STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING **02** B. WING _____	**06/30/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOVERWOOD	**7001 HOOVER RD** **INDIANAPOLIS, IN 46260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code and Preoccupancy Survey for the construction of a two story addition to the East wing with newly created resident rooms 1138 - 1141 and 2138 - 2141, the remodeling of resident rooms 2150, 2152 and a new social worker's office in room 2154, the remodeling of 10 resident rooms in 1100 West, the remodeling of 11 resident rooms in 2100 West and the remodeling of nurse's stations A140 and A240 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/30/17 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code and Preoccupancy survey, Hooverwood was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and with 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. 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 corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms.	K 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING **02** B. WING _____	**06/30/2017**

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HOOVERWOOD	**7001 HOOVER RD** **INDIANAPOLIS, IN 46260**

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K 000	Continued From page 1 The facility has a capacity of 171 and had a census of 121 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review on 07/11/17 - DA	K 000		