		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVABLE SUBJECT (X3) DATE SUB		ETED		
NAME OF P	PROVIDER OR SUPPLIER			7001 H	ADDRESS, CITY, STATE, ZIP COD DOVER RD APOLIS, IN 46260	I .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000 Bldg E 0041 SS=F Bldg	An Emergency Preponducted by the In accordance with 42 Survey Date: 04/04 Facility Number: 0 Provider Number: 1000 At this Emergency Hooverwood was for Emergency Prepare Medicare and Medicand Suppliers, 42 Comparison of the survey, the censurvey, the censurvey, the censurvey of the survey of the	paredness Survey was diana Department of Health in CFR 483.73. 4/24 000001 1555001 275310 Preparedness survey, pund not in compliance with dness Requirements for caid Participating Providers FR 483.73. 4 certified beds. At the time of us was 142. Impleted on 04/10/24 42 CFR, Subpart 483.73 is NOT by: (e), 485.625(e) LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1)	E 00		The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. The provider respectfully requests the 2567 plan of correction be considered the letter of credibiallegation and requests desk review (paper compliance) on after 5/31/2024.	ot s forth s, or This that	
	§483.73(e), §485. (e) Emergency an	625(e) d standby power systems.					

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

(X6) DATE

TITLE

Jennifer Voss Administrator 04/27/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/04/2024	
	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COI HOOVER RD NAPOLIS, IN 46260)
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
	implement emerg	and the CAH] must gency and standby power n the emergency plan set n (a) of this section.			
	Emergency genergenerator must be the location requirements of the location requirements for loc	183.73(e)(1), §485.625(e)(1) rator location. The e located in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim a 12-1, TIA 12-2, TIA 12-3, and NFPA 110, when a new or when an existing ing is renovated. 183.73(e)(2), §485.625(e)(2) rator inspection and testing. IH and LTC facility] must mergency power system g, and [maintenance] and in the Health Care IFPA 110, and Life Safety			
	Emergency generand LTC facilities source to power have a plan for hower systems of emergency, unless *[For hospitals at	33.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs of the maintain an onsite fuel emergency generators must ow it will keep emergency perational during the ss it evacuates. §482.15(h), LTC at CAHs §485.625(g):]			
	The standards in this section are a	corporated by reference in pproved for incorporation by Director of the Office of the			

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILD B. WING			COMPL 04/04/	ETED	
	F PROVIDER OR SUPPLIEI	2	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	552(a) and 1 CFF the material from You may inspect Information Reson Boulevard, Baltim Archives and Rec (NARA). For infor this material at NA go to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the charmounce the charmounce the charmounce the charmounce the charmounce, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NI 30, 2012.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED				
		155001	B. W	ING	_	04/04/2	024
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
		· ·	7001 HOOVER RD				
HOOVEF	RWOOD			INDIANAPOLIS, IN 46260			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	+	DATE
	l ` '	FPA 101, issued October					
	22, 2013.	tondord for Francisco as and					
		tandard for Emergency and					
		ystems, 2010 edition,					
	2009	chapter 7, issued August 6,					
	Based on record rev	view, observation and	E 0	041	What corrective action(s) wil	ıı İ -	05/31/2024
	interview; the facility failed to implement the				be accomplished for those		
	emergency power s	ystem inspection, testing and			residents found to have been	n	
	_	ements found in the Health			affected by the deficient		
	Care Facilities Code, NFPA 110, and Life Safety				practice?		
	Code in accordance with 42 CFR 483.73(e)(2).				The emergency generator	r	
	This deficient practice could affect all residents,				was inspected, tested and		
	staff and visitors.				maintained according to		
					requirements found in the Hea		
	Findings include:				Care Facilities Code, NFPA 1	10,	
	D1 ' C	Dina d Comple TELC I 1 1			and Life Safety Code. The		
		Direct Supply TELS Logbook			generator is inspected weekly		
		nergency Power Generator"			a monthly load test is perform	ea.	
		FELS Logbook Documentation Generator Test Generator			All activity is documented in TELS.		
		he Administrator, the Chief					
		ions Officer and the Director of			How will you identify other residents having the potential	al	
		g record review from 9:20 a.m.			to be affected by the same	aı	
		04/24, the following was noted:			deficient practice and what		
	_	by generator inspection			corrective action will be take	n?	
		three of four weeks in			No residents were affecte		
		the week of 02/17/24 was not			the alleged deficient practice.		
	available for review				All residents, visitors, staf		
		ting documentation for			have the potential to be affect		
	1	not available for review.			by the alleged deficient practic		
	1	at the time of record review,			'		
		ity Operations Officer and the			What measures will be put ir	nto	
	Director of Mainten	nance stated the facility has			place or what systemic		
	one diesel fired eme	ergency generator and agreed			changes you will make to		
		generator inspection			ensure that the deficient		
		he aforementioned four week			practice does not recur?		
		load testing documentation			The emergency		
	· ·	as not available for review. The			generator was inspected, teste	ed,	
	Chief Community (Operations Officer and the			and maintained according to		

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PRINTED: 05/01/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2024		
NAME OF E	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	Director of Mainter documentation date interview which sta for person not comp "generator checks v schedule". These findings were Administrator, the G	ance provided "Action Plan" d February 2024 at the time of ted "disciplinary action taken bleting checks" because were not done according to e reviewed with the Chief Community Operations ector of Maintenance during	TAU	requirements found in the He Care Facilities Code, NFPA and Life Safety Code. The generator is inspected weekly a monthly load test is perform All activity is documented in TELS. A Maintenance audit too ensuring emergency generat tested, will be completed more for six months with results reported to the Quality Assur Performance Improvement (Committee Administrator/designee to verify documentation is in TE the emergency power system been inspected, tested, and maintained according to LSC standards. How the corrective action(somily be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? A Maintenance audit too The emergency generator, to ensure it has been inspected tested, and maintained accord to LSC standards, will be completed monthly for six more with results reported to the Q Assurance Performance Improvement (QAPI) Commit overseen by the Administrator a threshold of 95% is not achieved, an action plan will developed to ensure compliants.	alth into, y and hed. I, or is hthly ance QAPI) O LS of has I, for ding onths uality ttee or. If

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PRINTED: 05/01/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING COMPLE		COMPLETED 04/04/2024		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				Any non-compliance with staff result in staff education and u disciplinary action.		
K 0000						
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 04/04 Facility Number: 00 Provider Number: 1002 At this Life Safety 0 found not in complication in Mec Subpart 483.90(a), I 2012 Edition of the Association (NFPA) Building 01 was sur Existing Health Car 16.2. This two story facility three portions of one determined to be of was fully sprinklere memory care wing w kitchen, the baseme on the first floor wh room. The facility is smoke detection in to open to the corridor detectors hard wired	00001 155001	K 0000	The creation and submission this plan of correction does not constitute an admission by thi provider of any conclusion set in the statement of deficiencie of any violation of regulation. provider respectfully requests the 2567 plan of correction be considered the letter of credib allegation and requests desk review (paper compliance) on after 5/31/2024.	ot s t forth es, or This that	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	MULTIPLE CONSTRUCTION (X3) DATE SURVE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	01	COMPL	
		155001	B. Wl	ING		04/04/	2024
NAME OF F	PROVIDER OR SUPPLIER	t		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	facility has a capaci 142 at the time of th	ty of 155 and had a census of nis survey.					
	were sprinklered an services were sprinl riser room closet in no detached buildin	idents have customary access d all areas providing facility klered except for the sprinkler Building 02. The facility has gs providing facility services.					
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alart Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record reversity failed to maintain 1 accordance with NF Code as required by 9.6. NFPA 72, Secontherwise permitted shall be performed schedules in Table by the authority have states that the followinspected semi-annuals. Control unit troub. Remote annuncials. Initiating devices	m is tested and maintained in an approved program requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. In acceptance, maintenance radily available. FPA 70, NFPA 72 View and interview, the facility of 1 fire alarm systems in FPA 72, National Fire Alarm of LSC Sections 19.3.4.5.1 and tion 14.3.1 states that unless in accordance with the 14.3.1, or more often if required raing jurisdiction. Table 14.3.1 wing must be visually unally:	K 0	345	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 potentiat to be affected by the same deficient practice and what corrective action will be take. No residents were affecte the alleged deficient practice. All residents, visitors, and staff have the potential to be	n al n? d by	05/31/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155001	B. Wl	ING		04/04/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			IOOVER RD			
HOOVEF	RWOOD		INDIANAPOLIS, IN 46260					
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDENCE NAMES CONSECUTOR			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLIANCE OF THE A		.TC	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	d. Notification appliances				affected by the alleged deficie	nt		
	e. Magnetic hold-o	pen devices			practice.			
	_	tice could affect all residents,						
	staff and visitors.							
					What measures will be put in	ito		
	Findings include:				place or what systemic			
					changes you will make to			
		e fire alarm system inspection			ensure that the deficient			
		Alarm Inspection and Testing			practice does not recur?			
		ion dated 07/24/23 with the				•••		
		Chief Community Operations			A Maintenance audit tool			
Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on				be completed semi-annually, t	.0			
		nual fire alarm system inspection			ensure the fire alarm system			
		months after 07/24/23 was not			inspection was completed. A Maintenance audit tool,			
		w. Based on interview at the		ensuring the fire alarm system,				
		ew, the Chief Community			will be inspected semi-annual			
		agreed semi-annual inspection			6 months with results reported	-		
	_	the facility's fire alarm system			the Quality Assurance	110		
		7/24/23 was not available for		Performance Impro		ΔPI)		
	review.				Committee.	,,		
					Administrator/designee to)		
	These findings wer	re reviewed with the			verify documentation is in TEL			
	Administrator, the	Chief Community Operations			the semi-annual system			
	Officer and the Dir	rector of Maintenance during			inspection has been complete	d		
	the exit conference	:			according to LSC standards.			
	3.1-19(b)				How the corrective action(s)	١		
	3.1-19(0)				will be monitored to ensure t			
					deficient practice will not	,11 C		
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place?			
					A Maintenance audit tool,			
					ensuring the fire alarm system			
					will be inspected semi-annual	-		
					6 months with results reported	•		
					the Quality Assurance			
					Performance Improvement (Q	API)		
					Committee monthly meeting for			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/04/2024	
NAME OF I	PROVIDER OR SUPPLIER		7001 F	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				months, QAPI is overseen by t Administrator. Any non-compliance with staff will result in staff education and up disciplinary action.	
K 0355 SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of accessible at all tim Portable Fire Exting	nguishers guishers are selected, d, and maintained in NFPA 10, Standard for nguishers. 12, NFPA 10 on and interview, the facility f 52 fire extinguishers were es. NFPA 10, Standard for guishers, 2010 Edition, 6.1.3.1	K 0355	What corrective action(s) will be accomplished for those residents found to have been The podium and stacked	
	located where they immediately availal deficient practice of staff and visitors in	hers shall be conspicuously are readily accessible and ble in the event of fire. This buld affect over 20 residents, the former dining room on the now a special events room.		chairs have been moved so the extinguisher is accessible and immediately available in the ev of a fire How will you identify other residents having the potentia to be affected by the same deficient practice and what	ent I
the Chief Composite Director of Ma facility from 1: podium and state the cabinet door		ons with the Administrator, ity Operations Officer and the nance during a tour of the .m. to 4:30 p.m. on 04/04/24, a chairs were placed up against a wall mounted ABC type uisher located in the former		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	
	dining room on the special events room cabinet door caused readily accessible a event of fire. Affix	first floor which is now a The storage up against the the extinguisher to not be and immediately available in the ed maintenance tags on the uisher inside the cabinet		What measures will be put interplace or what systemic changes you will make to ensure that the deficient practice does not recur?	to

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING	01	COMPLETED 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	performed by an ins 2023 and the facility inspections through interview at the time Community Operati Maintenance agreed was not readily acce available in the ever podium and the stace These findings were Administrator, the Community			A Maintenance audit tool be completed weekly, to ensure the extinguisher is accessible immediately available in the evorage of a fire. Maintenance director/designee will educate that no items can be stored in front of a fire extinguisher. The 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 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 printo place? A Maintenance audit tool be completed monthly, to ensure the extinguisher is accessible and immediately available in 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 (Quanthly meeting for 6 months QAPI is overseen by the Administrator. Any non compliance with staff will results at feducation and up to	staff nat le he and where will ure he of d API)

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01 </u>	COMPLETED
		155001	B. WING		04/04/2024
NAME OF P	PROVIDER OR SUPPLIER		700 ⁻	ET ADDRESS, CITY, STATE, ZIP COD 1 HOOVER RD IANAPOLIS, IN 46260	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	
TAG		LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI	DATE
				disciplinary action.	
K 0541 SS=D Bldg. 01	Chu Rubbish Chutes, I Chutes 2012 EXISTING (1) Any existing lir including pneumat systems, that oper corridor shall be seconstruction to preprovided with a firefire protection ratin shall comply with (2) Any rubbish chincluding pneumat systems, shall be extinguishing prote 9.7. (3) Any trash chuttrash collection roupurpose and prote 8.4. (Existing laun discharge into san automatic sprinkle 19.3.5.9 or 19.3.5. (4) Existing fuel-fe sealed by fire resistenther use. 19.5.4, 9.5, 8.4, N Based on observation failed to ensure dood discharge rooms was latching mechanism chutes shall be insta 82, 2009 Edition. N	nute or linen chute, tic rubbish and linen provided with automatic ection in accordance with e shall discharge into a om used for no other ected in accordance with dry chutes permitted to me room are protected by ers in accordance with .7.) ad incinerators shall be stive construction to prevent FPA 82 on and interview, the facility ers to 1 of 2 trash chute as equipped with a positive in. LSC 9.5.2 requires trash alled and maintained per NFPA FPA 82, Section 5.2.5.1.2 states,	K 0541	What corrective action(s) w be accomplished for those residents found to have been actionally the latch mechanism or south trash chute door has be fixed and latches properly	en n the
	trash collection roopurpose and prote 8.4. (Existing laun discharge into san automatic sprinkle 19.3.5.9 or 19.3.5. (4) Existing fuel-fe sealed by fire resisturther use. 19.5.4, 9.5, 8.4, N Based on observation failed to ensure dood discharge rooms was latching mechanism chutes shall be insta 82, 2009 Edition. N where service openions.	om used for no other ected in accordance with dry chutes permitted to me room are protected by ers in accordance with .7.) ad incinerators shall be stive construction to prevent FPA 82 on and interview, the facility ers to 1 of 2 trash chute as equipped with a positive in LSC 9.5.2 requires trash alled and maintained per NFPA	K 0541	be accomplished for those residents found to have been the latch mechanism or south trash chute door has be	en n the een

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/04/2024		
	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD		
HOOVEF	RWOOD		INDIA	NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		nimum of 1-hour construction		to be affected by the same		
		be protected by ¾-hour fire		deficient practice and what	_	
		80, 2010 Edition at 5.2.4.2(3) &		corrective action will be take		
		a minimum for fire rated doors,		No residents were affect		
	the door, frame, him	-		by the alleged deficient pract		
		eshold are secured, aligned, in no visible signs of damage and		All residents, visitors, state		
	•	operates and secures the door		have the potential to be affect		
	_	sed position. This deficient		by the alleged deficient practic	Le	
	practice could affect over two staff and visitors in the basement.			What measures will be put in	nto	
	the basement.			place or what systemic		
	Findings include:			changes you will make to		
				ensure that the deficient		
	Based on observations with the Administrator,			practice does not recur?		
	the Chief Communi	ity Operations Officer and the		1		
		nance during a tour of the		A Maintenance audit tool	will	
	facility from 1:30 p	.m. to 4:30 p.m. on 04/04/24, the		be completed weekly, to ensure		
	service opening roo	m for the south trash chute		the south trash door is latchin	g	
	discharge in the bas	sement was not provided with		properly		
		e latching mechanism. The		Administrator/designee to		
		on the door failed to latch the		ensure the south trash door is		
		rame when tested to close		latching properly, weekly		
	•	sed on interview at the time of				
	·	e Chief Community		How the corrective action(s)		
	Operations Officer			will be monitored to ensure	the	
	_	the latching mechanism on		deficient practice will not		
		tch the door into the door		recur, i.e., what quality		
	irame when tested t	o close multiple times.		assurance program will be p	out	
	These findings were	e reviewed with the		into place? A Maintenance audit tool	will	
	_	Chief Community Operations		be completed monthly, to ens		
		ector of Maintenance during		the south trash door is latchin		
	the exit conference.	_		properly and the results of the	-	
	Jame John Control			monitoring will be reviewed d		
	3.1-19(b)			the Quality Assurance		
				Performance Improvement (C	(API)	
				monthly meeting for 6 months	•	
				QAPI is overseen by the		
				Administrator. Any non		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) compliance with staff will resul		(X5) COMPLETION DATE
					staff education and up to disciplinary action.	IC III	
K 0712 SS=F Bldg. 01	alarm signal and seconditions. Fire drand unexpected ticonditions, at least The staff is familia aware that drills aroutine. Where draware that drills aroutine. Where draward facility and facility failed to cora. On the first shift facility failed to cora. On the first shift facility failed to cora. On the second shift c. on the second shift c. on the third shift This deficient pract and visitors. Findings include: Based on review of Documentation "Fin Administrator, the Cofficer and the Director of the driver of the drills of the drill	9.7.1.7 review and interview, the aduct quarterly fire drills: for 1 of 4 quarters. ft for 2 of 4 quarters. for 2 of 4 quarters. ice affects all residents, staff	K 0°	712	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 potentiat to be affected by the same deficient practice and what corrective action will be take No residents were affected 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 in	n? d by	05/31/2024

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLE	TED
		155001	B. W	ING	_	04/04/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			OOVER RD		
HOOVER	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	per) 2023 was also not available			place or what systemic		
		on interview at the time of			changes you will make to		
	· ·	Chief Community Operations			ensure that the deficient		
		ector of Maintenance stated the			practice does not recur?		
		ee shifts per day. The Chief			A NA-i-t	:11	
		ions Officer and the Director of			A Maintenance audit tool		
	Maintenance provid				be completed monthly, to ensi	ure	
		d February 2024 at the time of			fire drills are completed and		
		ted "disciplinary action taken			required documentation includ	-	
		bleting fire drills" because "fire according to schedule".			staff participation is uploaded TELS.	IIILO	
	diffis were not done	e according to schedule.					
	These findings were	e reviewed with the			Administrator/designee to verify fire drills are completed		
		Chief Community Operations			uploaded into TELS	anu	
		ector of Maintenance during			uploaded lillo TELS		
	the exit conference.				How the corrective action(s)		
	the care conference.				will be monitored to ensure t		
	3.1-19(b)				deficient practice will not		
	3.1-51(c)				recur, i.e., what quality		
	- ()				assurance program will be p	ut	
	2. Based on record	review and interview, the			into place?		
	facility failed to do	cument all staff who			A Maintenance audit tool	will	
		terly fire drills on the third shift			be completed monthly, to ensi		
	for 1 of 4 quarters.	LSC Section 19.7.1.8 states			fire drills are completed and		
	_	n care occupancies shall be			required documentation is		
	instructed in life saf	fety procedures and devices.			uploaded into TELS. The resu	lts of	
	This deficient pract	ice affects all residents, staff			the monitoring will be reviewed		
	and visitors.				during the Quality Assurance		
					Performance Improvement (Q	API)	
	Findings include:				monthly meeting for 6 months	,	
					QAPI is overseen by the		
		Direct Supply TELS Logbook			Administrator. Any		
	Documentation "Fi				noncompliance with staff will r	esult	
	· ·	Chief Community Operations			in staff education and up to		
		ector of Maintenance during			disciplinary action.		
		9:20 a.m. to 1:30 p.m. on					
		tation for the third shift fire drill					
		.m. on 03/30/24 did not include					
		ipated in the fire drill. Based					
	on interview at the	time of record review, the Chief					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0761	Maintenance stated shifts per day and a aforementioned thir all staff who participal these findings were Administrator, the Control of the state of	tons Officer and the Director of the facility operates three greed documentation for the d shift fire drill did not include pated in the fire drill. The reviewed with the Chief Community Operations ector of Maintenance during			
K 0761 SS=F Bldg. 01	interview; the facili inspection and testin were completed in a Communicating oper required by 19.1.1.4 corridors and shall be self-closing fire doc 8.3.) LSC 8.3.3.1 O protection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire Deprotectives, except a Code. NFPA 80 5.2 shall be inspected a annually, and a writ shall be signed and	riew, observation and ty failed to ensure annual ag of all fire door assemblies accordance of LSC 19.1.1.4.1.1. enings in dividing fire barriers in the permitted only in the protected by approved or assemblies. (See also Section penings required to have a fire Table 8.3.4.2 shall be red, listed, labeled fire door window assemblies and their ware, including all frames, thorage, and sills in a requirements of NFPA 80, thorage, and Other Opening as otherwise specified in this 2.1 states fire door assemblies and tested not less than ten record of the inspection kept for inspection by the 2.4.1 states fire door assemblies	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 potentiate to be affected by the same deficient practice and what corrective action will be taken No residents were affected 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 in place or what systemic	al en? ed by
		pected from both sides to		changes you will make to	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155001	B. W	NG	04/04/2024		
				_			
NAME OF 1	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					OOVER RD		
HOOVE	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	assess the overall co	ondition of door assembly.			ensure that the deficient		
		•			practice does not recur?		
	NFPA 80, 5.2.4.2 s	tates as a minimum, the					
	following items sha				A Maintenance audit tool,		
	_	or breaks exist in surfaces of			ensuring all doors are inspecte		
	either the door or fr				will be completed monthly for		
	(2) Glazing, vision	light frames, and glazing beads			months, with results reported		
	` ,	ely fastened in place, if so			the Quality Assurance		
	equipped.	-			Performance Improvement (Q	API)	
	(3) The door, frame	e, hinges, hardware, and			Committee	,	
	noncombustible thr	eshold are secured, aligned,			Administrator/designee to		
	and in working ord	er with no visible signs of			verify documentation is in TEL		
	damage.				the fire doors being inspected		
	(4) No parts are mis	ssing or broken.			according to Life Safety and N	IFPA	
	(5) Door clearances	s do not exceed clearances			Requirements		
	listed in 4.8.4 and 6	5.3.1.7.			All dire doors have been		
	(6) The self-closing	device is operational; that is,			inspected and tested, with the		
	the active door con	pletely closes when operated			appropriate documentation		
	from the full open p	oosition.			uploaded in TELS.		
	(7) If a coordinator	is installed, the inactive leaf					
	closes before the ac	etive leaf.					
	(8) Latching hardw	are operates and secures the			How the corrective action(s)		
	door when it is in the	ne closed position.			will be monitored to ensure t	he	
	(9) Auxiliary hardw	vare items that interfere or			deficient practice will not		
	prohibit operation a	are not installed on the door or			recur, i.e., what quality		
	frame.				assurance program will be p	ut	
	1 1	fications to the door assembly			into place?		
	have been performe	ed that void the label.			A Maintenance audit tool	will	
		edge seals, where required, are			be completed monthly, to ensu	ure	
		their presence and integrity.			all fire doors have been inspec	cted	
	-	ice could affect all residents,			and tested with the appropriate	е	
	staff and visitors.				documentation uploaded in TE	ELS.	
					This will be reviewed during th	ie	
	Findings include:				Quality Assurance Performand	ce	
					Improvement (QAPI) monthly		
		rect Supply TELS Logbook			meeting for 6 months, QAPI is		
		noke Door Inspection of Smoke			overseen by the Administrator		
		dated 03/01/24 with the			Any non-compliance with staff	will	
		Chief Community Operations			result in staff education and սլ	o to	
	Officer and the Dire	ector of Maintenance during			disciplinary action.		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING 01 B. WING			COMPLETED 04/04/2024			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LIGGUIDENTIFYING DEFORMATION	II PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION	
TAG	record review from 04/04/24, an itemize were inspected and most recent twelve available for review time of record revie Operations Officer a Maintenance agreed doors which were in facility within the mperiod was not avail observations with the Community Operation Maintenance during p.m. to 4:30 p.m. on stairwell door and be collection rooms in with 90 minute fire to the hinge side of These findings were Administrator, the Community Operation of the hinge side of	an itemized listing of fire aspected and tested in the assected and tested in the assected twelve month able for review. Based on the Administrator, the Chief consofficer and the Director of a tour of the facility from 1:30 at 04/04/24, the basement oth doors to the two trash the basement were equipped resistance rating labels affixed the doors.	TA	.cg			DATE	
SS=F Bldg. 01	Electrical Systems Testing Electrical Systems Testing Hospital-grade reclocations and whe anesthesia is adm initial installation, r Additional testing i defined by docume Receptacles not list	- Maintenance and - Maintenance and - Maintenance and - Maintenance and - Peptacles at patient bed - P						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155001	B. W	ING		04/04/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			OOVER RD		
HOOVER	RWOOD				IAPOLIS, IN 46260		
(VA) ID	CIDALADA	OT A TEMENT OF DEPLOIPAGE	1		· I		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
IAG		nths. Line isolation monitors		IAG			DAIL
	_	are tested at intervals of					
	, ,	to 1 month by actuating					
		h per 6.3.2.6.3.6, which					
		ual and audible alarm. For					
		utomated self-testing, this					
	manual test is per	formed at intervals less					
		2 months. LIM circuits are					
	tested per 6.3.3.3	.2 after any repair or					
	renovation to the	electric distribution system.					
		tained of required tests and					
	associated repairs						
	_	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)					_	0.5/0.1/0.004
		view, observation and	K 0	914	What corrective action(s) wil	l	05/31/2024
	interview; the facili	-			be accomplished for those		
		lectrical outlet receptacle			residents found to have beer	1	
		ent sleeping rooms was v in accordance with NFPA 99.			affected by the deficient practice?		
		Care Facilities Code, 2012			The receptacles that are r	not	
		3.4.1.3 states receptacles not			hospital grade, and hospital gr		
		rade at patient bed locations			receptacles that have either be		
		ere deep sedation or general			replaced or serviced during the		
		tested at intervals not			year, have been inspected and		
		hs. NFPA 99, Health Care			tested with documentation		
	Facilities Code, 201	12 Edition, Section 6.3.4.1.1			uploaded in TELS.		
	states hospital-grad	e receptacles testing shall be			How will you identify other		
	performed after init	ial installation, replacement or			residents having the potentia	al	
	servicing of the dev	vice. Section 6.3.3.2,			to be affected by the same		
		in Patient Care Rooms requires			deficient practice and what		
		ty of each receptacle shall be			corrective action will be take		
		l inspection. The continuity of			No residents were affecte	d by	
		it in each electrical receptacle			the deficient practice.		
		Correct polarity of the hot and			All residents, visitors, and		
		in each electrical receptacle			staff have the potential to be		
	· · · · · · · · · · · · · · · · · · ·	and retention force of the			affected by the alleged deficie	nt	
		each electrical receptacle			practice.		
		e receptacles) shall be not less			M/hat magazinas will be with he	4-	
	uian 115 grams (4 d	ounces). Section 6.3.4.2.1.2	- 1		What measures will be put in	lO .	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155001	B. Wl	ING		04/04/	2024
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t .			OOVER RD		
HOOVEF	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· ·	n, the record shall contain the			place or what systemic		
		reas tested, and an indication			changes you will make to		
		e met, or have failed to meet,			ensure that the deficient		
	_	quirements of this chapter.			practice does not recur?		
	This could affect al	residents.			The receptacles that are i		
	Findings in alud -				hospital grade, and hospital gr		
	Findings include:				receptacles that have either be		
	D11	.:			replaced or serviced during th		
		view with the Administrator, ity Operations Officer and the			year, have been inspected and	u	
		nance from 9:20 a.m. to 1:30 p.m.			tested with documentation		
		_			uploaded in TELS.		
		cal receptacle inspection and on within the most recent			A Maintenance audit tool	WIII	
	_	d was not available for review.			be completed monthly for 6	laa	
	_	at the time of record review,			months to ensure all receptac		
		ity Operations Officer and the			requiring annual inspection an		
		nance stated each resident			testing has been completed w		
		nultiple receptacle locations			required documentation uploa inTELS. This will be reviewed	ueu	
		be hospital-grade but agreed					
		e inspection and testing			during the Quality Assurance Performance Improvement (Q	۸DI\	
	-	he most recent twelve month			monthly meeting for 6 months	•	
		lable for review. Based on			QAPI is overseen by the	,	
		ne Administrator, the Chief			Administrator. Any		
		ions Officer and the Director of			non-compliance with staff will		
		nt sleeping rooms in the first			result in staff education and up	n to	
		wing had non-hospital-grade			disciplinary action.	- 10	
	receptacles.	9 nen verbirmi Birme			Administrator/designee to		
					verify documentation that all		
	These findings were	e reviewed with the			receptacles requiring annual		
	_	Chief Community Operations			inspection and testing have be	een	
	·	ector of Maintenance during			inspected and tested.		
	the exit conference.	_					
					How the corrective action(s)		
	3.1-19(b)				will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					A Maintenance audit tool,		
					ensuring all receptacles requir		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COME	E SURVEY PLETED 4/2024
NAME OF P	PROVIDER OR SUPPLIEF	- L		ADDRESS, CITY, STATE, ZIP	COD	
HOOVER	RWOOD			NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems Electrical Systems System Maintenar The generator or source and assoc of supplying servic 10-second criterio monthly test, a pro annually confirm t safety and critical and testing of the switches are perfo NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu loads, and are con personnel. Mainte energy power sou accordance with N	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power iated equipment is capable be within 10 seconds. If the n is not met during the pocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with e inspected weekly, pad 30 minutes 12 times a intervals, and exercised nths for 4 continuous hours. der load conditions include		annual inspection and be completed monthly months with results rethe Quality Assurance Performance Improve Committee overseen Administrator. If a thr 95% is not achieved, plan will be developed compliance. Any non with staff will result in education and up to daction.	y for 6 eported to e ement (QAPI) by the reshold of an action d to ensure n-compliance staff	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155001	B. W	ING		04/04/	2024	
NAME OF F	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD			
HOOVEF	RWOOD				OOVER RD IAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NEGLIDERIC IV AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE	
	program for period	dically exercising the						
	components is est	tablished according to						
	manufacturer requ	uirements. Written records						
	of maintenance ar	nd testing are maintained						
	and readily availal	ble. EES electrical panels						
	and circuits are m	arked, readily identifiable,						
	-	n normal power circuits.						
		ssibility of damage of the						
		source is a design						
	consideration for r							
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.10	` ,		0.1.0		_	0.5/0.1/0.00.1	
		review and interview, the	K 0	918	What corrective action(s) wil	I	05/31/2024	
	_	sure a written record of weekly			be accomplished for those			
	-	generator was maintained for 4			residents found to have been	า		
		recent 52 week period. NFPA			affected by the deficient			
	_	es onsite generators shall be			practice?			
		dance with NFPA 110, gency and Standby Power			The emergency generate			
	_	0, 8.4.1 requires an Emergency			was inspected, tested according	ng		
	-	em (EPSS) including all			to maintenance requirements found in the Health Care Facil	ition		
		nents, shall be inspected			Code, NFPA 110, and Life Sa			
		ed monthly. NFPA 99, Section			Code. The generator is check	-		
	1	ritten record of inspection,			weekly and monthly.	.eu		
	•	ising period, and repairs for the			How will you identify other			
	_	alarly maintained and available			residents having the potentia	al		
	for inspection by th	-			to be affected by the same			
		leficient practice could affect all			deficient practice and what			
	residents, staff and	-			corrective action will be take	n?		
					No residents were affecte			
	Findings include:				the alleged deficient practice.	•		
					All residents, visitors, staf			
	Based on review of	Direct Supply TELS Logbook			have the potential to be affect			
	Documentation "En	nergency Power Generator"			by the alleged deficient praction			
	with the Administra	ator, the Chief Community						
	Operations Officer				What measures will be put ir	ito		
	•	g record review from 9:20 a.m.			place or what systemic			
	•	04/24, weekly emergency			changes you will make to			
		n documentation for three of			ensure that the deficient			
	four weeks in Dece	mber 2023 and the week of			practice does not recur?			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155001	B. W	NG		04/04/	/2024
				_			
NAME OF 1	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					OOVER RD		
HOOVE	RWOOD			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE CLUDERIS N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	-	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		vailable for review. Based on			The emergency generato	or	
		e of record review, the Chief			was inspected, tested according		
		ions Officer and the Director of			to maintenance requirements	-9	
		the facility has one diesel			found in the Health Care Facil	ities	
		nerator and agreed weekly			Code, NFPA 110, and Life Sa		
		or inspection documentation			Code. The generator is check	-	
	1	ned four week period was not			weekly and monthly.		
		v. The Chief Community			A Maintenance audit tool,		
	Operations Officer				ensuring emergency generato		
	Maintenance provide				tested, will be completed mon		
	_	ed February 2024 at the time of			for six months with results		
		ited "disciplinary action taken			reported to the Quality Assura	nce	
		pleting checks" because			Performance Improvement (Q		
		were not done according to			Committee	,	
	schedule".				Administrator/designee to		
					verify documentation is in TEL		
	These findings wer	e reviewed with the			the emergency power system		
	_	Chief Community Operations			has been tested according to		
		ector of Maintenance during			standards		
	the exit conference.				0101100100		
					How the corrective action(s)		
	3.1-19(b)				will be monitored to ensure t	he	
					deficient practice will not		
	2. Based on record	review and interview, the			recur, i.e., what quality		
		ercise the generator for 1 of 12			assurance program will be p	ut	
	1	requirements of NFPA 110,			into place?		
		tandard for Emergency and			A Maintenance audit tool,	for	
		stems, Chapter 8.4.2. NFPA			The emergency generator, to		
		states diesel generator sets in			ensure it has been tested		
	· ·	ercised at least once monthly,			according to LSC standards, v	vill	
		60 minutes, using one of the			be completed monthly for six		
	following methods:				months with results reported to	n	
		aintains the minimum exhaust			the Quality Assurance	-	
		s recommended by the			Performance Improvement (Q	API)	
	manufacturer	,			Committee overseen by the	,	
		g temperature conditions and at			Administrator. If a threshold o	f	
		cent of the EPS (Emergency			95% is not achieved, an action		
	Power Supply) nam				plan will be developed to ensu		
	~ ~ ~ .	es diesel-powered EPS			compliance. Any non complia		
		o not meet the requirements of			with staff will result in staff		

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001		ILDING	nstruction <u>01</u>	(X3) DATE : COMPL 04/04 /	ETED		
	F PROVIDER OR SUPPLIED	R		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	EPSS (Emergency shall be exercised a loads (Load Bank? of the EPS namepla minutes and at not nameplate kW ratin total test duration of hours. This deficie residents, staff and Findings include: Based on review of Documentation "En Generator Under L the Chief Commun Director of Mainter from 9:20 a.m. to 1 documentation for for review. Based record review, the Officer and the Dir facility has one die and agreed monthly for January 2024 w Chief Community University Director of Mainter documentation data interview which stafor person not com "generator checks wischedule". These findings wer Administrator, the	EDirect Supply TELS Logbook mergency Power Generator Test oad" with the Administrator, ity Operations Officer and the nance during record review :30 p.m. on 04/04/24, load testing January 2024 was not available on interview at the time of Chief Community Operations ector of Maintenance stated the sel fired emergency generator y load testing documentation ras not available for review. The Operations Officer and the nance provided "Action Plan" and February 2024 at the time of ated "disciplinary action taken pleting checks" because were not done according to			education and up to disciplinal action.	у			

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CE.TERD I OI	THE COURT OF THE C	0211.1020			312 1.0. 0,00 00,	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155001	B. WING		04/04/2024	
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD HOOVER RD		
HOOVEF	RWOOD		INDIAI	NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
K 0000						
Bldg. 02						
Ŭ	A Life Safety Code	Recertification and State	K 0000	The creation and submission	of	
	Licensure Survey w	vas conducted by the Indiana		this plan of correction does n	ot	
	Department of Heal	Ith in accordance with 42 CFR		constitute an admission by th		
	483.90(a).			provider of any conclusion se in the statement of deficiencie	t forth	
	Survey Date(s): 04	/04/24		of any violation of regulation. provider respectfully requests	This	
	Facility Number: 0	000001		the 2567 plan of correction be		
	Provider Number:			considered the letter of credit		
	AIM Number: 100			allegation and requests desk		
	At this Life Safety	Code survey, Hooverwood was	review (paper compliance) on or after 5/31/2024.		n or	
	found not in compli	iance with Requirements for				
	Participation in Me	dicare/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 Bu	uilding 03 were surveyed using				
	Chapter 18, New H	ealth Care Occupancies and 410				
	IAC 16.2.					
	This two story facil	ity with a basement consists of				
	three portions of on	e building which was				
	determined to be of	Type II (111) construction and				
	was fully sprinklere	ed. Building 02 consists of the				
	2017 general renov	ation of all first and second				
	floor resident sleep	ing room areas not in the				
	memory care wing	and the addition of resident				
		8, 1239, 1240 and 1241 on the				
	first floor and resid	ent sleeping rooms 2238, 2239,				
		he second floor in 2018.				
	_	s of the renovated first floor				
		y, administrative support				
		room, gift shop and beauty				
		nas a fire alarm system with				
		the corridor and in all areas				
	open to the corridor	r. The facility has smoke				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAU	detectors hard wired installed in all resid facility has a capaci 142 at the time of the	I to the fire alarm system ent sleeping rooms. The ty of 155 and had a census of his survey.		TAG			DATE
	were sprinklered an services were sprink riser room closet in	dents have customary access d all areas providing facility klered except for the sprinkler Building 02. The facility has gs providing facility services.					
	Quality Review con	npleted on 04/10/24.					
K 0222 SS=E Bldg. 02	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security new used, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Security sides.	king arrangements for the leds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all led by staff at all times; or emeans available to the 2.2.6, 19.2.2.2.5.1,					

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		uilding <u>02</u>		(X3) DATE SURVEY COMPLETED 04/04/2024				
NAME OF I	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY) TAG DEFICIENCY		ΓE	(X5) COMPLETION DATE	
	release upon loss building is protect automatic sprinkle space is protected detection system at an attended los space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed on systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, superdetection system automatic sprinkles 18.2.2.2.4, 19.2.2 ACCESS-CONTELOCKING ARRANACCESS-CONTELOCKING ARRANACCESS-CONTELOCO	SS LOCKING S Ielayed-egress locking in accordance with permitted on door ig low and ordinary hazard rigs protected throughout by revised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS If Egress Door assemblies Iance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 7.2.1.6.3 shall be permitted res in buildings protected approved, supervised rection system and an ised automatic sprinkler	K 02:	22	What corrective action(s) will be		05/31/2024	
		means of egress through 1 of	K 02.	<i>LL</i>	accomplished for those reside		U3/31/2U2 4	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155001	B. WI	ING		04/04/	2024
NAME OF I	DDOVIDED OD CLIDDLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	K		7001 H	OOVER RD		
HOOVER	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ily accessible for residents			found to have been affected be	y the	
		diagnosis requiring specialized			deficient practice?		
	security measures. Doors within a required means				A delayed egress locking		
	_	be equipped with a latch or			system has been installed on	the	
	_	he use of a tool or key from the			1B lounge exit door.		
	_	otherwise permitted by LSC			How will you identify other		
		ocking arrangements shall be			residents having the potential		
	_	dance with 18.2.2.2.5.2. This			be affected by the same defic		
	_	could affect over 20 residents,			practice and what corrective	action	
	staff and visitors.				will be taken?		
					No residents were affected	-	
	Findings include:				the alleged deficient practice.		
					All residents, visitors, and statements		
	Based on observations with the Administrator,				have the potential to be affect		
		nity Operations Officer and the			by the alleged deficient practi	ce.	
		nance during a tour of the					
		p.m. to 4:30 p.m. on 04/04/24, the			What measures will be put in		
		cility at the 1B lounge which			place or what systemic chang		
		nory care wing was marked as a			you will make to ensure that t		
		n exit sign. The exit door was			deficient practice does not re-	cur?	
		signage stating "This door must			A delayed egress locking		
	1 -	imes" but the door was not			system has been installed on	the	
	_	when pushed to open. The 1B			1B lounge exit door.		
	_	kit discharge is into an outdoor			A Maintenance audit tool,		
		shared with memory care exit			ensuring the egress door loca	ited	
		f one courtyard gates in the			in the 1B lounge meets LSC	.	
		gnetically locked and could be			18.2.2.2.5.2., will be complete	∌a	
		g a four digit code but the code			monthly for six months with	_	
	_	he courtyard exit. Based on			results reported to the Quality	'	
		ne of the observations, the Chief tions Officer and the Director of			Assurance Performance	too	
		d residents with clinical			Improvement (QAPI) Commit	tee.	
					How the corrective action (a)	will be	
		a secure wing were housed in ving but agreed the code was			How the corrective action(s)		
	not posted at the co				monitored to ensure the defic		
	not posted at the Co	ourryaru exit uoor.			practice will not recur, i.e., wh		
	These findings was	re reviewed with the			quality assurance program will put into place?	ıı D C	
	_	Chief Community Operations			1 .		
	· ·	rector of Maintenance during			A Maintenance audit tool,	ntod	
	the exit conference	_			ensuring the egress door loca	แซน	
	I me exit conference	. .			in the 1B lounge meets LSC		

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	02	COMPLETED 04/04/2024			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	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) Committed overseen by the Administrator, a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Any non-compliance with staff result in staff education and up disciplinary action.	ee . If e ce. will			
K 0345 SS=F Bldg. 02	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on record rev failed to maintain 1 accordance with NF Code as required by 9.6. NFPA 72, Sect otherwise permitted	n - Testing and m is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. FPA 70, NFPA 72 riew and interview, the facility of 1 fire alarm systems in FPA 72, National Fire Alarm LSC Sections 19.3.4.5.1 and cion 14.3.1 states that unless by 14.3.2, visual inspections	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	n			
	schedules in Table 1 by the authority hav	ole signals		uploaded in TELS. How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be taken No residents were affected.	n?			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED
		155001	B. WING		04/04/2024
		-	STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIE	R		HOOVER RD	
HOOVEF	RWOOD		INDIA	NAPOLIS, IN 46260	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	_	s (e.g. duct detectors, manual		the alleged deficient practice	
		eat detectors, smoke detectors,		All residents, visitors, an	
	etc.)			staff have the potential to be	
	d. Notification app			affected by the alleged defici	ent
	e. Magnetic hold-open devices This deficient practice could affect all residents,			practice.	
	staff and visitors.				
				What measures will be put	into
	Findings include:			place or what systemic	
				changes you will make to	
		e fire alarm system inspection		ensure that the deficient	
		Alarm Inspection and Testing		practice does not recur?	
		ion dated 07/24/23 with the			
		Chief Community Operations		A Maintenance audit too	
		rector of Maintenance during		be completed semi-annually, to	
		9:20 a.m. to 1:30 p.m. on		ensure the fire alarm system	
		nual fire alarm system inspection		inspection was completed.	
		months after 07/24/23 was not		A Maintenance audit too	
		w. Based on interview at the		ensuring the fire alarm syste	
		ew, the Chief Community		will be inspected semi-annua	-
	1 -	agreed semi-annual inspection		6 months with results reported	ed to
		the facility's fire alarm system		the Quality Assurance	
		7/24/23 was not available for		Performance Improvement (QAPI)
	review.			Committee.	
				Administrator/designee t	
	_	re reviewed with the		verify documentation is in TE	LS of
		Chief Community Operations		the semi-annual system	
		rector of Maintenance during		inspection has been complet	ed
	the exit conference			according to LSC standards.	
	3.1-19(b)			How the corrective action(•
				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 too	
				ensuring the fire alarm syste	
				will be inspected semi-annua	•
	I		I	6 months with results reporte	ed to I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u> COI			COMPLETED	
		155001	B. W	ING		04/04/	/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER				OOVER RD			
HOOVER	WOOD				IAPOLIS, IN 46260			
TIOOVEI	WOOD			INDIAN	171 0210, 111 40200			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE	
					the Quality Assurance			
					Performance Improvement (Q	,		
					Committee monthly meeting for			
					months, QAPI is overseen by	the		
					Administrator. Any			
					non-compliance with staff will			
					result in staff education and սլ	o to		
					disciplinary action.	ļ		
V 0504	NIEDA 404							
K 0521 SS=F	NFPA 101							
Bldg. 02	HVAC							
Diug. 02	HVAC	n and air conditioning about						
	-	n, and air conditioning shall nd shall be installed in						
	accordance with the							
	specifications.	ie mandiacturer s						
	18.5.2.1, 19.5.2.1,	0.2						
		riew, observation and	$ _{K0}$	521	What corrective action(s) wil		05/31/2024	
		ty failed to ensure all fire	K U	321	be accomplished for those	'	03/31/2024	
		ity were inspected and			residents found to have been	1		
	_	maintenance at least every			affected by the deficient	•		
		ance with NFPA 90A. LSC			practice?			
	_	ng, ventilating and air			The 4-year fire damper			
	_	C) ductwork and related			inspection has been complete	ed l		
	- '	in accordance with NFPA 90A,			with proper documentation	,		
		tallation of Air-Conditioning			uploaded in TELS.			
		tems. NFPA 90A, 2012			How will you identify other			
	Edition, Section 5.4	.8.1 states fire dampers shall be			residents having the potentia	al		
	maintained in accor	dance with NFPA 80, Standard			to be affected by the same			
	for Fire Doors and O	Other Opening Protectives.			deficient practice and what			
	NFPA 80, 2010 Edi	tion, Section 19.4.1 states each			corrective action will be take	n?		
	damper shall be test	ed and inspected 1 year after			No residents were affecte	d by		
	installation. The tes	st and inspection frequency			the alleged deficient practice.			
	shall be every 4 year	rs. If the damper is equipped			All residents, visitors, and			
	with a fusible link,	the link shall be removed for			staff have the potential to be			
	testing to ensure ful	l closure and lock-in-place if			affected by the alleged deficie	nt		
		amper shall not be blocked			practice.			
	from closure in any	way. All inspections and						
	testing shall be docu	umented, indicating the			What measures will be put in	ito		
	location of the fire of	lamper, date of inspection,			place or what systemic			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	
		155001	B. W	NG	_	04/04/	/2024
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>			OOVER RD		
HOOVER	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		nd deficiencies discovered.			changes you will make to		
	The documentation shall have a space to indicate				ensure that the deficient		
	when and how the deficiencies were corrected.				practice does not recur?		
	1	ice could affect all residents,			The 4-year fire damper		
	staff and visitors.				inspection was inspected with		
	Findings include:				proper documentation uploade TELS.	ed to	
					A Maintenance audit tool,		
	Based record review	with the Administrator, the			ensuring there is proper		
	Chief Community (Operations Officer and the			documentation showing the 4-	year	
	Director of Mainten	ance during record review			fire damper inspection has be	en	
	from 9:20 a.m. to 1:	30 p.m. on 04/04/24, fire damper			completed, will be completed		
	inspection and testing	ng documentation within the			monthly for six months with		
	most recent four year	ar period was not available for			results reported to the Quality		
		nterview at the time of record			Assurance Performance		
		ommunity Operations Officer			Improvement (QAPI) Committ	ee.	
		Maintenance agreed fire					
		and testing documentation			How the corrective action(s)		
		ent four year period was not			will be monitored to ensure t	:he	
		. Based on observations with			deficient practice will not		
		he Chief Community			recur, i.e., what quality		
	Operations Officer				assurance program will be p	ut	
		g a tour of the facility from 1:30			into place?		
	1	n 04/04/24, one fire damper was			A Maintenance audit tool,		
		system ductwork in the			ensuring there is proper		
		n the second floor identified as			documentation that the fire		
		fire damper did not have any			damper has been inspected, v	vill	
		ion indicating the date of when			be completed monthly for six		
	_	pection and maintenance was			months with results reported to	0	
	_	on interview at the time of the			the Quality Assurance		
		hief Community Operations			Performance Improvement (Q	API)	
		ector of Maintenance agreed			Committee overseen by the	_	
		ion and maintenance			Administrator. If a threshold o		
		in the most recent four year			95% is not achieved, an action		
	period was not avai	lable for review.			plan will be developed to ensu		
					compliance. Any non complia	nce	
	These findings were				with staff will result in staff		
		Chief Community Operations			education and up to disciplina	ry	
		ector of Maintenance during			action.		
	the exit conference		1		1		I

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILD	A. BUILDING <u>02</u>			3) DATE SURVEY COMPLETED 04/04/2024	
		155001	B. WING			04/04/	2024
NAME OF F	PROVIDER OR SUPPLIER		70	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0541 SS=E Bldg. 02	3.1-19(b) NFPA 101 Rubbish Chutes, I Chu Rubbish Chutes, I Chutes 2012 NEW Rubbish chutes, ir chutes shall comp Section 9.5, unles 18.5.4.2. *The fire resistar room shall not be hour. *Any rubbish chr provided with auto protection in acco *Chutes shall dis collection room us and shall be prote 8.7. 18.5.4.2, 8.7, 9.5, Based on observation failed to maintain 1 self-closing and pos requires trash chute maintained per NFF Section 5.2.3.3.1.1 into a trash chute sh self-closing, positiv door assembly. This over 20 residents, st of Room 1148.	ncinerators, and Laundry ncinerators, and Laundry ncinerators, and laundry ly with the provisions of s otherwise specified in nce rating of chute charging required to exceed one ute or linen chute shall be matic extinguishing rdance with Section 9.7. scharge into a trash ed for no other purpose cted in accordance with	K 0541		What corrective action(s) will be accomplished for those residents found to have been. The latch mechanism on south trash chute door has befixed and latches properly. How will you identify other residents having the potentiato be affected by the same deficient practice and what corrective action will be take. No residents were affected.	n the en al n?	05/31/2024
	Findings include: Based on observations with the Administrator,				by the alleged deficient practice. All residents, visitors, staff have the potential to be affected.	f	
	the Chief Communi			by the alleged deficient practic			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BU B. WI	ILDING NG	02	COMPLETED 04/04/2024	
		133001	B. WII			U4/U4/ZUZ4	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
HOOVEF	RWOOD				OOVER RD IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PREFIX	,	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	3
		nance during a tour of the .m. to 4:30 p.m. on 04/04/24, the					
		Room 1148 was equipped with			What measures will be put in	to	
		e and a positive latching			place or what systemic		
	device but the latching mechanism failed to				changes you will make to		
	protrude into the ch	ute door frame when tested to			ensure that the deficient		
	-	s. Based on interview at the			practice does not recur?		
		tions, the Chief Community					
	Operations Officer				A Maintenance audit tool		
		d the trash chute door did not door frame when tested to			be completed weekly, to ensu		
	close multiple times				the south trash door is latching properly	9	
	close multiple times	5.			Administrator/designee to		
	These findings were	e reviewed with the			ensure the south trash door is		
		Chief Community Operations			latching properly, weekly		
		ector of Maintenance during					
	the exit conference.				How the corrective action(s)		
					will be monitored to ensure	he	
	3.1-19(b)				deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?	النب	
					A Maintenance audit tool be completed monthly, to ens		
					the south trash door is latching		
					properly and the results of the		
					monitoring will be reviewed d		
					the Quality Assurance	·	
					Performance Improvement (Q	, i	
					monthly meeting for 6 months		
					QAPI is overseen by the		
					Administrator. Any non	<u>.</u>	
					compliance with staff will resu staff education and up to	ı in	
					disciplinary action.		
					alsolphinary action.		
K 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 02	Fire Drills						
	Fire drills include	the transmission of a fire					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DAT			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETED	
		155001	B. W	ING	_	04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER	}	-		ADDRESS, CITY, STATE, ZIP COD		
		-			OOVER RD		
HOOVEF	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	_	simulation of emergency fire					
		rills are held at expected					
	· ·	mes under varying st quarterly on each shift.					
		ar with procedures and is					
		re part of established					
		rills are conducted between					
	9:00 PM and 6:00						
		ay be used instead of					
	audible alarms.	a, so about noticed of					
	18.7.1.4 through 1	18717					
		review and interview, the	K O	712	What corrective action(s) wil	ı	05/31/2024
		nduct quarterly fire drills:	110	712	be accomplished for those		03/31/2021
	a. on the first shift f				residents found to have been	n	
		ift for 2 of 4 quarters.			Fire drills are completed	-	
	c. on the third shift	-			monthly and documentation		
		ice affects all staff and			including staff participation is		
	residents.				uploaded into TELS.		
					How will you identify other		
	Findings include:				residents having the potentia	al	
					to be affected by the same		
	Based on review of	Direct Supply TELS Logbook			deficient practice and what		
	Documentation "Fin	re Drills" with the			corrective action will be take	n?	
	Administrator, the (Chief Community Operations			No residents were affecte	d by	
	Officer and the Dire	ector of Maintenance during			the alleged deficient practice.		
		9:20 a.m. to 1:30 p.m. on			All residents, visitors, and		
		tation of a first shift fire drill			staff have the potential to be		
		ird quarter (July, August,			affected by the alleged deficie	nt	
		as not available for review. In a			practice.		
		ation of a second shift and					
		conducted in the third quarter					
		rth quarter (October,			What measures will be put in	nto	
		per) 2023 was also not available			place or what systemic		
		on interview at the time of			changes you will make to		
		Chief Community Operations			ensure that the deficient		
		ector of Maintenance stated the			practice does not recur?		
		ee shifts per day. The Chief					
		ions Officer and the Director of			A Maintenance audit tool		
	Maintenance provid				be completed monthly, to ensi	ure	
	documentation date	d February 2024 at the time of			fire drills are completed and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>02</u>	COMPLETED
		155001	B. WING		04/04/2024
		<u>L</u>	STRI	EET ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	8		11 HOOVER RD	
HOOVEF	RWOOD			DIANAPOLIS, IN 46260	
	Г				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPR	
TAG		R LSC IDENTIFYING INFORMATION	TAG	<u>' </u>	DATE
		ted "disciplinary action taken bleting fire drills" because "fire		required documentation in	- I
		_		staff participation is upload TELS.	ded into
	drills were not done according to schedule".				es to
	These findings were reviewed with the			Administrator/designe verify fire drills are comple	
	_			uploaded into TELS	sted and
	Administrator, the Chief Community Operations Officer and the Director of Maintenance during			uploaded IIIO TELS	
	the exit conference.			How the corrective actio	n(e)
	the exit conference.			will be monitored to ensi	
	3.1-19(b)			deficient practice will no	
	3.1-51(c)			recur, i.e., what quality	`
	3.1-31(0)			assurance program will I	ne nut
	2 Based on record	review and interview, the		into place?	Se put
		cument all staff who		A Maintenance audit	tool will
	1	terly fire drills on the third shift		be completed monthly, to	
		LSC Section 18.7.1.8 states		fire drills are completed ar	
	_	care occupancies shall be		required documentation is	
		fety procedures and devices.		uploaded into TELS. The	
		ice affects all residents, staff		the monitoring will be revi	
	and visitors.	,		during the Quality Assura	
				Performance Improvemen	
	Findings include:			monthly meeting for 6 mo	
				QAPI is overseen by the	,
	Based on review of	Direct Supply TELS Logbook		Administrator. Any	
	Documentation "Fin			noncompliance with staff	will result
	Administrator, the	Chief Community Operations		in staff education and up t	
		ector of Maintenance during		disciplinary action.	
	record review from	9:20 a.m. to 1:30 p.m. on			
	04/04/24, document	tation for the third shift fire drill			
	conducted at 1:00 a	.m. on 03/30/24 did not include			
	the staff who partic	ipated in the fire drill. Based			
	on interview at the	time of record review, the Chief			
	Community Operat	ions Officer and the Director of			
		the facility operates three			
	shifts per day and a	greed documentation for the			
		d shift fire drill did not include			
	all staff who partici	pated in the fire drill.			
	These findings were				
	Administrator, the	Chief Community Operations	1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155001	B. W	ING		04/04	/2024
NAME OF P	PROVIDER OR SUPPLIER			7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE
	Officer and the Dire the exit conference.	ector of Maintenance during					
	3.1-19(b) 3.1-51(c)						
K 0761 SS=F Bldg. 02							
Blug. U2	interview; the facili inspection and testin were completed in a Communicating oper required by 19.1.1.4 corridors and shall be self-closing fire doc 8.3.) LSC 8.3.3.1 Oprotection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire D Protectives, except Code. NFPA 80 5.2 shall be inspected a	view, observation and ty failed to ensure annual ng of all fire door assemblies accordance of LSC 19.1.1.4.1.1. enings in dividing fire barriers 4.1 shall be permitted only in the protected by approved or assemblies. (See also Section repenings required to have a fire of Table 8.3.4.2 shall be ored, listed, labeled fire door window assemblies and their ware, including all frames, whorage, and sills in the requirements of NFPA 80, thorage, and other Opening as otherwise specified in this 2.1 states fire door assemblies and tested not less than then record of the inspection	K 0	761	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 potentiat to be affected by the same deficient practice and what corrective action will be take No residents were affected the alleged deficient practice. All residents, visitors, and staff have the potential to be affected by the alleged deficie practice.	n n? d by	05/31/2024
	shall be signed and AHJ. NFPA 80, 5.2 shall be visually ins assess the overall co	kept for inspection by the 2.4.1 states fire door assemblies spected from both sides to ondition of door assembly.			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	to	
	following items sha (1) No open holes of either the door or fraction (2) Glazing, vision	or breaks exist in surfaces of			A Maintenance audit tool, ensuring all doors are inspecte will be completed monthly for months, with results reported to the Quality Assurance	ed, 6	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY COMPLETED 04/04/2024	
NAME OF I	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
TAG	equipped. (3) The door, frame noncombustible thrand in working ordedamage. (4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open p (7) If a coordinator closes before the active door when it is in the (9) Auxiliary hardward prohibit operation a frame. (10) No field modification have been performed (11) Gasketing and inspected to verify the This deficient pract staff and visitors. Findings include: Based review of Dinascent of	do not exceed clearances 3.3.1.7. If device is operational; that is, appletely closes when operated position. It is installed, the inactive leaf tive leaf. It is eleaf are operates and secures the ne closed position. It is installed on the door or in the door assembly and that void the label. It is edge seals, where required, are their presence and integrity. It is could affect all residents, In the could affect all residents, In the could affect all residents are the could affect all residents. In the could affect all residents are the could affect all residents. In the could affect all residents are the could affect all residents. In the could affect all residents are the could affect all residents are the could affect all residents. In the could be a co	TAG	Performance Improvement (Committee Administrator/designee of verify documentation is in TE the fire doors being inspected according to Life Safety and Requirements All dire doors have been inspected and tested, with the appropriate documentation uploaded in TELS. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? A Maintenance audit too be completed monthly, to enall fire doors have been inspended to the completed with the appropriate documentation uploaded in This will be reviewed during Quality Assurance Performan Improvement (QAPI) monthly meeting for 6 months, QAPI overseen by the Administrate Any non-compliance with staresult in staff education and disciplinary action.	co ELs of d NFPA e ithe put I will sure ected ate TELS. the nce / is or. ff will	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001		JILDING	nstruction 02	(X3) DATE (COMPL 04/04 /	ETED
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0914 SS=F Bldg. 02	facility within the meriod was not available observations with the Community Operation Maintenance during p.m. to 4:30 p.m. or oxygen storage and equipped with 45 melabels and each stain a 60 minute fire resist the hinge side of the Community of the community of the exit conference of the exit con						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	02	COMPLETED	
		155001	B. W	ING		04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE
	than or equal to 1	2 months. LIM circuits are					
	tested per 6.3.3.3.	.2 after any repair or					
	renovation to the	electric distribution system.					
	Records are main	tained of required tests and					
	associated repairs	s or modifications,					
	containing date, ro	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)						
		view, observation and	K 0	914	What corrective action(s) wil	11	05/31/2024
	interview; the facili	•			be accomplished for those		
		lectrical outlet receptacle			residents found to have been	n	
	testing for all resident sleeping rooms was				affected by the deficient		
	available for review in accordance with NFPA 99.				practice?		
		are Facilities Code, 2012			The receptacles that are i		
		3.4.1.3 states receptacles not			hospital grade, and hospital g		
		ade at patient bed locations			receptacles that have either b		
		ere deep sedation or general tested at intervals not			replaced or serviced during th		
		ns. NFPA 99, Health Care			year, have been inspected an tested with documentation	a	
	_	2 Edition, Section 6.3.4.1.1			uploaded in TELS.		
		e receptacles testing shall be			How will you identify other		
		ial installation, replacement or			residents having the potentia	al	
	_	rice. Section 6.3.3.2,			to be affected by the same	aı	
		in Patient Care Rooms requires			deficient practice and what		
		ty of each receptacle shall be			corrective action will be take	n?	
		l inspection. The continuity of			No residents were affecte		
	I	it in each electrical receptacle			the deficient practice.	,	
		orrect polarity of the hot and			All residents, visitors, and	ı	
		in each electrical receptacle			staff have the potential to be		
		and retention force of the			affected by the alleged deficie	nt	
		each electrical receptacle			practice.		
	1	e receptacles) shall be not less					
	than 115 grams (4 c	ounces). Section 6.3.4.2.1.2			What measures will be put ir	nto	
	states, at a minimur	n, the record shall contain the			place or what systemic		
	i '	reas tested, and an indication			changes you will make to		
		e met, or have failed to meet,			ensure that the deficient		
		quirements of this chapter.			practice does not recur?		
	This could affect all	l residents.			The receptacles that are i		
					hospital grade, and hospital g		
	Findings include:				receptacles that have either b	een	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 04/04/2024	
HOOVEF	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COI HOOVER RD NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE COMPLETION DATE	N
	the Chief Commun Director of Mainter on 04/04/24, electri testing documentati twelve month perio Based on interview the Chief Commun Director of Mainter sleeping room has a some of which may electrical receptacle documentation for period was not avai observations with the Community Operat Maintenance reside and second floor ha non-hospital-grade These findings wer Administrator, the	e reviewed with the Chief Community Operations ector of Maintenance during		replaced or serviced durity year, have been inspected tested with documentation uploaded in TELS. A Maintenance audit be completed monthly formonths to ensure all recorrequiring annual inspectit testing has been completed monthly meeting the Quality Assurated performance Improvement monthly meeting for 6 mm QAPI is overseen by the Administrator. Any non-compliance with states result in staff education and disciplinary action. Administrator/design verify documentation thate receptacles requiring and inspection and testing has inspected and tested. How the corrective action will be monitored to ensuring all receptacles annual inspection and testing has inspected monthly formonths with results reported to ensuring all receptacles annual inspection and testing has inspected monthly formonths with results reported monthly formonths with	ed and in I tool will if 6 eptacles on and ited with uploaded ewed ance int (QAPI) onths, If will ind up to ee to it all inual ive been I tool, requiring esting, will if 6 inted to int (QAPI) inthe	

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	02	COMPLETED 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
HOOVEF	RWOOD			NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				95% is not achieved, an action plan will be developed to ensu compliance. Any non-complia with staff will result in staff education and up to disciplinal action.	re nce	
K 0918 SS=F Bldg. 02	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under for year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manu- loads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers are program for period components is est manufacturer requ- of maintenance ar and readily availat and circuits are mainured.	other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the becess shall be provided to inis capability for the life branches. Maintenance generator and transfer formed in accordance with e inspected weekly, and 30 minutes 12 times a intervals, and exercised inthis for 4 continuous hours. der load conditions include				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 04/04/2024 155001 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7001 HOOVER RD **HOOVERWOOD** INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0918 05/31/2024 What corrective action(s) will facility failed to ensure a written record of weekly be accomplished for those inspections for the generator was maintained for 4 residents found to have been weeks of the most recent 52 week period. NFPA affected by the deficient 99, 6.4.4.1.3 requires onsite generators shall be practice? maintained in accordance with NFPA 110, The emergency generator Standard for Emergency and Standby Power was inspected, tested according Systems. NFPA 110, 8.4.1 requires an Emergency to maintenance requirements Power Supply System (EPSS) including all found in the Health Care Facilities appurtenant components, shall be inspected Code, NFPA 110, and Life Safety weekly and exercised monthly. NFPA 99, Section Code. The generator is checked 6.4.4.2 requires a written record of inspection, weekly and monthly. performance, exercising period, and repairs for the How will you identify other generator to be regularly maintained and available residents having the potential for inspection by the authority having to be affected by the same jurisdiction. This deficient practice could affect all deficient practice and what residents, staff and visitors. corrective action will be taken? No residents were affected by Findings include: the alleged deficient practice. All residents, visitors, staff Based on review of Direct Supply TELS Logbook have the potential to be affected Documentation "Emergency Power Generator" by the alleged deficient practice with the Administrator, the Chief Community What measures will be put into Operations Officer and the Director of Maintenance during record review from 9:20 a.m. place or what systemic to 1:30 p.m. on 04/04/24, weekly emergency changes you will make to generator inspection documentation for three of ensure that the deficient four weeks in December 2023 and the week of practice does not recur? 02/17/24 was not available for review. Based on The emergency generator interview at the time of record review, the Chief was inspected, tested according Community Operations Officer and the Director of to maintenance requirements Maintenance stated the facility has one diesel found in the Health Care Facilities fired emergency generator and agreed weekly Code, NFPA 110, and Life Safety emergency generator inspection documentation Code. The generator is checked for the aforementioned four week period was not weekly and monthly.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>			COMPLETED	
		155001	B. WI	NG		04/04/2024	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t			OOVER RD		
HOOVEF	RWOOD				APOLIS, IN 46260		
11001				INDIAN	7.1 3210, 114 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	available for review. The Chief Community				A Maintenance audit tool,		
	Operations Officer and the Director of				ensuring emergency generato		
	Maintenance provided "Action Plan"				tested, will be completed mon	thly	
		d February 2024 at the time of			for six months with results		
		ted "disciplinary action taken			reported to the Quality Assura		
		bleting checks" because			Performance Improvement (Q	API)	
	-	vere not done according to			Committee		
	schedule".				Administrator/designee to		
					verify documentation is in TEL		
	These findings were				the emergency power system		
	Administrator, the Chief Community Operations				has been tested according to I	_SC	
	Officer and the Director of Maintenance during				standards		
	the exit conference.						
					How the corrective action(s)		
	3.1-19(b)				will be monitored to ensure t	he	
					deficient practice will not		
		review and interview, the			recur, i.e., what quality		
	1	ercise the generator for 1 of 12			assurance program will be p	ut	
		requirements of NFPA 110,			into place?		
		tandard for Emergency and			A Maintenance audit tool,	for	
		stems, Chapter 8.4.2. NFPA			The emergency generator, to		
		tates diesel generator sets in			ensure it has been tested		
		rcised at least once monthly,			according to LSC standards, v	vill	
		0 minutes, using one of the			be completed monthly for six		
	following methods:				months with results reported to)	
		intains the minimum exhaust			the Quality Assurance		
		recommended by the			Performance Improvement (Q	API)	
	manufacturer	4			Committee overseen by the	£	
	1 ' '	temperature conditions and at			Administrator. If a threshold o		
	·	cent of the EPS (Emergency			95% is not achieved, an action		
	Power Supply) nam	-			plan will be developed to ensu		
		es diesel-powered EPS	1		compliance. Any non complia	nce	
		not meet the requirements of			with staff will result in staff		
		ised monthly with the available			education and up to disciplina	У	
		Power Supply System) load and			action.		
		nnually with supplemental					
	`	est) at not less than 50 percent					
	_	te kW rating for 30 continuous					
		ess than 75 percent of the EPS					
	nameplate kW ratin	g for 1 continuous hour for a	1				

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER 155001 A. BUILDING 02 B. WING		COMPLETED 04/04/2024		
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
IAG	total test duration of	f not less than 1.5 continuous nt practice could affect all	TAG	BACIACI	DATE
	Findings include:				
	Documentation "Em Generator Under Lot the Chief Communi Director of Mainten from 9:20 a.m. to 1: documentation for J for review. Based or record review, the Cofficer and the Direfacility has one dies and agreed monthly for January 2024 was Chief Community Cobirector of Mainten documentation dated interview which stat for person not comp	Direct Supply TELS Logbook nergency Power Generator Test pad" with the Administrator, ty Operations Officer and the ance during record review 30 p.m. on 04/04/24, load testing anuary 2024 was not available on interview at the time of Chief Community Operations actor of Maintenance stated the el fired emergency generator load testing documentation as not available for review. The Operations Officer and the ance provided "Action Plan" d February 2024 at the time of ted "disciplinary action taken oleting checks" because were not done according to			
		Chief Community Operations ector of Maintenance during			
	3.1-19(b)				
K 0000					
Bldg. 03	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	The creation and submission of this plan of correction does no constitute an admission by this	t

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 03			COMPLETED	
		155001	B. WI	NG		04/04/2024	
		l	 	STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			OOVER RD		
HOOVEF	N/OOD				APOLIS, IN 46260		
TIOOVER	(11000			אואוטואוו	AI OLIO, III 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	483.90(a).				provider of any conclusion set	forth	
					in the statement of deficiencies	s, or	
	Survey Date(s): 04/04/24				of any violation of regulation. ٦	Γhis	
					provider respectfully requests	that	
	Facility Number: 0				the 2567 plan of correction be		
	Provider Number:	155001			considered the letter of credibl	le	
	AIM Number: 100	275310			allegation and requests desk		
					review (paper compliance) on	or	
	-	Code survey, Hooverwood was			after 5/31/2024.		
	_	ance with Requirements for					
	*	dicare/Medicaid, 42 CFR					
		Life Safety from Fire and the					
		National Fire Protection					
) 101, Life Safety Code (LSC).					
	-	ilding 03 were surveyed using					
	-	ealth Care Occupancies and 410					
	IAC 16.2.						
	-	ity with a basement consists of					
	-	e building which was					
		Type II (111) construction and					
		ed. Building 02 consists of the					
	_	ation of all first and second					
	•	ing room areas not in the					
		and the addition of resident					
		8, 1239, 1240 and 1241 on the					
		ent sleeping rooms 2238, 2239,					
		he second floor in 2018.					
	_	s of the renovated first floor					
		y, administrative support					
		room, gift shop and beauty					
		has a fire alarm system with the corridor and in all areas					
	_	The facility has smoke d to the fire alarm system					
		-					
		ent sleeping rooms. The					
		ty of 155 and had a census of					
	142 at the time of the	iis survey.					
	All areas where resi	idents have customary access					
	A THE ALCAS WHELE IES	idents have customaly access	1				l

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	03	COM	E SURVEY PLETED 4/2024
NAME OF P	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP CO OOVER RD APOLIS, IN 46260	DD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 0161	services were sprink riser room closet in no detached buildin	d all areas providing facility thered except for the sprinkler Building 02. The facility has gs providing facility services. hapleted on 04/10/24.				
SS=F Bldg. 03	Building Construct Building Construct 2012 NEW Building constructi	ion Type and Height ion Type and Height on type and stories meets less otherwise permitted by 8.1.6.7.				
		tion Type (332), II (222) Not allowed Any number of stories				
	2 II (111) non-sprinklered sprinklered	Not allowed Maximum 3 stories				
	3 II (000) non-sprinklered 4 III (211) sprinklered 5 IV (2HH) 6 V (111)	Not allowed Maximum 1 story				
	throughout by an a	Not allowed s must be sprinklered approved, supervised in accordance with section				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 03	(X3) DATE SURVEY COMPLETED 04/04/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	construction, the r basements, floors located, location of dates of approval. small floor plan of Based on observation failed to maintain the for new construction rooms. This deficient residents, staff and Findings include: Based on observation the Chief Community of Director of Maintent facility from 1:30 ptwo foot by six includings in the ceiling closet by the Human on the first floor whether decking of the sinterview at the time Chief Community of Director of Maintent drywall exposed the the second floor in the findings were administrator, the of the construction of the second floor in the second floor in the second floor in the ceiling of the second floor in the findings were administrator, the of the second floor in the second flo	ons with the Administrator, ty Operations Officer and the sance during a tour of the am. to 4:30 p.m. on 04/04/24, a section of drywall was ag of the sprinkler riser room an Resources Generalist's office sich exposed the underside of econd floor. Based on the observations, the Operations Officer and the sance agreed the missing the underside of the decking of the closet.	K 0161	What corrective action(s) will be accomplished for those residents found to have bee affected by the deficient practice? The ceiling drywall has bee repaired in the sprinkler room. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken No residents were affected 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 it place or what systemic changes you will make to ensure that the deficient practice does not recur? The ceiling drywall has be repaired in the sprinkler room. A Maintenance audit tool ensuring there is no missing ceiling drywall in the sprinkler room, will be completed month for six months with results reported to the Quality Assurate performance Improvement (Compared to the Quality Assurated to the	een i. ial en? ed by d ent nto een i. i, r thly ance

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 03	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF I	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY) Committee	(X5) E COMPLETION DATE
				How the corrective action(serial be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? A Maintenance audit too ensuring there is no missing drywall in the sprinkler room be completed monthly for six months with results reported the Quality Assurance Performance Improvement (Committee overseen by the Administrator. If a threshold 95% is not achieved, an actiplan will be developed to en compliance. Any non-comp with staff will result in staff education and up to disciplinaction.	put put pl, will to QAPI) of on sure liance
K 0351 SS=F Bldg. 03	an approved auto accordance with Installation of Spi In Type I and II of protection measu substituted for sp areas where state prohibit sprinklers Listed quick-resp	re protected throughout by somatic sprinkler system in NFPA 13, Standard for the rinkler Systems. Construction, alternative res are permitted to be rinkler protection in specific e and local regulations			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 03		COMPLETED	
		155001	B. W	ING		04/04/2024	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
140	compartments with In hospitals, sprink clothes closets of where the area of six square feet and the closet footpring Standard for Insta Systems. 18.3.5.1, 18.3.5.4, 9.7.1.1(1), 18.3.5. The facility failed to rooms were provided to ensure sprinkler of building. This deficit residents, staff and Findings include: Based on observation the Chief Community Director of Maintent facility from 1:30 p sprinkler riser room Human Resources Comprovided with an ausprinkler coverage in Based on interview observations, the Clofficer and the Director of Maintent facility from 1:30 p sprinkler riser room Human Resources Comprovided with an ausprinkler coverage in Based on interview observations, the Clofficer and the Director of Maintent facility from 1:30 p sprinkler riser room the Sprinkler riser room.	h patient sleeping rooms. It closes are not required in patient sleeping rooms the closet does not exceed does not exceed does required by NFPA 13, and a sprinkler coverage covers to as required by NFPA 13, and a sprinkler coverage in all portions of the building. The coverage in all portions of the building at the time of the coverage in all portions of the building. The coverage in all portions of the building at the time of the coverage in all portions of the building at the time of the coverage in all portions of the building. The coverage in all portions of the building at the time of the coverage in all portions of the building at the time of the coverage in all portions of the building. The coverage in all portions of the building at the time of the coverage in all portions of the building. The coverage in all portions of the building at the time of the coverage in all portions of the building.	K 0		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? An automatic sprinkler habeen installed in the sprinkler room. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. No residents were affected 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 in place or what systemic changes you will make to ensure that the deficient practice does not recur? An automatic sprinkler will installed in the sprinkler riser room. A Maintenance audit tool, ensuring there is an automatic	s riser al d by nt	05/31/2024

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	COMPLETED 14/04/2024
155001 B. WING 04	1/04/2024
	7/07/2027
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260	1
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
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.	