

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2014
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NAME OF PROVIDER OR SUPPLIER HOOVERWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/08/14</p> <p>Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident rooms.</p>	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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K010050 SS=F	<p>The facility has a capacity of 188 and had a census of 154 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/11/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 of 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall</p>	K010050	<p>K050</p> <p>1.Hooverwood's"Fire and Evacuation Drill Evaluation" form has been revised andimplemented. This revised form nowincludes the statement, "Was fire alarm security company notified to verifysignal following drill?" The form also requires that</p>	09/25/2014			

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K010051 SS=F	<p>include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports on 09/08/14 at 2:04 p.m. with Maintenance Supervisor, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months, from 08/2013 to 08/2014, indicated the fire alarm system had been activated, but the verification of the transmission of the signal was not documented. Based on interview on 09/08/14 at 2:05 p.m., it was acknowledged by Maintenance Supervisor none of the fire drill reports documented the transmission of the signal was received by the monitoring station.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved</p>		<p>the time of thenotification is documented. There wereno residents found to have been affected by this deficient practice. (see attachment#1)</p> <p>2.Asa result of this revised form, the potential for other residents to be affectedby this same deficient practice will be minimized.</p> <p>1.Followingeach fire drill, this revised form will be submitted to the Executive Directorfor review and approval.</p> <p>1.Anydeficient documentation identified as a result of this review and approval willlead toward disciplinary action, policy development or inserviceeducation. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. This monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee.</p> <p>1.Dateof Completion: 9/25/2014</p>				

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	<p>components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/08/14 at 12:56 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the basement lacked</p>	K010051	<p>K051</p> <p>1. The Fire Alarm Circuit Breaker is now clearly labeled with red marking that says, "Fire Alarm Circuit Control" along with red tape. (see attachment #2) There were no residents found to have been affected by this deficient practice.</p> <p>2. As a result of this new signage & tape, the potential for other residents to be affected by this same deficient practice will be minimized.</p> <p>3. On a quarterly basis, the Maintenance Director will be responsible for inspecting the signage to assure that it is intact and clearly legible. Any deficient practice will lead toward</p>	09/25/2014

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K010056 SS=F	<p>full identification. Inside the panel cover to the circuit breakers was a breaker with a tan unmarked piece of masking tape applied to it. Based on interview on 09/08/14 at 12:57 p.m. with the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled with red marking to say Fire Alarm Circuit Control.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 3 steel armover sprinkler pipes observed in the</p>	K010056	<p>the immediate replacement of the signage and tape.</p> <p>4. Any deficient practice identified as a result of these inspections will lead toward disciplinary action, policy development or inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI /QAPI Committee.</p> <p>1. Date of Completion: 9/25/2014</p> <p>1. As a result of this deficient practice, the unsupported</p>	09/25/2014

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	<p>north Patio on second floor were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 09/08/14 at 2:15 p.m. with the Maintenance Supervisor, the steel sprinkler pipe armover observed exposed and below the ceiling at the west portion of the north patio on second floor was measured to be four feet long and unsupported.</p> <p>Based on interview on 09/08/14 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported.</p> <p>3.1-19(b)</p>		<p>armover to the sprinkler on the 2A patio was supported with the necessary device. (see attachment #3) There were no residents found to have been affected by this deficient practice.</p> <p>2. As a result of the installation of this supportive device, the potential for other residents to be affected by this same deficient practice will be minimized. The 2B patio was also inspected as part of this plan of correction and was found to be in compliance with this requirement.</p> <p>1. On a quarterly basis, an outside vendor (Simplex Grinnell) will inspect the 2A & 2B patios to assure continued compliance with this requirement. Any deficient practice will be immediately addressed.</p> <p>1. Any deficient practice identified as a result of these inspections will lead toward disciplinary action, policy development or inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI / QAPI Committee.</p> <p>1. Date of Completion: 9/25/2014</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 14 residents on 2A and 2B as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 09/08/14 during the tour between 2:18 p.m. to 2:35 p.m. with the Maintenance Supervisor, there were metal rolling fire doors protecting the openings from the kitchenettes on 2A and 2B on the second from the respective main corridors serving the residents which did not have attached inspection tags. Furthermore,</p>	K010130	<p>K130</p> <p>1. Condon Fire & Safety has been contracted to inspect the 2A & 2B kitchenette metal rolling fire doors. (see attachment #4) This company will continue to inspect these doors on an annual basis. There were no residents found to have been affected by this deficient practice.</p> <p>2. As a result of future annual inspections by Condon Fire & Safety, the potential for other residents to be affected by this same deficient practice will be minimized.</p> <p>1. The Maintenance Director will be responsible for scheduling the annual inspections of the 2A & 2B kitchenette metal rolling fire doors on an annual basis and maintaining the inspection documentation. The inspection report will be submitted annually to the Executive Director. Any deficient practices or need for repairs during the annual inspections will be addressed immediately.</p> <p>1. Failure to assure that annual inspections are occurring will lead toward disciplinary action, policy development or inservice</p>	09/25/2014

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K010143 SS=F	<p>both kitchenettes were serving stations and were not considered hazardous areas so they did not have to close automatically when the fire alarm was activated. Based on interview on 09/08/14 at 2:37 p.m. with the Maintenance Supervisor there was no additional documentation of annual inspections or test to check for proper operation and full closure.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 4 of 4 electrical</p>	K010143	<p>education. Any trends of deficient practice will bereported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI /QAPI Committee.</p> <p>2.Dateof Completion: 9/25/2014</p> <p>1.Theflight switches located in</p>	09/25/2014			

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	<p>light switches were positioned five feet above the floor in the oxygen storage rooms on first and second floors where oxygen transfer occurs. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/08/14 during the tour between 1:00 p.m. to 2:00 p.m. with the Maintenance Supervisor, the oxygen rooms located on 1A east and 1B east, first floor and 2A east and 2B east second floor had one electrical light switch just inside each oxygen room located four feet above the floor. Based on interview on 09/08/14 concurrent with each observation with the Maintenance Supervisor, it was acknowledged the electrical light switches in the oxygen storage rooms used for oxygen transfer was located less than five feet above the floor.</p> <p>3.1-19(b)</p>		<p>the 1A, 1B, 2A, and 2B oxygen storage rooms wererelocated to at least 5 feet off the ground.(see attachment #5a & 5b) There were no residents found to have been affected by this deficient practice.</p> <p>2.As a result of relocating the 4 light switches in accordance with this requirement, the potential for other residents to be affected by this same deficient practice will be minimized.</p> <p>1.On an annual basis, the Maintenance Director will be responsible for assuring that the light switches are in working condition in accordance with this requirement. Any deficient practices will be immediately repaired / replaced.</p> <p>1.Failure to conduct these annual inspections and immediately address deficient practices will lead toward disciplinary action, policy development or inservice education. Any trends of deficient practice will be reported to the Quality Improvement / QAPI Committee on a monthly basis. This monitoring will continue ongoing as a continuous quality improvement measure unless determined otherwise by the QI / QAPI Committee.</p> <p>2.Date of Completion:</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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