	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED 05/06/2025		
NAME OF P	PROVIDER OR SUPPLIER			7001 H	NDDRESS, CITY, STATE, ZIP COD DOVER RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000							
Bldg			E 000	00			
	Hooverwood was for Emergency Prepare	155001 275310 Preparedness survey, bund not in compliance with dness Requirements for caid Participating Providers					
	the survey, the cens Quality Review con	npleted on 05/09/25 42 CFR, Subpart 483.73 is NOT					
E 0041 SS=F Bldg	Based on record revinterview; the facilities emergency power symaintenance require Care Facilities Code Code in accordance	(e), 485.542(e), 485.62 LTC Emergency Power riew, observation and ty failed to implement the system inspection, testing and ements found in the Health e, NFPA 110, and Life Safety with 42 CFR 483.73(e)(2). ice could affect all residents,	E 004	41	p="" paraid="34633230" paraeid="{4cc640a9-11f7-403 0-13ab634cb3c2}{238}">What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice. No resident were identified as being affect by the deficient practice.	nts s	06/30/2025
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	<u> </u>	TITLE		(X6) DATE

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

Robert Newcomer Administrator 05/28/2025

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING		COMPLETED 05/06/2025
NAME OF E	PROVIDER OR SUPPLIER		7001 HC	DOVER RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
	Documentation "En and Direct Supply To "Emergency Power Under Load" with the of Maintenance dure on 05/05/25, the fold as weekly emergency documentation for the available for review be monthly load test of the last twelve months was Based on interview Maintenance stated fired emergency generated for the aforemention testing documentation results of a fuel quarreview. These findings were	y generator inspection 5 of the last 52 weeks was not ing documentation for seven onths was not available for y test results within the last not available for review. at 1:20 p.m., the Director of the facility has one diesel nerator and agreed weekly or inspection documentation ned weeks, monthly load on for seven months and lity test was not available for e reviewed with the the Director of Maintenance		How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No of residents have been identified having the potential to be affected by the alleged deficient practive will be conducted documented in TELS. Month load testing will be conducted documented in TELS. Fuel the quality will be completed and documented in TELS. What measures will be put in place and what systemic characteristic will be made to ensure that the deficient practice does not on Audits of TELS for compliant with Generator preventative maintenance will be conducted the maintenance director and his designee weekly for four weeks and then monthly for months. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be place. The maintenance director and completed. Audit will be review by the QA Committee. Once 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 systematics will be sufficient practice of the sudits.	te de

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED 05/06/2025	
		155001	B. WING	B. WING		
NAME OF P	PROVIDER OR SUPPLIE	?	7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				changes for each deficiency was be completed. After submitting acceptable plan of correction, is determined that the correction will not be completed by the dispreviously submitted, the Divisioneeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated data plan of correction date. 06/30/	g an if it on ate sion n as to	
K 0000						
Bldg. 01						
	Licensure Survey v Department of Hea 483.90(a). Survey Dates: 05/0 Facility Number: (Provider Number: 100 At this Life Safety found not in compl Participation in Me Subpart 483.90(a), 2012 Edition of the Association (NFPA Building 01 was su Existing Health Ca 16.2. This two story facil three portions of or determined to be of	000001 155001	K 0000			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155001	B. WI	NG		05/06/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER				OOVER RD		
HOOVEF	RWOOD				APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE	DATE
K 0100 SS=E Bldg. 01	memory care wing kitchen, the baseme on the first floor whroom. The facility has moke detection in open to the corridor detectors hard wirer installed in all resid facility has a capaci 129 at the time of the All areas where resisted were sprinklered an services were sprinklered and services were equiped by the maintained or remound affect staff in Findings include: Based on observation of the Maintenance, the set basement corridor of latch when tested services were equipped with remained a one half when closed to their	idents have customary access d all areas providing facility klered. The facility has no providing facility services. Impleted on 05/09/25 Inents - Other In and interview, the facility atching harware on 1 of 1 sets ors. LSC 4.6.12.3 requires features obvious to the public he Code, shall be either ved. This deficient practice	K 01		What corrective action(s) will be accomplished for those resident 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 same deficient practice will be identified and what corrective action(s) will be taken.	pe nts s	DATE 06/30/2025

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING 01 B. WING	COMPLETED 05/06/2025
NAME OF PROVIDER OR SUPPI	ier	STREET ADDRESS, CITY, STATE, ZIP CO 7001 HOOVER RD INDIANAPOLIS, IN 46260	and and a
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PROVIDERS PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
this set of smoke This finding was	doors did not latch when tested. reviewed with the Administrator Maintenance during the exit	practice? The set of barrier doors basement have been re ensure that they proper and latch. What measu put into place and what changes will be made to that the deficient practic occur? An audit will be conduct for four weeks and then for three months by the Maintenance director are ensure that the smoke to doors in the basement a properly closing and late. How the corrective action monitored to ensure the practice will not recur, it quality assurance progreput into place? The Main director is responsible for the audit is completed. Initial audit is completed. Initial audit is completed. Initial audit is completed compliance is met the Committee may choose discontinue the review of audits. By What date does the changes for each deficit be completed. After subsacceptable plan of correction determined that the completed by previously submitted, the needs to be contacted a possible. The facility will submit an amended placorrection with the update of the correction with the updat	in the epaired to ly close ares will be systemic or ensure are ching. On(s) will be deficient are will be entenance or ensuring Once the drand QA arto of the systemic ency will omitting an are encion, if it correction by the date are soon as all need to n of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155001 B. WING 05/06/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7001 HOOVER RD **HOOVERWOOD** INDIANAPOLIS. IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE plan of correction date?06/30/2025 K 0321 **NFPA 101** SS=D Hazardous Areas - Enclosure Bldg. 01 Based on observation and interview, the facility K 0321 p="" paraid="542480093" 06/30/2025 failed to ensure the corridor doors to 1 of 1 paraeid="{633efced-c175-400b-bf5 hazardous areas, such as storage rooms a-17467bfb514a}{158}">What containing combustible storage and greater than corrective action(s) will be 50 square feet was separated from other spaces by accomplished for those residents smoke resistant partitions and doors. Doors shall to have been affected by the be self-closing or automatic closing in accordance deficient practice? with LSC 7.2.1.8. This deficient practice affects p="" paraid="542480093" staff in the basement. paraeid="{633efced-c175-400b-bf5 a-17467bfb514a}{158}">No Findings include: residents were identified as being affected by the deficient practice. Based on observation with the Director of Maintenance on 05/06/25 at 12:40 p.m., the How other residents having the basement storage room where a sprinkler riser is potential to be affected by the located, contained hazardous storage such as same deficient practice will be supplies and boxes, was greater than 50 square identified and what corrective feet, and was equipped with self-closing devices, action(s) will be taken? No other but the door was propped open with a five gallon residents have been identified as bucket. Based on interview at 12:42 p.m., the having the potential to be affected Director of Maintenance agreed the room is larger by the alleged deficient practice. than 50 square feet was used as storage, and the The five-gallon bucket was self closing door was propped open. removed so that it was no longer propping the door open. What The finding was reviewed with the Administrator measures will be put into place and Director of Maintenance during the exit and what systemic changes will conference on 05/06/25. be made to ensure that the deficient practice does not occur. 3.1-19(b) 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)

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF F	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				will be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place Maintenance director is responsible for ensuring the axis 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. submitting an acceptable plar correction, if it is determined to the correction will not be completed by the date previous submitted, the Division needs be contacted as soon as posson as posson to the initial audits.	ar, P?The audit After n of that usly s to sible. it an
K 0345 SS=F Bldg. 01	facility failed to ens was maintained in a LSC 9.6.1.3 require installed, tested, and with NFPA 70, Nat 72, National Fire A 14.4.5 states unless sections of this Codi in accordance with or more often if req	review and interview, the sure 1 of 1 fire alarm systems accordance with LSC 9.6.1.3. It is a fire alarm system to be domaintained in accordance ional Electrical Code and NFPA alarm Code. NFPA 72, Section otherwise permitted by other lee, testing shall be performed the schedules in Table 14.4.5, uired by the authority having 1.72, Section 14.4.5.3.1 states	K 0345	p="" paraid="1744006602" paraeid="{c407e67b-e181-44 d9-2e8978d62ab8}{73}">What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice?No residen were identified as being affect by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be	ents ts ted

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPI			ETED
		155001	B. WI	NG		05/06/2	2025
		<u> </u>	'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .			OOVER RD		
HOOVEF	RWOOD				IAPOLIS, IN 46260		
	 I				· · · · · · · · · · · · · · · · · · ·	1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG			DATE
		sitivity shall be checked within			identified and what corrective		
		tion. NFPA 72, 14.4.5.3.2 states			action(s) will be taken.?No oth		
		sitivity shall be checked every			residents have been identified	I	
	· ·	after unless otherwise			having the potential to be affe		
		iance with Section 14.4.5.3.3.			by the alleged deficient practic		
	inis deficient pract	ice could affect all occupants.			The smoke detector sensitivity		
	Findings include:				testing, inspection of control u	riit	
	rmanigs include:				trouble signals, remote	_	
	Rased on record res	view with the Administator and			annunciators, initiating device notification of appliance, magr		
		nance on 05/05/25 at 2:10 p.m.,			hold-open will be completed	i c tic	
		or a smoke detector sensitivity			semi-annually. What measure	<u> </u>	
		or review. The most recent			will be put into place and what		
		spection provided was dated			systemic changes will be mad		
		interview at 2:13 p.m., the			ensure that the deficient pract		
		nance confirmed that the most			does not occur?		
		tor sensitivity testing was not			4000 1101 00041 :		
		at the time of the survey.			The Maintenance director and	_{l/or}	
		·			his will utilize the TELS progra	I	
	This finding was re	viewed with the Administrator			to ensure that ongoing compli		
	1	intenance at the exit			is achieved. How the corrective		
	conference.				action(s) will be monitored to		
					ensure the deficient practice v	vill	
	2. Based on record	review and interview, the			not recur, i.e., what quality		
		intain 1 of 1 fire alarm systems			assurance program will be put	t into	
	1	NFPA 72, National Fire Alarm			place?The licensed administra		
		LSC Sections 19.3.4.5.1 and			will compliance and report to t		
	9.6. NFPA 72, Sec	tion 14.3.1 states that unless			QA Committee semi-annually		
	otherwise permitted	by 14.3.2, visual inspections			one year. By What date does		
	shall be performed	in accordance with the			systemic changes for each		
		14.3.1, or more often if required			deficiency will be completed.	After	
	by the authority hav	ring jurisdiction. Table 14.3.1			submitting an acceptable plan	of	
		wing must be visually			correction, if it is determined the	hat	
	inspected semi-anni	•			the correction will not be		
	a. Control unit troul				completed by the date previou	ısly	
	b. Remote annuncia				submitted, the Division needs	to	
	c. Initiating devices	(e.g. duct detectors, manual			be contacted as soon as poss	ible.	
	fire alarm boxes, he	eat detectors, smoke detectors,			The facility will need to submit	an	
	etc.)				amended plan of correction w	ith	
	d. Notification appl	iances			the updated dated plan of		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155001	B. WING		05/06/2025
		<u> </u>	STREI	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	ROVIDER OR SUPPLIER		7001	HOOVER RD	
HOOVER	RWOOD		INDI	ANAPOLIS, IN 46260	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION	TAG		DATE
	e. Magnetic hold-op	ice could affect all residents,		correction date?06/30/2025	
	staff and visitors.	ice could affect all residents,			
	Findings include:				
	D 1 : 01				
		fire alarm system inspection larm Inspection and Testing			
		on dated 07/08/24 with the			
		Director of Maintenance during			
		p.m. on 05/05/25, semi-annual			
	_	spection documentation six			
	months after 07/08/24 was not available for review.				
		at 1:07 p.m., the Director of			
	_	l semi-annual inspection			
		he facility's fire alarm system 08/24 was not available for			
	review.	08/24 was not available for			
	ieview.				
	These findings were	e reviewed with the			
	Administrator and I	Director of Maintenance during			
	the exit conference				
	3.1-19(b)				
K 0353	NFPA 101				
SS=F Bldg. 01	Sprinkler System -	- Maintenance and Testing			
	1. Based on record i	review and interview, the	K 0353	ol="" role="list" start="1"	06/30/2025
	_	eument sprinkler system		What corrective action(s) will l	ре
	-	dance with NFPA 25. NFPA		accomplished for those reside	nts
		Inspection, Testing, and		to have been affected by the	
		ter-Based Fire Protection		deficient practice?	
		ion, Section 5.2.4.2 states sprinkler systems shall be		No residents were identified a being affected by the deficient	
		ensure that normal air and		practice. How be identified ar	
	-	being maintained. Section		what corrective action(s be	
	5.1.2 states valves a	_		taken?	
		e inspected, tested, and		No other residents have been	
	maintained in accor	dance with Chapter 13. Section		identified as having the potent	ial to

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ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	01	COMPL	ETED
		155001	B. WING			05/06	2025
			l s	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	ER			OOVER RD		
HOOVE	RWOOD				IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	13.1.1.2 states Tab	ble 13.1.1.2 shall be utilized for			be affected by the alleged defi	cient	
	inspection, testing	and maintenance of valves,			practice.		
	valve components	and trim. Section 4.3.1 states			The weekly dry sprinkler syste	m	
	records shall be ma	ade for all inspections, tests,			gauge inspection will occur on	а	
	and maintenance o	of the system and its			weekly basis.		
	components and sh	nall be made available to the			ol="" role="list" start="3"		
	authority having ju	risdiction upon request. This			What measures will be put into)	
	deficient practice of	could affect all residents, staff,			place and what systemic chan	ges	
	and visitors.				will be made to ensure that the	e	
					deficient practice does not occ	:ur?	
	Findings include:						
					Audits of TELS for compliance	Э	
	Based on record re	eview on 05/06/25 at 1:05 p.m.			with the weekly dry sprinkler		
	with the Director of	of Maintenance, weekly dry			system gauge inspection will b	e	
	sprinkler system ga	auge inspection documentation			conducted by the Maintenance		
	for 48 weeks of the	e most recent 52-week period			director and/or his designee		
	was not available f	for review. In addition, monthly			weekly for four weeks and the	n	
	inspection docume	entation for all sprinkler system			monthly for three months. How		
	control valves for	8 months of the most recent			monitored to ensure the deficie		
	12-month period w	vas not available for review.			practice will not recur, i.e., wha	at	
	_	v on 05/06/25 at 1:10 p.m. the			quality assurance program will		
	Director of Mainte	enance confirmed sprinkler			put into place?		
	system gauge and	control valve inspection			The Maintenance director is		
	documentation for	the aforementioned weekly and			responsible for ensuring audits	s are	
	monthly periods w	as not available for review at			completed. Audit will be review		
	the time of the surv				by the QA Committee. Once the		
					initial audit is completed and		
	This item was revi	ewed with the Administrator			compliance is met the QA		
	and Director of Ma	aintenance at the exit			Committee may choose to		
	conference on 05/0	06/25.			discontinue the review of the		
					audits. By What date does the	•	
					systemic changes for each		
	2. Based on observ	vation and interview, the facility			deficiency will be completed. A	After	
		the ceiling construction in the			submitting an acceptable plan		
		2010 edition, Section 3.3.5.4			correction, if it is determined the		
	-	eiling as a continuous ceiling			the correction will not be		
		ant irregularities, lumps, or			completed by the date previou	slv	
		ceiling traps hot air and gases			submitted, the Division needs	-	

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around the sprinkler and causes the sprinkler to

operate at a specified temperature. Section

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be contacted as soon as possible.

The facility will need to submit an

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/06/2025	
NAME OF F	PROVIDER OR SUPPLIER		7001 F	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	deflector and the ce based on the type of construction. This	distance between the sprinkler iling above shall be selected f sprinkler and the type of deficient practice could affect and visitors in the Social Hall.		amended plan of correction withe updated dated plan of correction date? 06/30/2025	ith
	with the Director of Administrator on 05 ceiling tiles were m grid in the closet loo pendant sprinklers v Based on interview Maintenance confir and stated a leak wa tiles had not been pro-	issing from the drop ceiling cated in the Social Hall. Two were observed in the closet. at 11:27 a.m., the Director of med the missing ceiling tiles as recently repaired and the ut back in place.			
K 0363 SS=E Bldg. 01	failed to ensure 1 of to the corridor woul into the door frame.	on and interview, the facility Fover 50 Resident room doors d close completely and latch This deficient practice could 5 residents and staff in one t.	K 0363	1.p paraid="502647153" paraeid="{eca2ac14-ebd4-4f3 b-3ee5fe222289}{149}" >Wha corrective action(s) will be accomplished for those reside to have been affected by the deficient practice?	t
	facility with the Dir	on made during a tour of the ector of Maintenance on .m., the corridor door to resident			

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	01	COMPLETED 05/06/2025
NAME OF P	RWOOD		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	doorframe. Based of The Director of Mai door of resident roo latch into the doorfr	fully close and latch into the n an interview at 12:10 p.m., intenance agreed that corridor m 109 failed to fully close and ame adding that he would d at as soon as possible.		3.No residents were identified being affected by the deficient practice.	
		viewed with the Administrator ntenance during the exit 5/25.		How be identified and what corrective action(s be taken?	
	3.1-19(b)			·No other residents have be identified as having the potent be affected by the alleged defipractice.	ial to
				The corridor door to resider room 109 has been repaired to close and latch into the door from all other corridor to reside rooms have been inspected a repaired if needed.	o rame nt
				What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not occ	ges e

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF F	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				·An audit will be conducted monthly for four weeks and the monthly for three months by the Maintenance director and/or hensure that all corridor doors resident rooms close and late into door frames. How be monitored to ensure the deficient practice will not recuive, what quality assurance program will be put into place	the his to to th the
				The Maintenance director is responsible for ensuring audit completed. Audit will be revie by the QA Committee. Once to 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 system changes for each deficiency we be completed. After submitting	ts are wed the mic will

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001			A. BUILDING B. WING	01	COMPLETED 05/06/2025		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE		
				is determined that the correction will not be completed by the dispreviously submitted, the Divisioneeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated darplan of correction date?	ate sion n as to		
K 0374 SS=D Bldg. 01	Barrie Based on observation failed to ensure 1 of would close to form LSC, Section 19.3.7 barriers shall comply Section 8.5.4.1 required close the opening lecterance necessary defined as 1/8 inch to	Iding Spaces - Smoke on and interview, the facility 1 sets of smoke barrier doors a smoke resistant barrier. 8 requires that doors in smoke y with LSC, Section 8.5.4. LSC, ires doors in smoke barriers to aving only the minimum for proper operation which is to restrict the movement of ent practice could affect staff in	K 0374	1.p paraid="375783762" paraeid="{7d28658d-80c8-4f8 f-b993ea10e8ac}{80}" >What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice?			
	during a tour of the Maintenance, the se basement corridor d tested several times.	on on 05/06/25 at 12:45 p.m. facility with the Director of t of smoke barrier doors in the id not close completely when . These doors were equipped are. There remained a one half		3.No residents were identified being affected by the deficient practice. How be identified and what			
				I			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING	01	COMPLETED 05/06/2025	
	F PROVIDER OR SUPPLIEI	t	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	inch gap between the fullest. Based on in Director of Mainter	ne doors when closed to their terview at 12:50 p.m., the nance agreed this set of smoke nt the passage of smoke when		corrective action(s be taken?	
		viewed with the Administrator intenance during the exit		No other residents have be identified as having the poten be affected by the alleged depractice.	tial to
				·The set of barrier doors in basement have been repaired ensure that they properly clos and latch.	d to
				What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not oc	nges e
				·An audit will be conducted weekly for four weeks and the monthly for three months by t Maintenance director and/or I ensure that the smoke barrier doors in the basement are properly closing and latching.	he nis to

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIER	2	7001 H	ADDRESS, CITY, STATE, ZIP COD		
HOOVEF	RWOOD		INDIAN	IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
				How be monitored to ensure to deficient practice will not recui.e., what quality assurance program will be put into place	ır,	
				·The Maintenance director i responsible for ensuring the a 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 system changes for each deficiency was be completed. After submittin acceptable plan of correction, is determined that the correct will not be completed by the corrections are submitted, the Divineeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated deplan of correction date?	will g an , if it ion date sion on as	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction g	(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				·06/30/2025	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and	d Electric			
	failed to ensure 1 of boxes were maintal condition. LSC 19 with Section 9.1. It wiring and equipm National Electrical Article 314.28(3) (provided with coversuitable for the cometal covers shall requirements of 25 could affect staff a compartment. Findings include: Based on observativith the Director of 11:26 a.m., an electrop ceiling in the cover, but it was hexposed electrical box. Based on interior Maintenance cowiring and would the junction box.	ion and interview, the facility of over 75 electrical junction ined in a safe operating 0.5.1.1 requires utilities comply LSC 9.1.2 requires electrical tent to comply with NFPA 70, Code. NFPA 70, 2011 Edition, c) states junction boxes shall be ers compatible with the box and additions of use. Where used, comply with the grounding 0.110. This deficient practice and 15 residents in one smoke district in one smoke district in one smoke of the Social Hall had a tenging down by one screw and wiring was hanging out of the review at 11:27 a.m., the Director infirmed there was exposed have the cover refastened onto	K 0511	ol="" role="list" start="1" What corrective action(s) will be accomplished for those resident 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 potentiabe affected by the alleged deficipractice. The cover that was hanging from the electrical junction box in the closet of the social hall has bee repaired. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does occur? An audit will be conducted monthly for three months by the Maintenance director and/or his ensure that all electrical junction boxes have covers. How be	al to ient m n n n n n n to
	_	eviewed with the Administrator aintenance at the exit		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will l	:

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/06/2025		
NAME OF F	PROVIDER OR SUPPLIEF	e.	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(b)			put into place? The Maintenance director is responsible for ensuring the a 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 th systemic changes for each deficiency will be completed. Submitting an acceptable plar correction, if it is determined to the correction will not be completed by the date previous submitted, the Division needs be contacted as soon as posson The facility will need to submit amended plan of correction with updated dated plan of correction date? 06/30/2025	e After n of hat usly to sible. t an		
K 0541 SS=D Bldg. 01	Chu 1. Based on observation failed to maintain 1 be self-closing and requires trash chute maintained per NFI Section 5.2.3.3.1.1 into a trash chute shelf-closing, positive door assembly. This	ation and interview, the facility of 4 soiled linen chute doors to positive latching. LSC 9.5.2 s shall be installed and PA 82, 2009 Edition. NFPA 82, requires all chute loading doors hall be provided with a re latching frame and gasketed s deficient practice could affect the vicinity of the south in the basement.	K 0541	What corrective action(s) will accomplished for those reside to have been affected by the deficient practice? No residents were identified being affected by the deficient practice.	d as		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING <u>01</u> B. WING			COMPLETED 05/06/2025		
NAME OF I	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
140	Based on observation Maintenance during p.m. on 05/06/25, the basement collection interview at the time Director of Mainten linen chute door was recently noticed it rework order, so coult had not been on the collection room. This finding was reand the Director of conference. 2. Based on observation failed to ensure door discharge rooms was latching mechanism chutes shall be instaat 82, 2009 Edition. Now where service open.	on with the Director of g a tour of the facility at 12:35 he soiled linen chute door in the a room was missing. Based on the observation, the sance confirmed the soiled as missing and added that he missing and had not received a d not say how long the door chute in the basement. Wiewed with the Administrator Maintenance during the exit ation and interview, the facility for the sequipped with a positive in the LSC 9.5.2 requires trash alled and maintained per NFPA at FPA 82, Section 5.2.5.1.2 states, fing rooms are provided and attic sprinklers, the room shall		TAG	How be identified and what corrective action(s be taken? No other residents have be identified as having the potent be affected by the alleged defi practice. A door to the soiled linen chin the basement collection roo has been installed. The facility repaired 1 of 2 trash chute docequipped with a positive latchi	ial to cient nute m has ors	DATE
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				mechanism. All stanchions we removed from service opening room door for the south trash chute discharge in the baseme. What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not occ	ent.		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVE COMPLETED 05/06/2025	
NAME OF P	ROVIDER OR SUPPLIER		7001	T ADDRESS, CITY, STATE, ZIP COD HOOVER RD ANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION THE SERVICE OPENING FORM dOOR	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COM	(X5) PLETION DATE
	for the south trash of basement was propp Based on interview the Director of Mai self-closing door to propped open and f	the service opening room door what discharge in the ped open with a stanchion. at the time of the observation, intenance agreed the the trash collection room was failed to latch when tested. The wiewed with the Administrator Maintenance during the exit		An audit will be conducted monthly for three months by Maintenance director and/or ensure trash chute doors eq with a positive latching mechanism are working properties of the control of	the his to uipped perly. The not he in the ur, e?	
				By What date does the syste changes for each deficiency	will	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/06/2025		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				acceptable plan of correction is determined that the correct will not be completed by the correction previously submitted, the Divineeds to be contacted as socious possible. The facility will need submit an amended plan of correction with the updated diplan of correction date?	date date dision on as d to		
K 0712	NFPA 101			·06/30/2025			
SS=F Bldg. 01	Based on record reversal failed to conduct quarters. LSC 19.7. conducted quarterly conditions. This defand residents. Findings include: Based on record reversal failed to conducted quarterly conditions. This defand residents. Findings include: Based on record reversal failed fa	he following fire drills: Irill for the second quarter of 2024/2025 e drill for the third quarter	K 0712	1.p="" paraid="324815897" paraeid="{aefe83b7-874b-4c6b-eb0ddd82cdc7}{88}" style="font-family: "Times New Roman_MSFontService", ser font-size: 16px; -webkit-usernone; -webkit-tap-highlight-cctransparent; margin: 0px; pac 0px; user-select: text; cursor: text; overflow: visible;" 1.p paraid="324815897" paraeid="{aefe83b7-874b-4c6b-eb0ddd82cdc7}{88}" >What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice?	eb-a96 w if; drag: blor: dding: eb-a96 t		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLE				
		155001	B. WI	NG		05/06/	/2025
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
					OOVER RD		
HOOVEF	RWOOD			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ober, 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						
					3.No residents were		
					identified as being affected by	tne	
	drills as of the time	of this survey.			deficient practice.		
	This item was revie	ewed with the Administrator					
		intenance at the exit					
	conference on 05/0						
				How be identified and wha			
	3.1-19(b)				corrective action(s be taken?		
	3.1-51(c)		corrective action(s be take		,		
					3.No other residents have be		
					identified as having the potent		
					be affected by the alleged defi	cient	
					practice.		
					5.Fire drills will be conducted	d at	
					least once on a quarterly basis		
					each shift. Fire drills will be		
					documented in TELS.		
					What measures will be put into		
					place and what systemic chan	-	
					will be made to ensure that the		
			1		deficient practice does not occ	:ur?	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING 01 B. WING		COMPLETED 05/06/2025			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE		
				·Audits of TELS for complia with conducting fire least once a quarterly basis for each shift be conducted by the Maintendirector and/or his designee monthly for four months. How be monitored to ensure deficient practice will not recuive, what quality assurance program will be put into place	e on it. will ance the		
				The Maintenance director is responsible for ensuring audit completed. Audit will be revie by the QA Committee. Once is 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 system changes for each deficiency was completed. After submitting acceptable plan of correction	ts are wed the mic vill g an		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING <u>01</u> B. WING			COMPLETED 05/06/2025	
		100001	D. WI			05/06/	12020
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD OOVER RD		
HOOVEF	RWOOD				APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K 0914 SS=F Bldg. 01	NFPA 101 Electrical System Testing Based on record re	s - Maintenance and view, observation and	K 09	TAG	is determined that the correctivill not be completed by the dipreviously submitted, the Divisioneeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated darplan of correction date? 06/30/2025	ate sion n as to ted	06/30/2025
	interview; the facilidocumentation of etesting for all reside available for review NFPA 99, Health CE Edition, Section 6.3 listed as hospital-grand in locations what anesthesia shall be exceeding 12 mont Facilities Code, 20 states hospital-grand performed after iniservicing of the dex Receptacle Testing the physical integriconfirmed by visual the grounding circuments of the second of the dex of the physical integriconfirmed by visual the grounding circuments.	ity failed to ensure complete electrical outlet receptacle ent sleeping rooms was in accordance with NFPA 99. Care Facilities Code, 2012 3.4.1.3 states receptacles not rade at patient bed locations here deep sedation or general tested at intervals not hs. NFPA 99, Health Care 12 Edition, Section 6.3.4.1.1 he receptacles testing shall be tial installation, replacement or vice. Section 6.3.3.2, in Patient Care Rooms requires ty of each receptacle shall be all inspection. The continuity of tit in each electrical receptacle correct polarity of the hot and	K 0	714	paraeid="{e3e6c116-cb47-473 26-34ecb3ce56eb}{13}" > What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice? 3.No residents were identified being affected by the deficient practice.	it nts ed as	00/30/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/06/2025	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	neutral connections shall be confirmed; grounding blade of (except locking-typ than 115 grams (4 c	in each electrical receptacle and retention force of the each electrical receptacle e receptacles) shall be not less punces). Section 6.3.4.2.1.2 n, the record shall contain the			5.How be identified and what corrective action(s be taken?	t	
	of which items have	reas tested, and an indication e met, or have failed to meet, quirements of this chapter. This dents.			7.No other residents have be identified as having the potent be affected by the alleged defipractice.	ial to	
	and the Director of 05/05/25, electrical testing documentati twelve month perio however it was incomplete testing documentating the documentation of the recept interview at 12:35 g				9.Non-hospital grade receptacles will be tested on a annual basis and documented TELS (itemized).		
	has multiple recepta may be hospital-gra electrical receptacle documentation was location. Based on a Administrator and t resident sleeping ro	each resident sleeping room acle locations some of which ade but agreed the provided e inspection and testing not itemized by receptacle observations with the he Director of Maintenance, oms in the first floor memory hospital-grade receptacles.			What measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not occ	ges	
		viewed with the Administrator Maintenance during the exit 6/25.			·An audit of TELS will be completed to ensure that non-hospital grade receptable have been tested for 2025.	s	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	a. Building <u>01</u>			COMPLETED	
155001		B. WING			05/06/2025		
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OOVER RD		
HOOVER	N/OOD				IAPOLIS, IN 46260		
TIOOVER	·····			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					How be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place? The Maintenance director is responsible for ensuring audits completed. Audits will be reviet by the QA Committee. Once the initial audit is completed and compliance is met the QA Committee may choose to	r, ? s s are ewed	
					discontinue the review of the audits. By What date does the system changes for each deficiency who be completed. After submitting acceptable plan of correction, is determined that the correction will not be completed by the dispreviously submitted, the Division needs to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated darplan of correction date?	vill g an if it on ate sion n as to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155001 B. WING 05/06/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7001 HOOVER RD **HOOVERWOOD** INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 06/30/2025K 0918 **NFPA 101** SS=F Electrical Systems - Essential Electric Syste Bldg. 01 1. Based on record review and interview, the K 0918 p="" paraid="1654050273" 06/30/2025 facility failed to ensure a written record of weekly paraeid="{e3e6c116-cb47-473a-86 inspections for the generator was maintained for 26-34ecb3ce56eb}{192}">What 15 weeks of the most recent 52 week period. corrective action(s) will be NFPA 99, 6.4.4.1.3 requires onsite generators shall accomplished for those residents be maintained in accordance with NFPA 110, to have been affected by the Standard for Emergency and Standby Power deficient practice? Systems. NFPA 110, 8.4.1 requires an Emergency No residents were identified as Power Supply System (EPSS) including all being affected by the deficient appurtenant components, shall be inspected practice. weekly and exercised monthly. NFPA 99, Section How be identified and what 6.4.4.2 requires a written record of inspection, corrective action(s be taken? performance, exercising period, and repairs for the No other residents have been identified as having the potential to generator to be regularly maintained and available for inspection by the authority having be affected by the alleged deficient jurisdiction. This deficient practice could affect all practice. residents, staff and visitors. Weekly emergency generator inspections will be conducted and Findings include: documented in TELS. Monthly load testing will be conducted and Based on review of Direct Supply TELS Logbook documented in TELS. Fuel testing Documentation "Emergency Power Generator" quality will be completed and with the Administrator and the Director of documented in TELS. What Maintenance during record review at 1:15 p.m. on measures will be put into place 05/05/25, weekly emergency generator inspection and what systemic changes will documentation was last documented 04/11/25. be made to ensure that the Additionally, the weeks of 09/08/24, all weeks in deficient practice does not occur? January-March of 2025 were not available for review. Based on interview at 1:20 p.m., the Audits of TELS for compliance Director of Maintenance stated the facility has with Generator preventative one diesel fired emergency generator and agreed maintenance will be conducted by weekly emergency generator inspection the Maintenance director and/or

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documentation for the aforementioned week

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his designee weekly for four

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING	01	COMPLETED 05/06/2025			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
	SUMMARY S (EACH DEFICIENT REGULATORY OR Periods were not average the survey. This finding was revealed the Director of Eacility failed to exempt the 2010 Edition, the St Standby Powers System 110, Section 8.4.2 s service shall be exert for a minimum of 30 following methods: (1) Loading that magas temperatures as manufacturer (2) Under operating not less than 30 peropower Supply) names Section 8.4.2.3 state installations that do 8.4.2 shall be exercised as shall be exercised as stated as services as the supply of t	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ailable for review at the time of viewed with the Administrator Maintenance during the exit 5/25. review and interview, the recise the generator for 7 of 12 requirements of NFPA 110, randard for Emergency and stems, Chapter 8.4.2. NFPA tates diesel generator sets in recised at least once monthly, 0 minutes, using one of the intains the minimum exhaust recommended by the temperature conditions and at cent of the EPS (Emergency	7001 H	OOVER RD	e After of hat usly to ible. i an		
	of the EPS namepla minutes and at not I nameplate kW ratin total test duration of hours. This deficier residents, staff and v Findings include:	te kW rating for 30 continuous ess than 75 percent of the EPS g for 1 continuous hour for a f not less than 1.5 continuous nt practice could affect all		00/30/2023			
		oad" with the Administrator					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/06/2025	
	OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	review at 1:20 p.m. documentation for and April 2025 was on interview at 1:21 Maintenance stated fired emergency geload testing docum aforementioned moreview at the time of the second of the second during the exit contains a second facility failed to en was performed for generator. NFPA 2012 Edition Section (Essential Electrical be inspected and the Section 6.4.4.1.1.3 maintenance shall like with NFPA110, Standby Power System NFPA 110, Section shall be performed approved by ASTM practice could affect Findings include: Based on record reand Director of Map.m., no documentatest for the diesel greview. Based on in Director of Maintenance on the section of Maintenance of Maintenance in the section of Maintenance in the	onths were not available for of the survey. The reviewed with the the Director of Maintenance ference on 05/06/25. The review and interview, the sure an annual fuel quality test the facility's diesel powered 199, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES all System) generator sets shall sted in accordance with a Section 6.4.4.1.1.3 states the performed in accordance andard for Emergency and stems, 2010 Edition, Chapter 8. The section 6.4.4.1.1 states are performed in accordance andard for Emergency and stems, 2010 Edition, Chapter 8. The section 6.4.5 states a fuel quality test at least annually using tests of standards. This deficient					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SUR COMPLETED 05/06/202			ETED		
NAME OF I	PROVIDER OR SUPPLIE	R		7001 H	ADDRESS, CITY, STATE, ZIP COD DOVER RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	on the diesel gener						51112
	and Director of Ma conference. 4. 1. Based on reco	eviewed with the Administrator intenance at the exit					
	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 Power Systems sha every three years (assigned class is gr permitted to termin	s that all Level 1 Emergency all be tested at least once within 36 months). Where the reater than 4 hours, it shall be nate the test after 4 hours. 6.4.1.1.6.1 states that Type 1 and					
	Type 2 essential el shall be classified a	ectrical system power sources at Type 10, Class X, Level 1 is deficient practice could					
	Findings include:						
	a.m. and 3:00 p.m. present, the facility documentation of a emergency generat 36 month period.	wiew on 02/25/25 between 10:00 with the Maintenance Director was unable to provide a four hour load test of the for conducted within the past This was confirmed by the stor at the time of record review.					
	and Maintenance I conference.	eviewed with the Administrator Director during the exit					
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	COM	TE SURVEY MPLETED 06/2025			
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE		
	facility failed to entimaintenance and tegenerator was main NFPA 110, the Start Standby Powers Sywritten schedule for operational testing established. 8.3.4 mag the EPSS inspectionand repairs shall be available. 8.3.4.1 mag shall include the formaintenance report servicing personnel unsatisfactory conductation that including parepair for the time a manufacturer. This all residents, staff at Findings include: Based on record rewith the Administration Maintenance, there available to show that routine maintenants. The most report for the emergon 3/04/24. Based on review, the Director schedule for the general facility to perform the emergency general this finding was recorded.	view on 05/5/25 at 2:15 p.m. ator and Director of was no documentation he emergency generator has hance during the past 12 recent routine maintenance gency generator was dated hinterview at the time of record or of Maintenance said he would herator vendor to come to the routine maintenance service on						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETED B. WING 05/06/2029				
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD		700	EET ADDRESS, CITY, STATE, 2 11 HOOVER RD DIANAPOLIS, IN 46260	ZIP COD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI: TAG	CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
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).		K 0000			
	Survey Date(s): 05 Facility Number: 05 Provider Number: AIM Number: 100	155001				
	found not in compl Participation in Me Subpart 483.90(a), 2012 Edition of the Association (NFPA Building 02 and Bu	Code survey, Hooverwood was inance with Requirements for edicare/Medicaid, 42 CFR Life Safety from Fire and the e National Fire Protection A) 101, Life Safety Code (LSC). wilding 03 were surveyed using lealth Care Occupancies and 410				
	three portions of or determined to be of was fully sprinkler 2017 general renov floor resident sleep memory care wing sleeping rooms 123 first floor and resid 2240 and 2241 on a Building 03 consis main entrance lobb offices, conference	lity with a basement consists of the building which was f Type II (111) construction and ed. Building 02 consists of the ration of all first and second bing room areas not in the and the addition of resident 38, 1239, 1240 and 1241 on the lent sleeping rooms 2238, 2239, the second floor in 2018. Its of the renovated first floor by, administrative support a room, gift shop and beauty has a fire alarm system with				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 02 COMPLETED B. WING 05/06/2025			LETED		
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тE	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 02	open to the corridor detectors hard wired installed in all resid facility has a capaci 129 at the time of the All areas where resisted were sprinklered and services was maintained in a LSC 9.6.1.3 required installed, tested, and with NFPA 70, Nat 72, National Fire A 14.4.5 states unless sections of this Codin accordance with or more often if required jurisdiction. NFPA smoke detector sensity and the services after installar smoke detector sensity and services were sprinklered by compliance.	idents have customary access and all areas providing facility klered. The facility has no providing facility services. Impleted on 05/09/25 In - Testing and In review and interview, the sure 1 of 1 fire alarm systems accordance with LSC 9.6.1.3. It is a fire alarm system to be a maintained in accordance ional Electrical Code and NFPA alarm Code. NFPA 72, Section otherwise permitted by other let, testing shall be performed the schedules in Table 14.4.5, uired by the authority having 1.72, Section 14.4.5.3.1 states sitivity shall be checked within tion. NFPA 72, 14.4.5.3.2 states sitivity shall be checked every after unless otherwise iance with Section 14.4.5.3.3. iice could affect all occupants.	K 0	345	1.p paraid="2136884719" paraeid="{c407e67b-e181-44: d9-2e8978d62ab8}{73}" >Whate corrective action(s) will be accomplished for those resident to have been affected by the deficient practice? No residents were identified a being affected by the deficient practice. How be identified and whate corrective action(s be taken?	at ents s	06/30/2025
	Director of Mainter	nance on 05/05/25 at 2:10 p.m	ı				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155001		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 05/06/2025		
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	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.		No other residents have been identified as having the potenti be affected by the alleged defining practice.			
	This finding was reviewed with the Administrator and Director of Maintenance at the exit conference.		The smoke detector sensitivity testing, inspection of control ur trouble signals, remote annunciators, initiating devices notification of appliance, magn	nit s,		
	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		hold-open will be completed semi-annually.			
	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		What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not occ	ges		
	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.		The Maintenance director and/or his will utilize the TELS program to ensure that ongoin compliance is achieved.	g		
	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		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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING	02	COMPLETED 05/06/2025			
NAME OF P	RWOOD		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	months after 07/08/3 Based on interview Maintenance agreed documentation for t	spection documentation six 24 was not available for review. at 1:07 p.m., the Director of d semi-annual inspection he facility's fire alarm system 08/24 was not available for		The licensed administrator compliance and report to the Committee semi-annually for year.	QA		
	These findings were Administrator and I the exit conference	e reviewed with the Director of Maintenance during					
	3.1-19(b)			By What date does the systemic changes for each deficiency will be completed. A submitting an acceptable plan correction, if it is determined to the correction will not be completed by the date previous ubmitted, the Division needs be contacted as soon as poss. The facility will need to submit amended plan of correction with the updated dated plan of correction date?	of hat usly to ible. t an		
K 0353	NFPA 101						
SS=F Bldg. 02	Sprinkler System -	- Maintenance and Testing					
	failed to document s	riew and interview, the facility sprinkler system inspections in FPA 25. NFPA 25, Standard for	K 0353	ol="" role="list" start="1" What corrective action(s) will I accomplished for those reside			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	construction 02	(X3) DATE SURVEY COMPLETED 05/06/2025			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)			
PREFIX TAG	the Inspection, Test Water-Based Fire P Edition, Section 5.2 sprinkler systems sl ensure that normal a being maintained. S fire department con tested, and maintain 13. Section 13.1.1.2 utilized for inspectivalized for inspectivalized for inspectivalized, and maintenancomponents and sha authority having jur deficient practice co and visitors. Findings include: Based on record rev with the Director of sprinkler system ga for 48 weeks of the was not available for inspection documencontrol valves for 8 12-month period was Based on interview Director of Mainten system gauge and c documentation for t monthly periods was the time of the surve	ing, and Maintenance of rotection Systems, 2011 .4.2 states gauges on dry pipe hall be inspected weekly to hair and water pressures are section 5.1.2 states valves and mections shall be inspected, and in accordance with Chapter at states Table 13.1.1.2 shall be non, testing and maintenance of conents and trim. Section 4.3.1 he made for all inspections, note of the system and its hall be made available to the insidiction upon request. This hould affect all residents, staff, which weekly dry large inspection documentation most recent 52-week period for review. In addition, monthly station for all sprinkler system months of the most recent as not available for review. On 05/06/25 at 1:10 p.m. the nance confirmed sprinkler control valve inspection he aforementioned weekly and as not available for review at ey.	PREFIX TAG	to have been affected by the deficient practice? No residents were identified a being affected by the deficient practice. How be identified a what corrective action(s be taken? No other residents have been identified as having the potent be affected by the alleged derivactice. The weekly dry sprinkler system gauge inspection will occur of weekly basis. ol="" role="list" start="3" What measures will be put into place and what systemic chain will be made to ensure that the deficient practice does not occur and/or his designee weekly for four weeks and the monthly for three months. However, i.e., who quality assurance program with put into place? The Maintenance director is responsible for ensuring audit completed. Audit will be reviet by the QA Committee. Once in initial audit is completed and compliance is met the QA Committee may choose to	as t nd n tital to ficient em n a to nges ne cur? ce be se en ow be ient nat ill be ts are wed		
	3.1-19(b)			discontinue the review of the audits. By What date does the	ne		

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING	02	COMPLETED 05/06/2025
NAME OF P	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				systemic changes for each deficiency will be completed. A submitting an acceptable plan correction, if it is determined the correction will not be completed by the date previous submitted, the Division needs be contacted as soon as poss. The facility will need to submit amended plan of correction withe updated dated plan of correction date? 06/30/2025	of nat isly to ible. an
K 0355 SS=E Bldg. 02	failed to ensure 2 of the serverys were nowith NFPA 10, Star Extinguishers, 2010 states fire extinguish obscured from view affect 30 residents at the 2B and 1B server Findings include: Based on observation with the Administra Maintenance on 05/noted: a) at 10:55 a.m., the extinguisher located blocked by a refrige 10:56 a.m., the Dire refrigerator was in f	tion and interview, the facility 3 K Class fire extinguishers in of obstructed in accordance idard for Portable Fire Edition. Section 6.1.3.3.1 hers shall not be obstructed or . This deficient practice could not staff in dining rooms near erys. The during a tour of the facility tor and Director of 06/25, the following was K Class portable fire I in the 2B servery was rator. Based on interview at ctor of Maintenance agreed a front of the wall-mounted K	K 0355	ol class="NumberListStyle1 SCXW115579835 BCX0" role="list" start="1" style="-webkit-user-drag: none-webkit-tap-highlight-color: transparent; margin: 0px; padd 0px; user-select: text; cursor: text; overflow: visible;" What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice? No residents were identified as being affected by the deficient practice.	ding: De nts
		obstructing access to the fire the had never noticed it was		How be identified and what corrective action(s be taken?	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION G <u>02</u>	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF I	PROVIDER OR SUPPLIER		700	EET ADDRESS, CITY, STATE, ZIP CO 01 HOOVER RD DIANAPOLIS, IN 46260	DD
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFII TAG	CROSS-REFERENCED TO THE AP	OULD BE COMPLETION
	extinguisher located blocked by a refrige 10:56 a.m., the Dire refrigerator was in the Class extinguisher, extinguisher. The Director of Ma does not take place	E K Class portable fire I in the 1B servery was reator. Based on interview at rector of Maintenance agreed a front of the wall mounted K obstructing access to the fire intenance stated that cooking in the servery areas, as all rom the kitchen and served to		·No other residents hat identified as having the be affected by the allege practice.	potential 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			The K class portable extinguisher located in 1 serveries have been more they are no longer block refrigerator. Also, the mainspection tags for fire extinguishers near room 2236 and the K class fire extinguisher locate in the server have been and the have been updated.	Ib and 2b eved so that eved by the eved by
	(3) Pressure gauge operable range or p (4) Fullness determ self expelling-type cartridge-operated of (5) Condition of tire nozzle for wheeled (6) Indicator for not using push-to-test p Section 7.2.4.1 state	gnated place o access or visibility reading or indicator in the osition ined by weighing or hefting for extinguishers, extinguishers, and pump tanks es, wheels, carriage, hose, and extinguishers nrechargeable extinguishers		p class="Paragraph SCXW115579835 BCX0 xml:lang="EN-US" paraid="2131553405" paraeid="{019dca53-bf7 4-6dbf5ed00a3a}{9}" > What measures will be place and what systemic will be made to ensure the deficient practice does not seem to see the second seem to	out into c changes hat the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPL	ETED
		155001	B. WI	NG	05/06/2025		/2025
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OOVER RD		
HOOVEF	DWOOD				APOLIS, IN 46260		
HOOVER	RWOOD			INDIAN	APOLIS, IN 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		cted, including those found to					
	require corrective a	ction. Section 7.2.4.3 requires					
	where at least monthly manual inspections are						
	conducted, the date the manual inspection was						
	performed and the i	initials of the person			·An audit conducted monthly	/ for	
		pection shall be recorded.			three months from TELS will		
		uires where manual inspections			ensure that all fire extinguishe	rs	
	are conducted, reco	ords for manual inspections			have been inspected, the tags		
	shall be kept on a ta	ag or label attached to the fire			initialed, and information input	into	
	extinguisher, on an	inspection checklist			TELS. The Maintenance direc	tor is	
	maintained on file, or by an electronic method.				responsible for ensuring audits	s are	
	Section 7.2.4.5 requires records shall be kept to				completed. Audit will be review	ved	
demonstrate that at least the last 12 monthly				by the QA Committee. Once the	ne		
	inspections have be	een performed. This deficient			initial audit is completed and		
	practice could affect	et up to 40 residents, as well as			compliance is met the QA		
	staff and visitors.				Committee may choose to		
					discontinue the review of the		
	Findings include:				audits.		
		rations with the Director of					
		Administrator on 05/06/25			•		
		facility, the following was			l		
	noted:	and the second			How be monitored to ensure the		
	,	e monthly inspection tag on the			deficient practice will not recur	,	
	_	her located by resident room			i.e., what quality assurance		
		mentation of a monthly			program will be put into place?	?	
	inspections for Apr						
		e monthly inspection tag on the					
	_	her located by resident room					
		mentation of a monthly					
	inspections for Apr				<u> </u>		
		e monthly inspection tag on the			·The Maintenance director is		
		uisher located in 1A servery			responsible for ensuring audits		
		ion of a monthly inspections			completed. Audit will be review		
	for April 2025.	4.1 4. C 1			by the QA Committee. Once the	ne	
	Based on interview				initial audit is completed and		
	·	rector of Maintenance			compliance is met the QA		
		of monthly inspections for the			Committee may choose to		
	aforementioned fire	e extinguishers			discontinue the review of the		
	I		1		audits.		I

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF I	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	_	viewed with the Administrator intenance at the exit			
	3.1-19(b)			By What date does the syste changes for each deficiency be completed. After submittin acceptable plan of correction is determined that the correct will not be completed by the previously submitted, the Divinceds to be contacted as so possible. The facility will need submit an amended plan of correction with the updated of plan of correction date?	will ng an n, if it stion date vision on as d to
				·06/30/2025	
K 0531 SS=E Bldg. 02	interview; the facili all elevator firefigh 9.4.6, Elevator Test elevators with firefi in accordance with monthly operation findings made and I required by ASME for Elevators and E	view, observation and ty failed to maintain testing of ter recall in accordance with ing. LSC 9.4.6.2 states that all ghters' emergency operations 9.4.3 shall be subject to a with a written record of the kept on the premises as A17.1/CSA B44, Safety Code scalators. This deficient t over six residents, staff and ty.	K 0531	1.p paraid="1521812933" paraeid="{bf1b5d1e-7c78-42 9-9e69bbc2e15c}{41}" >What corrective action(s) will be accomplished for those residual to have been affected by the deficient practice?	at Jents

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001			LDING	02	COMPL 05/06/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF	- L			ADDRESS, CITY, STATE, ZIP COD		
HOOVEF	RWOOD				APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	Findings include:				3.No residents were identified being affected by the deficient practice.		
	Maintenance at 12:: documentation for a recall testing was no on observations wit Director of Mainter facility on 05/06/25 elevators with firefi of "Fire Fighter's So documentation loca room closest to Lau facility indicated m August, September not documented for Fighter's Service To located in the eleva basement Machenic facility on 05/06/25 July, October, Nove April 2025 was not	view with the Director of 50 p.m. on 05/06/25, all monthly elevator firefighter of available for review. Based the head of the Administrator and the nance during a tour of the 4, the facility had a total of two ghter recall capability. Review ervice Test Log Sheet" ted in the elevator machine andry during a tour of the onthly testing for May, June, of 2024 and April 2025 was the elevator. Review of "Fire test Log Sheet" documentation tor machine room in the teal room during a tour of the indicated monthly testing for tember, December of 2024 and documented for the elevator.			How be identified and what corrective action(s be taken? No other residents have bee identified as having the potent be affected by the alleged defipractice.	ial to cient	
	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				The monthly elevator firefigl recall testing will occur monthly . What measures will be put into	y.	
	aforementioned mo review.	nths was not available for			place and what systemic chan will be made to ensure that the deficient practice does not occ	ges e	
		viewed with the Administrator Maintenance during the exit					
	3.1-19(b)						
					·TELS will be audited month for three months to ensure tha	-	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED 05/06/2025	
		155001	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	monthly elevator firefighter rectesting is occurring. The Maintenance director is responsible for ensuring audit completed. Audit will be review 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 audit completed. Audit will be review 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.	call s are wed he r, ?	
				By What date does the systen changes for each deficiency w		

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be completed. After submitting an

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF P	RWOOD		7001 H	ADDRESS, CITY, STATE, ZIP COD IOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.112
				acceptable plan of correction is determined that the correct will not be completed by the correction previously submitted, the Divineeds to be contacted as soci possible. The facility will need submit an amended plan of correction with the updated diplan of correction date?	date dision on as d to
				·06/30/2025	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills				
	failed to conduct quarters. LSC 19.7. conducted quarterly	view and interview, the facility harterly fire drills for 3 of 4 1.6 requires drills to be on each shift under varied ficient practice affects all staff	K 0712	1.p paraid="324815897" paraeid="{aefe83b7-874b-4ccb-eb0ddd82cdc7}{88}" >What corrective action(s) will be accomplished for those reside to have been affected by the deficient practice?	t
	"Direct Supply - TE the Director of Mai 05/05/25 at 12:55 p documentation for t a) a third shift fire of (April, May, June) b) a second shift fir (July, August, Septe	the following fire drills: Hrill for the second quarter of 2024/2025 e drill for the third quarter		3.No residents were identifit being affected by the deficient practice.	

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	02	COMPLETED 05/06/2025
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD JAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	December) of 2024 Based on an intervior Director of Mainten aforementioned mis further documentati	sing fire drills stating that no on could be located for fire		How be identified and what corrective action(s be taken?	
	drills as of the time This item was revie and Director of Mai conference on 05/06 3.1-19(b) 3.1-51(c)	wed with the Administrator ntenance at the exit		·No other residents have be identified as having the potent be affected by the alleged def practice.	tial to
				·Fire drills will be conducted least once on a quarterly basi each shift. Fire drills will be documented in TELS.	
				What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not occ	nges e
				·Audits of TELS for complian with conducting fire least once a quarterly basis for each shif be conducted by the Maintena director and/or his designee monthly for four months.	e on t. will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 02 COMPLETED B. WING 05/06/2025		
NAME OF F	PROVIDER OR SUPPLIER	R	7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	How be monitored to ensure to deficient practice will not recursive., what quality assurance program will be put into place? The Maintenance director is responsible for ensuring auditocompleted. Audit will be review by the QA Committee. Once to 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 system changes for each deficiency who be completed. After submitting acceptable plan of correction, is determined that the correction will not be completed by the dispreviously submitted, the Divisioneeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated darplan of correction date?	nic vill g an if it on ate sion n as to

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155001 B. WING 05/06/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7001 HOOVER RD **HOOVERWOOD** INDIANAPOLIS. IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 06/30/2025K 0914 **NFPA 101** SS=F Electrical Systems - Maintenance and Bldg. 02 Based on record review, observation and K 0914 1.p paraid="1124918201" 06/30/2025 interview; the facility failed to ensure paraeid="{e3e6c116-cb47-473a-86 documentation of electrical outlet receptacle 26-34ecb3ce56eb}{13}" > What testing for all resident sleeping rooms was corrective action(s) will be available for review in accordance with NFPA 99. accomplished for those residents NFPA 99, Health Care Facilities Code, 2012 to have been affected by the Edition, Section 6.3.4.1.3 states receptacles not deficient practice? 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 3.No residents were identified as performed after initial installation, replacement or being affected by the deficient servicing of the device. Section 6.3.3.2, practice. 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 5. How be identified and what shall be confirmed; and retention force of the corrective action(s be taken? 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, 7.No other residents have been

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the performance requirements of this chapter.

This could affect all residents.

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practice.

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identified as having the potential to

be affected by the alleged deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIE	R	700 ⁻	EET ADDRESS, CITY, STATE, ZIP (1 HOOVER RD IANAPOLIS, IN 46260	COD
(X4) ID PREFIX TAG	EACH DEFICIE REGULATORY OF Findings include: Based on record reand the Director of 05/05/25, electricatesting documentatively month period however it was included but there was listed but there was		ID PREFIX TAG	PROVIDER'S PLAN OF COLUMN (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) 9.Non-hospital grade receptacles will be tes annual basis and docuTELS (itemized).	APPROPRIATE COMPLETION DATE e. tited on an
	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)			What measures will be place and what system will be made to ensure deficient practice does	nic changes e that the s not occur?
				·An audit of TELS w completed to ensure the non-hospital grade rec have been tested for 2	hat ceptables
				How be monitored to e deficient practice will r i.e., what quality assur program will be put int	not recur, rance
				·The Maintenance d	irector is

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	NG <u>02</u>	COMPLETED		
		155001	B. WING		05/06	6/2025	
	PROVIDER OR SUPPLIE	R	70	REET ADDRESS, CITY, STATE, ZIP COD 01 HOOVER RD	_		
HOOVEF	RWOOD		INI	DIANAPOLIS, IN 46260			
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREF	CROSS-REFERENCED TO THE APPRO	ON DBE PRIATE	(X5) COMPLETION	
K 0918	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAC		edits are eviewed be the ad stemic by will tting an on, if it ection e date Division soon as eed to f	DATE	
SS=F Bldg. 02	Electrical System 1. Based on record facility failed to en inspections for the	s - Essential Electric Syste review and interview, the sure a written record of weekly generator was maintained for	K 0918	1.p paraid="1654050273 paraeid="{e3e6c116-cb47- 26-34ecb3ce56eb}{192}" >	473a-86	06/30/2025	
	15 weeks of the mo	ost recent 52 week period.		corrective action(s) will be			

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CENTERS FO	CAID SERVICES				ON	IB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	02	COMPLETED		
		155001	B. WING			05/06/2025		
	PROVIDER OR SUPPLIE	R	<u> </u>	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION DDFFIY (EACH CORRECTIVE ACTION SHOULD B			COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE	
		3 requires onsite generators shall			accomplished for those resid	ents		
		ccordance with NFPA 110,			to have been affected by the			
		gency and Standby Power			deficient practice?			
		10, 8.4.1 requires an Emergency			general products			
	1 -	tem (EPSS) including all						
		onents, shall be inspected						
		sed monthly. NFPA 99, Section						
	-	vritten record of inspection,						
-		eising period, and repairs for the			3.No residents were identif	ied as		
	generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.				being affected by the deficier			
					practice.			
					'			
	Findings include:							
					How be identified and what			
	Based on review of	f Direct Supply TELS Logbook			corrective action(s be taken?			
	Documentation "En	mergency Power Generator"						
	with the Administr	rator and the Director of						
	Maintenance during	g record review at 1:15 p.m. on						
	05/05/25, weekly e	emergency generator inspection						
	documentation was	s last documented 04/11/25.						
	Additionally, the w	veeks of 09/08/24, all weeks in			·No other residents have be	een		
	January-March of 2	2025 were not available for			identified as having the poter	ntial to		
	review. Based on in	nterview at 1:20 p.m., the			be affected by the alleged de	ficient		
	Director of Mainter	nance stated the facility has			practice.			
	one diesel fired em	ergency generator and agreed						
		generator inspection						
	documentation for	the aforementioned week						
	periods were not av	vailable for review at the time of						
	the survey.							
					·Weekly emergency genera	ator		
		eviewed with the Administrator			inspections will be conducted			
	and the Director of	Maintenance during the exit			documented in TELS. Month	ly		
	conference on 05/0	06/25.			load testing will be conducted	and t		
					documented in TELS. Fuel to	esting		
		review and interview, the			quality will be completed and			
	facility failed to ex	ercise the generator for 7 of 12			documented in TELS.			
	months to meet the	requirements of NFPA 110,						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING 02 B. WING		COMPLETED 05/06/2025				
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			7001 H	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	110, Section 8.4.2 si service shall be exert for a minimum of 30 following methods: (1) Loading that material gas temperatures as manufacturer (2) Under operating not less than 30 percent power Supply) namended section 8.4.2.3 state installations that do 8.4.2 shall be exercised as loads (Load Bank Tof the EPS nameplate minutes and at not lenameplate kW rating total test duration of	s diesel-powered EPS not meet the requirements of sed monthly with the available Power Supply System) load and nually with supplemental est) at not less than 50 percent te kW rating for 30 continuous ess than 75 percent of the EPS g for 1 continuous hour for a Fnot less than 1.5 continuous at practice could affect all		What measures will be put interplace and what systemic char will be made to ensure that the deficient practice does not one. Audits of TELS for compliant with Generator preventative maintenance will be conducted the Maintenance director and his designee weekly for four weeks and then monthly for the months. How be monitored to ensure deficient practice will not recuive, what quality assurance	to nges ne ccur? ince ed by /or hree			
	Documentation "Em Generator Under Lo and the Director of I review at 1:20 p.m. documentation for I and April 2025 was on interview at 1:20 Maintenance stated fired emergency ger load testing docume	nths were not available for		The Maintenance director is responsible for ensuring audit completed. Audit will be reviet by the QA Committee. Once is initial audit is completed and compliance is met the QA Committee may choose to discontinue the review of the	is ts are wed			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	î ´	UILDING	onstruction 02	(X3) DATE COMPL 05/06/	ETED	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			•	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Administrator and t during the exit conf	e reviewed with the the Director of Maintenance Ference on 05/06/25.			audits.			
	facility failed to ensure was performed for generator. NFPA 9 2012 Edition Section (Essential Electrical be inspected and tessection 6.4.4.1.1.3. maintenance shall be with NFPA110, Standby Power System NFPA 110, Section shall be performed	review and interview, the sure an annual fuel quality test the facility's diesel powered 9, Health Care Facilities Code, on 6.5.4.1.1.2 states Type 2 EES 1 System) generator sets shall sted in accordance with Section 6.4.4.1.1.3 states be performed in accordance undard for Emergency and tems, 2010 Edition, Chapter 8. 8.3.8 states a fuel quality test at least annually using tests I standards. This deficient et all residents.			By What date does the system changes for each deficiency who be completed. After submitting acceptable plan of correction, is determined that the correcti will not be completed by the dipreviously submitted, the Divisioneeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated darplan of correction date?	vill g an if it on ate sion n as to		
	and Director of Ma p.m., no documenta test for the diesel greview. Based on ir Director of Mainter was not conducted on the diesel genera This finding was re	view with the Administrator intenance on 05/05/25 at 2:07 ation of an annual fuel quality enerator was available for atterview at 2:10 p.m., the nance stated a fuel quality test within the last twelve months ator. viewed with the Administrator intenance at the exit			-06/30/2025			
	4. 1. Based on reco facility failed to pro for the testing of 1 System in accordan	ord review and interview, the ovide complete documentation of 1 Emergency Power Standby ce with NFPA 110, Standard Standby Power Systems,						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE COMPI 05/06	LETED
NAME OF I	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Facilities Code, Sec Section 8.4.9 states Power Systems sha every three years (3 assigned class is green permitted to termin NFPA 99 Section 6 Type 2 essential ele shall be classified a generator sets. This affect all building of Findings include: Based on record revalum, and 3:00 p.m. present, the facility documentation of a emergency generate 36 month period. This finding was reand Maintenance Direct This finding was reand Maintenance Direct This finding was reand Maintenance and the generator was main NFPA 110, the Stat Standby Powers Sywritten schedule for operational testing established. 8.3.4 rethe EPSS inspection	quired by NFPA 99 Health Care stion 6.4.1.1.6.1. NFPA 110 that all Level 1 Emergency II be tested at least once within 6 months). Where the state than 4 hours, it shall be attee the test after 4 hours. 4.1.1.6.1 states that Type 1 and setrical system power sources to Type 10, Class X, Level 1 is deficient practice could occupants. All the Maintenance Director was unable to provide four hour load test of the for conducted within the past this was confirmed by the for at the time of record review. Wiewed with the Administrator irrector during the exit review and interview, the sure a written record of routine sting for 1 of 1 emergency tained and available for review. Indeed the test of the exit of the EPSS shall be equires a permanent record of the tests, exercising, operation, maintained and readily				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 05/06/2025
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	shall include the fol maintenance report servicing personnel unsatisfactory cond taken, including par repair for the time a	equires the permanent record lowing: (1) The date of the (2) Identification of the (3) Notification of any ition and the corrective action its replaced (4) Testing of any is recommended by the deficient practice could affect and visitors.			
	with the Administra Maintenance, there available to show the had routine maintenance. The most report for the emerge 03/04/24. Based on review, the Director schedule for the ger facility to perform the emergency general or this finding was recommendated.	was no documentation the emergency generator has thance during the past 12 recent routine maintenance tency generator was dated interview at the time of record of Maintenance said he would therefore vendor to come to the to outine maintenance service on			
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipme Extens 1. Based on observa failed to ensure a m as a substitute for fi rooms in 1A East ha wiring and equipme	ent - Power Cords and ation and interview, the facility ulti-plug adaptor was not used xed wiring in 1 of 15 resident all. LSC 9.1.2 requires electrical ent shall be in accordance with Electrical Code. NFPA 70, 2011	K 0920	1.p paraid="2089561590" paraeid="{b084f12a-9e12-4d7 9-c22465d93b97}{209}" > White corrective action(s) will be accomplished for those resident to have been affected by the	at

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	(X3) DATE SURVEY COMPLETED 05/06/2025	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG	Edition, Article 400	LSC IDENTIFYING INFORMATION 8 requires that, unless	TAG	deficient practice?	DATE
	shall not be used as	ed, flexible cords and cables a substitute for fixed wiring of			
	residents, staff and	icient practice could affect 15 visitors in one smoke			
	compartment. Findings include:			3.No residents were identifit being affected by the deficien	
	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.			practice.	
				How be identified and what corrective action(s be taken?	
	failed to ensure flex substitute for fixed electrical wiring an accordance with NF Code. NFPA 70, 20 requires that, unless cords and cables sh for fixed wiring of a practice could affect	ation and interview, the facility lible cords were not used as a wiring. LSC 9.1.2 requires dequipment shall be in SPA 70, National Electrical 11 Edition, Article 400.8 especifically permitted, flexible all not be used as a substitute a structure. This deficient t staff and up to 15 residents		·No other residents have be identified as having the poten be affected by the alleged de practice.	tial to
	in one smoke compartment. Findings include:			·The multi-plug adapter in resident room 1129 has been removed. Also, the extension	
	Maintenance and th 10:53 a.m., a refrige extension cord in th interview at 10:55 a Maintenance confir	med a refrigerator was plugged		being used to plug in the refrigerator on the 2b has been removed.	
	into an extension co	ord in the servery on 2B.		What measures will be put in	io l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	construction 02	(X3) DATE SURVEY COMPLETED 05/06/2025	
	PROVIDER OR SUPPLIE	P.R.	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	•
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This finding was reviewed with the Administrator and Director of Maintenance at the exit conference. 3.1-19(b)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) place and what systemic cha will be made to ensure that the deficient practice does not occord	nges ne	
				The maintenance director audit a unit each month for for months to ensure that multi-padapters and extension cords not being used. The Maintens director is responsible for ensudits are completed. Audit we reviewed by the QA Committe Once the initial audit is compand compliance is met the QA Committee may choose to discontinue the review of the audits.	our olug s are ance suring vill be ee. leted
				How be monitored to ensure deficient practice will not recui.e., what quality assurance program will be put into place	ır,
				The Maintenance director responsible for ensuring audi completed. Audit will be revie by the QA Committee. Once initial audit is completed and	ts are ewed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/06/2025	
NAME OF F	PROVIDER OR SUPPLIE	R	7001 H	ADDRESS, CITY, STATE, ZIP COD IOOVER RD IAPOLIS, IN 46260	l	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	BY FULL PREFIX (EACH CORRECTION CORRECTION CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
				Committee may choose to discontinue the review of the audits.		
				By What date does the syster changes for each deficiency was be completed. After submitting acceptable plan of correction, is determined that the correction will not be completed by the date previously submit the Division needs to be contains as soon as possible. The facil will need to submit an amenda plan of correction with the upon dated plan of correction date?	vill g an if it ed ted, acted ity ed dated	
K 0000						
Bldg. 03	Licensure Survey	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0000			
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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE (A. BUILDING B. WING	03		LETED 5/2025
NAME OF P	PROVIDER OR SUPPLIER		7001	T ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION .D BE .OPRIATE	(X5) COMPLETION DATE
	Provider Number: AIM Number: 100	275310				
	found not in compli Participation in Me Subpart 483.90(a), 2012 Edition of the Association (NFPA Building 02 and Bu	Code survey, Hooverwood was ance with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection) 101, Life Safety Code (LSC). ilding 03 were surveyed using ealth Care Occupancies and 410				
	three portions of on determined to be of was fully sprinklere 2017 general renovation resident sleeping memory care wing sleeping rooms 123 first floor and reside 2240 and 2241 on the Building 03 consist main entrance lobbin offices, conference shop. The facility has made detection in open to the corridor detectors hard wire installed in all reside	ity with a basement consists of e building which was a Type II (111) construction and id. Building 02 consists of the ation of all first and seconding room areas not in the and the addition of resident 8, 1239, 1240 and 1241 on the ent sleeping rooms 2238, 2239, the second floor in 2018. It is of the renovated first floor by, administrative support room, gift shop and beauty has a fire alarm system with the corridor and in all areas at the facility has smoke in the fire alarm system ent sleeping rooms. The ty of 155 and had a census of his survey.				
	were sprinklered an services were sprink	dents have customary access d all areas providing facility klered. The facility has no providing facility services.				
	Quality Review cor	npleted on 05/09/25				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULT: A. BUILD B. WING		NSTRUCTION 03	COMP	E SURVEY LETED 6/2025
NAME OF F	PROVIDER OR SUPPLIEF		7	001 HC	DDRESS, CITY, STATE, ZIP COD DOVER RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System	- Maintenance and Testing					
Blag. U3	Sprinkler System - Maintenance and Testing		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		06/30/2025
					system gauge inspection of conducted by the Maintena director and/or his designed weekly for four weeks and monthly for three months.	ance ee then How be	
					monitored to ensure the depractice will not recur, i.e., quality assurance program put into place? The Maintenance director responsible for ensuring a completed. Audit will be re-	what will be is udits are	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/06/2025		
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	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. A submitting an acceptable plan correction, if it is determined the correction will not be completed by the date previous submitted, the Division needs be contacted as soon as possion The facility will need to submitted amended plan of correction withe updated dated plan of correction date?	e After of nat isly to ible. an	

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