STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING -- B. WING	04/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/04/24 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Emergency Preparedness survey, Hooverwood was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 155 certified beds. At the time of the survey, the census was 142. Quality Review completed on 04/10/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/31/2024.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	04/27/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" and Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, the following was noted: a. weekly emergency generator inspection documentation for three of four weeks in December 2023 and the week of 02/17/24 was not available for review. b. monthly load testing documentation for January 2024 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for the aforementioned four week period and monthly load testing documentation for January 2024 was not available for review. The Chief Community Operations Officer and the	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency generator was inspected, tested and maintained according to requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is inspected weekly and a monthly load test is performed. All activity is documented in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The emergency generator was inspected, tested, and maintained according to	05/31/2024

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	Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of interview which stated "disciplinary action taken for person not completing checks" because "generator checks were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference.		requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is inspected weekly and a monthly load test is performed. All activity is documented in TELS. A Maintenance audit tool, ensuring emergency generator is tested, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of the emergency power system has been inspected, tested, and maintained according to LSC standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, for The emergency generator, to ensure it has been inspected, tested, and maintained according to LSC standards, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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			Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/04/24 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). Building 01 was surveyed using Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 01 consists of the memory care wing which is one story, the former kitchen, the basement and the former dining room on the first floor which is now a special events room. 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	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/31/2024.	

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	facility has a capacity of 155 and had a census of 142 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for the sprinkler riser room closet in Building 02. The facility has no detached buildings providing facility services. Quality Review completed on 04/10/24			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)	K 0345	**What corrective action(s) will be accomplished for those residents found to have been** The semi-annual fire alarm system inspection has been completed and documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be	05/31/2024

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	d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 07/24/23 with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, semi-annual fire alarm system inspection documentation six months after 07/24/23 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer agreed semi-annual inspection documentation for the facility's fire alarm system six months after 07/24/23 was not available for review. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference 3.1-19(b)		affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed semi-annually, to ensure the fire alarm system inspection was completed. A Maintenance audit tool, ensuring the fire alarm system, will be inspected semi-annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. Administrator/designee to verify documentation is in TELS of the semi-annual system inspection has been completed according to LSC standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring the fire alarm system, will be inspected semi-annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6	

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			months, QAPI is overseen by the Administrator. Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 52 fire extinguishers were accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, 6.1.3.1 states fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. This deficient practice could affect over 20 residents, staff and visitors in the former dining room on the first floor which is now a special events room. Findings include: Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, a podium and stacked chairs were placed up against the cabinet door for a wall mounted ABC type portable fire extinguisher located in the former dining room on the first floor which is now a special events room. The storage up against the cabinet door caused the extinguisher to not be readily accessible and immediately available in the event of fire. Affixed maintenance tags on the portable fire extinguisher inside the cabinet	K 0355	**What corrective action(s) will be accomplished for those residents found to have been** The podium and stacked chairs have been moved so the extinguisher is accessible and immediately available in the event of a fire **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	05/31/2024

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	indicated the most recent annual maintenance was performed by an inspection contractor in June 2023 and the facility had documented monthly inspections through March 2024. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance agreed the portable fire extinguisher was not readily accessible and immediately available in the event of fire and relocated the podium and the stacked chairs. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference 3.1-19(b)		A Maintenance audit tool will be completed weekly, to ensure the extinguisher is accessible and immediately available in the event of a fire Maintenance director/designee will educate staff that no items can be stored in front of a fire extinguisher. That the fire extinguisher has to be accessible and immediately available in the event of a fire. Administrator/designee to verify extinguisher is accessible and immediately available in the event of a fire and the podium and chairs have been moved **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure the extinguisher is accessible and immediately available in the event of a fire and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to	

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			disciplinary action.	
K 0541 SS=D Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 Based on observation and interview, the facility failed to ensure doors to 1 of 2 trash chute discharge rooms was equipped with a positive latching mechanism. LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.5.1.2 states, where service opening rooms are provided and protected by automatic sprinklers, the room shall	K 0541	**What corrective action(s) will be accomplished for those residents found to have been** The latch mechanism on the south trash chute door has been fixed and latches properly **How will you identify other residents having the potential**	05/31/2024

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	be enclosed in a minimum of 1-hour construction and openings shall be protected by ¾-hour fire rated doors. NFPA 80, 2010 Edition at 5.2.4.2(3) & (8) requires that at a minimum for fire rated doors, the door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, in working order with no visible signs of damage and latching hardware operates and secures the door when it is in the closed position. This deficient practice could affect over two staff and visitors in the basement. Findings include: Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, the service opening room for the south trash chute discharge in the basement was not provided with an operable positive latching mechanism. The latching mechanism on the door failed to latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance agreed the latching mechanism on the door failed to latch the door into the door frame when tested to close multiple times. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed weekly, to ensure the south trash door is latching properly Administrator/designee to ensure the south trash door is latching properly, weekly **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure the south trash door is latching properly and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non	

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			compliance with staff will result in staff education and up to disciplinary action.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to conduct quarterly fire drills: a. on the first shift for 1 of 4 quarters. b. on the second shift for 2 of 4 quarters. c. on the third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, documentation of a first shift fire drill conducted in the third quarter (July, August, September) 2023 was not available for review. In a addition, documentation of a second shift and third shift fire drill conducted in the third quarter 2023 and in the fourth quarter (October,	K 0712	**What corrective action(s) will be accomplished for those residents found to have been** Fire drills are completed monthly and documentation including staff participation is uploaded into TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into**	05/31/2024

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	155001	A. BUILDING 01 B. WING	04/04/2024

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

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	November, December) 2023 was also not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility operates three shifts per day. The Chief Community Operations Officer and the Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of interview which stated "disciplinary action taken for person not completing fire drills" because "fire drills were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to document all staff who participated in quarterly fire drills on the third shift for 1 of 4 quarters. LSC Section 19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, documentation for the third shift fire drill conducted at 1:00 a.m. on 03/30/24 did not include the staff who participated in the fire drill. Based on interview at the time of record review, the Chief		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed monthly, to ensure fire drills are completed and required documentation including staff participation is uploaded into TELS. Administrator/designee to verify fire drills are completed and uploaded into TELS **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure fire drills are completed and required documentation is uploaded into TELS. The results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any noncompliance with staff will result in staff education and up to disciplinary action.	

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	Community Operations Officer and the Director of Maintenance stated the facility operates three shifts per day and agreed documentation for the aforementioned third shift fire drill did not include all staff who participated in the fire drill. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to	K 0761	**What corrective action(s) will be accomplished for those residents found to have been** All fire doors have been inspected and tested with the appropriate documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to**	05/31/2024

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	assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based review of Direct Supply TELS Logbook Documentation "Smoke Door Inspection of Smoke Door Assemblies" dated 03/01/24 with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during		**ensure that the deficient practice does not recur?** A Maintenance audit tool, ensuring all doors are inspected, will be completed monthly for 6 months, with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELs of the fire doors being inspected according to Life Safety and NFPA Requirements All dire doors have been inspected and tested, with the appropriate documentation uploaded in TELS. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure all fire doors have been inspected and tested with the appropriate documentation uploaded in TELS. This will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non-compliance with staff will result in staff education and up to disciplinary action.	

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	record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, an itemized listing of fire doors which were inspected and tested in the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance agreed an itemized listing of fire doors which were inspected and tested in the facility within the most recent twelve month period was not available for review. Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, the basement stairwell door and both doors to the two trash collection rooms in the basement were equipped with 90 minute fire resistance rating labels affixed to the hinge side of the doors. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not			

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	exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2	K 0914	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The receptacles that are not hospital grade, and hospital grade receptacles that have either been replaced or serviced during the year, have been inspected and tested with documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into**	05/31/2024

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	states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Administrator, the Chief Community Operations Officer and the Director of Maintenance from 9:20 a.m. to 1:30 p.m. on 04/04/24, electrical receptacle inspection and testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated each resident sleeping room has multiple receptacle locations some of which may be hospital-grade but agreed electrical receptacle inspection and testing documentation for the most recent twelve month period was not available for review. Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance resident sleeping rooms in the first floor memory care wing had non-hospital-grade receptacles. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b)		**place or what systemic changes you will make to ensure that the deficient practice does not recur?** The receptacles that are not hospital grade, and hospital grade receptacles that have either been replaced or serviced during the year, have been inspected and tested with documentation uploaded in TELS. A Maintenance audit tool will be completed monthly for 6 months to ensure all receptacles requiring annual inspection and testing has been completed with required documentation uploaded inTELS. This will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non-compliance with staff will result in staff education and up to disciplinary action. Administrator/designee to verify documentation that all receptacles requiring annual inspection and testing have been inspected and tested. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring all receptacles requiring	

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			annual inspection and testing, will be completed monthly for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, weekly emergency generator inspection documentation for three of four weeks in December 2023 and the week of	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	05/31/2024

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	02/17/24 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for the aforementioned four week period was not available for review. The Chief Community Operations Officer and the Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of interview which stated "disciplinary action taken for person not completing checks" because "generator checks were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator for 1 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of		The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. A Maintenance audit tool, ensuring emergency generator is tested, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, for The emergency generator, to ensure it has been tested according to LSC standards, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff	

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	8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, load testing documentation for January 2024 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed monthly load testing documentation for January 2024 was not available for review. The Chief Community Operations Officer and the Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of interview which stated "disciplinary action taken for person not completing checks" because "generator checks were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b)		education and up to disciplinary action.	

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K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 04/04/24 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). Building 02 and Building 03 were surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 02 consists of the 2017 general renovation of all first and second floor resident sleeping room areas not in the memory care wing and the addition of resident sleeping rooms 1238, 1239, 1240 and 1241 on the first floor and resident sleeping rooms 2238, 2239, 2240 and 2241 on the second floor in 2018. Building 03 consists of the renovated first floor main entrance lobby, administrative support offices, conference room, gift shop and beauty shop. 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	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/31/2024.	

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 142 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for the sprinkler riser room closet in Building 02. The facility has no detached buildings providing facility services. Quality Review completed on 04/10/24.			
K 0222 SS=E Bldg. 02	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 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			

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	155001	A. BUILDING 02 B. WING	04/04/2024

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	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 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	K 0222	What corrective action(s) will be accomplished for those residents	05/31/2024

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	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 18.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 18.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, the exit door for the facility at the 1B lounge which was not in the memory care wing was marked as a facility exit with an exit sign. The exit door was also marked with signage stating "This door must stay locked at all times" but the door was not locked and opened when pushed to open. The 1B lounge exit door exit discharge is into an outdoor courtyard which is shared with memory care exit discharges. One of one courtyard gates in the courtyard was magnetically locked and could be opened by entering a four digit code but the code was not posted at the courtyard exit. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance stated residents with clinical diagnoses to be in a secure wing were housed in the memory care wing but agreed the code was not posted at the courtyard exit door. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference.		found to have been affected by the deficient practice? • A delayed egress locking system has been installed on the 1B lounge exit door. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • No residents were affected by the alleged deficient practice. • All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • A delayed egress locking system has been installed on the 1B lounge exit door. • A Maintenance audit tool, ensuring the egress door located in the 1B lounge meets LSC 18.2.2.2.5.2., will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • A Maintenance audit tool, ensuring the egress door located in the 1B lounge meets LSC	

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	3.1-19(b)		18.2.2.2.5.2, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators	K 0345	**What corrective action(s) will be accomplished for those residents found to have been** The semi-annual fire alarm system inspection has been completed and documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by	05/31/2024

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	c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 07/24/23 with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, semi-annual fire alarm system inspection documentation six months after 07/24/23 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer agreed semi-annual inspection documentation for the facility's fire alarm system six months after 07/24/23 was not available for review. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference 3.1-19(b)		the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed semi-annually, to ensure the fire alarm system inspection was completed. A Maintenance audit tool, ensuring the fire alarm system, will be inspected semi-annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. Administrator/designee to verify documentation is in TELS of the semi-annual system inspection has been completed according to LSC standards. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring the fire alarm system, will be inspected semi-annually for 6 months with results reported to	

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			the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0521 SS=F Bldg. 02	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection,	K 0521	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 4-year fire damper inspection has been completed with proper documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic**	05/31/2024

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	name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based record review with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, fire damper inspection and testing documentation within the most recent four year period was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance agreed fire damper inspection and testing documentation within the most recent four year period was not available for review. Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, one fire damper was installed in HVAC system ductwork in the mechanical room on the second floor identified as Room 2224A. The fire damper did not have any affixed documentation indicating the date of when the most recent inspection and maintenance was performed. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance agreed fire damper inspection and maintenance documentation within the most recent four year period was not available for review. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference		**changes you will make to ensure that the deficient practice does not recur?** The 4-year fire damper inspection was inspected with proper documentation uploaded to TELS. A Maintenance audit tool, ensuring there is proper documentation showing the 4-year fire damper inspection has been completed, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring there is proper documentation that the fire damper has been inspected, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	3.1-19(b)			
K 0541 SS=E Bldg. 02	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry Chutes 2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. *The fire resistance rating of chute charging room shall not be required to exceed one hour. *Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. *Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82 Based on observation and interview, the facility failed to maintain 1 of 4 trash chute doors to be self-closing and positive latching.n LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.3.1.1 requires all chute loading doors into a trash chute shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of Room 1148. Findings include: Based on observations with the Administrator, the Chief Community Operations Officer and the	K 0541	**What corrective action(s) will be accomplished for those residents found to have been** The latch mechanism on the south trash chute door has been fixed and latches properly **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice	05/31/2024

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	Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, the trash chute door in Room 1148 was equipped with a self-closing device and a positive latching device but the latching mechanism failed to protrude into the chute door frame when tested to close multiple times. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance agreed the trash chute door did not latch into the chute door frame when tested to close multiple times. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed weekly, to ensure the south trash door is latching properly Administrator/designee to ensure the south trash door is latching properly, weekly **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure the south trash door is latching properly and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 1. Based on record review and interview, the facility failed to conduct quarterly fire drills: a. on the first shift for 1 of 4 quarters. b. on the second shift for 2 of 4 quarters. c. on the third shift for 2 of 4 quarters. This deficient practice affects all staff and residents. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, documentation of a first shift fire drill conducted in the third quarter (July, August, September) 2023 was not available for review. In a addition, documentation of a second shift and third shift fire drill conducted in the third quarter 2023 and in the fourth quarter (October, November, December) 2023 was also not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility operates three shifts per day. The Chief Community Operations Officer and the Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of	K 0712	**What corrective action(s) will be accomplished for those residents found to have been** Fire drills are completed monthly and documentation including staff participation is uploaded into TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed monthly, to ensure fire drills are completed and	05/31/2024

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	interview which stated "disciplinary action taken for person not completing fire drills" because "fire drills were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to document all staff who participated in quarterly fire drills on the third shift for 1 of 4 quarters. LSC Section 18.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, documentation for the third shift fire drill conducted at 1:00 a.m. on 03/30/24 did not include the staff who participated in the fire drill. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility operates three shifts per day and agreed documentation for the aforementioned third shift fire drill did not include all staff who participated in the fire drill. These findings were reviewed with the Administrator, the Chief Community Operations		required documentation including staff participation is uploaded into TELS. Administrator/designee to verify fire drills are completed and uploaded into TELS **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure fire drills are completed and required documentation is uploaded into TELS. The results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any noncompliance with staff will result in staff education and up to disciplinary action.	

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	Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0761 SS=F Bldg. 02	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so	K 0761	**What corrective action(s) will be accomplished for those residents found to have been** All fire doors have been inspected and tested with the appropriate documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool, ensuring all doors are inspected, will be completed monthly for 6 months, with results reported to the Quality Assurance	05/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	04/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based review of Direct Supply TELS Logbook Documentation "Smoke Door Inspection of Smoke Door Assemblies" dated 03/01/24 with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, an itemized listing of fire doors which were inspected and tested in the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance agreed an itemized listing of fire		Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELs of the fire doors being inspected according to Life Safety and NFPA Requirements All dire doors have been inspected and tested, with the appropriate documentation uploaded in TELS. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure all fire doors have been inspected and tested with the appropriate documentation uploaded in TELS. This will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non-compliance with staff will result in staff education and up to disciplinary action.	

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	doors which were inspected and tested in the facility within the most recent twelve month period was not available for review. Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, corridor doors to oxygen storage and transfilling rooms were equipped with 45 minute fire resistance rating labels and each stairwell door was equipped with a 60 minute fire resistance rating label affixed to the hinge side of the doors. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference 3.1-19(b)			
K 0914 SS=F Bldg. 02	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less			

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	than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include:	K 0914	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The receptacles that are not hospital grade, and hospital grade receptacles that have either been replaced or serviced during the year, have been inspected and tested with documentation uploaded in TELS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The receptacles that are not hospital grade, and hospital grade receptacles that have either been	05/31/2024

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	Based on record review with the Administrator, the Chief Community Operations Officer and the Director of Maintenance from 9:20 a.m. to 1:30 p.m. on 04/04/24, electrical receptacle inspection and testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated each resident sleeping room has multiple receptacle locations some of which may be hospital-grade but agreed electrical receptacle inspection and testing documentation for the most recent twelve month period was not available for review. Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance resident sleeping rooms on the first and second floor had a mix of hospital-grade and non-hospital-grade receptacles. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b)		replaced or serviced during the year, have been inspected and tested with documentation uploaded in TELS. A Maintenance audit tool will be completed monthly for 6 months to ensure all receptacles requiring annual inspection and testing has been completed with required documentation uploaded inTELS. This will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non-compliance with staff will result in staff education and up to disciplinary action. Administrator/designee to verify documentation that all receptacles requiring annual inspection and testing have been inspected and tested. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring all receptacles requiring annual inspection and testing, will be completed monthly for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of	

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			95% is not achieved, an action plan will be developed to ensure compliance. Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits.			

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	Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, weekly emergency generator inspection documentation for three of four weeks in December 2023 and the week of 02/17/24 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for the aforementioned four week period was not	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly.	05/31/2024

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	available for review. The Chief Community Operations Officer and the Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of interview which stated "disciplinary action taken for person not completing checks" because "generator checks were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator for 1 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a		A Maintenance audit tool, ensuring emergency generator is tested, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, for The emergency generator, to ensure it has been tested according to LSC standards, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, load testing documentation for January 2024 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer and the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed monthly load testing documentation for January 2024 was not available for review. The Chief Community Operations Officer and the Director of Maintenance provided "Action Plan" documentation dated February 2024 at the time of interview which stated "disciplinary action taken for person not completing checks" because "generator checks were not done according to schedule". These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000	The creation and submission of this plan of correction does not constitute an admission by this	

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	483.90(a). Survey Date(s): 04/04/24 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). Building 02 and Building 03 were surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 02 consists of the 2017 general renovation of all first and second floor resident sleeping room areas not in the memory care wing and the addition of resident sleeping rooms 1238, 1239, 1240 and 1241 on the first floor and resident sleeping rooms 2238, 2239, 2240 and 2241 on the second floor in 2018. Building 03 consists of the renovated first floor main entrance lobby, administrative support offices, conference room, gift shop and beauty shop. 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 155 and had a census of 142 at the time of this survey. All areas where residents have customary access		provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/31/2024.	

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	were sprinklered and all areas providing facility services were sprinklered except for the sprinkler riser room closet in Building 02. The facility has no detached buildings providing facility services. Quality Review completed on 04/10/24.			
K 0161 SS=F Bldg. 03	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7. 18.1.6.4, 18.1.6.5 Construction Type 1 I (442), I (332), II (222) Not allowed non-sprinklered Any number of stories 2 II (111) Not allowed non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 1 story sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section			

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	9.7. (See 18.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type for new construction in 1 of 2 sprinkler riser rooms. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, a two foot by six inch section of drywall was missing in the ceiling of the sprinkler riser room closet by the Human Resources Generalist's office on the first floor which exposed the underside of the decking of the second floor. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance agreed the missing drywall exposed the underside of the decking of the second floor in the closet. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference 3.1-19(b)	K 0161	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The ceiling drywall has been repaired in the sprinkler room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The ceiling drywall has been repaired in the sprinkler room. A Maintenance audit tool, ensuring there is no missing ceiling drywall in the sprinkler room, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI)	05/31/2024

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			Committee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring there is no missing drywall in the sprinkler room, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non-compliance with staff will result in staff education and up to disciplinary action.	
K 0351 SS=F Bldg. 03	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 NEW Buildings are to be 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 and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 03 B. WING	04/04/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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 2 sprinkler riser rooms were provided with an automatic sprinkler to ensure sprinkler coverage in all portions of the building. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during a tour of the facility from 1:30 p.m. to 4:30 p.m. on 04/04/24, the sprinkler riser room closet on the first floor by the Human Resources Generalist Office was not provided with an automatic sprinkler to ensure sprinkler coverage in all portions of the building. Based on interview at the time of the observations, the Chief Community Operations Officer and the Director of Maintenance agreed an automatic sprinkler installed in the aforementioned sprinkler riser room closet could not be located. These findings were reviewed with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during the exit conference. 3.1-19(b) 3.1-19(ff)	K 0351	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** An automatic sprinkler has been installed in the sprinkler riser room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** An automatic sprinkler will be installed in the sprinkler riser room. A Maintenance audit tool, ensuring there is an automatic	05/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 03 B. WING	04/04/2024

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			sprinkler in the sprinkler riser room, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring there is an automatic sprinkler in the sprinkler riser room, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non-compliance with staff will result in staff education and up to disciplinary action.	