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	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hooverwood	7001 Hoover Rd Indianapolis, IN 46260

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32842 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. 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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, 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. 3.1-3(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32842 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. 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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32842 Based on interview and record review, the facility failed to ensure a staff member followed the policy and procedure when administering 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. 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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)