STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING -- B. WING	05/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 04/04/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/31/24 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this PSR survey to the Emergency Preparedness survey, Hooverwood was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 155 certified beds. At the time of the survey, the census was 147. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 06/04/24	E 0000	**The creating and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 6/28/2024**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	06/25/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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

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	(x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" and Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, the following was noted: a. weekly emergency generator inspection documentation for May 2024 was not available for review. b. monthly load testing documentation for May 2024 was not available for review. The aforementioned documentation listed the tasks to perform when conducting a weekly inspection and a monthly load test but a detailed report listing the findings for what was inspected and tested could not be retrieved from the TELS Logbook Documentation. Based on interview at the time of record review, the Director of Maintenance stated he could not view or retrieve weekly inspection documentation and monthly	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·No residents were affected by the alleged deficient practice. ·All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code,	06/28/2024

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	load testing documentation for May 2024 only that the task had been completed. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. ·A Maintenance audit tool, ensuring emergency generator is tested, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee ·Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·A Maintenance audit tool, for The emergency generator, to ensure it has been tested according to LSC standards, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/04/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/31/24 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this PSR survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 01 was surveyed using Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 01 consists of the memory care wing which is one story, the former kitchen, the basement and the former dining room on the first floor which is now a special events room. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 147 at the time of this survey. All areas where residents have customary access	K 0000	**The creating and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 6/28/2024**	

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	were sprinklered and all areas providing facility services were sprinklered except for the sprinkler riser room closet in Building 02. The facility has no detached buildings providing facility services. Quality Review conducted on 06/04/24			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors.	K 0345	**K345 Alarm system –Testing and Maintenance** **What corrective action(s) will be accomplished for those residents found to have been** The semi annual fire alarm system inspection has been completed **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice	06/28/2024

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	Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 07/24/23 with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, semi-annual fire alarm system inspection documentation six months after 07/24/23 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer agreed semi-annual inspection documentation for the facility's fire alarm system six months after 07/24/23 was not available for review. Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 05/21/24 with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, semi-annual fire alarm system inspection documentation six months after 07/24/23 was not available for review. In addition, the 05/21/24 inspection documentation only listed 25 initiating devices in the facility as being inspected or tested. Based on interview at the time of record review, the Director of Maintenance agreed the 05/21/24 fire alarm system inspection documentation did not list all initiating devices in the facility as being inspected or tested. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed semi annually, to ensure the fire alarm system inspection was completed A Maintenance audit tool, ensuring the fire alarm system, will be completed semi annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of the semi annual system inspection has been completed according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring the fire alarm system, will be completed semi annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non	

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	failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		compliance with staff will result in staff education and up to disciplinary action.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design			

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	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, weekly emergency generator inspection documentation for May 2024 was not available for review. The aforementioned documentation listed the tasks to perform when conducting a weekly inspection but a detailed report listing the findings for what was inspected could not be retrieved from the TELS Logbook Documentation. Based on interview at the time of record review, the Director of Maintenance stated he could not view or retrieve weekly inspection documentation for May 2024 only that the task had been completed.	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. A Maintenance audit tool, ensuring emergency generator is	06/28/2024

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	These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator for 1 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include:		tested, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, for The emergency generator, to ensure it has been tested according to LSC standards, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, monthly load testing documentation for May 2024 was not available for review. The aforementioned documentation listed the tasks to perform when conducting a monthly load test but a detailed report listing the findings for what was inspected and tested could not be retrieved from the TELS Logbook Documentation. Based on interview at the time of record review, the Director of Maintenance stated he could not view or retrieve monthly load testing documentation for May 2024 only that the task had been completed. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/04/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/31/24	K 0000	**The creating and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the**	

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	155001	A. BUILDING 02 B. WING	05/31/2024

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 02 and Building 03 were surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 02 consists of the 2017 general renovation of all first and second floor resident sleeping room areas not in the memory care wing and the addition of resident sleeping rooms 1238, 1239, 1240 and 1241 on the first floor and resident sleeping rooms 2238, 2239, 2240 and 2241 on the second floor in 2018. Building 03 consists of the renovated first floor main entrance lobby, administrative support offices, conference room, gift shop and beauty shop. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 147 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for the sprinkler riser room closet in Building 02. The facility has no detached buildings providing facility services.		**2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 6/28/2024**	

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	Quality Review conducted on 06/04/24			
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.			

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	18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 18.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 18.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors.	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The signage stating, “This door must stay locked at all times” has been removed and the exit sign above the door has been removed. **How will you identify other residents having the potential**	06/28/2024

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	Findings include: Based on observations with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during a tour of the facility from 10:50 a.m. to 11:10 a.m. on 05/31/24, the exit door for the facility at the 1B lounge which was not in the memory care wing was marked as a facility exit with an exit sign. The exit door was also marked with signage stating "This door must stay locked at all times" but the door was not locked and opened when pushed to open. The 1B lounge exit door exit discharge is into an outdoor courtyard which is shared with memory care exit discharges. One of one courtyard gates in the courtyard was magnetically locked and could be opened by entering a four digit code but the code was not posted at the courtyard exit. Based on interview at the time of the observations, the Director of Maintenance stated residents with clinical diagnoses to be in a secure wing were housed in the memory care wing but agreed the code was not posted at the courtyard exit door. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The signage stating, “This door must stay locked at all times” has been removed and the exit sign above the door has been removed. A Maintenance audit tool, ensuring there are no signs are posted on the doors, 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 are no signs are posted on the doors, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee	

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			overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 18.3.4.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents,	K 0345	**K345 Alarm system –Testing and Maintenance** **What corrective action(s) will be accomplished for those residents found to have been** The semi annual fire alarm system inspection has been completed **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice	06/28/2024

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	staff and visitors. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 07/24/23 with the Administrator, the Chief Community Operations Officer and the Director of Maintenance during record review from 9:20 a.m. to 1:30 p.m. on 04/04/24, semi-annual fire alarm system inspection documentation six months after 07/24/23 was not available for review. Based on interview at the time of record review, the Chief Community Operations Officer agreed semi-annual inspection documentation for the facility's fire alarm system six months after 07/24/23 was not available for review. Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 05/21/24 with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, semi-annual fire alarm system inspection documentation six months after 07/24/23 was not available for review. In addition, the 05/21/24 inspection documentation only listed 25 initiating devices in the facility as being inspected or tested. Based on interview at the time of record review, the Director of Maintenance agreed the 05/21/24 fire alarm system inspection documentation did not list all initiating devices in the facility as being inspected or tested. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference.		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** A Maintenance audit tool will be completed semi annually, to ensure the fire alarm system inspection was completed A Maintenance audit tool, ensuring the fire alarm system, will be completed semi annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of the semi annual system inspection has been completed according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring the fire alarm system, will be completed semi annually for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the	

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	This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0521 SS=F Bldg. 02	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents,	K 0521	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility is requesting a temporary waiver. The fire damper is scheduled to be inspected with proper documentation on 7/24/24. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	07/24/2024

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	staff and visitors. Findings include: Based record review with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician from 9:40 a.m. to 10:50 a.m. on 05/31/24, fire damper inspection and testing documentation within the most recent four year period was not available for review. Based on interview at the time of record review, the Director of Maintenance agreed fire damper inspection and testing documentation within the most recent four year period was not available for review. The Director of Maintenance provided a letter dated 05/29/24 from a fire damper inspection contractor stating the project start date to conduct fire damper inspection and testing for the facility was 06/27/24. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		The facility is requesting a temporary waiver. The fire damper is scheduled to be inspected with proper documentation on 7/24/24. A Maintenance audit tool, ensuring there is proper documentation that the fire damper has been inspected, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring there is proper documentation that the fire damper has been inspected, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary	
K 0541 SS=E Bldg. 02	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry			

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	Chutes 2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. *The fire resistance rating of chute charging room shall not be required to exceed one hour. *Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. *Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82 Based on observation and interview, the facility failed to maintain 1 of 4 trash chute doors to be self-closing and positive latching. LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.3.3.1.1 requires all chute loading doors into a trash chute shall be provided with a self-closing, positive latching frame and gasketed door assembly. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of Room 1148. Findings include: Based on observations with the Director of Nursing, the Director of Maintenance and Maintenance Technician during a tour of the facility from 10:50 a.m. to 11:10 a.m. on 05/31/24, the trash chute door in Room 1148 was equipped with a self-closing device and a positive latching device but the latching mechanism failed to protrude into the chute door frame when tested to close multiple times. Based on interview at the	K 0541	**What corrective action(s) will be accomplished for those residents found to have been** Facility is requesting a temporary waiver. Prolex compacting solutions has ordered the Parts but will not receive until 8/9/24 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic**	08/09/2024

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	time of the observations, the Director of Maintenance agreed the trash chute door did not latch into the chute door frame when tested to close multiple times and provided a written quote from a trash chute door installation contractor dated 05/23/24 stating four chute door assemblies in the facility were to be replaced within the next 30 days. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**changes you will make to ensure that the deficient practice does not recur?** Facility is requesting a temporary waiver. Prolex compacting solutions has ordered the Parts but will not receive until 8/9/24 Administrator/designee to ensure the south trash door is latching properly, weekly **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool will be completed monthly, to ensure The latch mechanism on the door frame of the trash chute by room 1148 has been fixed and latches properly and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 02	Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 weeks of the most recent 52 week period. NFPA	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/28/2024

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	99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, weekly emergency generator inspection documentation for May 2024 was not available for review. The aforementioned documentation listed the tasks to perform when conducting a weekly inspection but a detailed report listing the findings for what was inspected could not be retrieved from the TELS Logbook Documentation. Based on interview at the time of record review, the Director of Maintenance stated he could not view or retrieve weekly inspection documentation for May 2024 only that the task had been completed. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction		**practice?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The emergency generator was inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. The generator is checked weekly and monthly. A Maintenance audit tool, ensuring emergency generator is tested, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee Administrator/designee to verify documentation is in TELS of	

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	155001	A. BUILDING 02 B. WING	05/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to prevent recurrence. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator for 1 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during record review from 9:40 a.m. to 10:50 a.m. on 05/31/24, monthly		the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, for The emergency generator, to ensure it has been tested according to LSC standards, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	load testing documentation for May 2024 was not available for review. The aforementioned documentation listed the tasks to perform when conducting a monthly load test but a detailed report listing the findings for what was inspected and tested could not be retrieved from the TELS Logbook Documentation. Based on interview at the time of record review, the Director of Maintenance stated he could not view or retrieve monthly load testing documentation for May 2024 only that the task had been completed. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0000 Bldg. 03	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/04/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/31/24 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for	K 0000	**The creating and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 6/28/2024**	

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	155001	A. BUILDING 03 B. WING	05/31/2024

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	Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 02 and Building 03 were surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 02 consists of the 2017 general renovation of all first and second floor resident sleeping room areas not in the memory care wing and the addition of resident sleeping rooms 1238, 1239, 1240 and 1241 on the first floor and resident sleeping rooms 2238, 2239, 2240 and 2241 on the second floor in 2018. Building 03 consists of the renovated first floor main entrance lobby, administrative support offices, conference room, gift shop and beauty shop. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 147 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for the sprinkler riser room closet in Building 02. The facility has no detached buildings providing facility services. Quality Review conducted on 06/04/24			
K 0161 SS=F Bldg. 03	NFPA 101 Building Construction Type and Height Building Construction Type and Height			

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	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7. 18.1.6.4, 18.1.6.5 Construction Type 1 I (442), I (332), II (222) Not allowed non-sprinklered Any number of stories 2 II (111) Not allowed non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 1 story sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type for new construction in 1 of 2 sprinkler riser	K 0161	**What corrective action(s) will be accomplished for those residents found to have been**	06/28/2024

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	rooms. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician during a tour of the facility from 10:50 a.m. to 11:10 a.m. on 05/31/24, a three inch in diameter hole was noted in the ceiling of the sprinkler riser room closet by the Human Resources Generalist's office on the first floor which exposed the underside of the decking of the second floor. Based on interview at the time of the observations, the Director of Maintenance agreed the hole in the ceiling exposed the underside of the decking of the second floor in the closet. These findings were reviewed with the DON, the Director of Maintenance and the Maintenance Technician during the exit conference. This deficiency was cited on 04/04/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**affected by the deficient practice?** The drywall has been replaced in the sprinkler room **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were affected by the alleged deficient practice. All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The drywall has been replaced in the sprinkler room A Maintenance audit tool, ensuring there is no missing drywall in the sprinkler room, will be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A Maintenance audit tool, ensuring there is no missing drywall in the sprinkler room, will	

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			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.	