

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/22/2025
NAME OF PROVIDER OR SUPPLIER  Hooverwood		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure a dependent resident was free from neglect and was provided incontinence care during an eight-hour shift for 1 of 3 residents reviewed for neglect. (Resident E) The deficient practice was corrected on 6/26/25, prior to the start of the survey, and was therefore past noncompliance. Findings include: During an interview, on 12/19/25 at 2:06 p.m., Resident E's daughter indicated she went to visit her mother on 6/2/25 at approximately 6:00 p.m. Upon entering Resident E's room, Resident E was sitting in her recliner covered with a blanket. She noted a strong odor of stale urine and feces and requested CNA 3 take her mother to the restroom. She asked CNA 3 why her mother had not been changed and provided incontinence care. CNA 3 indicated during shift report CNA 2 indicated she had just changed and provided incontinence care to Resident E. Resident E's daughter indicated when CNA 3 and another staff member stood Resident E up with the stand-up lift, Resident E's pants as well as her recliner was completely saturated with urine and feces. Her mother's incontinence brief was so saturated the brief fell to Resident E's knees. She took pictures of her mother's soiled pants and recliner and sent the photos to the Director of Nursing (DON). In a signed facility statement, dated 6/2/25, CNA 3 indicated when taking Resident E to the bathroom, CNA 3 and another staff member stood Resident E up using the stand-up lift. Resident E's pants and recliner were soiled and saturated with urine and poop. The clinical record for Resident E was reviewed on 12/19/25 at 12:33 p.m. The diagnoses included, but were not limited to, cerebral infarction (stroke), dementia, and type 2 diabetes mellitus. A care plan, dated 7/10/24, indicated Resident E had frequent bladder incontinence. Interventions included, but were not limited to, ensure peri-care with each incontinence episode was completed. A care plan, dated 7/10/24, indicated Resident E had a self-care deficit, required a stand lift with the assistance of 2 staff members for toileting, and was totally dependent on staff for toileting hygiene. A care plan, dated 7/10/24, indicated Resident E required long-term care placement due to the need for 24-hour 7 day a week care, with a goal to meet Resident E's needs daily. A Minimum Data Set (MDS) assessment, dated 3/19/25, indicated Resident E was always incontinent of bladder and was frequently incontinent of bowels. The facility's point of care report (where CNAs document the completion of their shift duties), dated 6/2/25, indicated CNA 2 did not document the completion of toilet use which included, but were not limited to, how Resident E used the toilet, transferred on/off the toilet, cleansed her-self after elimination, and how Resident E changed her pad (brief) during CNA 2's entire eight-hour shift. During an interview, on 12/19/25 at 11:40 a.m., the DON indicated Resident E's daughter had reported neglect of care by CNA 2 during the CNAs shift on 6/2/25. Resident E's daughter sent pictures of Resident E wearing saturated pants and a saturated recliner. CNA 2 had messaged her (DON) and admitted to neglecting her CNA duties during the shift on 6/2/25. A facility CNA job description, dated 9/11/23 and signed by CNA 2, indicated the responsibilities of a CNA included, but were not limited to, adhering to all resident right policies and procedures, visually checking each assigned resident at least every two hours or more frequently if their condition required, performing all nursing procedures in accordance with facility policy and as recommended by state-approved training and competency programs. The procedures/tasks included, but were not limited to, preparing residents for meals including toileting, assisting the residents in toileting and incontinent needs, observing and correctly recording resident care provided, assuring both the residents and resident's clothing were kept clean throughout the shift, and correctly completing required documentation prior to clocking out. A current facility policy, titled Resident Rights, dated as last revised on 10/2018 and received from the DON on 12/22/25 12:26 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. A current facility policy, titled Resident Rights Know your Rights under Federal Nursing Home Regulations, dated as last updated 3/15/17 and received from the DON on 12/22/25 at 12:26 p.m., indicated .You have the right to a dignified existence. You have the right to be informed, and participate in, your treatment. This includes the right to. Receive the services and/or items included in the plan of care. You have the right to be free from abuse, neglect. The right to reside and receive services in the facility with reasonable accommodation of your needs. The deficient practice was corrected by 6/26/25, after the facility completed audits, interviews, staff were re-educated, and CNA 2 was terminated. This citation relates to Intake 1765422.3.1-27(a)(3)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure narcotic medications were free from theft of an employee for 1 of 3 residents reviewed for misappropriation of property. (Resident C) The deficient practice was corrected on 12/17/25, prior to the start of the survey, and was therefore past noncompliance. Findings include: In a signed facility statement, dated 11/22/25, LPN 1 indicated about 2 weeks ago, Resident C had requested a Norco. According to the narcotic count sheet, it was too early for her to have one. The previous nurse (RN 6) had signed out Norco for Resident C twice that day and it had not been 6 hours since the last dose. Resident C indicated she had not received any Norco that day or any other day. She had only taken narcotic pain medications in the evening before bed to help her rest. RN 6 consistently signed out Norco one tablet at around 8:00 a.m., and 1:00 p.m. LPN 1 called the evening supervisor and let her know everything. In a signed facility statement, dated 11/22/25, LPN 4 indicated LPN 1 reported a discrepancy between Resident C's narcotic count sheet, her order, and her MAR. Norco one (1) tablet had been signed out on the narcotic count sheet at 8:00 a.m., and another one (1) tablet around 1:00 p.m. The order was for two (2) tablets every six (6) hours as needed. Resident C indicated she was upset because she had never received Norco during the day, only at bedtime to help her sleep. Resident C could identify her Norco tablets by sight, and she had looked at her pills before she took them. Resident C knew what medications she took each time and knew she had not taken Norco during the daytime hours. The clinical record for Resident C was reviewed on 12/19/25 at 10:46 a.m. The diagnoses included, but were not limited to, thrombosis of the left popliteal vein, uropathy, diastolic congestive heart failure, type 2 diabetes mellitus, and pain. A physician's order, dated 12/5/23 and discontinued on 12/1/25, indicated to administer Norco (a narcotic pain medication) 5-325 milligrams (mg) two (2) tablets every 6 hours as needed for pain. 1. The Medication Administration Record (MAR), dated September 2025, indicated RN 6 administered Resident C Norco on 9/10/25 at 10:32 a.m., and 9/16/25 at 10:15 a.m. The narcotic count sheet for Resident C, dated 8/29/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 9/2/25 at 10:00 a.m. On 9/3/25 at 11:00 a.m. On 9/6/25 at 9:00 a.m. On 9/7/25 at 10:00 a.m. The narcotic count sheet for Resident C, dated 9/21/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 9/24/25 at 10:30 a.m. On 9/25/25 at 11:00 a.m. 2. The MAR, dated October 2025, indicated RN 6 administered Resident C Norco on 10/10/25 at 12:00 p.m., and 10/13/25 at 11:00 a.m. The narcotic count sheet for Resident C, dated 10/11/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 10/13/25 at 1:14 p.m. On 10/14/25 at 12:00 p.m. On 10/15/25 at 11:30 a.m. On 10/16/25 at 11:30 a.m. On 10/17/25 at 11:30 a.m. On 10/19/25 at 11:45 a.m. The narcotic count sheet for Resident C, dated 10/20/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 10/22/25 at 11:30 a.m. On 10/23/25 at 8:30 a.m. and 11:00 a.m. On 10/24/25 at 1:00 p.m. On 10/27/25 at 8:30 a.m. and 1:00 p.m. On 10/28/25 at 8:45 a.m. and 1:30 p.m. On 10/29/25 at 8:00 a.m. and 1:00 p.m. On 10/31/25 at 8:30 a.m. and 1:00 p.m. 3. The MAR, dated November 2025, indicated Resident C had not received any doses of Norco during the dayshift hours. The narcotic count sheet for Resident C, dated 10/31/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 11/5/25 at 8:00 a.m. and 1:00 p.m. On 11/6/25 at 9:00 a.m. and 1:00 p.m. On 11/7/25 at 9:00 a.m. and 1:00 p.m. On 11/10/25 at 8:30 a.m. and 1:15 p.m. On 11/11/25 at 8:30 a.m. The narcotic count sheet for Resident C, dated 11/10/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 11/10/25 at 1:00 pm. On 11/12/25 at 8:00 a.m. and 1:00 p.m. On 11/14/25 at 8:20 a.m. and 1:30 p.m. On 11/15/25 at 8:40 a.m. and 1:00 p.m. On 11/16/25 at 8:30 a.m. and 1:00 p.m. On 11/19/25 at 8:00 a.m. and 1:45 p.m. On 11/20/25 at 8:00 a.m. The narcotic count sheet for Resident C, dated 11/21/25, indicated RN 6 had administered the Norco medication to Resident C on the following dates and times: On 11/20/25 at 8:20 a.m. and 1:00 p.m. On 11/24/25 2 tablets at 8:00 a.m. A progress note, dated 11/14/25 at 12:34 p.m., indicated Resident C was cognitively intact. During an interview, on 12/19/25 at 10:35 a.m., the Director of Nursing (DON) indicated Resident C was a good historian, completely alert and oriented, and a retired registered nurse. Resident C indicated she had not received any narcotics for pain during the day shift and only took the medication at night to help her rest. Resident C had identified RN 6 as the nurse assigned to her on the diversion dates. When a nurse removed a narcotic, it must be signed out on the narcotic sheet and documented as administered to the resident on the electronic medication administration record. If it was not documented on the MAR then it was not</p>		