STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hoosier Village	9875 Cherryleaf Dr Indianapolis, IN 46268

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51296 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan related to falls, intrusive wandering, and elopement for 1 of 5 residents (Resident 5) reviewed for care plan implementation. Findings include: On 5/5/25 at 11:04 a.m. Resident 5 was observed as he was walking into his room after his shower. He had a wander guard (a bracelet sensor used to prevent elopement) on his right wrist. Resident 5's son indicated his father had advanced Alzheimer's and was on hospice. On 5/7/25 at 10:33 a.m. Resident 5's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to Alzheimer's disease and dementia. A fall risk evaluation note, dated 3/29/25, indicated the Resident had 1 to 2 falls in the past three months. A nursing progress note, dated 4/1/25, indicated Resident 5 was observed walking out an exit door. An unknown staff member followed the Resident outside and asked where he was going. He explained he was trying to find a group that gets together weekly but was not sure where to go. The unknown staff member notified the nurse and was given a wander guard to put on the Resident. A health status note, dated 4/11/25, indicated at 10:55 a.m. Resident 5 had a fall. He was found face down on the floor by the A-wing nurse's station, with his hands between the floor and his forehead. The note indicated another staff member saw him lose his footing and tried to get to him in time before he fell , but was unable to get to him in time. A behavior note, dated 4/14/25, indicated the resident refused to go to his room and was attempting to enter other residents' rooms and administrative offices. A health status note, dated 4/22/25, indicated Resident 5 was restless, pacing and going into other residents' rooms after dinner. A behavior note, dated 4/30/25, indicated Resident 5 was wandering, going into other residents' rooms, moving things out of his room to the hallway, and exit seeking. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note, dated 5/1/25, indicated Resident 5 was up throughout the night intermittently roaming the halls indicated he had work to do. The note indicated the Resident walked to the front doors and tried to go outside. Resident 5's care plans were reviewed and lacked documentation of a care plan with interventions related to falls, elopement, or intrusive wandering. On 5/9/25 at 9:50 a.m., the Director of Nursing (DON) provided a copy of a current facility policy titled, Comprehensive Care Plans, undated. This policy indicated, . it is the policy of this facility to develop and implement A comprehensive person-centered care plan for each resident . other factors identified by the interdisciplinary team or in accordance with the residence preferences will also be addressed in the plan of care . 3. The comprehensive care plan will describe at minimum the following: . e. Resident specific interventions that reflect the resident's needs 3.1-35(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 51296 Based on observation and record review, the facility failed to review and revise a care plan for 1 of 5 residents (Resident 9) reviewed for care plan revision. Findings include: On 5/5/25 at 11:04 a.m., Resident 9 was observed as he was walking out of the bathroom with his son. The Resident's son indicated his father had advanced Alzheimer's disease and would often forget his walker when he got up to go to the bathroom. On 5/7/25 at 12:02 p.m., Resident 9's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to displaced fracture of the base of the femur neck and an unspecified fall. An admission summary note, dated 2/20/25, indicated Resident 9 had a left hip fracture, was able to walk with assistance by staff, was alert to person but not to place or time, he was confused and needed to be cued. An incident note, dated 2/23/25, indicated an unknown Certified Nursing Assistant (CNA) notified an unknown Licensed Practical Nurse (LPN) that the CNA observed Resident 9 on the floor next to his bed on floor mat. Resident 9 stated he was trying to go to the restroom. An incident note, dated 2/25/25, indicated an unknown CNA found Resident 9 on the floor of his bedroom. The resident indicated he had to go to the bathroom. An incident note, dated 2/28/25, indicated Resident 9 was found next to the toilet sitting on the floor. A behavior note, dated 3/1/25, indicated an unknown staff member witnessed Resident 9 walking without his walker attempting to go to the bathroom. A behavior note, dated 3/2/25, indicated an unknown staff member overheard Resident 9 talking loudly in his room. Upon investigation, Resident 9 was observed as he sat at the foot of his bed, grabbing his walker. He indicated he had to urinate right now. An incident note, dated 3/4/25, indicated Resident 9 was observed as he sat in the restroom doorway on the floor. The resident walked himself to the restroom without assistance or assistive devices. A behavior note, dated 3/6/25, indicated an unknown staff member witnessed Resident 9 up walking with walker. When the unknown staff member asked the resident what he was doing, the resident indicated he had to urinate. A behavior note, dated 3/7/25, indicated Resident 9 was observed as he attempted to transfer himself. The resident indicated he needed to go to the bathroom. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note, dated 3/12/25, indicated Resident 9 was heard talking to himself in his room. Upon entering the room, the Resident was observed as he attempted to walk unassisted to the bathroom. A behavior note, dated 3/16/25, indicated Resident 9 was heard talking to himself in his room. The Resident was observed as he attempted to walk by himself to the bathroom. A behavior note, dated 3/30/25, indicated Resident 9 was observed as he walked by himself out into the hallway with the use of his walker. The Resident indicated he was trying to park his walker out in the common area. An unknown staff member offered to assist the resident to the bathroom and the resident accepted. A health status note, dated 4/2/25, indicated an unidentified CNA observed Resident 9 as he sat on the floor against the closet cabinets. He indicated he was trying to walk to the bathroom. A behavior note, dated 4/13/25, indicated Resident 9 was observed as he was seated on the edge of his bed, attempting to get up to go to the bathroom. The resident indicated he needed to urinate. A behavior note, dated 4/18/25, indicated Resident 9 was attempting to walk by himself to the bathroom. A care plan titled, Falls, indicated Resident 9 was at risk for falls. The care plan was initiated 2/21/25 and it was last revised 4/29/25. The interventions for this care plan were as follows: anticipate the needs of the resident dated 2/21/25, Be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Dated 2/21/25, encourage limited soda consumption in evening. Dated 2/26/25, encourage resident to get ready for bed prior to day shift departure. Dated 4/3/25, encourage resident to toilet with assistance upon arising, before and after meals and as needed. Dated 2/24/25, Encourage resident to wear appropriate nonskid footwear when ambulating or mobilizing in wheelchair. Dated 2/21/25, encourage to keep walker to be kept within Resident 9's reach. Dated 4/30/25, follow facility fall protocol. Dated 2/21/25, offer 1 on 1 activities to keep resident in sight as needed. Dated 4/30/25, evaluate and treat as ordered or as needed. Dated 2/21/25. Upon review of the rest of Resident 9's care plans, there was no care plan that indicated anything about the Residents bathroom habits or his tendency to walk without assistance or his walker. 3.1-35(c)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 51296 Based on observations, interviews and record reviews, the facility failed to complete the proper testing to confirm an infection was present before putting a resident (Resident 5) on an antibiotic. This deficient practice affected 1 of 1 Resident's reviewed for bowel and bladder concerns. Findings include: On 5/7/25 at 10:33 a.m. Resident 5's medical record was reviewed.He was a long-term care resident whose diagnoses included but were not limited to Alzheimer's disease and dementia. A health status note, dated 3/29/25, indicated Resident 5 had a foley (an anchored urinary catheter). A health status note, dated 4/1/25, indicated Resident 5 pulled out his catheter around 3:40 a.m. A health status note, dated 4/2/25, indicated Resident 5 started an antibiotic today for a Urinary Tract Infection (UTI). Resident 5's laboratory results were reviewed, and it was found that there was no urinalysis (UA) or culture and sensitivity (CNS) done on this resident. On 5/7/25 at 1:20 p.m. the Health Care Administrator provided copies of hospice notes for Resident 5. A hospice note, dated 4/1/25, indicated Resident 5's son indicated the resident pulled out his foley catheter early that morning. The note indicated at the time of that note the Resident was complaining of pain when urinating. The catheter was not replaced. The note indicated Resident 5's son was concerned about a possible UTI. There was no strong odor to urine, and no color change to urine at that time. The hospice note indicated the resident's son was educated on pain with trauma. The resident's son indicated he would like to talk with the case manager about potentially getting a urine sample if the nurse felt it was needed. A hospice note, dated 4/2/25, indicated Resident 5 had no longer complained of painful urination and there were no signs of pain or distress. The note indicated a new order for Macrobid (an antibiotic used to treat UTIs) was received for possible UTI. The note indicated the writer reviewed that the pain was most likely from the resident pulling out his catheter. During an interview on 5/7/25 at 1:25 p.m., the Director of Nursing (DON) indicated hospice put Resident 5 on an antibiotic after the Resident pulled his catheter out. She indicated that no UA or CNS was completed before, during or after putting the resident on an antibiotic. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the survey entrance conference on 5/5/25 at 9:15 a.m., a copy of the facility's infection prevention and control program was requested and provided by the Administrator. The policy was undated and titled, Antibiotic Stewardship Program. The policy indicated, It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . nursing staff shall assess residents who are suspected to have an infection and notify the physician. Laboratory testing shall be in accordance with current standards of practice 3.1-41(a)(1)