PRINTED: 12/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>01</u> COMPI			ETED	
		155001	B. W	NG			
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OOVER RD		
HOOVER	WOOD				APOLIS, IN 46260		
TIOOVEN				INDIAN	AFOLIS, IN 40200		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K 0000							
D. 1. 0.4							
Bldg. 01					<u> </u>		
	•	ode Recertification and	K 0	000	The Plan of Correction		
	State Licensure S	Survey was conducted by			constitutes the written		
	the Indiana State	Department of Health in			allegation of compliance	for	
	accordance with	42 CFR 483.90(a).			the deficiencies cited.		
					However, the submission	of	
	Survey Date: 11	/16/17			the Plan of Correction is a		
	Sarvey Date. 11	110/11			an admission that a		
	F 3124 N 1	000001			deficiency exists or that o	ne	
	Facility Number				is cited correctly. This Pla		
	Provider Number				1		
	AIM Number: 1	00275310			of Correction is submitted		
					to meet the requirements		
	At this Life Safe	ty Code survey,			established by State and		
	Hooverwood wa				Federal law. Hooverwood	t	
		Requirements for			desires this Plan of		
		Medicare/Medicaid, 42			Correction to be consider	ed	
	•	· ·			the facility's allegation of		
	•	3.90(a), Life Safety from			compliance. Compliance	is	
		2 Edition of the National			effective December 7,		
	Fire Protection A	Association (NFPA) 101,			2017.		
	Life Safety Code	e (LSC), Chapter 19,			2017.		
	Existing Health	Care Occupancies and					
	410 IAC 16.2. T	The original building,					
		s surveyed with Chapter					
	_	th Care Occupancies.					
	1) Existing fical	till Care Occupancies.					
	This tree stars C	ailite with a bacamant					
	-	acility with a basement					
		to be of Type II (111)					
		was fully sprinklered					
	except for the ba	sement telephone room					
	and the resident	laundry room by Room					
		ity consists of Building					
		02. Building 01 consists					
	or and building	va. Danama vi volisists					

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/16/2017
NAME OF F		7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD APOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	of the original builing. 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. 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 except for the except for the resident laundry room by Room 1122. All areas providing facility services were sprinklered except for the basement telephone room. The facility has no detached buildings providing facility services. Quality Review completed on 11/22/17 - DA			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001	(X2) MULTI A. BUILD B. WING		NSTRUCTION 01	(X3) DATE : COMPL 11/16/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	t	70	001 HC	DOVER RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	be made for the raby: remote controlocks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the Clinical or Secare being met. In electrical locks that release upon loss building is protect automatic sprinkle space is protected detection system at an attended loc space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved, significant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an approved automatic specificant of the contents in building by an	sking arrangements for the le patient are used, all of curity Locking requirements addition, the locks must be lat fail safely so as to of power to the device; the led by a supervised er system and the locked dropped by a complete smoke (or is constantly monitored lation within the locked the sprinkler and detection loged to unlock the doors of the locked leaved-egress locking in accordance with permitted on door log low and ordinary hazard logs protected throughout logs protected throughout logs protected throughout logs protected logs protected logs protected logs low and logs protected logs low and logs protected logs low logs lows logs lows logs logs logs logs logs logs logs log					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 01 COMPLET B. WING 11/16/20			ETED
		155001	B. W	NG		11/16/2	2017
NAME OF I	PROVIDER OR SUPPLIEF	2		7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD APOLIS, IN 46260		
(X4) ID	SUMMARY S	MARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblic throughout by an a automatic fire dete approved, supervi system. 18.2.2.2.4, 19.2.2 Based on observ facility failed to egress through 1 readily accessible clinical diagnosi security measure required means of equipped with a requires the use egress side unless LSC 19.2.2.2.4. arrangements sh accordance with deficient practice residents, staff a Findings include Based on observ Maintenance Dir facility from 12: 11/16/17, the se outside of the fact first floor in the marked as a faci	at access door locking in 7.2.1.6.3 shall be permitted as in buildings protected approved, supervised approved, supervised action system and an ised automatic sprinkler action and interview, the ensure the means of of over 10 exits were the for residents without a strequiring specialized actions. Doors within a coff egress shall not be alatch or lock that of a tool or key from the action of a tool or key from the action of the could affect over 10 and visitors. The extreme the means of the could affect over 10 and visitors. The extreme the means of the could affect over 10 and visitors. The extreme the means of the could affect over the could be th	KO	222	It is the policy of this facilithat all egress doors be maintained per the requirements of the code 1. Upon further investigation of the exit doors located by the Salcon the first floor Alzheime wing, it was determined the magnetic locking deviwas functional by entering the 4-digit code. What was preventing the east door the door set from opening was an old alarm sensor that had dropped from the "frame" of the door set an lodged into a small void at the top of the door. Since the alarm sensor was no longer in use, it was removed on November 1 2017 by the maintenance department and verification that the door, upon enterithe 4-digit code did indeed	on er's hat ice g as of g end at er's ing	11/17/2017

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Event ID:

GMRT21 Facility ID: 000001

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	of correction identification number: 155001	A. BUILDING 01 B. WING	COMPI	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CT 7001 HOOVER RI INDIANAPOLIS, IN	D	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROV PREFIX (EACH CO CROSS-REF	VIDER'S PLAN OF CORRECTION IRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by entering a four digit code but the east door in the door set would not release after the code to open the door was entered and the door was pushed to open five separate times. Based on interview at the time of the observations, the Maintenance Director stated the east door in the aforementioned door set should have released when the code was entered to open the door but agreed the east door in the door set would not open. 3.1-19(b)	opened this old dropped but could based used to renovation occurring. The pattentrance signification previous 2. All through evaluate this same sensing on other found, it is other reaffected similar sensors thus it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors thus it is other reaffected similar sensors the sensors thus it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that it is other reaffected similar sensors the sensors that is sensors that it is other reaffected similar sensors the sensors that it is other reaffected sim	and was able to be . It is uncertain why alarm sensor d out of the frame, Id have been jarred upon the amount of ion / construction ng near this area. io area outside this e had just had some ant demolition the s days to the survey. I other exit doors out the facility were ed to determine if ne type of old alarm device was located r doors and where he old alarm s were removed, s unlikely that any esidents would be d by the same or situation. The maintenance nent routinely (at least weekly) doors for proper on and to assure e maintained per the specially those with etic locking device continue to do so.	

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		A. BUILDING B. WING	Onstruction 01	COMPLETED 11/16/2017	
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0346	NFPA 101			This isolated incident appears to have occurre because the old sensing device was not removed the time the system was upgraded and it likely became loose or ajar fro the extensive construction renovation project. 4. Routine preventation maintenance checks on egress doors will continuately by the maintenance department and any doo found to be non-operation as per the requirements the code will be repaired immediately.	m on / /e all le nce r onal of
SS=C Bldg. 01	Fire Alarm System Fire Alarm - Out of Where required fir services for more period, the authoribe notified, and the evacuated or an abe provided for all the shutdown until been returned to \$9.6.1.6 Based on record the facility failed written policy for	f Service e alarm system is out of than 4 hours in a 24-hour ty having jurisdiction shall e building shall be pproved fire watch shall parties left unprotected by the fire alarm system has	K 0346	K 346 It is the policy of this faci to have a complete written	· ·

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GMRT21 Facility ID: 000001

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/16/2017	
NAME OF P	RWOOD		7001 H	ADDRESS, CITY, STATE, ZIP CODE HOOVER RD NAPOLIS, IN 46260	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	followed in the esystem has to be four hours or more period in accord 9.6.1.6. This deresidents, staff a Findings included Based on review Preparedness Plawith the Mainter record review from 11/16/17 fire alarm system incomplete. The contacting the Irrof Health via the https://gateway.imethod or by the ISDH Gatew completing the I and e-mailing it incidents@isdh.interview at the the Maintenance watch document system impairmed Indiana State Decreed in according to the Island	placed out of service for ore in a twenty four hour ance with LSC, Section ficient practice affects all and visitors. To f "Disaster Emergency an: Fire Watch System" ance Director during om 9:20 a.m. to 12:00 %, the fire watch plan for an impairment was explan failed to include adiana State Department ex ISDH Gateway link at sold.in.gov as the primary execondary method when any is nonoperational by incident Reporting form	TAG	policy if the fire alarm system has to be placed out of service for four ho or more during a twenty-four hour period the requirements of the code. 1. The Hooverwood "Alarm Impairment / Sprinkler System Impairment / Fire Watch Policy and Procedure" wrevised on November 17 2017 to include contactifithe Indiana State Department of Health via the ISDH Gateway link a https://gateway.isdh.in.gas the primary method; of the Gateway is non-operational, by completing the ISDH — Incident Reporting Form and e-mailing it to incidents@isdh.in.gov as the secondary method; as if both the Gateway and e-mail system is non-operational, by telephoning the event to	Fire - vas 7, ng a at ov or if
	e-mail address li 3.1-19(b)	sted above.		ISDH at 317-460-7278, leaving a voicemail message. The REVISED Policy and Procedure is	

	OF CORRECTION	IDENTIFICATION NUMBER: 155001	A. BUILDING B. WING	01	COMPLETED 11/16/2017
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE	
HOOVEF	RWOOD		7001 F INDIAN		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				being provided as ATTACHMENT A.	
				2. As indicated in the 2567, the previous policidid indicate that "the authority having jurisdict would be notified", the ISDH, but the specific manner of notification would not addressed in the policy and ISDH Report Care – Reportable Incided Policy and ISDH Report Unusual Occurrence Policy and ISDH Report Unusual Occurrence Policy and Ispective As such, it is felt that no residents were affected the alleged deficient practice.	tion ras licy, the DH lent cable blicy.
				3. As policy and procedures are updated Hooverwood Administra will endeavor to assure the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Proced are reviewed on at least annual basis by the QAA Committee and evaluate	ures t an

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2017
NAME OF I	PROVIDER OR SUPPLIER	7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD IAPOLIS, 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 APPROPRIA DEFICIENCY)	DATE
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation		for changes, revisions, et	CC.
Bidg. 01	2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) The facility failed to ensure 1 of 1 basement telephone rooms were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect over 5 staff and visitors in the basement. Findings include: Based on observations with the Maintenance Director during a tour of the	K 0351	It is the policy of this facil that it is protected throughout by an approve automatic sprinkler syste per the requirements of the code. 1. Due to an extensive renovation / construction project, the sprinkler piping above the Resident Laundry Room - Room	ed m he

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155001	B. WING		11/16/2017
NAME OF F	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP CODE HOOVER RD NAPOLIS, IN 46260	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE COMPLETION DATE
	11/16/17, the bar was not provided sprinklers. Base time of the obser Director stated the	00 p.m. to 2:45 p.m. on sement telephone room d with automatic d on interview at the rvations, the Maintenance he basement is currently and agreed the basement does not have sprinkler		1122 was present, but actual sprinkler head worth installed. Hooverw Administration met wit Construction Contracted (Hagerman) and advision them that sprinkler protection to this area be provided. As such, Fire Protection installed missing sprinkler head November 17, 2017. A photograph of the Sprinkler head in the Resident Laundry Room - Room 1122 is being provided ATTACHMENT B-2. 2. Maintenance state toured all areas of the facility and other than a basement telephone reconstruction that minimizing the number residents that have be affected by the alleged deficient practice. 3. Hooverwood Administration has met the Construction	vas ood h the or, ed must Ryan d the l on inkler a as ff has the com n this other iffied e us r of en d

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		A. BUILDING B. WING	01	COMPLETED 11/16/2017	
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD IAPOLIS, IN 46260	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Contractor, (Hagerman) and advised that while it understood that the construction project is extensive and that many current use areas will not be the same upon construction completion, must maintain the various requirements of the code and that they must assur that all areas are adequately protected with sprinkler coverage. 4. During daily rounds the Hooverwood Maintenance staff, observations of areas unconstruction will be made and any noted discrepancies will be addressed with the Construction Company for immediate resolution.	we see
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system	Maintenance and Testing Maintenance and Testing and standpipe systems and, and maintained in IFPA 25, Standard for the and Maintaining of Protection Systems. and design, maintenance, and gramma maintained in a			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155001	B. W	NG		11/16/	/2017
HOOVE				7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD IAPOLIS, IN 46260		aro.
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B.			(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION
TAG		a LSC IDENTIFYING INFORMATION) nd readily available.		TAG	BLI ICILIACT)		DATE
		system last checked					
	b) Who provided system test						
	c) Water system	supply source					
	Based on record	review, observation and	K 0	353	It is the policy of this facil	ity	11/17/2017
	interview; the fa	cility failed to document			that automatic sprinkler a	ınd	
	sprinkler system	inspections in			standpipe systems are		
	accordance with	NFPA 25. NFPA 25,			inspected, tested, and		
		Inspection, Testing, and			maintained per the		
		Water-Based Fire			requirements of the code	! <u>.</u>	
		ems, 2011 Edition,					
	_	states gauges on wet pipe			1. The Hooverwood		
		is shall be inspected			"Sprinkler System – Wee	kly	
		re that they are in good			Inspection Form – Dry	,	
		-			System" AND "Sprinkler		
		at normal water supply			System – Weekly		
		g maintained. Section			Inspection Form – Wet		
	_	uges on dry pipe			System" forms were revise	sed	
	1 1	s shall be inspected			on November 17, 2017 to		
	1	e that normal air and			include but not limited to	•	
	water pressures	are being maintained.			condition, inspection of		
	Section 5.1.2 sta	ites valves and fire			valves in the locked or		
	department conr	nections shall be				ina	
	inspected, tested	l, and maintained in			unlocked position, incomi	nig	
	_	Chapter 13. Section			water PSI, system water		
		Table 13.1.1.2 shall be			PSI, and dry system air		
		ection, testing and			PSI. The initial inspection		
	_	valves, valve components			took place on November		
		on 4.3.1 states records			17, 2017 and will continue	е	
		or all inspections, tests,			weekly thereafter. The		
	shan be made to	or an inspections, tests,			REVISED forms are bein	g	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155001	B. W	NG		11/16/2017	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t.			OOVER RD		
HOOVER	RWOOD				APOLIS, IN 46260		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION DATE
TAG		, , , , , , , , , , , , , , , , , , ,		TAG	·	VIT.	DATE
	and maintenance of the system and its components and shall be made available				provided as ATTACHMEI C.	N 1	
	_				C.		
	1	naving jurisdiction upon			2. The revised forms -		
	_	ficient practice could					
	affect all residen	ts, staff, and visitors.			"Sprinkler System – Wee	KIY	
					Inspection Form – Dry		
	Findings include	:			System" AND "Sprinkler		
					System – Weekly Inspection – Wet System	,,	
		of SimplexGrinnell			ı ·		
		ection" and "Sprinkler			have been posted in each of the three Riser location		
	_	ocumentation dated			at Hooverwood; Basemer		
	· ·	17, 05/26/17, 08/18/17			– Riser #1, Main Building		
		th the Maintenance			1st Floor – Riser #2 and	_	
	Director during	record review from 9:20					
	a.m. to 12:00 p.r	n. on 11/16/17, weekly			C-Wing – Riser #3. The	slv.	
	dry sprinkler sys	stem gauge inspection			Maintenance Staff routine inspects these Riser area	•	
	documentation f	or 47 weeks of the most			(usually daily), and will	15,	
	recent 52 week p	period was not available			begin documenting on the		
	for review. Mor	nthly wet sprinkler			weekly inspection forms t		
	system gauge in	spection documentation			required inspections as	iie	
	for 7 months of	the most recent 12 month			required hispections as		
	period was also	not available for review.			required by the code.		
	In addition, mon	thly inspection			3. The Administrator w	_{/ill}	
	documentation f	or all sprinkler system			randomly audit the weekl		
		or 7 months of the most			inspection forms located	-	
		period was not available			the Riser locations on at	"1	
		ed on interview at the			least a monthly basis to		
	time of record re	eview, the Maintenance			assure that the required		
		he facility checks			inspections are being		
		and valves on a daily			conducted. If discrepance	es l	
		er system gauge and			are noted, the Administra		
		spection documentation			will bring the issue to the		
		tioned weekly and			attention of the		
		was not available for			Maintenance Director.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155001	A. BUILDING B. WING	COMPLETED 11/16/2017		
		100001	_	A A D D D D D D D D D D D D D D D D D D	11/10/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
HOOVE	RWOOD		INDIANAPOLIS, IN 46260			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
		on observations with the				
		rector during a tour of the		4. The Maintenance		
		:00 p.m. to 2:45 p.m. on		Director will be asked to		
	11/16/17, the fa	cility has supervised wet		bring the weekly inspection		
	and dry sprinkle	er systems.		forms to the next two QA	Α	
				Committee Meetings for		
	3.1-19(b)			review and discussion. If	no	
				issues are identified, the Maintenance Director will	ı	
				be asked to bring the		
				weekly inspection forms	for	
				review by the QAA		
				Committee at least every		
				six months thereafter.		
K 0354	NFPA 101					
SS=C	Sprinkler System					
Bldg. 01	Sprinkler System Where the sprinkl	- Out of Service ler system is impaired, the				
		on of the impairment has				
	been determined,	, areas or buildings				
	involved are inspendent involved are involv	ected and risks are				
		agement or designated				
	representative, ar	nd the fire department and				
		having jurisdiction have				
		here the sprinkler system is more than 10 hours in a				
	24-hour period, th	ne building or portion of the				
		are evacuated or an				
	1 ' '	ch is provided until the has been returned to				
	service.	ido been retarrios to				
		, 9.7.5, 15.5.2 (NFPA 25)				
		I review and interview,	K 0354	It is the policy of this facil	· ·	
	1	d to provide a complete		to have a complete writte	n	
	written policy co	ontaining procedures to		policy if the sprinkler		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		l í	JILDING	ONSTRUCTION 01	(X3) DATE SU COMPLET 11/16/2	ГЕО	
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	be followed for the 121 residents in sprinkler system out-of-service for 24-hour period it Section 9.7.5. It sprinkler impairs with NFPA 25, 25 Standard for the Maintenance of Protection System requires nine protection System requires nine protection for the Maintenance of Protection System requires nine protection system regularity and efficient protection system residents, staff a sidentification of the staff and review from the Mainten record review fro	the protection of 121 of the event the automatic has to be placed or 10 hours or more in a maccordance with LSC, SC 9.7.5 requires ment procedures comply 2011 Edition, the Inspection, Testing and Water-Based Fire ms. NFPA 25, 15.5.2 ocedures that the dinator shall follow. actice could affect all nd visitors. To f "Disaster Emergency m: Fire Watch System" mance Director during om 9:20 a.m. to 12:00 of the facility fire watch ic sprinkler system incomplete. The plan contacting the Indiana at of Health via the ISDH sedh.in.gov as the primary execondary method when any is nonoperational by incident Reporting form			system has to be placed out of service for more the ten hours in a twenty-four hour period per the requirements of the code. 1. The Hooverwood "I Alarm Impairment / Sprinkler System Impairment / Fire Watch Policy and Procedure" we revised on November 17 2017 to include contacting the Indiana State Department of Health via the ISDH Gateway link a https://gateway.isdh.in.go as the primary method; of the Gateway is non-operational, by completing the ISDH — Incident Reporting Form and e-mailing it to incidents@isdh.in.gov as the secondary method; as if both the Gateway and e-mail system is non-operational, by telephoning the event to ISDH at 317-460-7278, leaving a voicemail message. The REVISED Policy and Procedure is being provided as ATTACHMENT A.	eire -as t or if	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2017
	PROVIDER OR SUPPLIER RWOOD	7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD JAPOLIS, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	interview at the time of record review, the Maintenance Director stated the fire watch documentation for automatic sprinkler system impairment stated to contact the Indiana State Department of Health but not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		2. As indicated in the 2567, the previous policy did indicate that "the authority having jurisdicti would be notified", the ISDH, but the specific manner was not address in the policy, although we known by the Administrativa the ISDH – Division of Long Term Care – Reportable Incident Policy and ISDH Reportable Unusual Occurrence Pole As such, it is felt that no residents were affected to the alleged deficient practice. 3. As policy and procedures are updated, Hooverwood Administrativill endeavor to assure to the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Procedure reviewed on at least annual basis by the QAA Committee and evaluate for changes, revisions, etc.	ed ell tor of cy icy. oy ion hat

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 11/16/2017				
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the smoke barrier door set by the first floor Library. Findings include:	K 0374	It is the policy of this facilito maintain smoke barriedoors per the requirement of the code. 1. The set of corridor smoke barrier doors on the code. 1. The set of corridor smoke barrier doors on the code of the code. 2nd Floor by Room 2155 were installed as part of the renovation / construction project underway at the project underway a	nts ne the		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/16/2017
NAME OF I	PROVIDER OR SUPPLIER RWOOD	7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD IAPOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:45 p.m. on 11/16/17, the set of corridor smoke barrier doors by the first floor Library had a one quarter inch gap where the doors came together in the closed position. The door set was not equipped with a rabbet, bevel or an astragal. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor smoke barrier door set had a one quarter inch gap between the meeting edges of the door set. 3.1-19(b)		Administration has met withe Construction Contractor, (Hagerman) and advised them that the must insure that construction / remodeling complete per the specific plans and to meet the construction / remodeling complete per the specific plans and to meet the construction / remodeling complete per the specific plans and to meet the construction of the second of the Corridor Smoke Barrier Doors on 2nd Floor by Room 2155 with the astragal brush installed is being provide as ATTACHMENT D-2. 2. The maintenance is has conducted a tour of the building and other than the Corridor Smoke Barrier Doors by the 1st Floor Library, (identified elsewhere in this survey document), only one other door was found to be absent the astragal brush and all have now been installed, thus minimizing the number of residents that have been affected in the alleged deficient practice.	ey g is ed de. on or the d taff he ne

	of Correction identification number: 155001	A. BUILDING B. WING	01	COMPLETED 11/16/2017
NAME OF F	PROVIDER OR SUPPLIER	7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD APOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0711	NEDA 101		3. Hooverwood Administration has met withe Construction Contractor, (Hagerman) and advised that while it understood that the construction project is extensive, we must maintain the various requirements of the code and that they must assur that the construction plar are followed in their entirincluding the installation the astragal brushes on the new corridor smoke barridoors. 4. During daily rounds the Hooverwood Maintenance staff, observations of areas un construction will be made and any noted discrepancies will be addressed with the Construction Company for immediate resolution.	is e e e e ns e ety of che er s by der
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ЛLDING	01	COMPL	
		155001	B. W	ING		11/16	/2017
HOOVEF			STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION) eriodically instructed and		TAG			DATE
	kept informed with plan, and a copy of available with teles security. The plan response required and provides for a components per 1 18.7.1.1 through 1 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.2. Based on record interview; the fawritten plan that components in 1 LSC 19.7.2.2 recare occupancy provide for the f (1) Use of alarm (2) Transmission department (3) Emergency provide for the f (5) Isolation of f (6) Evacuation of f (6) Evacuation of f (7) Evacuation of f (8) Preparation of evacuation (9) Extinguishm Section 19.2.3.4 aisle or corridor inches in clear with means of egress rooms. Projections	their duties under the of the plan is readily phone operator or with addresses the basic of staff per 18/19.7.2.1.2 fell of the fire safety plan 8/19.2.2. 18.7.1.3, 18.7.2.1.2, 19.7.1.1 through 19.7.1.3, 19.7.2.3 review, observation and cility failed to provide a addressed all of 1 written fire plans. Equires a written health fire safety plan that shall collowing: In of alarm to fire In of alarm to fire In of floors and building for ent of fire (4) states any required shall not be less than 48 width where serving as from patient sleeping ons into the required	K 0	711	It is the policy of this facil to maintain the Disaster Emergency Preparednes Plan, (now called the All Hazards Emergency Operations Plan) per the requirements of the code including the relocation of wheeled equipment during a fire or similar emergency. 1. The Hooverwood "Code RED – Fire Policy and Procedure" as a part the Emergency Operation Plan was revised on November 17, 2017 to include the relocation of wheeled equipment during a fire or similar emergency. The REVISED Policy and Procedure is being provides ATTACHMENT E. 2. Hooverwood staff was a part to make the procedure is being provided as ATTACHMENT E.	s f f g cy. of ns	12/07/2017
	width shall be pe	ermitted for wheeled			be in-serviced on the Pol		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MUL A. BUIL B. WING	LDING	NSTRUCTION 01	(X3) DATE : COMPL 11/16/	ETED	
NAME OF	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	equipment provi wheeled equipm similar emergent written fire safet program for the equipment is limit. Equipment in a ii. Equipment in a iii. Medical emertuse iiii. Patient lift and This deficient propersidents, staff and Findings included Based on review Preparedness Planding in a.m. to 12:00 p.r. written fire safet the relocation of during a fire or so Based on observe Maintenance Diffacility from 12: 11/16/17, crash of wheelchairs were the first and second interview at the sand of the observe Director agreed plan did not additional second in the safet of	ded the relocation of ent during a fire or cy is addressed in the y plan and training facility. The wheeled atted to: use and carts in use gency equipment not in ad transport equipment factice could affect all and visitors. To of "Disaster Emergency an" with the Maintenance record review from 9:20 m. on 11/16/17, the y plan did not address wheeled equipment similar emergency. ations with the rector during a tour of the 00 p.m. to 2:45 p.m. on carts, hoyer lifts and e noted in the corridor on fond floor. Based on time of record review wations, the Maintenance the written fire safety ress the relocation of ent during a fire or			and Procedure change or or before December 7, 2017 and the new information will be included in any new employee orientations conducted or or after November 17, 20 as well the annual refresh in-service regarding the Emergency Operations Plan. In-servicing will less the likelihood that any residents will be affected the alleged deficient practice. A copy of the In-Service Record is bein provided as ATTACHMEI F. 3. During unannounce but pre-planned drills, or through an actual fire or similar emergency event, the maintenance staff will evaluate how well the stadoes in the relocation of the wheeled equipment. Depending on the outcomfurther in-servicing or education will be provided to staff members to assurt compliance. 4. The Maintenance Director will be asked to bring the unannounced, but the stadoes in the unannounced, but the stadoes in the relocation of the outcomfurther in-servicing or education will be provided to staff members to assurt compliance.	ed 17 17 19 19 19 19 19 19 19 19 19 19 19 19 19	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	PLE CONSTRUCTIONS NG 01	ON	COMPLI		
		155001	B. WING	<u>01</u>		11/16/2	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	FIX (EACH C CROSS-R	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	3.1-19(b)			throug similar drills to Comm review issues Mainte be ask unannupre-plathroug similar drills fo Comm	anned drills, or the an actual fire or the next two QA nittee Meetings for and discussion. The are identified, the enance Director when an actual fire or the an actual fire or the are review by the Conttee at least even anths thereafter.	nt AA r If no e vill r nt QAA	
K 0000							1
Bldg. 02	State Licensure State Indiana State accordance with Survey Date: 11 Facility Number: Provider Number AIM Number: 1 At this Life Safe Hooverwood was compliance with	: 000001 r: 155001 00275310 ty Code survey,	K 0000	constitution allegate the december the Plant an adress of Corresponding to meeting the constitution of Corresponding to th	lan of Correction tutes the written tion of compliance ficiencies cited. Wer, the submission of Correction is mission that a ency exists or that discorrectly. This Frection is submitted the requirementished by State and law. Hooverwoods this Plan of ection to be consideration.	on of s not t one Plan ed ts ad	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		ILDING	nstruction 02	(X3) DATE (COMPL 11/16/	ETED	
NAME OF F	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP CODE DOVER RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	CFR Subpart 48.7 Fire and the 2017 Fire Protection A Life Safety Code New Health Card IAC 16.2. Build with Chapter 18 Occupancies. This two story fa was determined construction and except for the ba and the resident 1122. This facil 01 and Building of the two story 3 Wing, the remod 2150, 2152, 2154 resident rooms in remodeling of 11 West, the remod A140 and A240 building addition main entrance lo areas. The facili system with smo corridor and in a corridor. The faci detectors hard w system installed rooms. The faci	3.90(a), Life Safety from 2 Edition of the National Association (NFPA) 101, e (LSC), Chapter 18, e Occupancies and 410 ing 02 was surveyed New Health Care acility with a basement to be of Type II (111) was fully sprinklered sement telephone room laundry room by Room ity consists of Building 02. Building 02 consists addition to the East leling of resident rooms 4, the remodeling of 10 in 1100 West, the resident rooms in 2100 eled nurse's stations and the single story in which expanded the bby and administrative ty has a fire alarm ke detection in the II areas open to the	IAU	the facility's allegation of compliance. Compliance effective December 7, 2017.	is	DATE
	uns survey.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPLETED B. WING 11/16/2017		
		155001	_		11/16/2017
NAME OF I	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0346 SS=C Bldg. 02	access were spriexcept for the re Room 1122. Al services were sp basement teleph has no detached facility services. Quality Review DA NFPA 101 Fire Alarm System Fire Alarm - Out of Where required fire services for more hour period, the a shall be notified, a evacuated or an a be provided for all the shutdown until been returned to a 9.6.1.6 Based on record the facility failed written policy for residents indicate followed in the a system has to be four hours or mo period in accord	n - Out of Service of Service re alarm system is out of than four hours in a 24 uthority having jurisdiction and the building shall be approved fire watch shall I parties left unprotected by I the fire alarm system has service. review and interview, d to provide a complete or the protection of ing procedures to be event the fire alarm e placed out of service for ore in a twenty four hour ance with LSC, Section ficient practice affects all and visitors.	K 0346	K 346 It is the policy of this facil to have a complete writte policy if the fire alarm system has to be placed out of service for four hot or more during a twenty-four hour period p the requirements of the code.	urs

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Event ID:

GMRT21 Facility ID: 000001

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/16/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	Based on review of "Disaster Emergency Preparedness Plan: Fire Watch System" with the Maintenance Director during record review from 9:20 a.m. to 12:00 p.m. on 11/16/17, the fire watch plan for fire alarm system impairment was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Maintenance Director stated the fire watch documentation for fire alarm system impairment stated to contact the Indiana State Department of Health but not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		1. The Hooverwood "F Alarm Impairment / Sprinkler System Impairment / Fire Watch - Policy and Procedure" was revised on November 17, 2017 to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.go as the primary method; of the Gateway is non-operational, by completing the ISDH — Incident Reporting Form and e-mailing it to incidents@isdh.in.gov as the secondary method; as if both the Gateway and e-mail system is non-operational, by telephoning the event to the ISDH at 317-460-7278, leaving a voicemail message. The REVISED Policy and Procedure is being provided as ATTACHMENT A. 2. As indicated in the 2567, the previous policy did indicate that "the authority having jurisdiction would be notified", the	as g v rif		

PRINTED: 12/13/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/16/2017	
NAME OF P	RWOOD	STREET. 7001 H INDIAN			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
			ISDH, but the specific manner of notification was not addressed in the poli although well known by the Administrator via the ISD — Division of Long Term Care — Reportable Incide Policy and ISDH Reportation Unusual Occurrence Policy and ISDH Reportation of Long Term Care — Reportable Incide Policy and ISDH Reportation of Long Term Care and Long Term Care reviewed Administration of Long Term Care reviewed on at least annual basis by the QAA Committee and evaluate for changes, revisions, experience of Long Term Care reviewed on at least annual basis by the QAA Committee and evaluate for changes, revisions, experience of Long Term Care and Long Term C	cy, he pH ent able icy. py ion hat	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 11/16/2017				
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 The facility failed to ensure 1 of 1 basement telephone rooms were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the resident laundry room by Room 1122. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:45 p.m. on 11/16/17, the resident laundry room by Room 1122 was not provided with automatic sprinklers. Based on interview at the time of the observations, the Maintenance Director agreed the resident	K 0351	It is the policy of this faci that it is protected throughout by an approvautomatic sprinkler systeper the requirements of tode. 1. Due to an extensive renovation / construction project, the sprinkler pipi above the Resident Laundry Room - Room 1122 was present, but the actual sprinkler head was not installed. Hooverwood Administration met with the Construction Contractor, (Hagerman) and advised them that sprinkler	ed em he e ng ng ne s ad he		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155001	A. BUILDING B. WING	02	COME	E SURVEY PLETED 6/2017
NAME OF I	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP IOOVER RD NAPOLIS, IN 46260	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	laundry room by have sprinkler co	Room 1122 does not overage.		protection to this a be provided. As since Protection insimissing sprinkler November 17, 20 photograph of the Head in the Reside Laundry Room - Filipping 1122 is being protected all areas of facility and other to basement telephone (identified elsewhas urvey document) areas have been as not having ade sprinkler protection minimizing the nuresidents that have affected by the all deficient practice. 3. Hooverwood Administration has the Construction Contractor, (Hage and advised that will understood that the construction project extensive and the current use areas be the same upon	uch, Ryan stalled the head on 17. A Sprinkler dent Room vided as -2. e staff has f the chan the one room ere in this one other identified equate on thus mber of re been deged d s met with erman) while it is ne ect is t many will not	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155001		A. BUILDING B. WING	<u>02</u>	COMPLETED 11/16/2017	
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP CODE OOVER RD JAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 02	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system			construction completion must maintain the various requirements of the code and that they must assus that all areas are adequately protected wisprinkler coverage. 4. During daily round the Hooverwood Maintenance staff, observations of areas un construction will be made and any noted discrepancies will be addressed with the Construction Company immediate resolution.	us e ire ith is by inder ile

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	JILDING	02	COMPLETED	
		155001	B. WING			11/16/	2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
HOOVER	RVVOOD			INDIAN			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record interview; the farsprinkler system accordance with Standard for the Maintenance of Protection System Section 5.2.4.1 sprinkler system monthly to ensure condition and the pressure is being 5.2.4.2 states gas sprinkler system weekly to ensure water pressures a Section 5.1.2 state department conninspected, tested accordance with 13.1.1.2 states Tutilized for inspermaintenance of vand trim. Section shall be made for and maintenance components and to the authority frequest. This de	non-required or partial or system. and NFPA 25 review, observation and cility failed to document inspections in NFPA 25. NFPA 25, Inspection, Testing, and Water-Based Fire ms, 2011 Edition, tates gauges on wet pipe is shall be inspected re that they are in good at normal water supply is maintained. Section inges on dry pipe is shall be inspected in that normal air and in the being maintained.	K 0		It is the policy of this facilithat automatic sprinkler a standpipe systems are inspected, tested, and maintained per the requirements of the code. 1. The Hooverwood "Sprinkler System – Weel Inspection Form – Dry System" AND "Sprinkler System – Wet System" forms were revis on November 17, 2017 to include but not limited to condition, inspection of valves in the locked or unlocked position, incomi water PSI, system water PSI, and dry system air PSI. The initial inspection took place on November 17, 2017 and will continue weekly thereafter. The REVISED forms are being provided as ATTACHMENC. 2. The revised forms – "Sprinkler System – Weekl Inspection Form – Dry	ity nd kly	11/17/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	02	COMPLET	ΓED
		155001	B. W	ING		11/16/20	017
E 0E 1				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	ę.		7001 H	OOVER RD		
HOOVER	RWOOD			INDIANAPOLIS, IN 46260			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	TE (COMPLETION
TAG			+	TAG	·		DATE
	Findings include	2 :			System" AND "Sprinkler		
					System – Weekly	,,	
	Based on review of SimplexGrinnell				Inspection – Wet System		
	"Report of Inspection" and "Sprinkler				have been posted in each		
	_	ocumentation dated			of the three Riser location		
	1	17, 05/26/17, 08/18/17			at Hooverwood; Basemer		
	and 11/10/17 wi	th the Maintenance			– Riser #1, Main Building	-	
	Director during	record review from 9:20			1st Floor – Riser #2 and		
a.m. to 12:00 p.m. on 11/16/17, weekly				C-Wing – Riser #3. The			
dry sprinkler system gauge inspection					Maintenance Staff routine	· 1	
	documentation for 47 weeks of the most				inspects these Riser area	ıs,	
	recent 52 week period was not available			(usually daily), and will			
	for review. Mor	nthly wet sprinkler			begin documenting on the		
		spection documentation			weekly inspection forms t	he	
		the most recent 12 month			required inspections as		
		not available for review.			required by the Code.		
	In addition, mon						
		For all sprinkler system			3. The Administrator w		
		or 7 months of the most			randomly audit the weekl	· .	
		period was not available			inspection forms located	in	
		ed on interview at the			the Riser locations on at		
					least a monthly basis to		
		eview, the Maintenance			assure that the required		
		he facility checks			inspections are being		
		and valves on a daily			conducted. If discrepance	es	
	_	er system gauge and			are noted, the Administra	tor	
		spection documentation			will bring the issue to the		
		ntioned weekly and			attention of the		
		was not available for			Maintenance Director.		
		on observations with the					
	Maintenance Director during a tour of the facility from 12:00 p.m. to 2:45 p.m. on 11/16/17, the facility has supervised wet				4. The Maintenance		
					Director will be asked to		
					bring the weekly inspection	on	
	and dry sprinkle	r systems.			forms to the next two QA		
					Committee Meetings for		

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NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	3.1-19(b)				review and discussion. If issues are identified, the Maintenance Director will be asked to bring the weekly inspection forms freview by the QAA Committee at least every six months thereafter.		
K 0354 SS=C Bldg. 02	extent and duration been determined, involved are insper determined, recommend submitted to manarepresentative, an other authorities have been notified. Whout of service for representative, an other authorities have been notified. Whout of service for representative, an other authorities have been notified. Whout of service for representative fire water sprinkler system have service. 18.3.5.1, 19.3.5.1, Based on record the facility failed written policy contained by the followed for the sprinkler system out-of-service for 24-hour period in	Out of Service er system is impaired, the n of the impairment has areas or buildings cted and risks are nmendations are agement or designated d the fire department and aving jurisdiction have ere the sprinkler system is nore than 10 hours in a 24 uilding or portion of the are evacuated or an the is provided until the as been returned to 9.7.5, 15.5.2 (NFPA 25) review and interview, I to provide a complete ontaining procedures to the protection of 121 of the event the automatic	K 0	354	It is the policy of this facili to have a complete writter policy if the sprinkler system has to be placed out of service for more that ten hours in a twenty-four hour period per the requirements of the code.	an	11/17/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02			COMPLE	
		155001	B. W	ING		11/16/2	2017
NAME OF F	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
			7001 HOOVER RD				
HOOVEF	RWOOD			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		nent procedures comply			The Hooverwood "F	ire	
	with NFPA 25, 2011 Edition, the				Alarm Impairment /		
		Inspection, Testing and			Sprinkler System		
	Maintenance of	Water-Based Fire			Impairment / Fire Watch -		
	Protection Syste	ms. NFPA 25, 15.5.2			Policy and Procedure" wa		
	requires nine pro	ocedures that the			revised on November 17,	I	
	impairment coor	dinator shall follow.			2017 to include contacting	g	
	This deficient pr	actice could affect all			the Indiana State		
	residents, staff a	nd visitors.			Department of Health via		
					the ISDH Gateway link at		
	Findings include:				https://gateway.isdh.in.go	V	
					as the primary method; or	rif	
	Based on review	of "Disaster Emergency			the Gateway is		
		nn: Fire Watch System"			non-operational, by		
	_	nance Director during			completing the ISDH –		
		om 9:20 a.m. to 12:00			Incident Reporting Form		
		7, the facility fire watch			and e-mailing it to		
	_	ic sprinkler system			incidents@isdh.in.gov as		
		incomplete. The plan			the secondary method; a	nd	
	-	contacting the Indiana			if both the Gateway and		
		t of Health via the ISDH			e-mail system is		
		t of Health via the ISDH			non-operational, by		
	Gateway link at				telephoning the event to t	he	
		sdh.in.gov as the primary			ISDH at 317-460-7278,		
	1	e secondary method when			leaving a voicemail		
		ay is nonoperational by			message. The REVISED		
		ncident Reporting form			Policy and Procedure is		
	and e-mailing it				being provided as		
	_	n.gov. Based on			ATTACHMENT A.		
		time of record review,					
		Director stated the fire			2. As indicated in the		
	watch documentation for automatic sprinkler system impairment stated to				2567, the previous policy		
					did indicate that "the		
	contact the India	na State Department of			authority having jurisdiction	on	
	Health but not vi	a the ISDH Gateway			would be notified", the		

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	of Correction identification number: 155001	A. BUILDING B. WING	02	COMPLETED 11/16/2017		
NAME OF F	RWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	link or at the e-mail address listed above. 3.1-19(b)		ISDH, but the specific manner was not address in the policy, although we known by the Administrativa the ISDH – Division of Long Term Care – Reportable Incident Policiand ISDH Reportable Unusual Occurrence Policiand IsDH Reportable Unusual Occurrence Policians were affected by the alleged deficient practice. 3. As policy and procedures are updated, Hooverwood Administrativill endeavor to assure the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Procedurare reviewed on at least annual basis by the QAA Committee and evaluated for changes, revisions, etc.	ell tor f f cy cy. by ion hat		
K 0374 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPLETED B. WING 11/16/2017				
		155001	B. W.	ING		11/16/	2017
HOOVEF			STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260			QVE)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	minute fire protect 1-3/4 inch thick so Required clear with 18.3.7.6(4) and (5) Nonrated protective exceed 48 inches door are permitted comply with 7.2.1 be arranged so th opposite direction Doors shall be see bevels, or astragate meeting edges. Prequired. 18.3.7.6, 18.3.7.7 Based on observe facility failed to smoke barrier do movement of sm minutes. LSC, 52 rabbets, bevels, required at the need doors and doors comply with LS Section 8.5.4.1 repairers to close the minimum close the minimum close proper operation inch to restrict the This deficient present the section of	ve plates that do not from the bottom of the d. Horizontal-sliding doors 1.14. Swinging doors shall at each door swings in an If-closing and rabbets, als are required at the ositive latching is not 18.3.7.8 ration and interview, the ensure 1 of over 5 sets of cors would restrict the noke for at least 20 Section 18.3.7.8(4) states or astragals shall be neeting edges of pairs or in smoke barriers shall C, Section 8.5.4. LSC, requires doors in smoke the opening leaving only earance necessary for a which is defined as 1/8 ne movement of smoke. Factice could affect over a ff and visitors in the moke barrier door set by brary.	K 0	374	It is the policy of this facil to maintain smoke barrier doors per the requirement of the code. 1. The set of corridor smoke barrier doors on the 2nd Floor by Room 2155 were installed as part of the renovation / construction project underway at Hooverwood. Under the "construction" plans for these doors is that each door was to have an "astragal brush" assembly installed by the construction contractors and this was omitted. Hooverwood Administration has met withe Construction Contractor, (Hagerman)	nts ne the	12/05/2017

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	OF CORRECTION	IDENTIFICATION NUMBER: 155001	A. BUILDING B. WING	02	COMP	E SURVEY PLETED 6/2017
NAME OF I	PROVIDER OR SUPPLIEF	!	7001 H	ADDRESS, CITY, STATE, ZIP (HOOVER RD NAPOLIS, IN 46260	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	facility from 12: 11/16/17, the set barrier doors on Room 2155 had where the doors closed position. equipped with a astragal. Based of the observation Director agreed corridor smoke thalf inch gap be	rector during a tour of the 00 p.m. to 2:45 p.m. on a of corridor smoke the second floor by a one half inch gap came together in the The door set was not rabbet, bevel or an on interview at the time ons, the Maintenance the aforementioned parrier door set had a one tween the meeting edges and was not equipped with		and advised them must insure that construction / remore complete per the seplans and to meet. The astragal brush assembly was instemed December 5, 2017 photograph of the Smoke Barrier Docent 2nd Floor by Room with the astragal beinstalled is being pas ATTACHMENT. 2. The maintent has conducted a total building and other Corridor Smoke Barrier Doors by the 1st Flibrary, (identified elsewhere in this separate document), only of door was found to absent the astragal and all have now be installed, thus min the number of resithat have been affected. 3. Hooverwood Administration has the Construction	odeling is specified the code. In talled on 7. A Corridor ors on the m 2155 orush provided D-2. ance staff our of the than the arrier floor survey ne other be all brush peen imizing idents fected by ent	

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	OF CORRECTION IDENTIFICATION NUMBI	ſ ´	02	COMPLETED 11/16/2017			
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD		7001 H	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED I REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE COMPLETION DATE			
			Contractor, (Hagerman and advised that while understood that the construction project is extensive, we must maintain the various requirements of the coand that they must assist that the construction pare followed in their erincluding the installation the astragal brushes onew corridor smoke bactors. 4. During daily rour the Hooverwood Maintenance staff, observations of areas construction will be mad any noted discrepancies will be addressed with the Construction Company immediate resolution.	ode sure lans ntirety on of on the arrier ads by under ade			
K 0711 SS=C Bldg. 02	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection all patients and for their evacuation in the event of an emergency. Employees are periodically instructed a kept informed with their duties under th plan, and a copy of the plan is readily available with telephone operator or with	ne and e					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>02</u>		COMPLETED		
	155001		B. WING 11/16			/2017	
AVAIG OF PROVIDER OF COMPANIES				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			7001 HOOVER RD				
HOOVERWOOD			INDIANAPOLIS, IN 46260				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) addresses the basic		TAG	DEFICIENCY)		DATE
		of staff per 18/19.7.2.1.2					
		Ill of the fire safety plan					
	components per 1	· · · · · · · · · · · · · · · · · · ·					
		18.7.1.3, 18.7.2.1.2,					
	l '	, 19.7.1.1 through 19.7.1.3,					
	19.7.2.1.2, 19.7.2		VO	711	It is the policy of this facil	itv	12/07/2017
		review, observation and cility failed to provide a	K U	K 0711 It is the policy of this formation to maintain the Disast		ıty	12/0//201/
	written plan that	•			Emergency Preparednes	s	
		of 1 written fire plans.			Plan, (now called the All	-	
		quires a written health			Hazards Emergency		
		fire safety plan that shall			Operations Plan) per the		
	provide for the f	• •			requirements of the code		
	(1) Use of alarm	_			including the relocation of		
	(2) Transmission				wheeled equipment durin		
	` ′	i or alarm to me			a fire or similar emergence	•	
	department	.h				, y .	
	(3) Emergency p	onone can to me			1. The Hooverwood		
	department	-1			"Code RED – Fire Policy		
	(4) Response to				and Procedure" as a part	of	
	(5) Isolation of f				the Emergency Operation		
	` ′	of immediate area			Plan was revised on		
		of smoke compartment			November 17, 2017 to		
		of floors and building for			include the relocation of		
	evacuation				wheeled equipment durin	a	
	(9) Extinguishm				a fire or similar emergence	_	
		(4) states any required			The REVISED Policy and	•	
		shall not be less than 48			Procedure is being provide		
		yidth where serving as			as ATTACHMENT E.		
	_	from patient sleeping					
	I -	ons into the required			2. Hooverwood staff w	rill	
	_	ermitted for wheeled			be in-serviced on the Poli	су	
		ded the relocation of			and Procedure change or	•	
		ent during a fire or			or before December 7,		
	similar emergen	cy is addressed in the			2017 and the new		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFI		IDENTIFICATION NUMBER:	A. BUILDING <u>02</u>		COMPLETED			
155001		B. WING 11/16/2017						
NAME OF DROVIDED OR CURRING				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				7001 H	OOVER RD			
HOOVERWOOD				INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	IPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE	
		ty plan and training			information will be included in any new employee			
	program for the facility. The wheeled				orientations conducted on			
	equipment is limited to:							
	i. Equipment in use and carts in use				or after November 17, 20			
	ii. Medical emergency equipment not in				as well the annual refresher			
	use				in-service regarding the			
		nd transport equipment			Emergency Operations Plan. In-servicing will lessen			
		ractice could affect all			the likelihood that any	sen		
	residents, staff a	and visitors.			residents will be affected	hv		
					the alleged deficient	Dy		
	Findings include	e:			practice. A copy of the			
					In-Service Record is bein	<u> </u>		
		v of "Disaster Emergency			provided as ATTACHME	~ I		
	_	an" with the Maintenance			F.	`'		
		record review from 9:20			' '			
		m. on 11/16/17, the			3. During unannounce	d		
	written fire safe	ty plan did not address			but pre-planned drills, or	u,		
	the relocation of	f wheeled equipment			through an actual fire or			
	during a fire or similar emergency. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:45 p.m. on 11/16/17, crash carts, hoyer lifts and				similar emergency event,			
					the maintenance staff will			
					evaluate how well the sta			
					does in the relocation of t			
					wheeled equipment.			
	wheelchairs wer	re noted in the corridor on			Depending on the outcon	ne		
	the first and sec	ond floor. Based on			further in-servicing or	,		
	interview at the	time of record review			education will be provided			
	and of the obser	vations, the Maintenance			to staff members to assur			
	Director agreed	the written fire safety			compliance.			
	plan did not add	ress the relocation of			4. The Maintenance			
	wheeled equipm	nent during a fire or			Director will be asked to			
	similar emergen	cy.			bring the unannounced, b	out		
					pre-planned drills, or			
	3.1-19(b)	3.1-19(b)			through an actual fire or			
					similar emergency event			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001	ì ′	ILDING NG	ONSTRUCTION 02 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE COMPL 11/16/	ETED
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
					drills to the next two QAA Committee Meetings for review and discussion. If issues are identified, the Maintenance Director will be asked to bring the unannounced, but pre-planned drills, or through an actual fire or similar emergency event drills for review by the QA Committee at least every six months thereafter.	no	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

GMRT21 Facility ID: 000001

If continuation sheet

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