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	03/26/2025

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48525 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) 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 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. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44598 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, 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., 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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)

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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. 44598 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) 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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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, 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)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49891 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. 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. 44598 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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders indicated Resident 92 received olanzapine (an antipsychotic medication). 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)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50901 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: 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 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. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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)