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	03/26/2025

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: March 20, 21, 24, 25 and 26, 2025. Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census Bed Type: SNF/NF: 27 NF: 96 SNF: 9 Residential: 19 Total: 151 Census Payor Type: Medicare: 9 Medicaid: 96 Other: 27 Total: 132 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on April 4, 2025.	F 0000	0000 Please accept the attached plan of correction as our credible allegation of compliance effective April 28, 2025. The facility respectfully requests a desk review. If you have any questions, please feel free to contact me at 317-503-3316, Best regards, Robert Newcomer, HFA, Administrator	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview and record review, the facility failed to ensure residents had self-medication administration assessments completed by the interdisciplinary team for 2 of 2 residents reviewed for self-medication administration. (Resident 73 and 77)	F 0554	F 554 D It is the intent of this facility to ensure that residents are treated in a respectful and dignified manner. 1. What corrective action will be	04/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Becky Nash	BSN, RN, DON	04/18/2025

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	03/26/2025

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
	Findings include: 1. During an observation, on 3/20/25 at 12:21 p.m., Resident 73 had Afrin nasal spray (a decongestant) on her bedside table. The clinical record for Resident 73 was reviewed on 3/20/25 at 12:47 p.m. The diagnoses included, but were not limited to, unspecified edema, bilateral cataract, and hypertension. The clinical record did not contain a self-administration evaluation completed by the interdisciplinary team for the resident to self-administer medications or keep them in her room. 2. During an observation, on 3/20/25 at 12:34 p.m., Resident 77 had lubricant eye drops and diclofenac/lidocaine cream (anti-inflammatory cream) on her bedside table. During an observation, on 3/24/25 at 10:22 a.m., Resident 77 had lubricant eye drops on her bedside table. The clinical record for Resident 77 was reviewed on 3/24/25 at 9:15 a.m. The diagnoses included, but were not limited to, type 2 diabetes, unspecified pain, and low back pain. The clinical record did not contain a self-administration evaluation completed by the interdisciplinary team for the resident to self-administer medications or keep them in her room. During an interview, on 3/24/25 at 10:29 a.m., Licensed Practical Nurse (LPN) 6 indicated she did		accomplished for those residents found to have been affected by the deficient practice? Resident #73, #77 have had medication self-administration assessments completed. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected. Education will be provided to all nursing staff and “Care” rounds team regarding Medication Self-Administration policy and not keeping medications at resident bedside. 3 What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All other residents have the potential to be affected, and education will be provided to all staff regarding Medication Self-Administration policy, and medication storage at bedside. Self- administration assessment will be done as requested by the resident, with storage in secured drawer or box, and care planned. DON will communicate with responsible party through the facility newsletter.	

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	03/26/2025

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
	not see a self-administer medication evaluation for Resident 73 or 77 in their records and they should have one if they had medications in their room. During an interview, on 3/24/25 at 10:43 a.m., Unit Manager (UM) 7 indicated the residents should have had self-administration evaluations if they had medications in their rooms. A current facility policy, titled "Medication Administration-Self Administration Evaluation," dated as last revised in May 2022 and received from the Director of Nursing (DON) on 3/26/25 at 1:05 p.m., indicated "...If the resident wishes to administer their own medications, they will be assessed by the nursing staff as to their capability. The IDT and physician will review the assessment and decide if the resident will be allowed to administer their medications. 2. If it is the decision not to allow the resident to administer their medications, then all medications shall be removed from the resident's room and kept in the nursing station...." 3.1-11(a)		4 How corrective actions will be monitored to ensure the deficient practice will not recur? Department managers will continue with “Care” rounds to ensure that resident’s do not have medications at bedside. Findings will be addressed daily to the Unit Manager. “Care” audit tool will be reviewed weekly x 4 and monthly x3 and then quarterly, or until QAPI committee determines substantial compliance has been achieved. 5 By what date the systematic changes will be completed? April 28, 2025	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the ombudsman and resident, or resident's representative was notified in writing of the reason for the resident's transfer and discharge to the hospital for 2 of 6 residents reviewed for transfer and discharge. (Resident 80 and 9) Findings include: 1. The clinical record for Resident 80 was reviewed	F 0623	Deficiency ID: F - 623 Completion Date: April 28, 2025 Plan of Correction Text: 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #80 and # 9 have returned to the facility as anticipated. 2. How other residents having the	04/28/2025

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	03/26/2025

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
	on 3/24/25 at 10:52 a.m. The diagnoses included, but were not limited to, diabetes, bipolar disorder, anxiety, borderline personality disorder, seizures, transient ischemic attack, and cerebrovascular accident. A nursing progress note, dated 8/14/24 at 11:00 a.m., indicated the resident was sent to the hospital for a psychiatric evaluation. A social service progress note, dated 8/14/24 at 1:23 p.m., indicated Resident 80 had an active plan to harm himself. The crisis center was contacted, and the resident was willing to go for a psychiatric stay. There was no documentation found in the resident's clinical record to indicate the resident and resident's representative were given information in writing regarding the reason for the resident's transfer to the hospital. There was no documentation found in the resident's clinical record to indicate the ombudsman was notified of the resident's hospitalization.2. The clinical record for Resident 9 was reviewed on 3/24/25 at 10:01 a.m. The diagnoses included, but were not limited to, osteomyelitis, muscle weakness, and fracture of the left fibula. The clinical record indicated Resident 9 experienced a fall, on 6/14/24, and she was transferred out of the facility by emergency services to the hospital and was expected to return to the facility. Resident 9 was discharged from the facility 6/14/24 through 6/17/24.		potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Audit of notification for transfers and discharges to resident or responsible party completed for the past 30 days to ensure Ombudsman notification with no additional findings. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Clinical Leadership and Social Services were in-serviced on notification requirements for all transfers and discharges. Licensed Nursing staff was educated by DON/ Designee regarding Transfer / Discharge policy and Bed-Hold documentation. Facility policy updated related to Ombudsman notification in keeping with CMS guidelines. 4 How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Administrator will continue to make monthly Ombudsman notifications according to CMS guidelines; including those residents whose return is anticipated. Social Services Director or designee will monitor notification to the resident or responsible	

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	03/26/2025

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
	There was no documentation found in the resident's clinical record to indicate the ombudsman was notified of the resident's hospitalization. During an interview, on 3/25/25 at 9:31 a.m., the Social Service Director indicated the facility did not notify the ombudsman and was under the impression if residents were expected to return to the facility, they did not need to send notification of the transfer or discharge to the ombudsman. A policy the facility was currently using, titled "Ombudsman Notification," last updated 3/2023 and received from the Director of Nursing on 3/26/25 at 1:05 p.m., indicated "...The facility will notify the Ombudsman office on a monthly basis all residents who are sent out to the Hospital who the facility does not anticipate a return...." A document, titled "Family of Social Service Administration," last updated October 2024, indicated "...Dear Nursing Home Administrator: As you know, CMS requires nursing facilities to notify the Long-Term Care (LTC) Ombudsman of the majority of residents' transfers and discharges...When a resident is transferred on an emergency basis to an acute care facility and expected to return, the SLTCO must be notified. Information from facilities regarding emergency transfers should be provided in a monthly list to the SLTCO, which should include residents' names, dates of transfer, facilities to which residents were transferred, and reasons for the transfers. Please make sure your facility's name is included on the monthly list...." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)		party for discharges and transfers weekly for 4 weeks, then monthly x 3 months. Results will be submitted to QAPI for review to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	03/26/2025

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 0625 SS=E Bldg. 00	3.1-12(a)(6)(A)(iv) 483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to ensure residents and/or residents' representatives were provided a notice of the facility bed hold policy at the time of transfer, or in cases of emergency transfer, within 24 hours for 5 of 6 residents reviewed for transfer and discharge. (Resident 80, 9, 66, 108 and 138) Findings include: 1. The clinical record for Resident 80 was reviewed on 3/24/25 at 10:52 a.m. The diagnoses included, but were not limited to, diabetes, bipolar disorder, anxiety, borderline personality disorder, seizures, transient ischemic attack, and cerebrovascular accident. A nursing progress note, dated 8/14/24 at 11:00 a.m., indicated the resident was sent to the hospital for a psychiatric evaluation. A social service progress note, dated 8/14/24 at 1:23 p.m., indicated Resident 80 had an active plan to harm himself. The crisis center was contacted, and the resident was willing to go for a psychiatric stay. There was no documentation in the clinical record to indicate the resident or resident's representative was provided with notice of the facility bed hold policy at the time of transfer, or in cases of emergency transfer, within 24 hours.2. The clinical record for Resident 9 was reviewed on 3/24/25 at 10:01 a.m. The diagnoses included, but were not limited to, osteomyelitis, bacteremia, and	F 0625	Deficiency ID: F - 625 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #80, #9, #66, #108, and #138 have returned to the facility. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Residents who transferred and/or discharged within the last 30 days were audited for presence of Bed-Hold notices and those were corrected as necessary. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Clinical Leadership and Social Services were in-serviced on notification requirements for all transfers and discharges. Licensed Nursing staff were educated by the DON/Designee on Bed-Hold documentation to accompany resident or responsible party upon transfer and/or discharge. Nursing will send notice of transfer/ discharge form and bed-hold policy with resident upon	04/28/2025

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	03/26/2025

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
	fracture of the left fibula. The clinical record indicated Resident 9 experienced a fall, on 6/14/24, and she was transferred out of the facility by emergency services to the hospital and was expected to return to the facility. Resident 9 was discharged from the facility 6/14/24 through 6/17/24. A skilled nursing facility to hospital transfer form, a notice of transfer or discharge, an appeal rights, a notice of transfer or discharge request for hearing, and a bed hold policy, dated 6/14/24, were reviewed. The clinical record did not include documentation to indicate the above documents were given to Resident 9 or Resident 9's family representative at the time of transfer, or in cases of emergency transfer, within 24 hours. 3. The clinical record for Resident 66 was reviewed on 3/24/25 at 3:51 p.m. The diagnoses included, but were not limited to, gastrostomy status, interstitial pulmonary disease, and cerebral infarction. The clinical record indicated Resident 66 was transferred to the hospital after the resident's gastrostomy tube (a tube inserted into the stomach to provide nutrition) had become dislodged, on 1/2/25. A progress note, dated 1/2/25, indicated the nurse contacted Resident 66's POA (Power of Attorney) about the dislodged gastrostomy tube. The POA requested Resident 66 be sent to the hospital.		transfer. Social Service will follow up the next business day to mail/ document copy to family, responsible party or POA. 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: Residents who have been discharged/ transferred will be reviewed for appropriate documentation, including Bed-Hold documentation weekly for 4 weeks, then monthly x3 months. Results will be submitted to QAPI for review to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	03/26/2025

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
	A skilled nursing facility to hospital transfer form, a notice of transfer or discharge, an appeal rights, a notice of transfer or discharge request for hearing, and a bed hold policy, dated 1/2/25, were reviewed. The clinical record did not include documentation to indicate the above documents were given to Resident 66 or Resident 66's family representative at the time of transfer, or in case of emergency transfer, within 24 hours. During an interview, on 3/21/25 at 11:49 a.m., Resident 66's POA indicated the facility contacted him about the dislodged G-tube. The facility did not provide him with a notice of the facility bed hold policy when Resident 66 was transferred to the hospital. He was unaware the facility was supposed to provide him with a notice of the facility bed hold policy. 4. The clinical record for Resident 108 was reviewed on 3/24/25 at 12:10 p.m. The diagnoses included, but were not limited to, benign prostatic hyperplasia, retention of urine, and congestive heart failure. a. The clinical record indicated Resident 108 was transferred to the hospital due to issues which arose while staff attempted to re-insert his urinary catheter, on 11/20/24. A progress note, dated 11/20/24, indicated Resident 108's wife was present at the time and requested the resident be sent to the hospital. A skilled nursing facility to hospital transfer form, a notice of transfer or discharge, an appeal rights, a notice of transfer or discharge request for hearing, and a bed hold policy, dated 11/20/24,			

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	03/26/2025

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
	were reviewed. The clinical record did not include documentation to indicate the above documents were given to Resident 108 or Resident 108's wife at the time of transfer. b. The clinical record indicated Resident 108 was transferred to the hospital again for hypertension (high blood pressure) and low oxygen saturation, on 11/26/24. A skilled nursing facility to hospital transfer form, a notice of transfer or discharge, an appeal rights, and a notice of transfer or discharge request for hearing, dated 11/26/24, were reviewed. A bed hold policy was not included. The clinical record did not include documentation to indicate the above documents were given to Resident 108 or Resident 108's wife at the time of transfer, or in cases of emergency transfer, within 24 hours. During an interview, on 3/25/25 at 9:58 a.m., the Director of Nursing (DON) indicated the facility could not find the bed hold policy provided for the hospital transfer, dated 11/26/24.5. The clinical record for Resident 138 was reviewed on 3/24/25 at 11:47 a.m. The diagnoses included, but were not limited to stage 5 kidney disease, heart failure, and end stage renal disease. A progress note, dated 2/18/25 at 4:28 p.m., indicated the spouse wanted the resident to be sent out to the hospital due to continual decline and complaints of back pain. The resident was sent to the emergency room.			

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	03/26/2025

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
	A notice of transfer or discharge form was reviewed and observed to be not filled out. There was no documentation in the clinical record to indicate Resident 138 or Resident 138's representative was provided with notice of the facility bed hold policy at the time of transfer, or in cases of emergency transfer, within 24 hours. During an interview, on 3/26/25 at 4:43 p.m., the Director of Nursing indicated the facility staff did not document in the clinical record the bed hold policy had been provided to the resident or resident's representative. The facility did not provide a policy and procedure related to sending and documenting a notice of bed hold policy to the resident or resident's representative for transfers and discharges. 3.1-12(a)(25)(A) 3.1-12(a)(25)(B) 3.1-12(a)(26)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record review, the facility failed to ensure staff dressed a resident in a manner to avoid allowing her breast to be exposed and to provide incontinence care in a timely manner for 1 of 1 dependent resident reviewed for activities of daily living (ADL) care. (Resident 28) Findings include: The clinical record for Resident 28 was reviewed on 3/24/25 at 11:29 p.m. The diagnoses included,	F 0677	Deficiency ID: F 677 1 What corrective action will be accomplished for those residents found to have been affected by deficient practice: ADL care was provided immediately to Resident #28. Education provided to CNA #9. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	04/28/2025

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	03/26/2025

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
	but were not limited to, dementia and depression. A care plan, dated as revised on 6/20/24, indicated Resident 28 was dependent on staff for activities of daily living. Interventions included, but were not limited to, assistance by 1 staff for personal hygiene and dressing, and assistance by 2 staff for toileting. A quarterly Minimum Data Set (MDS) assessment, dated 2/10/25, indicated Resident 28 was severely cognitively impaired. 1. During an observation, on 3/20/25 at 2:25 p.m., Resident 28 was sitting in the lounge across from the nurse's station with another resident. Resident 28's shirt was pulled up and her left breast was exposed. The Director of Nursing (DON) entered the room, noticed the resident's breast, and pulled her shirt down. During an observation, on 3/25/25 at 9:47 a.m., Resident 28 was sitting in the lounge with two residents. Resident 28's shirt was pulled up exposing half of her left breast. The Assistant Director of Nursing (ADON) entered the room, approached the resident, noticed the resident's exposed breast, and pulled her shirt down. During an interview, on 3/25/25 at 10:09 a.m., the ADON indicated she was not aware the resident's shirt was pulled up and they needed to make sure she was covered. During an interview, on 3/25/25 at 11:29 a.m., the DON indicated the ADON had told her the resident's breast was exposed again and the resident needed to be watched closely. 2. During an observation, on 3/20/25 at 10:30 a.m.,		action will be taken: All residents have the potential to be affected. During “Care” rounds Department managers will assess residents for dignity/care issues and inform charge nurse of any concerns. 3 What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: Review and update CNA care guides. Nursing staff were educated by DON/ Designee regarding ADL care, including incontinence care, nail care , as well as documentation of completion or refusals. Refusals to be reported to the unit Charge Nurse. 4 How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place: “Care” rounds audit will be reviewed weekly for 4 weeks, then monthly x 3 months. Results will be submitted to QAPI for review to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	03/26/2025

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
	Resident 28 was sitting in the lounge across from the nurse's station with bath blankets wrapped around the resident. During an observation, on 3/20/25 at 12:10 p.m., Resident 28 continued to sit in the lounge across from the nurse's station. A strong bowel movement and urine odor came from the resident. The resident was leaning to the right side trying to get off her buttock. The Unit Manager walked by the resident and was informed of the resident condition. The resident was taken to her room for care. During an observation, on 3/20/25 at 12:30 p.m., the Unit Manager told Certified Nursing Assistant (CNA) 9 she would help her change the resident's brief. CNA 9 gathered her supplies and unfastened the resident's brief. The brief was soaked with urine and a large loose bowel movement. A Certified Nursing Assistant job description, dated as revised 8/2007, indicated to visually check each assigned resident at least every two hours, or more frequently if their condition is required, to assist in identifying care needs. During an interview, on 3/20/25 at 12:37 p.m., the Unit Manager indicated the resident's brief was soaked with urine and bowel movement and the resident needed to be checked more often. During an interview, on 3/26/25 at 3:38 p.m., CNA 8 indicated residents needed to be checked and changed every 2 hours or when needed. A current facility policy, titled "Incontinence," dated 2021 and received from the Regional Director of Clinical Operations on 4/25/22 at 1:31			

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	03/26/2025

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
	p.m., indicated "...Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services...Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible...." A current facility policy, titled "Resident Care-Perineal Care," dated as revised 7/18 and received from the DON on 3/24/25 at 1:59 p.m., indicated "...To provide cleanliness and comfort, prevent infection and skin irritation, and to observe the skin condition of the resident...Perineal cleansing and care is performed as a part of the daily hygiene routine as well as after episodes of incontinence...." A current facility policy, titled "Resident Right Know Your Rights under Federal Nursing Home Regulations," dated 3/15/17 and received from the DON on 3/24/25 at 1:59 p.m., indicated "...You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...You have the right to be treated with respect and dignity...." 3.1-38(a)(2)(A) 3.1-38(a)(2)(C)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure a dependent resident was evaluated prior to being transferred with a sit-to-stand mechanical lift to ensure a safe transfer for 1 of 3 residents reviewed for accidents hazards. (Resident 28)	F 0689	F 689 – D It is the intent of this facility to ensure that the resident environment remains as free as hazards as possible; and that each resident receives adequate	04/28/2025

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	03/26/2025

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
	Findings include: During an observation, on 3/20/25 at 12:10 p.m., Resident 28 was sitting in the lounge across from the nurse's station. A strong bowel movement and urine odor came from the resident. Unit Manager 10 walked by the resident and was informed of the resident condition. The resident was taken to her room for care. During an observation, on 3/20/25 at 12:30 p.m., Unit Manager 10 informed CNA 8 she would help transfer the resident into bed. CNA 8 left the room and returned with a sit-to-stand mechanical lift. Unit Manager 10 put the sling strap for the sit-to-stand lift behind the resident's back and attached it to the lift. CNA 8 instructed Resident 28 to hold on to the handlebars on the top of the lift. The resident was yelling at the staff and refused to hold onto the handlebars. Unit Manager 10 instructed CNA 8 to lift the resident while she guided the resident to bed. The resident was not holding onto the handlebars when CNA 8 started using the lift. While the resident was being lifted, the strap slipped under the resident's armpits and the resident was not using her legs to stand. Unit Manager 10 took the resident by the waist and assisted her to the bed. The clinical record for Resident 28 was reviewed on 3/24/25 at 11:29 p.m. The diagnoses included, but were not limited to, hypertension, dementia, and depression. A quarterly Minimum Data Set (MDS) assessment, dated 2/10/25, indicated the resident was severely cognitively impaired. A care plan, dated 5/31/23, indicated Resident 28		supervision and assistive devices to prevent accidents. 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident # 28 CNA care guide/ care plan has been reviewed and updated as appropriate. CNA # 8 and #9 have received education on updated plan of care. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All other residents are at risk, and all have been audited for appropriate transfers. Care plans and CNA care guides have been reviewed and updated as needed. 3 What measures will be put into place, or what systematic changes will be made to ensure that the deficient practice does not recur? Nursing staff educated by DON/ Designee regarding policy and procedure required for resident transfers and use of gait belt. Lift and transfer evaluation will be conducted upon admission, quarterly and with any significant change. Care guides/ care plans will be reviewed weekly by Unit Managers. 4. How will corrective actions be monitored to ensure the deficient	

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	03/26/2025

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
	had a self-care deficit related to dementia and blindness. Interventions included, but were not limited to, Resident 28 required total dependence and assistance by 2 staff members to transfer between surfaces. The care plan did not indicate Resident 28 should be transferred with a sit-to-stand lift. The clinical record did not indicate a sit-to-stand mechanical lift evaluation had been completed for safety prior to the resident being transferred using the lift. During an interview, on 3/20/25 at 12:40 p.m., Unit Manager 10 indicated the sit-to-stand mechanical lift was probably not a safe way to transfer the resident. During an interview, on 3/20/25 at 12:43 p.m., CNA 8 indicated the resident had not always held on to the handlebars when the sit-to-stand lift was used. During an interview, on 3/24/25 at 11:11 a.m., Unit Manager 7 indicated when a resident was admitted, they had an evaluation for transfers. If a resident was a 2 person assist and a gait belt (a transfer belt placed around the waist to aid in safe movement during transfers) must be used. During an interview, on 3/24/25 at 12:31 p.m., the Director of Nursing (DON) indicated the unit manager told her the resident was transferred by using the wrong lift. The CNA assignment sheet (a document used to guide CNAs care specific to each resident) was incorrect. The resident should not have been transferred using the sit-to-stand mechanical lift.		practice will not recur? Resident transfers will be audited to ensure the correct lift is being used. Audit will be reviewed weekly x3, monthly x2 and then, quarterly, or until such time as QAPI committee determines substantial compliance has been achieved.	

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	03/26/2025

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
	During an interview, on 3/26/25 at 3:38 p.m., CNA 8 indicated the CNA assignment sheet had all the information needed to take care of the residents. The sheet would instruct you how the resident transferred. The facility Certified Nursing Assistant job description, dated as revised 8/2007 and received from the DON on 3/24/25 at 2:00, indicated to correctly follow all unit routines as assigned by a supervisor, secure and maintain resident safety devices as needed, correctly transfer the resident in accordance with the CNA assignment sheet and report changes in the resident's transfer abilities to the Unit Manager. A current facility policy, titled "Mechanical Lift-Sit to Stand," dated as revised 3/2022 and received from the DON on 3/24/25 at 2:00 p.m., indicated "...To provide guidelines for staff to safely transfer residents...The staff shall safely transfer residents using mechanical lifts...Check assignment sheet for appropriate and approved transfer method...Check the lift and sling before transfer to ensure all safety belts are intact and functioning...Ensure the second staff person required for transfer is present...Apply sling to resident...Fasten leg belts to both legs before transfer takes place....Instruct the resident to place hands on handle bars, grip for duration of transfer and use his/her upper body to help support their body...Begin transfer with remote control. The person operating the controls should stand closest to the resident being transferred...Raise the resident only as high as necessary to clear his/her body from the transfer surface...Lower the resident to his/her destination surface...Carefully release resident from sling and leg belts...." A current facility policy, titled "Gait Belt Use,"			

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	03/26/2025

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
	dated as revised 3/2022 and received from the DON on 3/24/25 at 2:00 p.m., indicated "...To provide stability for a resident during ambulation or transfer...If the resident is not able to independently self-transfer, the resident shall be transferred utilizing a gait belt...." 3.1-45(a)(1)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to ensure residents medications were reviewed monthly by the pharmacist for 3 of 5 residents reviewed for unnecessary medications. (Resident 55, 91 and 92) Findings include: 1. The clinical record for Resident 55 was reviewed on 3/24/25 at 11:49 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder with delusions, peripheral vascular disease, severe kidney disease, diabetes mellitus with diabetic polyneuropathy, depression, anxiety disorder, and hypertension. The physician's orders indicated Resident 55 received lorazepam (an anti-anxiety medication), sertraline (an antidepressant medication), and Zyprexa (an antipsychotic medication). The clinical record included pharmacy reviews for Resident 55's medications on 3/24, 4/24, 5/24, 6/24, 8/24, 9/24, 10/24, 11/24, 12/24, 1/25, 2/25, and 3/25. There were no pharmacist reviews for July of 2024 between the dates of 6/18/24 and 8/9/24.	F 0756	F ~ 756 D It is the intent of this facility to ensure that resident's drug regimen is reviewed by a licensed pharmacist at least monthly. 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #55, #91 and #92 medications have been reviewed every month, except for July 2024. (Pharmacy transition was root cause of the omission). Facility unable to correct July 2024 deficiency. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All other residents have received medication reviews by the licensed pharmacist since the pharmacy transition in July, 2024 was completed. 3 What measures will be put into place, or what systematic	04/28/2025

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	03/26/2025

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
	During an interview, on 3/25/25 at 1:35 p.m., the Director of Nursing (DON) indicated the facility had changed pharmacy providers in August. She could not find a record of a pharmacist review of the resident's medications for the month of July. She contacted the previous pharmacy provider, but they did not have a record of a review for Resident 55 for July.2. The clinical record for Resident 91 was reviewed on 3/25/25 at 3:18 p.m. The diagnoses included, but were not limited to, seizure disorder, anxiety disorder, and depression. The physician's orders indicated Resident 91 received aripiprazole (an antipsychotic medication) and Cymbalta (an antidepressant medication). The clinical record included pharmacy reviews for Resident 91's medications on 4/24, 5/24, 8/24, 9/24, 10/24, 11/24, 12/2024. There were no pharmacist reviews for 6/24, 7/24, 1/25 and 2/25. During an interview, on 3/26/25 at 3:13 p.m., the DON indicated the facility changed pharmacies and she had contacted the old pharmacy. They provided all the monthly pharmacy reviews the facility had for the Resident 91 and several months were missing. 3. The clinical record for Resident 92 was reviewed on 3/25/25 at 11:05 a.m. The diagnoses included, but were not limited to, hypertension, anxiety disorder, and manic depression. The physician's orders indicated Resident 92 received olanzapine (an antipsychotic medication).		changes will be made to ensure that the deficient practice does not recur? Medication reviews will be kept in a binder and under the supervision of the ADON/ Designee to ensure timely completion according to regulatory requirements. 4 How will corrective actions be monitored to ensure the deficient practice will not recur? Audit of completed medication reviews by licensed pharmacist will be performed monthly thereafter, or until QAPI committee determines compliance has been achieved. 5 By what date will the systematic changes be completed? April 28, 2025	

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	03/26/2025

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
	The clinical record included pharmacy reviews for Resident 92's medications on 6/17/24, 8/14/24, 9/6/24, 10/17/24, 11/12/24, 12/17/24, 1/17/25, 2/11/25. There were no pharmacist reviews for July of 2024. During an interview, on 3/26/25 at 3:15 p.m., the DON indicated the monthly pharmacy review for July of 2024 could not be found. A current facility policy, titled "Psychoactive Medications," dated as last revised in November 2018 and received from the DON on 3/26/25 at 1:05 p.m., indicated "...Psychoactive medications shall be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and review in accordance with regulatory requirements...." 3.1-25(h)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on observation, interview, and record review, the facility failed to ensure an as needed (PRN) psychotropic medication was limited to 14 days and an Abnormal Involuntary Movement Scale (AIMS) assessment was completed for a resident taking a psychotropic medication for 2 of 5 residents reviewed for unnecessary medications. (Residents 137 and 91) Findings include: 1. The clinical record for Resident 137 was reviewed on 3/24/25 at 10:08 a.m. The diagnoses included, but were not limited to, anxiety disorder, depression, and major depressive disorder.	F 0758	F ~ 758 = D It is the intent of this facility to ensure that resident's drug regimen is free from unnecessary Psychotropic Medications/ PRN use and that AIMS assessments are completed every 6 months. 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #137 has been discharged. Resident #91 has had AIMS assessment. 2 How will other residents	04/28/2025

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	03/26/2025

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
	A physician's order, with a start date of 2/27/25, indicated to give lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) every 8 hours as needed with an indefinite stop date. The medication order had gone past the 14 days without changes or a physician's rationale for extending the medication. During an interview, on 3/24/25 at 11:09 a.m., Unit Manager (UM) 6 indicated there was no stop date on the lorazepam order. 2. The clinical record for Resident 91 was reviewed on 3/25/25 at 3:18 p.m. The diagnoses included, but were not limited to, anxiety disorder, depression, and seizure disorder. A physician's order, with a start date of 2/11/25, indicated to give Aripiprazole (an antipsychotic medication) in the evening. An admission/annual/quarterly evaluation, dated 10/30/24, had an open AIMS assessment which was not completed. An admission/annual/quarterly evaluation, dated 11/22/24, had an open AIMS assessment which was not completed. The last completed AIMS assessment was on 2/27/24. During an interview, on 3/26/25 at 3:10 p.m., the Director of Nursing (DON) indicated she could not find any other completed AIMS assessment. During an interview, on 3/26/25 at 3:13 p.m., the Assistant Director of Nursing (ADON) indicated		having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All resident's on antipsychotic medication have been audited for AIMS assessments. Residents that were not in compliance had AIMS assessments completed. All residents' receiving psychoactive medications have been reviewed by the ADON for 14 day stop dates and/or for rationale from MD/NP for continuation beyond the time limited order and orders brought into compliance. Education provided to NP/ hospice providers regarding 14-day PRN stop date requirement. 3 What measures will be put into place, or what systematic changes will be made to ensure that the deficient practice does not recur? All new psychotropics orders will be reviewed in daily clinical meeting to ensure an appropriate stop date/and /or rationale. Education provided to NP/ hospice providers regarding 14-day PRN stop date requirement. Education provided to licensed nursing staff with regards to the 14 day PRN stop date requirement and the AIMS assessment that nursing will complete at least every 6 months. 4 How corrective actions will be	

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	03/26/2025

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
	she could not find any other AIMS assessment and they should have been completed. A current facility policy, titled "Psychoactive Medications," dated as last revised in November 2018 and received from the DON on 3/26/25 at 1:05 p.m., indicated "...PRN orders for psychoactive drugs are limited to 14 days, unless the attending physician/consultant believes that it is appropriate for the PRN medication to be extended beyond the 14 days, he should document the rationale in the medical record and indicate the duration for the PRN order...." A current facility policy, titled "Admission Assessment," dated as revised in October 2024 and received from the DON on 3/26/25 at 4:59 p.m., indicated "...The admission process will include a complete assessment of the individual in order to determine the care treatment and services that will be required by the resident...Other evaluations include, but not limited to...AIMS-(if on psychotropics)...The above assessments are repeated every 4 months...." 3.1-48(a)(2) 3.1-48(a)(3)		monitored to ensure the deficient practice will not recur? Audit of new psychoactive medication orders and AIMS assessments will be performed weekly x 3 weeks, monthly x 3 and quarterly thereafter, or until QAPI committee determines compliance has been achieved. 5 By what date will the systematic changes be completed? April 28, 2025	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview and record review, the facility failed to ensure a resident was alerted and awakened when her meal delivery occurred so the meal could be consumed at an appetizing temperature for 1 of 1 resident reviewed for room trays. (Resident 34) Findings include:	F 0804	F 804- D It is the intent of this facility to provide food and drink that is palatable, attractive, and at a safe and appetizing temperature. 1. What corrective action will be accomplished for those residents found to have been affected by the	04/28/2025

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	03/26/2025

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
	During an interview, on 3/21/25 at 9:12 a.m., Resident 34 indicated her meals were served cold. During an observation, on 3/25/25 at 1:39 p.m., Resident 34's lunch, which included grilled cheese and tomato soup, had been delivered and was sitting on her bedside table. The surveyor knocked on Resident 34's door and asked permission to enter. Resident 34 was asleep but woke up and gave the surveyor permission to enter. Resident 34 indicated she was unaware her lunch had been delivered and indicated the staff did not always wake her up when they delivered her meals. During an observation, on 3/26/25 at 9:12 a.m., Resident 34 was asleep in her recliner. Her breakfast, which included, two eggs prepared over easy, oatmeal, and French toast, had been delivered and was sitting on her bedside table. The surveyor knocked on Resident 34's door and asked permission to enter. Resident 34 was asleep but woke up and gave the surveyor permission to enter. Once again, Resident 34 indicated she was unaware her meal had been delivered. A request was made to check the food temperature on Resident 34's breakfast tray. During an interview, on 3/26/25 at 9:12 a.m., Unit Manager 3 indicated it was Resident 34's preference not to be woken up for tray delivery. During an interview, on 3/26/25 at 9:15 a.m., Certified Nursing Assistant 2 indicated she delivered Resident 34's room tray. She indicated the resident preferred not to be woken up for meal delivery. During an interview, on 3/26/25 at 9:17 a.m., Resident 34 indicated she wanted the staff to		deficient practice? Resident #34 was given a freshly prepared breakfast tray. Resident #34 care plan and CNA care guide was updated with her current preferences and reviewed with staff. 2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All residents have the potential to be affected; care guides reviewed by Unit Manager and updated as needed. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Staff and residents will be in the dining room prior to food delivery to ensure timely distribution of the meal. Nursing staff educated by DON/ Designee regarding the timely passing of trays and ensuring that resident preferences are being honored. Implement insulated plate covers; will cover plates with foil until covers arrive. Department heads to complete “Care” rounds 3x weekly to ensure residents are receiving meals that are appropriate temperatures and reported in daily meeting.	

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	03/26/2025

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
	wake her up when they delivered her meal trays. During an interview, on 3/26/25 at 9:30 a.m., Unit Manager 3 indicated the kitchen manager had indicated the kitchen staff were not allowed to enter a resident's room and would not be able to check the temperature of the breakfast tray. During an interview, on 3/26/25 at 9:36 a.m., the Director of Nursing (DON) indicated the Executive Chef would check the temperature of the breakfast tray and they were not sure why the staff member did not check the temperature of the food at the time it was requested to be checked. During an interview, on 3/26/25 at 9:40 a.m., the Executive Chef indicated the breakfast tray had been sitting in the resident's room for a while now and the food would be cold. The tray should not be served to her if the food had been sitting this long. During an observation, on 3/26/25 at 9:40 a.m., with the DON and General Manager, the Executive Chef obtained the temperature of Resident 34's breakfast tray, and indicated the oatmeal was 108.3 degrees, the eggs were 83 degrees, and the French toast was 78.9 degrees. The Executive Chef indicated the food was below the required temperature and more specifically, the eggs should have been over 140 degrees Fahrenheit. The temperature of her food was checked 28 minutes after the request was made. The clinical record for Resident 34 was reviewed on 3/25/25 at 11:41 a.m. The diagnoses included, but were not limited to, anxiety disorder, tracheostomy status, and chronic obstructive pulmonary disease.		4. How corrective actions will be monitored to ensure the deficient practice will not recur? Audit random meals to ensure residents are served timely. Dietary department to obtain meal temperatures three times per meal service. (Beginning, mid and end of service) Follow up with Resident Council for feedback concerning meal temps. Audit results will be reviewed weekly for 4 weeks, then monthly x 3 months. Results will be submitted to QAPI for review to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes.	

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	03/26/2025

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

A care plan, dated 9/12/24, indicated the resident had a self-care performance deficit. Interventions included, but were not limited to, Resident 34 required set-up assistance by staff to eat.

The care plan did not include preferences regarding meal delivery.

A care plan, dated 10/8/24, indicated Resident 34 had preferences and refusals. Interventions included, but were not limited to, staff would maintain consistency in timing, caregivers, and routine as much as possible.

The care plan did not include preferences regarding meal delivery.

A care plan, dated 3/25/25, indicated Resident 34 had verbal aggression toward staff. Interventions included, but were not limited to, assessing and anticipating Resident 34's needs, which included food.

The care plan did not include preferences regarding meal delivery.

During an interview, on 3/25/25 at 10:10 a.m., the resident council attendees indicated they had received cold food delivered to their rooms. They could ask for the food to be reheated but believed they should not have to ask. The food should be served hot.

A facility document, titled "Meal Delivery," dated 9/7/22 and received from the General Manager on 9/26/25 at 11:37 a.m., indicated "...Meals will be delivered to all residents/patients in a timely, organized, safe and sanitary manner...Positions resident/patient to ensure comfort and safety

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	03/26/2025

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
	while eating and drinking. Aids with meal set-up as appropriate and assists residents/patients who require assistance...." A facility document, titled "Meal Temperature Records Meal Service," dated 9/7/22 and received from the General Manager on 9/26/25 at 11:37 a.m., indicated "...Food is maintained at proper temperatures during services to meet resident expectations for palatability and to ensure that food safety principles are maintained to prevent foodborne illness...." The facility did not have a policy related to delivery of room trays. 3.1-21(a)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: March 20, 21, 24, 25 and 26, 2025 Facility number: 000001 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on April 4, 2025.	R 0000	0000 Please accept the attached plan of correction as our credible allegation of compliance effective April 28, 2025. The facility respectfully requests a desk review. If you have any questions, please feel free to contact me at 317-503-3316, Best regards, Robert Newcomer, HFA, Administrator	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility	R 0217	R 217	04/28/2025

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	03/26/2025

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
	failed to ensure service plans were signed by the resident or resident's representative for 3 of 5 residents reviewed for signed service plans. (Resident 5, 15, and 21) Findings include: 1. The clinical record for Resident 5 was reviewed on 3/20/25. The diagnoses included, but were not limited to, depression, heart disease, anemia, anxiety disorder, chronic obstructive pulmonary disease, and Parkinson's disease. A service plan, dated 12/17/24, was not signed by the resident or resident's representative. 2. The clinical record for Resident 15 was reviewed on 3/21/25. The diagnoses included, but were not limited to, hypertension, chronic obstructive pulmonary disease, depression, spinal stenosis, osteoarthritis, lymphedema, and atrial fibrillation. A service plan, dated 12/4/24, was not signed by the resident or resident's representative. 3. The clinical record for Resident 21 was reviewed on 3/20/25. The diagnoses included, but were not limited to, peripheral vascular disease, osteoarthritis, basal cell carcinoma of skin conditions, and essential hypertension. A service plan, dated 12/17/24, was not signed by the resident or resident's representative. During an interview, on 3/20/25 at 4:12 p.m., the Assisted Living Manager indicated the service plans were all done electronically on the computer and did not include an electronic signature. She indicated the facility did not print the service plans to have the resident sign.		It is the intent of this facility to ensure that resident service plans are signed by the resident/ resident representative. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #5, #15and #21 have been reviewed, signed and copied for resident and/or their representative. 2 How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? All other residents had their service plans reviewed, signed and copy offered to them or their representative. 3 What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? All new admissions will have service plans reviewed, signed, and copies offered to resident and/or their representative. 4 How corrective actions will be monitored to ensure the deficient practice will not recur? Service plans will be updated at least semi-annually and upon a known substantial change in resident’s condition, or more often	

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	03/26/2025

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
			at the resident's or facility's request. 5 By what date the systematic changes will be completed? April 28, 2025.	