PRIN DEPARTMENT OF HEALTH AND HUMAN SERVICES FOI CENTERS FOR MEDICARE & MEDICAID SERVICES OM						
	NT OF DEFICIENCIES OF CORRECTION	TRECTION IDENTIFICATION NUMBER  155001  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/31/2024		
NAME OF PROVIDER OR SUPPLIER  HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, 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 BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 0000 Bldg	Preparedness Surv	1/24 0000001 155001 0275310	E 0000	The creating and submission this plan of correction does constitute an admission by provider of any conclusion of forth in the statement of deficiencies, or of any violator of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper	a not this set ition r	

The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:

Quality Review conducted on 06/04/24

E 0041
SS=F
Bldg. -Bldg. --

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

(i) and (ii) of this section.

Preparedness survey, Hooverwood was found not

The facility has 155 certified beds. At the time of

in compliance with Emergency Preparedness

Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR

the survey, the census was 147.

483.73.

TITLE (X6) DATE

compliance) on or after

6/28/2024

Jennifer Voss Administrator 06/25/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4WEU22 Facility ID: 000001 If continuation sheet Page 1 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES  AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	•	SURVEY LETED /2024
	OF PROVIDER OR SUPPLIE.	R	7001 H	ADDRESS, CITY, STATE, ZIP COI OOVER RD APOLIS, IN 46260	D	
(X4) ID PREFIX TAG	REGULATORY O  \$483.73(e), \$485  (e) Emergency ar  The [LTC facility a implement emergency are a complement emergency and a complement emergency and a comple	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION .625(e) nd standby power systems. and the CAH] must ency and standby power n the emergency plan set	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	§482.15(e)(1), §48 Emergency generator must be the location requirements To the location requirements TIA and TIA 12-4), and structure is built of structure or building the location and TIA 12-4), and structure or building the location of the location of the location, testing requirements four	n (a) of this section.  83.73(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 nd TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, nd NFPA 110, when a new or when an existing				
	Emergency gene and LTC facilities source to power of have a plan for he power systems of emergency, unless	3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the as it evacuates.				
	§483.73(g), and 0	Q462.15(II), LTC at CAHs §485.625(g):] corporated by reference in				

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 2 of 30

	INT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001		ILDING	NSTRUCTION	(X3) DATE COMPI 05/31	LETED	
	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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	RE	(X5) COMPLETION DATE	
	reference by the I Federal Register 552(a) and 1 CFF the material from You may inspect Information Reson Boulevard, Baltim Archives and Rec (NARA). For infor this material at Normal States of Information Reson Boulevard, Baltim Archives and Rec (NARA). For information this material at Normal States of Information Inf	Protection Association, 1 rk, 9, www.nfpa.org,  Ith Care Facilities Code, led 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,  ife Safety Code, 2012						

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 3 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING COMPLETED		
		155001	B. W	ING		05/31/2024
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	DROWIDERIG BY AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	REGULATORY OR  (x) TIA 12-3 to NF 22, 2013.  (xi) TIA 12-4 to NF 22, 2013.  (xiii) NFPA 110, S Standby Power Sy including TIAs to c 2009.  Based on record rev failed to implement inspection, testing a found in the Health 110, and Life Safety CFR 483.73(e)(2). affect all residents,  Findings include:  Based on review of Documentation "En and Direct Supply T "Emergency Power Under Load" with t the Director of Main	ELSC IDENTIFYING INFORMATION PA 101, issued October  FPA 101, issued October  tandard for Emergency and ystems, 2010 edition, chapter 7, issued August 6,  view and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA by Code in accordance with 42 This deficient practice could	E 0		CROSS-REFERENCED TO THE APPROPRIA	DATE  DATE  DATE  DATE
	a. weekly emergeno	2/24, the following was noted:			·No residents were affected the alleged deficient practice	
	review.	May 2024 was not available for			·All residents, visitors, staff the potential to be affected by	
	2024 was not availa				alleged deficient practice	
		l documentation listed the			What measures will be put in	nto
		nen conducting a weekly			place or what systemic	
		onthly load test but a detailed			changes you will make to	
		adings for what was inspected			ensure that the deficient	
		t be retrieved from the TELS			practice does not recur?	
		tation. Based on interview at			The emergency generator	
		eview, the Director of			inspected, tested according to	
		he could not view or retrieve			maintenance requirements fo	
	weekly inspection d	locumentation and monthly			in the Health Care Facilities C	Code,

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 4 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING  155001 B. WING		ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  05/31/2024	
NAME OF F	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF load testing docume that the task had bee These findings were Director of Mainter Technician during t This deficiency was	e reviewed with the DON, the nance and the Maintenance he exit conference.  s cited on 04/04/24. The facility a systemic plan of correction	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIVE DEFICIENCY)  NFPA 110, and Life Safety Co. The generator is checked were and monthly.  A Maintenance audit tool, ensuring emergency generator tested, will be completed more for six months with results reported to the Quality Assurate Performance Improvement (Committee  Administrator/designee to verify documentation is in TEI the emergency power system has been tested according to standards  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place?  A Maintenance audit tool, for the emergency generator, to ensure it has been tested according to LSC standards, be completed monthly for six months with results reported to the Quality Assurance  Performance Improvement (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. Any non compliance with staff will result in staff education and up to disciplinate action.	DATE  DATE  DODE.  DODE  DATE  DODE  DATE  DATE

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 5 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  05/31/2024		
		155001	B. WI	NG		05/31/20	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEI RWOOD	R		7001 H	ADDRESS, CITY, STATE, ZIP COD IOOVER RD IAPOLIS, 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 APPROPRIA	TE C	OMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
K 0000							
Bidg. 01	Code Recertification conducted on 04/04 Indiana Department 42 CFR 483.90(a).  Survey Date: 05/3  Facility Number: 09 Provider Number: AIM Number: 1000 At this PSR survey in compliance with in Medicare/Medic Life Safety from Finational Fire Prote Life Safety Code (I using Chapter 19, I Occupancies and 4 This two story facilithree portions of or determined to be of was fully sprinkler memory care wing kitchen, the basemed on the first floor where the safety code (I using Chapter 19, I Occupancies and 4 This two story facilithree portions of or determined to be of was fully sprinkler memory care wing kitchen, the basemed on the first floor where the safety smoke detection in open to the corridor detectors hard wire installed in all residuation and the safety of the	noncomplete the control of the contr	K 0	000	The creating and submission this plan of correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violat 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	not his eet ion	

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 6 of 30

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 05/31/2024		
NAME OF P	ROVIDER OR SUPPLIER		700	EET ADDRESS, CITY, STATE, ZIP COD 11 HOOVER RD DIANAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	services were sprind riser room closet in no detached buildin Quality Review con NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm system Maintenance A fire alarm system in accordance with complying with the National Electric Continual Fire Alarm Records of system and testing are ready as a second testing asecond testing as a second testing as a second testing as a second	n - Testing and n - Testing and m is tested and maintained n an approved program e 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 of LSC Sections 19.3.4.5.1 and tion 14.3.1 states that unless by 14.3.2, visual inspections in accordance with the 14.3.1, or more often if required ring jurisdiction. Table 14.3.1 wing must be visually ually: ble signals itors (e.g. duct detectors, manual eat detectors, smoke detectors,	K 0345	K345 Alarm system –Test and Maintenance What corrective action(s) with be accomplished for those residents found to have bee a The semit annual fire alasystem inspection has been completed. How will you identify other residents having the potentiation be affected by the same deficient practice and what corrective action will be taken No residents were affected by the alleged deficient practice and what corrective action will be taken action.	II  n rm  dal  en? eted dice. aff ted

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 7 of 30

PRINTED: 06/26/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONS	TRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG	01	COMPL	ETED
		155001	B. WING			05/31/2024	
			STF	REET ADI	ORESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			OVER RD		
HOOVE	RWOOD				POLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREF	ΊΧ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	G	DEFICIENCY)		DATE
				V	Vhat measures will be put in	to	
	Findings include:			-	place or what systemic		
				C	changes you will make to		
		e fire alarm system inspection		е	ensure that the deficient		
		Alarm Inspection and Testing		p	practice does not recur?		
		ion dated 07/24/23 with the					
		Chief Community Operations			A Maintenance audit tool		
		rector of Maintenance during			e completed semi annually, to	0	
		n 9:20 a.m. to 1:30 p.m. on			ensure the fire alarm system		
	· ·	nual fire alarm system inspection		ir	nspection was completed		
		months after 07/24/23 was not			A Maintenance audit tool		
		w. Based on interview at the			ensuring the fire alarm system		
		ew, the Chief Community			vill be completed semi annual	•	
	_	agreed semi-annual inspection			or 6 months with results repor	ted	
		the facility's fire alarm system			o the Quality Assurance		
		7/24/23 was not available for		F	Performance Improvement (Q	API)	
	review.			C	Committee		
					Administrator/designee to		
		f the fire alarm system			erify documentation is in TEL	S of	
	-	tor's "Fire Alarm Inspection			he semi annual system		
	_	documentation dated 05/21/24			nspection has been complete	ed	
		of Nursing (DON), the Director		а	according to LSC standards		
		d the Maintenance Technician					
		ew from 9:40 a.m. to 10:50 a.m.					
		annual fire alarm system					
	_	entation six months after			low the corrective action(s)	_	
		vailable for review. In addition,			vill be monitored to ensure t	he	
	_	ction documentation only listed			leficient practice will not		
		es in the facility as being			ecur, i.e., what quality		
		. Based on interview at the			ssurance program will be pr	ut	
		ew, the Director of Maintenance		"	nto place?		
	_	4 fire alarm system inspection			A Maintenance audit tool,		
		not list all initiating devices in			ensuring the fire alarm system		
	the facility as being	g inspected or tested.			vill be completed semi annual	-	
	TI (* 1)	1 14 4 2007 4			or 6 months with results repor	ted	
	_	re reviewed with the DON, the			o the Quality Assurance	. 51)	
		nance and the Maintenance			Performance Improvement (Q	,	
	Technician during	the exit conference.		0	Committee monthly meeting for	or 6	

This deficiency was cited on 04/04/24. The facility

Administrator. Any non

months, QAPI is overseen by the

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	ľ	UILDING	onstruction 01	(X3) DATE COMPI 05/31	LETED
	PROVIDER OR SUPPLIER	<b>R</b>		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD		
HOOVE	RWOOD			INDIAN	APOLIS, IN 46260		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	to prevent recurrence	t a systemic plan of correction ce.			compliance with staff will resu staff education and up to disciplinary action.	lit in	
	3.1-19(b)				, a.c., pa., a.c.		
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01	Electrical Systems	s - Essential Electric					
	System Maintena	_					
	_	other alternate power					
		iated equipment is capable					
		ce within 10 seconds. If the					
		on is not met during the					
		ocess shall be provided to					
	I	this capability for the life					
	•	branches. Maintenance					
	_	generator and transfer					
		ormed in accordance with					
	NFPA 110.						
		re inspected weekly,					
		oad 30 minutes 12 times a					
	1 -	intervals, and exercised					
		onths for 4 continuous hours.					
		nder load conditions include					
	'	ated cold start and					
		ual transfer of all EES					
		nducted by competent enance and testing of stored					
	· •	urces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and a					
		dically exercising the					
		tablished according to					
		uirements. Written records	1				
	1	nd testing are maintained					
		ble. EES electrical panels					
	•	narked, readily identifiable,					
		n normal power circuits.					
	•	ssibility of damage of the					
		r source is a design					
		<u> </u>					

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 9 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/31/2024 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 06/28/2024 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 Findings include: by 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 Director of Nursing (DON), the Director of Maintenance and the Maintenance Technician What measures will be put into during record review from 9:40 a.m. to 10:50 a.m. place or what systemic on 05/31/24, weekly emergency generator changes you will make to inspection documentation for May 2024 was not ensure that the deficient available for review. The aforementioned practice does not recur? documentation listed the tasks to perform when The emergency generator conducting a weekly inspection but a detailed was inspected, tested according report listing the findings for what was inspected to maintenance requirements could not be retrieved from the TELS Logbook found in the Health Care Facilities Documentation. Based on interview at the time of Code, NFPA 110, and Life Safety record review, the Director of Maintenance stated Code. The generator is checked he could not view or retrieve weekly inspection weekly and monthly. documentation for May 2024 only that the task A Maintenance audit tool, had been completed. ensuring emergency generator is

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155001	B. WI	NG		05/31/	/2024
NAME OF P	ROVIDER OR SUPPLIER	3		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	· ·	ICY MUST BE PRECEDED BY FULL			.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
PREFIX TAG	These findings were Director of Mainter Technician during to This deficiency was failed to implement to prevent recurrence 3.1-19(b)  2. Based on record facility failed to examonths to meet the 2010 Edition, the S Standby Powers Sy 110, Section 8.4.2 service shall be exercised an immum of 3 following methods: (1) Loading that magas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) nam Section 8.4.2.3 statinstallations that do 8.4.2 shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not inameplate kW ratin total test duration of	e reviewed with the DON, the nance and the Maintenance the exit conference.  Is cited on 04/04/24. The facility that a systemic plan of correction correction correction to the exit conference of NFPA 110, tandard for Emergency and testems, Chapter 8.4.2. NFPA states diesel generator sets in the process of the exit conference of the exit commended by the states diesel generator sets in the exit commended by the exit commended by the exit conference of the EPS (Emergency		PREFIX TAG	tested, will be completed monifor six months with results reported to the Quality Assura Performance Improvement (Q Committee Administrator/designee to verify documentation is in TEL the emergency power system has been tested according to 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 printo place?  A Maintenance audit tool The emergency generator, to ensure it has been tested according to LSC standards, where the Quality Assurance Performance Improvement (Q Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non complian with staff will result in staff education and up to disciplinal action.	thly ince API) c.S of ithe ut the API) o API) o API) o ince	DATE
	residents, staff and	VISILOI'S.					
	Findings include:						

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION			COMPLETED 05/31/2024	
NAME OF P	ROVIDER 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
	Documentation "Em Generator Under Lo Nursing (DON), the the Maintenance Te from 9:40 a.m. to 10 load testing docume available for review documentation lister conducting a month report listing the fin and tested could not Logbook Document the time of record re Maintenance stated monthly load testing only that the task has These findings were Director of Mainten Technician during the time deficiency was	e reviewed with the DON, the nance and the Maintenance he exit conference.  s cited on 04/04/24. The facility a systemic plan of correction			
K 0000					
Bldg. 02	Code Recertification conducted on 04/04	sit (PSR) to the Life Safety n and State Licensure Survey /24 was conducted by the of Health in accordance with	K 0000	The creating and submission this plan of correction does constitute an admission by t provider of any conclusion s forth in the statement of deficiencies, or of any violat of regulation. This provider respectfully requests that the	not his et ion

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 12 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 02 COMPLETED  B. WING 05/31/2024			
NAME OF P	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX		SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	DATE
	found not in complication from the Subpart 483.90(a), 2012 Edition of the Association (NFPA Building 02 and Bu Chapter 18, New Hold 16.2.  This two story facil three portions of on determined to be of was fully sprinklere 2017 general renovation floor resident sleeping memory care wing sleeping rooms 123 first floor and reside 2240 and 2241 on the Building 03 consists main entrance lobby offices, conference shop. The facility home to the corridor of the subpart of the corridor of the subpart of the corridor of the subpart of	155001		2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 6/28/2024	
	installed in all resid	ent sleeping rooms. The ty of 155 and had a census of			
	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.			

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 13 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155001		A. BUILDING B. WING	02	COMP	E SURVEY PLETED 1/2024	
NAME OF F	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP O OOVER RD IAPOLIS, IN 46260	COD	
(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 COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Quality Review con	ducted on 06/04/24				
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 neused, 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. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (at an attended lock space); and both the control of the control	king arrangements for the eds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1,				

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 14 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SU	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>02</u> COMPLET	COMPLETED	
155001 B. WING 05/31/20	024	
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER  7001 HOOVER RD		
HOOVERWOOD INDIANAPOLIS, IN 46260		
1100 VEI (VVOOD		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
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  K 0222 What corrective action(s) will	06/28/2024	
failed to ensure the means of egress through 1 of  be accomplished for those	00/28/2024	
10 exits was readily accessible for residents residents residents found to have been		
without a clinical diagnosis requiring specialized  without a clinical diagnosis requiring specialized  affected by the deficient		
security measures. Doors within a required means practice?		
of egress shall not be equipped with a latch or  The signage stating, "This		
lock that requires the use of a tool or key from the door must stay locked at all		
egress side unless otherwise permitted by LSC times" has been removed and the		
18.2.2.2.4. Door-locking arrangements shall be exit sign above the door has been		
permitted in accordance with 18.2.2.2.5.2. This removed.		
deficient practice could affect over 20 residents,  How will you identify other		
staff and visitors.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE COMPI 05/31	LETED	
NAME OF I	PROVIDER OR SUPPLIE	R	700	EET ADDRESS, CITY, STATE, ZIP CO 1 HOOVER RD	OD	
HOOVEF	RWOOD		IND	IANAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORE	RECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				to be affected by the s		
	Findings include:			deficient practice and		
	D 1 1 4	'4 4 B' ( C		corrective action will be		
		ons with the Director of		No residents were		
		e Director of Maintenance and echnician during a tour of the		by the alleged deficien	•	
		a.m. to 11:10 a.m. on 05/31/24,		All residents, visite have the potential to be		
		e facility at the 1B lounge which		by the alleged deficient		
		nory care wing was marked as a		by the alleged delicient	practice	
		n exit sign. The exit door was		What measures will be	a nut into	
		ignage stating "This door must		place or what systemi		
				changes you will make		
	stay locked at all times" but the door was not locked and opened when pushed to open. The 1B			ensure that the deficie		
	lounge exit door exit discharge is into an outdoor			practice does not recu		
	_	shared with memory care exit		The signage statir		
		f one courtyard gates in the		door must stay locked a	-	
	_	netically locked and could be		times" has been remov		
		g a four digit code but the code		exit sign above the doo		
	was not posted at the	he courtyard exit. Based on		removed.		
	interview at the tim	ne of the observations, the		A Maintenance au	ıdit tool,	
	Director of Mainter	nance stated residents with		ensuring there are no s	signs are	
	clinical diagnoses t	to be in a secure wing were		posted on the doors, w	ill be	
	housed in the mem	ory care wing but agreed the		completed monthly for	six months	
	code was not poste	d at the courtyard exit door.		with results reported to	the Quality	
				Assurance Performanc		
	_	re reviewed with the DON, the		Improvement (QAPI) C	ommittee	
	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.					
				How the corrective ac		
				will be monitored to e		
				deficient practice will		
				recur, i.e., what quality		
				assurance program w	III be put	1
	2.1.10(b)			into place?	dit to al	
	3.1-19(b)			A Maintenance au	•	
				ensuring there are no s posted on the doors, w	•	
				completed monthly for		1
				with results reported to		
				Assurance Performanc	•	1
				Improvement (QAPI) C		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	î ´	(X2) MULTIPLE CONSTRUCTION       (X3) DA         A. BUILDING       02       COM         B. WING       05/	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			700	EET ADDRESS, CITY, STATE, ZIP COD 1 HOOVER RD NANAPOLIS, IN 46260	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	NFPA 101 Fire Alarm Syster Maintenance Fire Alarm Syster Maintenance A fire alarm syste in accordance wit complying with the National Electric ( National Fire Alar Records of syster and testing are re 9.6.1.3, 9.6.1.5, N Based on record refailed to maintain 1 accordance with NI Code as required by	n - Testing and n - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance		CROSS-REFERENCED TO THE APPROP	tor. If I be ance. aff will up to  esting 06/28/2024  will
	otherwise permitted shall be performed schedules in Table by the authority has states that the followinspected semi-annua. Control unit troub. Remote annunciate. Initiating devices fire alarm boxes, he etc.)  d. Notification applee. Magnetic hold-opter shall be performed by the permitted states and the performance of the permitted by the permitted shall be performed by the permitted shall be performed by the permitted by the permitted shall be performed by the permitted shall be performed by the permitted by th	I by 14.3.2, visual inspections in accordance with the 14.3.1, or more often if required ving jurisdiction. Table 14.3.1 wing must be visually ually: ble signals ators (e.g. duct detectors, manual eat detectors, smoke detectors, iances		residents found to have be The semi annual fire a system inspection has beer completed How will you identify othe residents having the potent to be affected by the same deficient practice and what corrective action will be tan No residents were affected by the alleged deficient practice and what the potential to be affected by the alleged deficient practice.	darm  r ntial  t ken? ected ctice. staff ected

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 17 of 30

06/26/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

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 05/31/2024 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE staff and visitors. What measures will be put into Findings include: place or what systemic changes you will make to Based review of the fire alarm system inspection ensure that the deficient contractor's "Fire Alarm Inspection and Testing practice does not recur? Form" documentation dated 07/24/23 with the Administrator, the Chief Community Operations A Maintenance audit tool will Officer and the Director of Maintenance during be completed semi annually, to record review from 9:20 a.m. to 1:30 p.m. on ensure the fire alarm system 04/04/24, semi-annual fire alarm system inspection inspection was completed documentation six months after 07/24/23 was not A Maintenance audit tool, available for review. Based on interview at the ensuring the fire alarm system, time of record review, the Chief Community will be completed semi annually Operations Officer agreed semi-annual inspection for 6 months with results reported documentation for the facility's fire alarm system to the Quality Assurance six months after 07/24/23 was not available for Performance Improvement (QAPI) review. Committee Administrator/designee to Based on review of the fire alarm system verify documentation is in TELS of inspection contractor's "Fire Alarm Inspection the semi annual system and Testing Form" documentation dated 05/21/24 inspection has been completed with the Director of Nursing (DON), the Director according to LSC standards 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 How the corrective action(s) 07/24/23 was not available for review. In addition, will be monitored to ensure the the 05/21/24 inspection documentation only listed deficient practice will not 25 initiating devices in the facility as being recur, i.e., what quality inspected or tested. Based on interview at the assurance program will be put time of record review, the Director of Maintenance into place? agreed the 05/21/24 fire alarm system inspection A Maintenance audit tool, documentation did not list all initiating devices in ensuring the fire alarm system, the facility as being inspected or tested. will be completed semi annually

These findings were reviewed with the DON, the

Director of Maintenance and the Maintenance

Technician during the exit conference.

for 6 months with results reported

Performance Improvement (QAPI)

Committee monthly meeting for 6 months, QAPI is overseen by the

to the Quality Assurance

ENTERSTO	K WEDICHKE & WEDIC	THE SERVICES			GMB 1(0: 0)20 02)		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE Co	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED		
155001			B. WING 05/31/2024				
NAME OF I	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COD IOOVER RD IAPOLIS, IN 46260			
(V4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	ID		(V5)		
(X4) ID		STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE		
	-	s cited on 04/04/24. The facility		Administrator. Any non			
	-	t a systemic plan of correction		compliance with staff will result	in		
	to prevent recurren	ce.		staff education and up to			
	3.1-19(b)			disciplinary action.			
K 0521	NFPA 101						
SS=F	HVAC						
Bldg. 02	HVAC						
D.ag. 02	Heating, ventilation	on, and air conditioning shall nd shall be installed in					
	' '	he manufacturer's					
	specifications.	o manaratarer e					
	18.5.2.1, 19.5.2.1	0.2					
		view and interview the facility	K 0521	What corrective action(s) will	07/24/2024		
		fire dampers in the facility were	K 0321	1	07/24/2024		
		ided necessary maintenance at		be accomplished for those residents found to have been			
		ars in accordance with NFPA		affected by the deficient			
		quires heating, ventilating and		practice?			
		VAC) ductwork and related		The facility is requesting a			
		in accordance with NFPA 90A,		temporary waiver. The fire dam	•		
		stallation of Air-Conditioning		is scheduled to be inspected w	ith		
		stems. NFPA 90A, 2012		proper documentation on			
		4.8.1 states fire dampers shall be		7/24/24.			
		rdance with NFPA 80, Standard		How will you identify other			
		Other Opening Protectives.		residents having the potential	ı		
		ition, Section 19.4.1 states each		to be affected by the same			
	damper shall be tes	ted and inspected 1 year after		deficient practice and what			
	installation. The te	est and inspection frequency		corrective action will be taken	ı?		
	shall be every 4 year	ars. If the damper is equipped		No residents were affected	t		
	with a fusible link,	the link shall be removed for		by the alleged deficient practic	e.		
	testing to ensure fu	ll closure and lock-in-place if		All residents, visitors, staff			
		lamper shall not be blocked		have the potential to be affected			
		way. All inspections and		by the alleged deficient practice			
	· ·	umented, indicating the		,			
		damper, date of inspection,		What measures will be put int	0		
		and deficiencies discovered.		place or what systemic	Ť		
	^	shall have a space to indicate		changes you will make to			
		deficiencies were corrected.		ensure that the deficient			
		tice could affect all residents,					
	I mis deficient pract	ace could affect all residefits,	I	practice does not recur?	1		

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 19 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	of correction (X1) Provider/supplier/clia (DENTIFICATION NUMBER (155001)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02		SURVEY LETED /2024
NAME OF I	PROVIDER OR SUPPLIER RWOOD	7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, 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 CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	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 temporary waiver. The find is scheduled to be inspect proper documentation on A Maintenance auditensuring there is proper documentation that the find damper has been inspect be completed monthly for months with results report the Quality Assurance Performance Improvement Committee  How the corrective action will be monitored to ensuring the monitored to ensuring there is proper documentation that the find damper has been inspect be completed monthly for months with results report the Quality Assurance Performance Improvement Committee overseen by the Administrator. If a thresh 95% is not achieved, an a plan will be developed to compliance. Any non corwith staff will result in staff education and up to discipline in the complete in the staff education and up to discipline in the find the compliance. Any non corwith staff will result in staff education and up to discipline in the compliance in the complete in the compliance.	re damper cted with 7/24/24. It tool, re ted, will resix ted to re ted, will residue ted, will resix ted to re ted, will resix ted to resix ted to re ted, will resix ted to r	
K 0541 SS=E Bldg. 02	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu Rubbish Chutes, Incinerators, and Laundry				

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 20 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. Bl	A. BUILDING <u>02</u> COMPLET		ETED		
155001		B. W	B. WING 05/31/2024			2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			OOVER RD		
HOOVER	RWOOD			INDIAN	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	ΛΤΕ.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Chutes						
	2012 NEW	coincretors and laundry					
		ncinerators, and laundry ly with the provisions of					
		s otherwise specified in					
	18.5.4.2.	s otherwise specified in					
		nce rating of chute charging					
		required to exceed one					
	hour.	required to exoced one					
		ute or linen chute shall be					
	-	omatic extinguishing					
		rdance with Section 9.7.					
		scharge into a trash					
		sed for no other purpose					
		cted in accordance with					
	8.7.						
	18.5.4.2, 8.7, 9.5,	9.7, NFPA 82					
		on and interview, the facility	K 0	541	What corrective action(s) will	l l	08/09/2024
		of 4 trash chute doors to be			be accomplished for those		
		sitive latching. LSC 9.5.2			residents found to have been	n	
	_	s shall be installed and			Facility is requesting a		
	_	PA 82, 2009 Edition. NFPA 82,			temporary waiver. Prolex		
		requires all chute loading doors			compacting solutions has ord		
		nall be provided with a			the Parts but will not receive u	ıntil	
	O	re latching frame and gasketed			8/9/24		
	-	s deficient practice could affect					
	over 20 residents, si	taff and visitors in the vicinity			How will you identify other	-1	
	01 K00III 1148.				residents having the potentia	aı	
	Findings include:				to be affected by the same deficient practice and what		
	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,				corrective action will be take	n2	
					No residents were affect		
					by the alleged deficient practi		
					All residents, visitors, sta		
					have the potential to be affect		
	-	in Room 1148 was equipped			by the alleged deficient practic		
		device and a positive latching			, 5 5 p.do		
	_	ing mechanism failed to					
		ute door frame when tested to			What measures will be put in	nto	
	close multiple times. Based on interview at the				place or what systemic		

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 21 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>02</u>	(X3) DATE SURVEY  COMPLETED  05/31/2024
NAME OF I	PROVIDER OR SUPPLIEI	R	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION tions, the Director of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  changes you will make to	(X5) COMPLETION DATE
	Maintenance agree latch into the chute close multiple time	d the trash chute door did not door frame when tested to s and provided a written quote door installation contractor		ensure that the deficient practice does not recur?  Facility is requesting a	
	dated 05/23/24 stat	ing four chute door assemblies to be replaced within the next		temporary waiver. Prolex compacting solutions has ord the Parts but will not receive u 8/9/24	ı
	Director of Mainter	e reviewed with the DON, the nance and the Maintenance the exit conference.		Administrator/designee to ensure the south trash door is latching properly, weekly	
	1	s cited on 04/04/24. The facility t a systemic plan of correction ce.		How the corrective action(s)	
	3.1-19(b)			will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place?  A Maintenance audit tool be completed monthly, to ensurance of the trash chute by room 1148 has been fixed and latch properly and the results of the monitoring will be reviewed duthe Quality Assurance Performance Improvement (Quantity monthly meeting for 6 months QAPI is overseen by the Administrator. Any non compliance with staff will result staff education and up to disciplinary action.	will ure door om es es uring API)
K 0918 SS=F	NFPA 101 Electrical System	s - Essential Electric Syste			

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 22 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 02 COMPLETED			ETED
155001		B. W	B. WING 05/31/2024				
NAME OF T	DROLUDED OF CURRY WA			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	Š.			OOVER RD		
HOOVER	RWOOD			INDIAN	APOLIS, 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
Bldg. 02	1	s - Essential Electric					
	System Maintenar	_					
	_	other alternate power					
		iated equipment is capable					
		ce within 10 seconds. If the					
		n is not met during the					
		ocess shall be provided to					
	1	his capability for the life					
	1	branches. Maintenance					
		generator and transfer					
	I	ormed in accordance with					
	NFPA 110.	- 5					
		e inspected weekly,					
		oad 30 minutes 12 times a					
	1 -	intervals, and exercised					
	· ·	nths for 4 continuous hours.					
		der load conditions include					
	a complete simula						
		ual transfer of all EES					
		nducted by competent					
	I '	nance and testing of stored					
		rces (Type 3 EES) are in IFPA 111. Main and feeder					
		re inspected annually, and a					
		•					
		dically exercising the tablished according to					
	-	uirements. Written records					
		nd testing are maintained					
		ble. EES electrical panels					
	1	·					
	and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the						
	I	source is a design					
	consideration for r						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.10	•					
		review and interview, the	K 0	918	What corrective action(s) wil	,	06/28/2024
		sure a written record of weekly	K U	710	be accomplished for those	•	00/20/2024
	1	generator was maintained for 4			residents found to have been	,	
	1 -	ecent 52 week period. NFPA			affected by the deficient	-	
		1					

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 23 of 30

CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER		STREET			
HOOVEDWOOD		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD			
HOOVERWOOD		INDIAI	NAPOLIS, IN 46260		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIE ST BE PRECEDED BY FULL DENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
99, 6.4.4.1.3 requires onsi maintained in accordance Standard for Emergency a Systems. NFPA 110, 8.4. Power Supply System (EF appurtenant components, weekly and exercised mor 6.4.4.2 requires a written performance, exercising performance, exercis	te generators shall be with NFPA 110, and Standby Power 1 requires an Emergency PSS) including all shall be inspected athly. NFPA 99, Section record of inspection, eriod, and repairs for the maintained and available ority having at practice could affect all s.  E Supply TELS Logbook cy Power Generator" and (DON), the Director faintenance Technician and 9:40 a.m. to 10:50 a.m. agency generator for May 2024 was not aforementioned asks to perform when the ection but a detailed for what was inspected and the TELS Logbook and interview at the time of the or of Maintenance stated even weekly inspection 224 only that the task weed with the DON, the and the Maintenance to conference.		The emergency generate was inspected, tested according to maintenance requirements found in the Health Care Facil Code, NFPA 110, and Life Sac Code. The generator is check weekly and monthly.  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 by the alleged deficient practice. All residents, visitors, state have the potential to be affected by the alleged deficient practice. What measures will be put implace or what systemic changes you will make to ensure that the deficient practice does not recur?  The emergency generate was inspected, tested according to maintenance requirements found in the Health Care Facil Code, NFPA 110, and Life Sac Code. The generator is check weekly and monthly.  A Maintenance audit tool ensuring emergency generator tested, will be completed monter for six months with results reported to the Quality Assurate Performance Improvement (Quality Assurate Performance Improvement (	or ng ities fety ked al en? ed ce. Iff ed ce ento or ng ities fety ked ce ento or ng ities fety ked ed ce. Iff ed ce ento or ng ities fety ked ed ce. Iff ed ce ento or ng ities fety ked ed ento en ce en	

155001 B. WING	COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER  HOOVERWOOD  STREET ADDRES  7001 HOOVE  INDIANAPOL	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	PROVIDER'S PLAN OF CORRECTION CCH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (X5)  COMPLETION DATE
	mergency power system been tested according to LSC dards
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	the corrective action(s) be monitored to ensure the cient practice will not r, i.e., what quality rance program will be put place?  A Maintenance audit tool, for cemergency generator, to re it has been tested rding to LSC standards, will completed monthly for six hs with results reported to coulity Assurance commance Improvement (QAPI) mittee overseen by the consistrator. If a threshold of cis not achieved, an action will be developed to ensure coliance. Any non compliance staff will result in staff ation and up to disciplinary n.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING 02 COMPLETED  B. WING 05/31/2024			
NAME OF P	PROVIDER OR SUPPLIER		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  LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	load testing docume available for review documentation liste conducting a month report listing the fin and tested could not Logbook Document the time of record re Maintenance stated monthly load testing only that the task has These findings were Director of Mainten Technician during to	e reviewed with the DON, the nance and the Maintenance he exit conference.  s cited on 04/04/24. The facility a systemic plan of correction	TAG	DEFICIENCY	DATE
K 0000					
Bldg. 03	Code Recertification conducted on 04/04 Indiana Department 42 CFR 483.90(a).  Survey Date: 05/31  Facility Number: 0  Provider Number: 1000  At this Life Safety 0	00001 155001	K 0000	The creating and submission this plan of correction does constitute an admission by provider of any conclusion of 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	not this set tion

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet

Page 26 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001		UILDING	NSTRUCTION 03	(X3) DATE COMPI 05/31	LETED	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 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 I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE	
	Participation in Me Subpart 483.90(a), 2012 Edition of the Association (NFPA Building 02 and Bu Chapter 18, New H IAC 16.2.  This two story facilithree portions of or determined to be of was fully sprinklere 2017 general renow floor resident sleep memory care wing sleeping rooms 123 first floor and resid 2240 and 2241 on t Building 03 consist main entrance lobb offices, conference shop. The facility I smoke detection in open to the corridor detectors hard wire installed in all resic facility has a capace 147 at the time of the All areas where reswere sprinklered ar services were sprin riser room closet in no detached building of the subpart of the corridor of th	dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection  1) 101, Life Safety Code (LSC).  1) 101, Life Safety						
K 0161 SS=F Bldg. 03	•	tion Type and Height tion Type and Height						

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 27 of 30

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155001		A. BUILDING 03  B. WING		COMPLETED 05/31/2024			
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	2012 NEW Building constructi Table 18.1.6.1, un 18.1.6.2 through 1 18.1.6.4, 18.1.6.5  Construct 1 I (442), I non-sprinklered  2 II (111) non-sprinklered	ion type and stories meets nless otherwise permitted by 18.1.6.7.					
	sprinklered  3 II (000) non-sprinklered 4 III (211) sprinklered 5 IV (2HH) 6 V (111)	Not allowed  Maximum 1 story					
	throughout by an a automatic system 9.7. (See 18.3.5) Give a brief descriconstruction, the ribasements, floors located, location odates of approval. small floor plan of	Not allowed  s must be sprinklered approved, supervised in accordance with section accordance with section in REMARKS, of the number of stories, including on which patients are of smoke or fire barriers and accomplete sketch or attach the building as appropriate. On and interview, the facility	K 0161	What corrective action(s) will	06/28/2024		
	failed to maintain th	on and interview, the facility he building construction type n in 1 of 2 sprinkler riser	K 0161	What corrective action(s) will be accomplished for those residents found to have been			

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

Event ID:

4WEU22 Facility ID: 000001

If continuation sheet Page 28 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	construction 03	(X3) DATE SURVEY  COMPLETED  05/31/2024			
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			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 DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG			TAG	DEFICIENCY)	DATE		
	rooms. This deficient practice could affect all			affected by the deficient			
residents, staff and visitors.			practice?				
				The drywall has been			
	Findings include:			replaced in the sprinkler room			
				How will you identify other			
		ons with the Director of		residents having the potenti	al		
		e Director of Maintenance and		to be affected by the same			
		echnician during a tour of the a.m. to 11:10 a.m. on 05/31/24, a		deficient practice and what	2		
	-	ter hole was noted in the		No residents were affect			
				by the alleged deficient pract			
	ceiling of the sprinkler riser room closet by the Human Resources Generalist's office on the first			All residents, visitors, sta			
	floor which exposed the underside of the decking			have the potential to be affect			
	of the second floor. Based on interview at the			by the alleged deficient practi			
				by the alleged deficient practi			
	time of the observations, the Director of Maintenance agreed the hole in the ceiling			What measures will be put in	nto		
		ide of the decking of the		place or what systemic			
	second floor in the closet.			changes you will make to			
	second floor in the croset.			ensure that the deficient			
	These findings were	e reviewed with the DON, the		practice does not recur?			
	Director of Maintenance and the Maintenance Technician during the exit conference.			The drywall has been			
				replaced in the sprinkler room	1		
				A Maintenance audit too	l,		
		s cited on 04/04/24. The facility		ensuring there is no missing			
	failed to implement	a systemic plan of correction		drywall in the sprinkler room,	will		
	to prevent recurrence	ce.		be completed monthly for six			
				months with results reported	to		
	3.1-19(b)			the Quality Assurance			
				Performance Improvement (C	(API)		
				Committee			
				l			
				How the corrective action(s)			
				will be monitored to ensure	uie		
				deficient practice will not			
				recur, i.e., what quality assurance program will be p	Nut		
				into place?	יענ		
				A Maintenance audit too			
			ensuring there is no missing	',			
			drywall in the sprinkler room,	will			
			1				

PRINTED: 06/26/2024 FORM APPROVED OMB NO. 0938-039

i '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/31/2024	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIAT DEFICIENCY)  be completed monthly for six months with results reported to the Quality Assurance Performance Improvement (Qu. Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non complian with staff will result in staff education and up to disciplinary action.	o API) f n ire nce	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4WEU22 Facility ID: 000001 If continuation sheet Page 30 of 30