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	05/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 05/05/25 & 05/06/25 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Emergency Preparedness survey, Hooverwood was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 155 certified beds. At the time of the survey, the census was 129. Quality Review completed on 05/09/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0041	p="" paraid="34633230" paraeid="{4cc640a9-11f7-4035-be90-13ab634cb3c2}{238}">What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice. No residents were identified as being affected by the deficient practice.	06/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Newcomer	Administrator	05/28/2025

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	05/06/2025

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	Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" and Direct Supply TELS Logbook Documentation "Emergency Power Generator Test Generator Under Load" with the Administrator and Director of Maintenance during record review at 1:15 p.m. on 05/05/25, the following was noted: a. weekly emergency generator inspection documentation for 15 of the last 52 weeks was not available for review. b. monthly load testing documentation for seven of the last twelve months was not available for review. c. diesel fuel quality test results within the last twelve months was not available for review. Based on interview at 1:20 p.m., the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for the aforementioned weeks, monthly load testing documentation for seven months and results of a fuel quality test was not available for review. These findings were reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No other residents have been identified as having the potential to be affected by the alleged deficient practice. Weekly emergency generator inspections will be conducted and documented in TELS. Monthly load testing will be conducted and documented in TELS. Fuel testing quality will be completed and documented in TELS. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. Audits of TELS for compliance with Generator preventative maintenance will be conducted by the maintenance director and/or his designee weekly for four weeks and then monthly for three months. 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. The maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the systemic	

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			changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date. 06/30/2025	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 05/05/25 & 05/06/25 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 01 was surveyed using Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 01 consists of the	K 0000		

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	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 129 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 05/09/25			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain latching harware on 1 of 1 sets of smoke barrier doors. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff in the basement. Findings include: Based on observation on 05/06/25 at 12:45 p.m. during a tour of the facility with the Director of Maintenance, the set of smoke barrier doors in the basement corridor did not close completely and latch when tested several times. These doors were equipped with latching hardware. There remained a one half inch gap between the doors when closed to their fullest. Based on interview at 12:50 p.m., the Director of Maintenance agreed	K 0100	What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No other residents have been identified as having the potential to be affected by the alleged deficient	06/30/2025

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	this set of smoke doors did not latch when tested. This finding was reviewed with the Administrator and Director of Maintenance during the exit conference. 3.1-19(b)		practice? The set of barrier doors in the basement have been repaired to ensure that they properly close and latch. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? An audit will be conducted weekly for four weeks and then monthly for three months by the Maintenance director and/or his to ensure that the smoke barrier doors in the basement are properly closing and latching. 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?The Maintenance director is responsible for ensuring the audit is completed. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated	

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			plan of correction date?06/30/2025	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 hazardous areas, such as storage rooms containing combustible storage and greater than 50 square feet was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice affects staff in the basement. Findings include: Based on observation with the Director of Maintenance on 05/06/25 at 12:40 p.m., the basement storage room where a sprinkler riser is located, contained hazardous storage such as supplies and boxes, was greater than 50 square feet, and was equipped with self-closing devices, but the door was propped open with a five gallon bucket. Based on interview at 12:42 p.m., the Director of Maintenance agreed the room is larger than 50 square feet was used as storage, and the self closing door was propped open. The finding was reviewed with the Administrator and Director of Maintenance during the exit conference on 05/06/25. 3.1-19(b)	K 0321	p="" paraid="542480093" paraeid="{633efced-c175-400b-bf5a-17467bfb514a}{158}">What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? p="" paraid="542480093" paraeid="{633efced-c175-400b-bf5a-17467bfb514a}{158}">No residents were identified as being affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?No other residents have been identified as having the potential to be affected by the alleged deficient practice. The five-gallon bucket was removed so that it was no longer propping the door open. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur. An audit will be conducted weekly for four weeks and then monthly for three months by the Maintenance director and/or his to ensure that there are no five-gallon buckets propping the door open? How the corrective action(s)	06/30/2025

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Maintenance director is responsible for ensuring the audit is completed. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits.. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date?06/30/2025	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states	K 0345	p="" paraid="1744006602" paraeid="{c407e67b-e181-443c-81d9-2e8978d62ab8}{73}">What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice?No residents were identified as being affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be	06/30/2025

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	smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Administator and Director of Maintenance on 05/05/25 at 2:10 p.m., no documentation for a smoke detector sensitivity test was available for review. The most recent annual fire alarm inspection provided was dated 07/08/24. Based on interview at 2:13 p.m., the Director of Maintenance confirmed that the most recent smoke detector sensitivity testing was not available for review at the time of the survey. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 2. 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		identified and what corrective action(s) will be taken.?No other residents have been identified as having the potential to be affected by the alleged deficient practice. The smoke detector sensitivity testing, inspection of control unit trouble signals, remote annunciators, initiating devices, notification of appliance, magnetic hold-open will be completed semi-annually. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? The Maintenance director and/or his will utilize the TELS program to ensure that ongoing compliance is achieved. 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?The licensed administrator will compliance and report to the QA Committee semi-annually for one year. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of	

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	e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 07/08/24 with the Administrator and Director of Maintenance during record review 1:05 p.m. on 05/05/25, semi-annual fire alarm system inspection documentation six months after 07/08/24 was not available for review. Based on interview at 1:07 p.m., the Director of Maintenance agreed semi-annual inspection documentation for the facility's fire alarm system six months after 07/08/24 was not available for review. These findings were reviewed with the Administrator and Director of Maintenance during the exit conference 3.1-19(b)		correction date?06/30/2025	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section	K 0353	ol="" role="list" start="1" What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? No other residents have been identified as having the potential to	06/30/2025

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	13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/06/25 at 1:05 p.m. with the Director of Maintenance, weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52-week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12-month period was not available for review. Based on interview on 05/06/25 at 1:10 p.m. the Director of Maintenance confirmed sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review at the time of the survey. This item was reviewed with the Administrator and Director of Maintenance at the exit conference on 05/06/25. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in the facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section		be affected by the alleged deficient practice. The weekly dry sprinkler system gauge inspection will occur on a weekly basis. ol="" role="list" start="3" What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? Audits of TELS for compliance with the weekly dry sprinkler system gauge inspection will be conducted by the Maintenance director and/or his designee weekly for four weeks and then monthly for three months. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an	

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	8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 10 residents, staff, and visitors in the Social Hall. Findings include: Based on observation during a tour of the facility with the Director of Maintenance and Administrator on 05/06/25 at 11:25 a.m., five ceiling tiles were missing from the drop ceiling grid in the closet located in the Social Hall. Two pendant sprinklers were observed in the closet. Based on interview at 11:27 a.m., the Director of Maintenance confirmed the missing ceiling tiles and stated a leak was recently repaired and the tiles had not been put back in place. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference on 05/06/25. 3.1-19(b)		amended plan of correction with the updated dated plan of correction date? 06/30/2025	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 50 Resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect as many as 15 residents and staff in one smoke compartment. Findings include: Based on observation made during a tour of the facility with the Director of Maintenance on 05/06/25 at 12:07 p.m., the corridor door to resident	K 0363	1.p paraid="502647153" paraeid="{eca2ac14-ebd4-4f38-b31b-3ee5fe222289}{149}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice?	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	room 109 failed to fully close and latch into the doorframe. Based on an interview at 12:10 p.m., The Director of Maintenance agreed that corridor door of resident room 109 failed to fully close and latch into the doorframe adding that he would have the door looked at as soon as possible. This finding was reviewed with the Administrator and Director of Maintenance during the exit conference on 05/06/25. 3.1-19(b)		3.No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·The corridor door to resident room 109 has been repaired to close and latch into the door frame and all other corridor to resident rooms have been inspected and repaired if needed. . What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur?	

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			·An audit will be conducted monthly for four weeks and then monthly for three months by the Maintenance director and/or his to ensure that all corridor doors to resident rooms close and latch into door frames. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0374 SS=D Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect staff in the basement. Findings include: Based on observation on 05/06/25 at 12:45 p.m. during a tour of the facility with the Director of Maintenance, the set of smoke barrier doors in the basement corridor did not close completely when tested several times. These doors were equipped with latching hardware. There remained a one half	K 0374	1.p paraid="375783762" paraeid="{7d28658d-80c8-4f8e-9eaf-b993ea10e8ac}{80}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? 3.No residents were identified as being affected by the deficient practice. How be identified and what	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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

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	inch gap between the doors when closed to their fullest. Based on interview at 12:50 p.m., the Director of Maintenance agreed this set of smoke doors did not prevent the passage of smoke when tested. This finding was reviewed with the Administrator and Director of Maintenance during the exit conference. 3.1-19(b)		corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·The set of barrier doors in the basement have been repaired to ensure that they properly close and latch. . What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·An audit will be conducted weekly for four weeks and then monthly for three months by the Maintenance director and/or his to ensure that the smoke barrier doors in the basement are properly closing and latching.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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			. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring the audit is completed. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date?	

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	155001	A. BUILDING 01 B. WING	05/06/2025

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			·06/30/2025	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of over 75 electrical junction boxes were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 15 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 05/06/25 at 11:26 a.m., an electrical junction box above the drop ceiling in the closet of the Social Hall had a cover, but it was hanging down by one screw and exposed electrical wiring was hanging out of the box. Based on interview at 11:27 a.m., the Director of Maintenance confirmed there was exposed wiring and would have the cover refastened onto the junction box. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference.	K 0511	ol="" role="list" start="1" What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. ol="" role="list" start="2" How be identified and what corrective action(s be taken? No other residents have been identified as having the potential to be affected by the alleged deficient practice. The cover that was hanging from the electrical junction box in the closet of the social hall has been repaired. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? An audit will be conducted monthly for three months by the Maintenance director and/or his to ensure that all electrical junction boxes have covers. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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	3.1-19(b)		put into place? The Maintenance director is responsible for ensuring the audit is completed. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? 06/30/2025	
K 0541 SS=D Bldg. 01	NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chu 1. Based on observation and interview, the facility failed to maintain 1 of 4 soiled linen 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 staff and visitors in the vicinity of the south soiled linen room in the basement. Findings include:	K 0541	What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? ·No residents were identified as being affected by the deficient practice.	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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	Based on observation with the Director of Maintenance during a tour of the facility at 12:35 p.m. on 05/06/25, the soiled linen chute door in the basement collection room was missing. Based on interview at the time of the observation, the Director of Maintenance confirmed the soiled linen chute door was missing and added that he recently noticed it missing and had not received a work order, so could not say how long the door had not been on the chute in the basement collection room. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 2. Based on observation and interview, the facility failed to ensure doors to 1 of 2 trash chute discharge rooms was equipped with a positive latching mechanism. LSC 9.5.2 requires trash chutes shall be installed and maintained per NFPA 82, 2009 Edition. NFPA 82, Section 5.2.5.1.2 states, where service opening rooms are provided and protected by automatic sprinklers, the room shall be enclosed in a minimum of 1-hour construction and openings shall be protected by ¾-hour fire rated doors. NFPA 80, 2010 Edition at 5.2.4.2(3) & (8) requires that at a minimum for fire rated doors, the door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, in working order with no visible signs of damage and latching hardware operates and secures the door when it is in the closed position. This deficient practice could affect over two staff and visitors in the basement. Findings include: Based on observation with the Director of Maintenance during a tour of the facility at 12:38		. How be identified and what corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·A door to the soiled linen chute in the basement collection room has been installed. The facility has repaired 1 of 2 trash chute doors equipped with a positive latching mechanism. All stanchions were removed from service opening room door for the south trash chute discharge in the basement. . What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur?	

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	155001	A. BUILDING 01 B. WING	05/06/2025

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

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	p.m. on 05/06/25, the service opening room door for the south trash chute discharge in the basement was propped open with a stanchion. Based on interview at the time of the observation, the Director of Maintenance agreed the self-closing door to the trash collection room was propped open and failed to latch when tested. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		·An audit will be conducted monthly for three months by the Maintenance director and/or his to ensure trash chute doors equipped with a positive latching mechanism are working properly. To ensure that stanchions are not used to prop room door for the south trash chute discharge in the basement. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring the audit is completed. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an	

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			acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the documents titled "Direct Supply - TELS (Conduct a fire drill) with the Director of Maintenance and Administrator on 05/05/25 at 12:55 p.m., there was no documentation for the following fire drills: a) a third shift fire drill for the second quarter (April, May, June) of 2024/2025 b) a second shift fire drill for the third quarter (July, August, September) of 2024. c) a first, second and third shift fire drills for the	K 0712	1.p="" paraid="324815897" paraeid="{aefe83b7-874b-4ceb-a96b-eb0ddd82cdc7}{88}" style="font-family: "Times New Roman", "Times New Roman_MSFontService", serif; font-size: 16px; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" 1.p paraid="324815897" paraeid="{aefe83b7-874b-4ceb-a96b-eb0ddd82cdc7}{88}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice?	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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

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	fourth quarter (October, November, and December) of 2024 Based on an interview on 05/05/25 at 1:00 p.m., the Director of Maintenance confirmed the aforementioned missing fire drills stating that no further documentation could be located for fire drills as of the time of this survey. This item was reviewed with the Administrator and Director of Maintenance at the exit conference on 05/06/25. 3.1-19(b) 3.1-51(c)		3.No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? 3.No other residents have been identified as having the potential to be affected by the alleged deficient practice. 5.Fire drills will be conducted at least once on a quarterly basis for each shift. Fire drills will be documented in TELS. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur?	

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	155001	A. BUILDING 01 B. WING	05/06/2025

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

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			·Audits of TELS for compliance with conducting fire least once on a quarterly basis for each shift. will be conducted by the Maintenance director and/or his designee monthly for four months. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it	

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	155001	A. BUILDING 01 B. WING	05/06/2025

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

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			is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? . 06/30/2025	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure complete documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and	K 0914	1.p paraid="1124918201" paraeid="{e3e6c116-cb47-473a-8626-34ecb3ce56eb}{13}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? 3.No residents were identified as being affected by the deficient practice.	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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

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	neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Administrator and the Director of Maintenance at 12:30 p.m. on 05/05/25, electrical receptacle inspection and testing documentation within the most recent twelve month period was available for review, however it was incomplete. The 'LSC receptacle testing' documentation dated 02/17/25 had each room location listed but there was not an itemized listing of the receptacles in each room. Based on interview at 12:35 p.m. the Director of Maintenance stated each resident sleeping room has multiple receptacle locations some of which may be hospital-grade but agreed the provided electrical receptacle inspection and testing documentation was not itemized by receptacle location. Based on observations with the Administrator and the Director of Maintenance, resident sleeping rooms in the first floor memory care wing had non-hospital-grade receptacles. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25. 3.1-19(b)		5.How be identified and what corrective action(s be taken? 7.No other residents have been identified as having the potential to be affected by the alleged deficient practice. 9.Non-hospital grade receptacles will be tested on an annual basis and documented in TELS (itemized). What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·An audit of TELS will be completed to ensure that non-hospital grade receptables have been tested for 2025. .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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

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			How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audits will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date?	

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	155001	A. BUILDING 01 B. WING	05/06/2025

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

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			·06/30/2025	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 15 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" with the Administrator and the Director of Maintenance during record review at 1:15 p.m. on 05/05/25, weekly emergency generator inspection documentation was last documented 04/11/25. Additionally, the weeks of 09/08/24, all weeks in January-March of 2025 were not available for review. Based on interview at 1:20 p.m., the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for the aforementioned week	K 0918	p="" paraid="1654050273" paraeid="{e3e6c116-cb47-473a-8626-34ecb3ce56eb}{192}">What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? No other residents have been identified as having the potential to be affected by the alleged deficient practice. Weekly emergency generator inspections will be conducted and documented in TELS. Monthly load testing will be conducted and documented in TELS. Fuel testing quality will be completed and documented in TELS. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? Audits of TELS for compliance with Generator preventative maintenance will be conducted by the Maintenance director and/or his designee weekly for four	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	05/06/2025

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

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	periods were not available for review at the time of the survey. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25. 2. Based on record review and interview, the facility failed to exercise the generator for 7 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 Administrator		weeks and then monthly for three months. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? 06/30/2025	

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	and the Director of Maintenance during record review at 1:20 p.m. on 05/05/25, load testing documentation for December 2024 February 2025 and April 2025 was not available for review. Based on interview at 1:20 p.m., the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed monthly load testing documentation for the aforementioned months were not available for review at the time of the survey. These findings were reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25. 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and Director of Maintenance on 05/05/25 at 2:07 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at 2:10 p.m., the Director of Maintenance stated a fuel quality test was not conducted within the last twelve months			

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	on the diesel generator. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 4. 1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			

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	2. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available for review. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/5/25 at 2:15 p.m. with the Administrator and Director of Maintenance, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 03/04/24. Based on interview at the time of record review, the Director of Maintenance said he would schedule for the generator vendor to come to the facility to perform routine maintenance service on the emergency generator. This finding was reviewed with the Administrator and Director of Maintenance during the exit conference.			

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	3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 05/05/25 & 05/06/25 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	K 0000		

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	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 129 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 05/09/25			
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Administator and Director of Maintenance on 05/05/25 at 2:10 p.m.,	K 0345	1.p paraid="2136884719" paraeid="{c407e67b-e181-443c-81d9-2e8978d62ab8}{73}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? .	06/30/2025

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	no documentation for a smoke detector sensitivity test was available for review. The most recent annual fire alarm inspection provided was dated 07/08/24. Based on interview at 2:13 p.m., the Director of Maintenance confirmed that the most recent smoke detector sensitivity testing was not available for review at the time of the survey. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 2. 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. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 07/08/24 with the Administrator and Director of Maintenance during record review 1:05 p.m. on 05/05/25, semi-annual		No other residents have been identified as having the potential to be affected by the alleged deficient practice. The smoke detector sensitivity testing, inspection of control unit trouble signals, remote annunciators, initiating devices, notification of appliance, magnetic hold-open will be completed semi-annually. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·The Maintenance director and/or his will utilize the TELS program to ensure that ongoing compliance is achieved. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	fire alarm system inspection documentation six months after 07/08/24 was not available for review. Based on interview at 1:07 p.m., the Director of Maintenance agreed semi-annual inspection documentation for the facility's fire alarm system six months after 07/08/24 was not available for review. These findings were reviewed with the Administrator and Director of Maintenance during the exit conference 3.1-19(b)		·The licensed administrator will compliance and report to the QA Committee semi-annually for one year. ·By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0353 SS=F Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for	K 0353	ol="" role="list" start="1" What corrective action(s) will be accomplished for those residents	06/30/2025

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	the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/06/25 at 1:05 p.m. with the Director of Maintenance, weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52-week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12-month period was not available for review. Based on interview on 05/06/25 at 1:10 p.m. the Director of Maintenance confirmed sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review at the time of the survey. This item was reviewed with the Administrator and Director of Maintenance at the exit conference on 05/06/25. 3.1-19(b)		to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? No other residents have been identified as having the potential to be affected by the alleged deficient practice. The weekly dry sprinkler system gauge inspection will occur on a weekly basis. ol="" role="list" start="3" What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? Audits of TELS for compliance with the weekly dry sprinkler system gauge inspection will be conducted by the Maintenance director and/or his designee weekly for four weeks and then monthly for three months. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the	

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			systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? 06/30/2025	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers 1. Based on observation and interview, the facility failed to ensure 2 of 3 K Class fire extinguishers in the serverys were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3.1 states fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect 30 residents and staff in dining rooms near the 2B and 1B serverys. Findings include: Based on observations during a tour of the facility with the Administrator and Director of Maintenance on 05/06/25, the following was noted: a) at 10:55 a.m., the K Class portable fire extinguisher located in the 2B servery was blocked by a refrigerator. Based on interview at 10:56 a.m., the Director of Maintenance agreed a refrigerator was in front of the wall-mounted K Class extinguisher, obstructing access to the fire extinguisher, adding he had never noticed it was	K 0355	ol class="NumberListStyle1 SCXW115579835 BCX0" role="list" start="1" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; overflow: visible;" What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken?	06/30/2025

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	blocked. b) at 11:35 a.m., the K Class portable fire extinguisher located in the 1B servery was blocked by a refrigerator. Based on interview at 10:56 a.m., the Director of Maintenance agreed a refrigerator was in front of the wall mounted K Class extinguisher, obstructing access to the fire extinguisher. The Director of Maintenance stated that cooking does not take place in the servery areas, as all meals are brought from the kitchen and served to residents. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 2. Based on observation and interview, the facility failed to inspect 3 of 63 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push-to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire		·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·The K class portable fire extinguisher located in 1b and 2b serveries have been moved so that they are no longer blocked by the refrigerator. Also, the monthly inspection tags for fire extinguishers near rooms 2201, 2236 and the K class fire extinguisher locate in the 1A server have been and the tags have been updated. p class="Paragraph SCXW115579835 BCX0" xml:lang="EN-US" paraid="2131553405" paraeid="{019dca53-bf7b-409c-a254-6dbf5ed00a3a}{9}" > What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur?	

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	extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect up to 40 residents, as well as staff and visitors. Findings include: Based on an observations with the Director of Maintenance and Administrator on 05/06/25 during a tour of the facility, the following was noted: a) at 10:40 a.m., the monthly inspection tag on the ABC fire extinguisher located by resident room #2236 lacked documentation of a monthly inspections for April 2025. b) at 10:45 a.m., the monthly inspection tag on the ABC fire extinguisher located by resident room #2201 lacked documentation of a monthly inspections for April 2025. c) at 12:15 p.m., the monthly inspection tag on the K Class fire extinguisher located in 1A servery lacked documentation of a monthly inspections for April 2025. Based on interview at the time of each observation, the Director of Maintenance confirmed the lack of monthly inspections for the aforementioned fire extinguishers		·An audit conducted monthly for three months from TELS will ensure that all fire extinguishers have been inspected, the tags initialed, and information input into TELS. The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0531 SS=E Bldg. 02	NFPA 101 Elevators Based on record review, observation and interview; the facility failed to maintain testing of all elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with firefighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect over six residents, staff and visitors in the facility.	K 0531	1.p paraid="1521812933" paraeid="{bf1b5d1e-7c78-4253-aed9-9e69bbc2e15c}{41}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice?	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	Findings include: Based on record review with the Director of Maintenance at 12:50 p.m. on 05/06/25, documentation for all monthly elevator firefighter recall testing was not available for review. Based on observations with the Administrator and the Director of Maintenance during a tour of the facility on 05/06/25, the facility had a total of two elevators with firefighter recall capability. Review of "Fire Fighter's Service Test Log Sheet" documentation located in the elevator machine room closest to Laundry during a tour of the facility indicated monthly testing for May, June, August, September of 2024 and April 2025 was not documented for the elevator. Review of "Fire Fighter's Service Test Log Sheet" documentation located in the elevator machine room in the basement Machenical room during a tour of the facility on 05/06/25 indicated monthly testing for July, October, November, December of 2024 and April 2025 was not documented for the elevator. Annual inspection service was conducted on 11/07/2024 for both elevators by an outside vendor. Based on interview at 1:00 p.m., the Director of Maintenance stated the elevator inspection contractor conducts monthly elevator recall testing but agreed documentation for the monthly elevator firefighter recall testing for the aforementioned months was not available for review. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference. 3.1-19(b)		3.No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·The monthly elevator firefighter recall testing will occur monthly. . What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·TELS will be audited monthly for three months to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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			monthly elevator firefighter recall testing is occurring. The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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			acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the documents titled "Direct Supply - TELS (Conduct a fire drill) with the Director of Maintenance and Administrator on 05/05/25 at 12:55 p.m., there was no documentation for the following fire drills: a) a third shift fire drill for the second quarter (April, May, June) of 2024/2025 b) a second shift fire drill for the third quarter (July, August, September) of 2024. c) a first, second and third shift fire drills for the	K 0712	1.p paraid="324815897" paraeid="{aefe83b7-874b-4ceb-a96b-eb0ddd82cdc7}{88}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? 3.No residents were identified as being affected by the deficient practice.	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	fourth quarter (October, November, and December) of 2024 Based on an interview on 05/05/25 at 1:00 p.m., the Director of Maintenance confirmed the aforementioned missing fire drills stating that no further documentation could be located for fire drills as of the time of this survey. This item was reviewed with the Administrator and Director of Maintenance at the exit conference on 05/06/25. 3.1-19(b) 3.1-51(c)		How be identified and what corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·Fire drills will be conducted at least once on a quarterly basis for each shift. Fire drills will be documented in TELS. . What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·Audits of TELS for compliance with conducting fire least once on a quarterly basis for each shift. will be conducted by the Maintenance director and/or his designee monthly for four months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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			. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date?	

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	155001	A. BUILDING 02 B. WING	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			·06/30/2025	
K 0914 SS=F Bldg. 02	NFPA 101 Electrical Systems - Maintenance and Testing Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents.	K 0914	1.p paraid="1124918201" paraeid="{e3e6c116-cb47-473a-8626-34ecb3ce56eb}{13}" >What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? 3.No residents were identified as being affected by the deficient practice. 5.How be identified and what corrective action(s be taken? 7.No other residents have been identified as having the potential to be affected by the alleged deficient practice.	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	Findings include: Based on record review with the Administrator and the Director of Maintenance at 12:30 p.m. on 05/05/25, electrical receptacle inspection and testing documentation within the most recent twelve month period was available for review, however it was incomplete. The 'LSC receptacle testing' documentation had each room location listed but there was not an itemized listing of the receptacles in each room. Based on interview at 12:35 p.m. the Director of Maintenance stated each resident sleeping room has multiple receptacle locations some of which may be hospital-grade but agreed the provided electrical receptacle inspection and testing documentation was not itemized by receptacle location. Based on observations with the Administrator and the Director of Maintenance, resident sleeping rooms on the first and second floor had a mix of hospital-grade and non-hospital-grade receptacles. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25. 3.1-19(b)		9.Non-hospital grade receptacles will be tested on an annual basis and documented in TELS (itemized). What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·An audit of TELS will be completed to ensure that non-hospital grade receptables have been tested for 2025. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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			responsible for ensuring audits are completed. Audits will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 15 weeks of the most recent 52 week period.	K 0918	1.p paraid="1654050273" paraeid="{e3e6c116-cb47-473a-8626-34ecb3ce56eb}{192}" >What corrective action(s) will be	06/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" with the Administrator and the Director of Maintenance during record review at 1:15 p.m. on 05/05/25, weekly emergency generator inspection documentation was last documented 04/11/25. Additionally, the weeks of 09/08/24, all weeks in January-March of 2025 were not available for review. Based on interview at 1:20 p.m., the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for the aforementioned week periods were not available for review at the time of the survey. This finding was reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25. 2. Based on record review and interview, the facility failed to exercise the generator for 7 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and		accomplished for those residents to have been affected by the deficient practice? 3.No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·Weekly emergency generator inspections will be conducted and documented in TELS. Monthly load testing will be conducted and documented in TELS. Fuel testing quality will be completed and documented in TELS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	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 Administrator and the Director of Maintenance during record review at 1:20 p.m. on 05/05/25, load testing documentation for December 2024 February 2025 and April 2025 was not available for review. Based on interview at 1:20 p.m., the Director of Maintenance stated the facility has one diesel fired emergency generator and agreed monthly load testing documentation for the aforementioned months were not available for review at the time of the survey.		· What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? ·Audits of TELS for compliance with Generator preventative maintenance will be conducted by the Maintenance director and/or his designee weekly for four weeks and then monthly for three months. · How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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

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	These findings were reviewed with the Administrator and the Director of Maintenance during the exit conference on 05/06/25. 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and Director of Maintenance on 05/05/25 at 2:07 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at 2:10 p.m., the Director of Maintenance stated a fuel quality test was not conducted within the last twelve months on the diesel generator. This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 4. 1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems,		audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	05/06/2025

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
	Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available for review. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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	available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 05/5/25 at 2:15 p.m. with the Administrator and Director of Maintenance, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 03/04/24. Based on interview at the time of record review, the Director of Maintenance said he would schedule for the generator vendor to come to the facility to perform routine maintenance service on the emergency generator. This finding was reviewed with the Administrator and Director of Maintenance during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens 1. Based on observation and interview, the facility failed to ensure a multi-plug adaptor was not used as a substitute for fixed wiring in 1 of 15 resident rooms in 1A East hall. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011	K 0920	1.p paraid="2089561590" paraeid="{b084f12a-9e12-4d71-b2b9-c22465d93b97}{209}" >What corrective action(s) will be accomplished for those residents to have been affected by the	06/30/2025

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	Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 15 residents, staff and visitors in one smoke compartment. Findings include: Based on observation during tour of the facility with the Director of Maintenance at 12:30 p.m., on 05/06/25, resident room 1129 had a multi-plug adapter in use to power an electric clock and a humidifier. Based on interview at 12:33 p.m., the Director of Maintenance stated he was not aware of the muti-plug adapter prior to observation during tour. 2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff and up to 15 residents in one smoke compartment. Findings include: Based on observation with the Director of Maintenance and the Administrator on 05/06/25 at 10:53 a.m., a refrigerator was plugged into an extension cord in the 2B servery. Based on interview at 10:55 a.m., the Director of Maintenance confirmed a refrigerator was plugged into an extension cord in the servery on 2B.		deficient practice? 3.No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? ·No other residents have been identified as having the potential to be affected by the alleged deficient practice. ·The multi-plug adapter in resident room 1129 has been removed. Also, the extension cord being used to plug in the refrigerator on the 2b has been removed. . What measures will be put into	

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	This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		place and what systemic changes will be made to ensure that the deficient practice does not occur? ·The maintenance director will audit a unit each month for four months to ensure that multi-plug adapters and extension cords are not being used. The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed by the QA Committee. Once the initial audit is completed and	

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			compliance is met the QA Committee may choose to discontinue the review of the audits. . By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? ·06/30/2025	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 05/05/25 & 05/06/25 Facility Number: 000001	K 0000		

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	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 129 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 05/09/25			

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K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 05/06/25 at 1:05 p.m. with the Director of Maintenance, weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52-week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12-month period was not available for review. Based on interview on 05/06/25 at 1:10 p.m. the Director of Maintenance confirmed sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review at the time of the survey.	K 0353	ol="" role="list" start="1" What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice. How be identified and what corrective action(s be taken? No other residents have been identified as having the potential to be affected by the alleged deficient practice. The weekly dry sprinkler system gauge inspection will occur on a weekly basis. ol="" role="list" start="3" What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not occur? Audits of TELS for compliance with the weekly dry sprinkler system gauge inspection will be conducted by the Maintenance director and/or his designee weekly for four weeks and then monthly for three months. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance director is responsible for ensuring audits are completed. Audit will be reviewed	06/30/2025

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	This item was reviewed with the Administrator and Director of Maintenance at the exit conference on 05/06/25. 3.1-19(b)		by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the audits. By What date does the systemic changes for each deficiency will be completed. After submitting an acceptable plan of correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated dated plan of correction date? 06/30/2025	