident went limp, and they both went down. CNA 1 indicated the resident was weak on one side. She did call the nurse and together they assisted the resident to her bed. During an interview, on 07/14/23 at 11:25 a.m., the Assistant Director of Nursing indicated CNA 1 was interviewed to find out why she did not follow the CNA assignment sheet. During an interview, on 07/14/23 at 11:38 a.m., TX 3 (Therapy Staff) indicated Resident 2 was to transfer using two (2) people and a gait belt. She was assessed on 04/24/23 (prior to the event) upon her admit to facility and was totally dependent on staff for transfers, meaning a full body mechanical lift was to be used or two (2) staff members with a gait belt for transfers. How the resident was transferred was determined by the resident's pain level and the resident's weight bearing status. He indicated the CNA assignment sheet needed to be updated. During an interview, on 07/14/23 at 1:01 p.m., LPN 2 indicated she was at her medication cart parked across the hall. She did not hear anything. CNA 1 came out of the room and asked her to come into the room. LPN 2 entered the room and found Resident 2 on the floor with her leg bent behind her. She had the CNA remain with Resident 2 and left to get the vital sign instruments. Once she had finished assessing the resident, both her and			

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	CNA 1 transferred the resident to her bed via two people and a gait belt. She indicated it was more of a lift and carry to the bed due to the observation of the leg and the resident was not able to assist with transfer. Once the resident was in bed, she displayed seizure activity. LPN 2 indicated she knew how to transfer the resident because it was documented on the care card. During a telephone interview, on 07/17/23 at 3:15 p.m., the family member of Resident 2 indicated her mother did not self-transfer due to weakness and paralysis on her right side. She was dependent on 2 staff members and a gait belt to be transferred. The resident had at least three (3) gait belts in her room. A facility document, titled "Job Description...CERTIFIED NURSING ASSISTANT," dated as last reviewed in August 2007 and received from the Executive Director on 07/14/23 at 1:47 p.m., indicated "...To receive and complete resident care assignments...in accordance with facility policies...To perform all nursing procedures in accordance with facility policy...These procedures/tasks include but are not limited to the following...Correctly transfers the resident in accordance with the CNA Assignment Sheet...." A current policy, titled "Transferring Residents," dated as last reviewed in 04/2022 and received from the Executive Director on 07/14/23 at 1:47 p.m., indicated "...C.N.A.s assigned to the resident need to review the assignment sheet/care plan to determine if the resident requires more than a one person assist...." 3.1-45(a)(2)			