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	04/20/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure Minimum Date Set (MDS) assessments were accurately coded for 5 of 7 residents reviewed for resident assessments. (Resident 6, 8, 22, 46, and 105)Findings include:1. The clinical record for Resident 6 was reviewed on 4/20/26 at 9:00 a.m. The diagnoses included, but were not limited to muscle weakness, abnormalities of gait and mobility, and falls.A nursing progress note, dated 3/27/26, indicated Resident 6 had a fall in her room, sustained a hematoma to her forehead, and was sent to the emergency room for evaluation.A MDS assessment, dated 3/29/26, indicated Resident 6 had no falls with an injury since admission.During an interview, on 4/17/26 at 3:04 p.m., the MDS coordinator indicated Resident 6's MDS assessment was on 3/29/26 and should have been marked for a fall with injury.2. The clinical record for Resident 8 was reviewed on 4/17/26 at 3:33 p.m. The diagnoses included, but were not limited to, partial intestinal obstruction, congestive heart failure, and hypoglycemia.A MDS assessment, dated 3/25/26, indicated the resident had a tracheostomy.The clinical record did not indicate Resident 8 had a tracheostomy or any physician's orders or care plans for a tracheostomy.During an interview, on 4/17/26 at 3:04 p.m., the MDS coordinator indicated Resident 8 was marked as having a tracheostomy on the 3/25/26 assessment and should not have been marked as having a tracheostomy.3. The clinical record for Resident 22 was reviewed on 4/20/26 at 1:10 p.m. The diagnoses included, but were not limited to, history of falling, hearing loss, and anemia.A nursing progress note, dated 2/24/26, indicated Resident 22 had a fall, a head laceration, and was assessed in the emergency room. She returned with 12 staples to the head.A MDS assessment, dated 3/12/26, indicated Resident 22 did not have any falls with major injuries.During an interview, on 4/17/26 at 3:04 p.m., the MDS coordinator indicated Resident 22 had a fall with injury and it should have been marked on the MDS assessment in completed in March.4. The clinical record for Resident 46 was reviewed on 4/17/26 at 12:00 p.m. The diagnoses included, but were not limited to, fracture of part of the neck of the right femur, unsteadiness on feet, and muscle weakness.A nursing progress note, dated 3/18/26, indicated Resident 46 was recently hospitalized , on 3/14/26, due to a fall which resulted in a right femoral neck fracture.A MDS assessment, dated 3/23/26, indicated Resident 46 had no falls with major injury since admission.A MDS assessment, dated 4/16/26, indicated Resident 46 had no falls with major injury since admission.During an interview, on 4/17/26 at 3:04 p.m., the MDS coordinator indicated Resident 46's fall with injury should have been on the March MDS assessment.5. The clinical record for Resident 105 was reviewed on 4/20/26 at 11:00 a.m. The diagnoses included, but were not limited to, multiple fractures of the ribs, unsteadiness, and lack of coordination.A nursing progress note, dated 1/9/26, indicated Resident 105 had a fall on 1/9/26, a left hip hematoma, and was sent to the emergency room.A MDS assessment, dated 1/28/26, indicated Resident 105 did not have any falls with injuries.During an interview, on 4/17/26 at 3:04 p.m., the MDS coordinator indicated the last MDS assessment for Resident 105 was 1/28/26 and was not marked for any falls. The facility followed the Resident Assessment Instrument (RAI) manual as their policy.During an interview, on 4/20/26 at 11:28 a.m., the MDS coordinator indicated Resident 8's assessment was modified today. She modified and fixed the MDS assessments for the other residents also, but the original MDS completion date remained the same. A RAI manual, titled (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, dated October 2025, indicated .nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.410 IAC (Indiana Administrative Code) 16.2-3.1-31(d)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure physician's orders were followed, medications were administered according to the ordered parameters, and a daily weight was obtained for 4 of 4 residents reviewed for quality of care. (Resident 130, 16, 108 and 14)Findings Include: 1. The clinical record for Resident 130 was reviewed on 4/15/26 at 3:04 p.m. The diagnoses included, but were not limited to, congestive heart failure (CHF), acute osteomyelitis (a serious bone infection) of the right ankle and foot, cognitive communication deficit, hypertension, and malignant neoplasm of the prostate. A care plan, dated 1/21/26, indicated Resident 130 had a diagnosis of congestive heart failure. Interventions included, but were not limited to, monitoring the resident's weight daily. A physician's order, dated 4/10/26, indicated to obtain a daily weight and to notify the physician if the weight was greater than 3 pounds in 24 hours or greater than 5 pounds in 1 week. The Medication Administration Record (MAR) indicated a daily weight for Resident 130 was not obtained on 2/14/26 and 3/17/26. During an interview, on 4/20/26 at 11:21 a.m., the Director of Nursing (DON) indicated if the resident had an order for daily weights, the nurses were expected to obtain the weight and document the weight in the MAR. 2. The clinical record for Resident 16 was reviewed on 4/15/26 at 9:56 a.m. The diagnoses included, but were not limited to, congestive heart failure (CHF), diabetes mellitus, chronic kidney disease, cognitive communication, and hypertension. A care plan, dated 1/21/26, indicated Resident 16 had CHF. The interventions included, but were not limited to, obtaining a daily weight. A physician's order, dated 1/21/26, indicated to obtain a daily weight and to notify the physician if the weight was greater than 3 pounds in 24 hours or greater than 5 pounds in 1 week. The MAR, dated 2/1/26 through 2/28/26, indicated Resident 16 had a 6.2-pound weight increase on 2/28/26. The MAR, dated 3/1/26 through 3/31/26, indicated Resident 16 had an 11.2-pound weight increase on 3/7/26. There was no documentation the physician was notified of Resident 16's weight gain on 2/26/26 and 3/7/26. 3. The clinical record for Resident 108 was reviewed on 4/20/26 at 12:50 p.m. The diagnoses included, but were not limited to, syncope, stroke, high blood pressure, dizziness, and Alzheimer's disease. A care plan, dated 3/12/26, indicated Resident 108 had syncope and to administer medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan, dated 3/18/26, indicated Resident 108 had hypertension and to administer antihypertensive medications as ordered. A physician's order, dated 3/5/26, indicated to administer midodrine (a medication used to increase blood pressure) 2.5 milligrams (mg) as needed three times daily for a systolic blood pressure less than 130 related to syncope. A physician's order, dated 3/16/26, indicated to administer amlodipine (a medication used to decrease blood pressure) 2.5 mg every 24 hours as needed for systolic blood pressure greater than 160 related to hypertension. A physician's order, dated 3/10/26, indicated to check Resident 108's blood pressure before meals, and to administer the as needed midodrine 2.5 mg if the systolic blood pressure was less than 130 or administer the as needed amlodipine 2.5 mg if the systolic blood pressure was greater than 160, and do not administer after 6 p.m. The MAR, dated 4/1/26 to 4/19/26, indicated the following systolic blood pressures were less than 130 and midodrine was not administered: a. The 7:30 a.m., systolic blood pressure, on 4/4/26 was 126, on 4/9/26 was 129, on 4/11/26 was 129, and on 4/18/26 was 127. b. The 11:00 a.m., systolic blood pressure, on 4/6/26 was 113, on 4/9/26 was 119, on 4/11/26 was 129, and on 4/18/26 was 123. c. The 4:00 p.m., systolic blood pressure, on 4/6/26 was 113 and on 4/11/26 was 128. The MAR, dated 4/1/26 to 4/19/26, indicated the following systolic blood pressures were greater than 160 and amlodipine was not administered: a. The 7:30 a.m. systolic blood pressure check, on 4/2/26 was 188, on 4/5/26 was 163, and on 4/16/26 was 163. b. The 11:00 a.m. systolic blood pressure check, on 4/2/26 was 174 and on 4/4/26 was 175. c. The 4:00 p.m., systolic blood pressure on 4/16/26 was 165. The MAR, dated March 2026, indicated there were 13 times the systolic blood pressure was less than 130 and midodrine was not administered and two (2) times the systolic blood pressure was greater than 160 and amlodipine was not administered. 4. The clinical record for Resident 14 was reviewed on 4/16/26 at 1:34 p.m. The diagnoses included, but were not limited to, hypotension, hypertension, and congestive heart failure. A care plan, dated 5/22/24, indicated Resident 14 had hypertension (high blood pressure) and to obtain blood pressure readings as ordered. A care plan, dated 8/19/24, indicated Resident 14 had congestive heart failure and to administer medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated 1/7/26, indicated to administer metoprolol (a blood pressure medication), two times a day and to hold the medication for a systolic blood pressure less than 100, a diastolic blood pressure less than 60, and a heartrate less than 60. The MAR, dated 4/1/26 to 4/16/26, indicated metoprolol was administered with the blood pressure readings outside of the physician's hold parameter of a diastolic blood pressure less than 60: a. On 4/3/26, the AM dose was administered with a diastolic blood pressure of 41 and the PM dose was administered with a diastolic blood pressure of 46. b. On 4/6/26, the PM dose was administered with a diastolic blood pressure of 36. c. On 4/8/26, the PM dose was administered with a diastolic blood pressure of 39. d. On 4/10/26, the AM dose was administered with a diastolic blood pressure of 52 and the PM dose was administered with a diastolic blood pressure of 53. e. On 4/13/26, the AM dose was administered with a diastolic blood pressure of 42. f. On 4/16/26, the AM dose was administered with a diastolic blood pressure of 58. The MAR also indicated metoprolol was administered seven (7) times with the diastolic blood pressure outside of the hold parameters in the month of February, and four (4) times with the diastolic blood pressure outside of the hold parameters in the month of March. During an interview, on 4/17/26 at 10:36 a.m., the Director of Nursing (DON) indicated when a physician's order included hold parameters, the nurse would record the vital signs prior to administration and hold the medication according to the order. During an interview, on 4/17/26 at 11:15 a.m., LPN 2 indicated a check mark on the MAR indicated the medication was administered. Medications should not be administered if any vital signs were outside of the ordered hold parameters. During an interview, on 4/20/26 at 12:54 p.m., RN 5 indicated if a physician's order included hold parameters, vital signs would be obtained first. If the vital signs were within the parameters, the medication would be administered. If the vital signs were not within the hold parameters, the medication would be held, and the vital signs would be documented. A note would be attached to the initials of the nurse who administered or held the medication on the medication administration record. A current facility policy, titled Physician Orders, dated 3/2022 and received from the DON on 4/17/26 at 3:00 p.m., indicated .All activities that effect the resident shall be ordered by the physician/designee.Nursing shall follow all orders as written. A current facility policy, titled Weights, dated 10/2023 and received from the Risk Management Director on 4/20/26 at 12:47 p.m., indicated .CHF Diagnosis: Weights for these residents are often performed on a daily basis as ordered by the physician. A current facility policy, titled Medication Administration, dated 8/2022 and received from the DON on 4/17/26 at 3:00 p.m., indicated .The facility will administer medications and treatments in a safe (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manner.Check order for parameters for withholding medications. If parameters are set in order take blood pressure and/or heart rate prior to administering medication. 410 IAC (Indiana Administrative Code) 3.1-37(a)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure a call light was in reach for 1 of 1 resident reviewed for accommodation of needs. (Resident 11) Findings include:During an observation, on 4/15/26 at 9:45 a.m., Resident 11 was sitting in his room in a Broda chair. His call light was coiled up on his night stand out of the resident's reach.During an observation, on 4/17/26, the resident was lying in his bed with the call light on the ground under the bed.The clinical record for Resident 11 was reviewed on 4/17/26 at 3:21 p.m. The diagnoses included, but were not limited to, Parkinson's disease, dislocation of the T3/T4 thoracic vertebra, and history of falling.A care plan, dated 7/8/24, indicated Resident 11 was at risk of falls. Interventions included, but were not limited to, be sure the resident's call light was within reach, and the resident needed a safe environment with a reachable call light.During an interview, on 4/17/26 at 3:21 p.m., CAN 10 indicated the call light was under the resident's bed and it should not be out of reach.During an interview, on 4/20/26 at 11:06 a.m., the Director of Nursing (DON) indicated the call light should be in the resident's reach.During an interview, on 4/20/26 at 12:53 p.m., CNA 9 indicated if a resident was taken to their room or laid down in bed, their call light need to be in reach.A current facility policy, titled Call Lights, dated as last revised/reviewed on 3/2022 and provided by the Director of Risk Management on 4/20/26 at 9:33 a.m., indicated .When the resident is in bed or in a chair be sure the call light is within easy reach.410 IAC (Indiana Administrative Code) 3.1-3(v)(1)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medication was labeled with an open date in 3 of 5 medication carts reviewed for medication storage. (1B [NAME] Medication Cart, 2B East Medication Cart and 1A East Medication Cart)Findings include:1. During an observation, on 4/17/26 at 3:03 p.m. with Licensed Practical Nurse (LPN) 3, the 1B [NAME] medication cart had the following:a. One opened bottle of loperamide hydrochloride (a medication used to treat loose stools) 2 milligrams (mg) was not labeled with an open date and had another resident's name label on the bottle.b. One opened bottle of alendronate (a medication used to treat osteoporosis) 70 mg was not labeled with an open date.During an interview, on 4/17/26 at 3:09 p.m., LPN 3 indicated the other resident's label should not have been on the medication and medication should have been labeled with an open date.2. During an observation, on 4/20/26 at 8:34 a.m. with LPN 4, the 2B East medication cart had the following:a. One opened bottle of liquid morphine (a narcotic medication used to treat pain) 20mg/ml (milliliter) was not labeled with an open date.During an interview, on 4/20/26 at 8:39 a.m., LPN 4 indicated the morphine should have had an open date.3. During an observation, on 4/20/26 at 10:16 a.m. with Registered Nurse (RN) 5, the 1A East medication cart had the following:a. One opened bottle of probiotic (Lactobacillus) was not labeled with an open date.During an interview, on 4/20/26 at 12:54 p.m., RN 5 indicated if a new bottle of medication was opened, the nurse should label it with the date and time it was opened.During an interview, on 4/20/2026 at 11:06 a.m., the DON indicated medications should be labeled with an open date at the time they are opened.A current facility policy, titled Medication Labeling, dated 5/2022 and provided by the Director of Risk Management on 4/20/26 at 9:33 a.m., indicated .To assure all medications are labeled in compliance with State and Federal laws governing prescription dispensing.The facility shall maintain accurately labeled medications to assure safe and effective medication administration to the residents. 410 IAC (Indiana Administrative Code)3.1-25(j)