STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	11/16/2017

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 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/16/17 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The original building, Building 01, was surveyed with Chapter 19 Existing Health Care Occupancies. This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered except for the basement telephone room and the resident laundry room by Room 1122. This facility consists of Building 01 and Building 02. Building 01 consists	K 0000	The Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Hooverwood desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective December 7, 2017.	

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

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	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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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors. 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 set of exit doors to the outside of the facility by the Salon on the first floor in the Alzheimer's wing were marked as a facility exit, were magnetically locked and could be opened	K 0222	It is the policy of this facility that all egress doors be maintained per the requirements of the code. 1. Upon further investigation of the exit doors located by the Salon on the first floor Alzheimer's wing, it was determined that the magnetic locking device was functional by entering the 4-digit code. What was preventing the east door of the door set from opening was an old alarm sensor that had dropped from the "frame" of the door set and 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 17, 2017 by the maintenance department and verification that the door, upon entering the 4-digit code did indeed	11/17/2017

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	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)		release and was able to be opened. It is uncertain why this old alarm sensor dropped out of the frame, but could have been jarred based upon the amount of renovation / construction occurring near this area. The patio area outside this entrance had just had some significant demolition the previous days to the survey. 2. All other exit doors throughout the facility were evaluated to determine if this same type of old alarm sensing device was located on other doors and where found, the old alarm sensors were removed, thus it is unlikely that any other residents would be affected by the same or similar situation. 3. The maintenance department routinely checks, (at least weekly) egress doors for proper operation and to assure they are maintained per the code, especially those with a magnetic locking device and will continue to do so.	

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			This isolated incident appears to have occurred because the old sensing device was not removed at the time the system was upgraded and it likely became loose or ajar from the extensive construction / renovation project. 4. Routine preventative maintenance checks on all egress doors will continue weekly by the maintenance department and any door found to be non-operational as per the requirements of the code will be repaired immediately.	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be	K 0346	K 346 It is the policy of this facility to have a complete written	11/17/2017

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	followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: 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)		policy if the fire alarm system has to be placed out of service for four hours or more during a twenty-four hour period per the requirements of the code. 1. The Hooverwood “Fire 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.gov as the primary method; or if 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; and 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	

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			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 ISDH, but the specific manner of notification was not addressed in the policy, although well known by the Administrator via the ISDH – Division of Long Term Care – Reportable Incident Policy and ISDH Reportable Unusual Occurrence Policy. As such, it is felt that no residents were affected by the alleged deficient practice. 3. As policy and procedures are updated, Hooverwood Administration will endeavor to assure that the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Procedures are reviewed on at least an annual basis by the QAA Committee and evaluated	

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			for changes, revisions, etc.	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 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 facility that it is protected throughout by an approved automatic sprinkler system per the requirements of the code. 1. Due to an extensive renovation / construction project, the sprinkler piping above the Resident Laundry Room - Room	12/07/2017

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	facility from 12:00 p.m. to 2:45 p.m. on 11/16/17, the basement telephone room was not provided with automatic sprinklers. Based on interview at the time of the observations, the Maintenance Director stated the basement is currently being renovated and agreed the basement telephone room does not have sprinkler coverage. 3.1-19(b) 3.1-19(ff)		1122 was present, but the actual sprinkler head was not installed. Hooverwood Administration met with the Construction Contractor, (Hagerman) and advised them that sprinkler protection to this area must be provided. As such, Ryan Fire Protection installed the missing sprinkler head on November 17, 2017. A photograph of the Sprinkler Head in the Resident Laundry Room - Room 1122 is being provided as ATTACHMENT B-2. 2. Maintenance staff has toured all areas of the facility and other than the basement telephone room (identified elsewhere in this survey document), no other areas have been identified as not having adequate sprinkler protection thus minimizing the number of residents that have been affected by the alleged deficient practice. 3. Hooverwood Administration has met with the Construction	

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			Contractor, (Hagerman) and advised that while it is understood that the construction project is extensive and that many current use areas will not be the same upon construction completion, we must maintain the various requirements of the code and that they must assure that all areas are adequately protected with sprinkler coverage. 4. During daily rounds by the Hooverwood Maintenance staff, observations of areas under construction will be made and any noted discrepancies will be addressed with the Construction Company for immediate resolution.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a			

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	secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests,	K 0353	It is the policy of this facility that automatic sprinkler and standpipe systems are inspected, tested, and maintained per the requirements of the code. 1. The Hooverwood "Sprinkler System – Weekly Inspection Form – Dry System" AND "Sprinkler System – Weekly Inspection Form – Wet System" forms were revised on November 17, 2017 to include but not limited to condition, inspection of valves in the locked or unlocked position, incoming 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	11/17/2017

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	and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of SimplexGrinnell "Report of Inspection" and "Sprinkler Components" documentation dated 11/18/16, 02/03/17, 05/26/17, 08/18/17 and 11/10/17 with the Maintenance Director during record review from 9:20 a.m. to 12:00 p.m. on 11/16/17, weekly dry sprinkler system gauge inspection documentation for 47 weeks of the most recent 52 week period was not available for review. Monthly wet sprinkler system gauge inspection documentation for 7 months of the most recent 12 month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 7 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility checks sprinkler gauges and valves on a daily basis but sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for		provided as ATTACHMENT C. 2. The revised forms - "Sprinkler System – Weekly Inspection Form – Dry System" AND "Sprinkler System – Weekly Inspection – Wet System" have been posted in each of the three Riser locations at Hooverwood; Basement – Riser #1, Main Building – 1st Floor – Riser #2 and C-Wing – Riser #3. The Maintenance Staff routinely inspects these Riser areas, (usually daily), and will begin documenting on the weekly inspection forms the required inspections as required by the Code. 3. The Administrator will randomly audit the weekly inspection forms located in the Riser locations on at least a monthly basis to assure that the required inspections are being conducted. If discrepancies are noted, the Administrator will bring the issue to the attention of the Maintenance Director.	

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	review. 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 facility has supervised wet and dry sprinkler systems. 3.1-19(b)		4. The Maintenance Director will be asked to bring the weekly inspection forms to the next two QAA Committee Meetings for review and discussion. If no issues are identified, the Maintenance Director will be asked to bring the weekly inspection forms for review by the QAA Committee at least every six months thereafter.	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to	K 0354	It is the policy of this facility to have a complete written policy if the sprinkler	11/17/2017

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	be followed for the protection of 121 of 121 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: 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 facility fire watch plan for automatic sprinkler 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		system has to be placed out of service for more than ten hours in a twenty-four hour period per the requirements of the code. 1. The Hooverwood “Fire 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.gov as the primary method; or if 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; and 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.	

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	155001	A. BUILDING 01 B. WING	11/16/2017

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	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 jurisdiction would be notified", the ISDH, but the specific manner was not addressed in the policy, although well known by the Administrator via the ISDH – Division of Long Term Care – Reportable Incident Policy and ISDH Reportable Unusual Occurrence Policy. As such, it is felt that no residents were affected by the alleged deficient practice. 3. As policy and procedures are updated, Hooverwood Administration will endeavor to assure that the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Procedures are reviewed on at least an annual basis by the QAA Committee and evaluated for changes, revisions, etc.	

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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 facility to maintain smoke barrier doors per the requirements 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	12/05/2017

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	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 with the Construction Contractor, (Hagerman) and advised them that they must insure that construction / remodeling is complete per the specified plans and to meet the code. The astragal brush assembly was installed on December 5, 2017. A photograph of the Corridor Smoke Barrier Doors on the 2nd Floor by Room 2155 with the astragal brush installed is being provided as ATTACHMENT D-2. 2. The maintenance staff 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 by the alleged deficient practice.	

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			3. Hooverwood Administration has met with the Construction Contractor, (Hagerman) and advised that while it is understood that the construction project is extensive, we must maintain the various requirements of the code and that they must assure that the construction plans are followed in their entirety including the installation of the astragal brushes on the new corridor smoke barrier doors. 4. During daily rounds by the Hooverwood Maintenance staff, observations of areas under construction will be made and any noted discrepancies will be addressed with the Construction Company for immediate resolution.	
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.			

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	Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled	K 0711	It is the policy of this facility to maintain the Disaster Emergency Preparedness 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 of the Emergency Operations 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 provided as ATTACHMENT E. 2. Hooverwood staff will be in-serviced on the Policy	12/07/2017

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	equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Emergency Preparedness Plan" with the Maintenance Director during record review from 9:20 a.m. to 12:00 p.m. on 11/16/17, the written fire safety plan did not address the relocation of wheeled equipment 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 wheelchairs were noted in the corridor on the first and second floor. Based on interview at the time of record review and of the observations, the Maintenance Director agreed the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency.		and Procedure change on or before December 7, 2017 and the new information will be included in any new employee orientations conducted on or after November 17, 2017 as well the annual refresher in-service regarding the Emergency Operations Plan. In-servicing will lessen the likelihood that any residents will be affected by the alleged deficient practice. A copy of the In-Service Record is being provided as ATTACHMENT F. 3. During unannounced, but pre-planned drills, or through an actual fire or similar emergency event, the maintenance staff will evaluate how well the staff does in the relocation of the wheeled equipment. Depending on the outcome, further in-servicing or education will be provided to staff members to assure compliance. 4. The Maintenance Director will be asked to bring the unannounced, but	

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	3.1-19(b)		pre-planned drills, or through an actual fire or similar emergency event drills to the next two QAA Committee Meetings for review and discussion. If no 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 QAA Committee at least every six months thereafter.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/16/17 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42	K 0000	The Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. Hooverwood desires this Plan of Correction to be considered	

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	CFR Subpart 483.90(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 410 IAC 16.2. Building 02 was surveyed with Chapter 18 New Health Care Occupancies. This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered except for the basement telephone room and the resident laundry room by Room 1122. This facility consists of Building 01 and Building 02. Building 02 consists of the two story addition to the East Wing, the remodeling of resident rooms 2150, 2152, 2154, the remodeling of 10 resident rooms in 1100 West, the remodeling of 11 resident rooms in 2100 West, the remodeled nurse's stations A140 and A240 and the single story building addition which expanded the main entrance lobby and administrative areas. 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 128 and had a census of 121 at the time of this survey.		the facility's allegation of compliance. Compliance is effective December 7, 2017.	

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	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 0346 SS=C Bldg. 02	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include:	K 0346	K 346 It is the policy of this facility to have a complete written policy if the fire alarm system has to be placed out of service for four hours or more during a twenty-four hour period per the requirements of the code.	11/17/2017

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	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 "Fire 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.gov as the primary method; or if 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; and 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	

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			ISDH, but the specific manner of notification was not addressed in the policy, although well known by the Administrator via the ISDH – Division of Long Term Care – Reportable Incident Policy and ISDH Reportable Unusual Occurrence Policy. As such, it is felt that no residents were affected by the alleged deficient practice. 3. As policy and procedures are updated, Hooverwood Administration will endeavor to assure that the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Procedures are reviewed on at least an annual basis by the QAA Committee and evaluated for changes, revisions, etc.	
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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	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 facility that it is protected throughout by an approved automatic sprinkler system per the requirements of the code. 1. Due to an extensive renovation / construction project, the sprinkler piping 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	11/17/2017

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	laundry room by Room 1122 does not have sprinkler coverage. 3.1-19(b) 3.1-19(ff)		protection to this area must be provided. As such, Ryan Fire Protection installed the missing sprinkler head on November 17, 2017. A photograph of the Sprinkler Head in the Resident Laundry Room - Room 1122 is being provided as ATTACHMENT B-2. 2. Maintenance staff has toured all areas of the facility and other than the basement telephone room (identified elsewhere in this survey document), no other areas have been identified as not having adequate sprinkler protection thus minimizing the number of residents that have been affected by the alleged deficient practice. 3. Hooverwood Administration has met with the Construction Contractor, (Hagerman) and advised that while it is understood that the construction project is extensive and that many current use areas will not be the same upon	

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			construction completion, we must maintain the various requirements of the code and that they must assure that all areas are adequately protected with sprinkler coverage. 4. During daily rounds by the Hooverwood Maintenance staff, observations of areas under construction will be made and any noted discrepancies will be addressed with the Construction Company for immediate resolution.	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on			

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	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors.	K 0353	It is the policy of this facility that automatic sprinkler and standpipe systems are inspected, tested, and maintained per the requirements of the code. 1. The Hooverwood "Sprinkler System – Weekly Inspection Form – Dry System" AND "Sprinkler System – Weekly Inspection Form – Wet System" forms were revised on November 17, 2017 to include but not limited to condition, inspection of valves in the locked or unlocked position, incoming 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 ATTACHMENT C. 2. The revised forms - "Sprinkler System – Weekly Inspection Form – Dry	11/17/2017

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	Findings include: Based on review of SimplexGrinnell "Report of Inspection" and "Sprinkler Components" documentation dated 11/18/16, 02/03/17, 05/26/17, 08/18/17 and 11/10/17 with the Maintenance Director during record review from 9:20 a.m. to 12:00 p.m. on 11/16/17, weekly dry sprinkler system gauge inspection documentation for 47 weeks of the most recent 52 week period was not available for review. Monthly wet sprinkler system gauge inspection documentation for 7 months of the most recent 12 month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 7 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility checks sprinkler gauges and valves on a daily basis but sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. 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 facility has supervised wet and dry sprinkler systems.		System" AND "Sprinkler System – Weekly Inspection – Wet System" have been posted in each of the three Riser locations at Hooverwood; Basement – Riser #1, Main Building – 1st Floor – Riser #2 and C-Wing – Riser #3. The Maintenance Staff routinely inspects these Riser areas, (usually daily), and will begin documenting on the weekly inspection forms the required inspections as required by the Code. 3. The Administrator will randomly audit the weekly inspection forms located in the Riser locations on at least a monthly basis to assure that the required inspections are being conducted. If discrepancies are noted, the Administrator will bring the issue to the attention of the Maintenance Director. 4. The Maintenance Director will be asked to bring the weekly inspection forms to the next two QAA Committee Meetings for	

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	3.1-19(b)		review and discussion. If no issues are identified, the Maintenance Director will be asked to bring the weekly inspection forms for review by the QAA Committee at least every six months thereafter.	
K 0354 SS=C Bldg. 02	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 121 of 121 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires	K 0354	It is the policy of this facility to have a complete written policy if the sprinkler system has to be placed out of service for more than ten hours in a twenty-four hour period per the requirements of the code.	11/17/2017

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	sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: 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 facility fire watch plan for automatic sprinkler 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 automatic sprinkler system impairment stated to contact the Indiana State Department of Health but not via the ISDH Gateway		1. The Hooverwood "Fire 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.gov as the primary method; or if 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; and 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	

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	link or at the e-mail address listed above. 3.1-19(b)		ISDH, but the specific manner was not addressed in the policy, although well known by the Administrator via the ISDH – Division of Long Term Care – Reportable Incident Policy and ISDH Reportable Unusual Occurrence Policy. As such, it is felt that no residents were affected by the alleged deficient practice. 3. As policy and procedures are updated, Hooverwood Administration will endeavor to assure that the written policy is all inclusive to include such matters as the reporting guidance, etc. 4. Policy and Procedures are reviewed on at least an annual basis by the QAA Committee and evaluated for changes, revisions, etc.	
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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	Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 Based on observation and interview, the facility failed to ensure 1 of over 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 18.3.7.8(4) states rabbets, bevels, or astragals shall be required at the meeting edges of pairs or doors and 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 facility to maintain smoke barrier doors per the requirements 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 with the Construction Contractor, (Hagerman)	12/05/2017

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	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 on the second floor by Room 2155 had a one half 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 half inch gap between the meeting edges of the door set and was not equipped with a rabbet, bevel, or astragal. 3.1-19(b)		and advised them that they must insure that construction / remodeling is complete per the specified plans and to meet the code. The astragal brush assembly was installed on December 5, 2017. A photograph of the Corridor Smoke Barrier Doors on the 2nd Floor by Room 2155 with the astragal brush installed is being provided as ATTACHMENT D-2. 2. The maintenance staff 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 by the alleged deficient practice. 3. Hooverwood Administration has met with the Construction	

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			Contractor, (Hagerman) and advised that while it is understood that the construction project is extensive, we must maintain the various requirements of the code and that they must assure that the construction plans are followed in their entirety including the installation of the astragal brushes on the new corridor smoke barrier doors. 4. During daily rounds by the Hooverwood Maintenance staff, observations of areas under construction will be made and any noted discrepancies will be addressed with the Construction Company for immediate resolution.	
K 0711 SS=C Bldg. 02	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. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with			

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	security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the	K 0711	It is the policy of this facility to maintain the Disaster Emergency Preparedness 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 of the Emergency Operations 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 provided as ATTACHMENT E. 2. Hooverwood staff will be in-serviced on the Policy and Procedure change on or before December 7, 2017 and the new	12/07/2017

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	written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Emergency Preparedness Plan" with the Maintenance Director during record review from 9:20 a.m. to 12:00 p.m. on 11/16/17, the written fire safety plan did not address the relocation of wheeled equipment 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 wheelchairs were noted in the corridor on the first and second floor. Based on interview at the time of record review and of the observations, the Maintenance Director agreed the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. 3.1-19(b)		information will be included in any new employee orientations conducted on or after November 17, 2017 as well the annual refresher in-service regarding the Emergency Operations Plan. In-servicing will lessen the likelihood that any residents will be affected by the alleged deficient practice. A copy of the In-Service Record is being provided as ATTACHMENT F. 3. During unannounced, but pre-planned drills, or through an actual fire or similar emergency event, the maintenance staff will evaluate how well the staff does in the relocation of the wheeled equipment. Depending on the outcome, further in-servicing or education will be provided to staff members to assure compliance. 4. The Maintenance Director will be asked to bring the unannounced, but pre-planned drills, or through an actual fire or similar emergency event	

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			drills to the next two QAA Committee Meetings for review and discussion. If no 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 QAA Committee at least every six months thereafter.	