PRINTED: 02/10/2023 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER	COMPLETED 01/19/2023 ESS, CITY, STATE, ZIP COD ER RD
NAME OF PROVIDER OR SUPPLIER	ER RD
7001 HOO\	LIS, IN 46260
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE
conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/19/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Emergency Preparedness survey,	e creation and submission of splan of correction does not istitute an admission by this vider of any conclusion set forth the statement of deficiencies, or any violation of regulation. Is provider respectfully requests the 2567 plan of correction be insidered the letter of credible regation and requests desk liew (paper compliance) on or let 2/20/2023

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

TITLE (X6) DATE

Jennifer Voss Administrator 02/06/2023

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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PRINTED: 02/10/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	î ´	UILDING	NSTRUCTION	(X3) DATE COMPL 01/19/	ETED
NAME OF F	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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	implement emerge systems based or forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location requir Care Facilities Co Interim Amendme	e located in accordance with rements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA					
	Code (NFPA 101 Amendments TIA	<u> </u>					
	Emergency gener The [hospital, CAI implement the em inspection, testing requirements four	3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system I, and [maintenance] Ind in the Health Care FPA 110, and Life Safety					
	Emergency gener and LTC facilities] source to power e have a plan for ho	3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency perational during the sit evacuates.					
	§483.73(g), and C The standards inc this section are ap	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in oproved for incorporation by Director of the Office of the					

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF I	PROVIDER OR SUPPLIEF		7001 H	ADDRESS, CITY, STATE, ZIP COD IOOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE COMPLETION COMPLETION
TAG	REGULATORY OF Federal Register i 552(a) and 1 CFR the material from You may inspect a Information Resource Boulevard, Baltim Archives and Rec (NARA). For information Resource this material at NA go to: http://www.archive_of_federal_regularing the properties of th	n accordance with 5 U.S.C. part 51. You may obtain the sources listed below. a copy at the CMS urce Center, 7500 Security ore, MD or at the National ords Administration mation on the availability of ARA, call 202-741-6030, or es.gov/federal_register/code ations/ibr_locations.html. this edition of the Code are eference, CMS will publish a rederal Register to riges. Protection Association, 1 k, p, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued March 3, fe Safety Code, 2012	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE DATE
ĺ	ــــــــــــــــــــــــــــــــــــــ				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 01/19/2023			
NAME OF I	PROVIDER OR SUPPLIER	R	7001	T ADDRESS, CITY, STATE, ZIP COD HOOVER RD ANAPOLIS, IN 46260	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	REGULATORY OR (xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to or 2009. Based on record rev interview; the facility emergency power sy maintenance required Care Facilities Code Code in accordance This deficient pract staff and visitors. Findings include: a. Based on review Generator Operating documentation with Director of Operation Maintenance during to 1:00 p.m. on 01/1 generator inspection was not available for at the time of record Maintenance stated fired emergency get inspection document available for review B. Based on review Generator Operating documentation with Director of Operation	R LSC IDENTIFYING INFORMATION FPA 101, issued October standard for Emergency and ystems, 2010 edition, chapter 7, issued August 6, view, observation and ty failed to implement the ystem 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, of "Emergency/Auxiliary g Log (Inspection Testing)" in the Administrator, the one and the Director of g record review from 9:15 a.m. 19/23, weekly emergency in documentation after 06/30/22 for review. Based on interview d review, the Director of the facility has one diesel fuel merator and agreed weekly intation after 06/30/22 was not		E041 Hospital CAH and LTC Emergency Power What corrective action(s) w be accomplished for those residents found to have be affected by the deficient practice? The emergency power system has been inspected, tested according to LSC requirements How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be tak No residents were affe by the alleged deficient practice by the alleged deficient pract All residents, visitors, shave the potential to be affected by the alleged deficient pract What measures will be put if place or what systemic changes you will make to ensure that the deficient practice does not recur? Evapar, our service prohas been contacted to provide	DATE DATE 02/20/2023 ill en r ial en? cted tice. staff ted tice into
	documentation for t	19/23, monthly load testing the facility's diesel fuel fired		preventative maintenance ev months; the 90 minute annua	al
		or after 6/30/22 was not		load bank test, and the 4 hou	
	available for review	7. Based on interview at the		load bank test that is required	d l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/19/2023		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	time of record revie agreed monthly load the facility's diesel: 6/30/22 was not avant c. Based on review Generator Operating documentation with	of "Emergency/Auxiliary g Log (Inspection Testing)" the Administrator, the ons and the Director of	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA every 3 years, with document A Maintenance audit to ensuring corridors are continuously maintained free obstructions, will be complete monthly for one year with resure reported to the Quality Assura Performance Improvement (Committee	ation ol, of all d ults ance (AAPI)	
	to 1:00 p.m. on 01/2 generator testing do period prior to 06/3 generator load testin the name plate ratin time of record revie stated the facility po agreed emergency §	g record review from 9:15 a.m. 19/23, weekly emergency recumentation for the six month 0/22 indicated emergency ng does not achieve 30% of g. Based on interview at the w, the Director of Maintenance erforms a weekly load test, generator load testing does not		Administrator/designee verify documentation is in TEI the emergency power system has been inspected, tested according to LSC requiremen How the corrective action(s) will be monitored to ensure deficient practice will not	_S of n ts	
	rating and agreed do load bank test for the conducted within the period was not available. Based on record	load of 30% of the name plate ocumentation of an annual see emergency generator see most recent twelve month lable for review. review with the Administrator, rations and the Director of		recur, i.e., what quality assurance program will be p into place? A Maintenance audit to The emergency power system has been inspected, tested according to maintenance	ol, n	
	Maintenance from 9 01/19/23, thirty-six generator testing do continuous hours for emergency generate Based on interview the Director of Mai one diesel fuel fired agreed documentati testing for four hour	rations and the Director of 0:15 a.m. to 1:00 p.m. on month period emergency reumentation for four or the facility's diesel fired or was not available for review, at the time of record review, ntenance stated the facility has a temergency generator and on of supplemental load rs within the most recent three available for review.		requirements, will be complet monthly for one year with rest reported to the Quality Assura Performance Improvement (C Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinate action	ults ance (API) of n ure ance	
		ons with the Director of ector of Maintenance and the				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/19/2023	
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)	TE	(X5) COMPLETION DATE
	Maintenance Techn facility from 1:00 p diesel fuel fired em- facility located outs nameplate indicatin 800 kW and was ma These findings were Administrator, the I	ician during a tour of the .m. to 3:45 p.m. on 01/19/23, the ergency generator for the ide the building had an affixed g the generator was rated at anufactured in July 2016. e reviewed with the Director of Operations, the lance and the Maintenance					
K 0000							•
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/19 Facility Number: 0 Provider Number: 100 At this Life Safety of found not in complication in Measure Subpart 483.90(a), 3 2012 Edition of the Association (NFPA Building 01 was sur Existing Health Car 16.2.	00001 155001 275310 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). Eveyed using Chapter 19, the Occupancies and 410 IAC	K 0	000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. This provider respectfully requitate the 2567 plan of correction considered the letter of credible allegation and requests desk review (paper compliance) on after 2/20/2023	t s forth s, or ests n be e	
	three portions of on determined to be of	ity with a basement consists of e building which was Type II (111) construction and d. Building 01 consists of the					

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	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 01 155001 B. WING			(X3) DATE SURVEY COMPLETED 01/19/2023			
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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0761 SS=F Bldg. 01	memory care wing kitchen, the baseme on the first floor whroom. The facility smoke detection in open to the corridor detectors hard wired installed in all resid facility has a capaci 138 at the time of the All areas where resist were sprinklered an services were sprinklered and services were completed in a Communicating operation and testing were completed in a Communicating operation and shall be corridors and shall be serviced as a service with the services were sprinklered and s	which is one story, the former nt and the former dining room iich is now a special events has a fire alarm system with the corridor and in all areas. The facility has smoke if to the fire alarm system ent sleeping rooms. The try of 155 and had a census of his survey. I dents have customary access if all areas providing facility clered. The facility has no providing facility services.	K 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All Fire doors have been inspected, with the appropriate documentation	II 02/20/2023 n		
	8.3.) LSC 8.3.3.1 O protection rating by protected by approvassemblies and fire accompanying hard closing devices, and accordance with the Standard for Fire D Protectives, except	penings required to have a fire Table 8.3.4.2 shall be red, listed, labeled fire door window assemblies and their ware, including all frames,		How will you identify other residents having the potentiato be affected by the same deficient practice and what corrective action will be take. No residents were affe by the alleged deficient practice. All residents, visitors, so have the potential to be affect by the alleged deficient practice.	en? ected ice. taff ted		
		nd tested not less than		,gea aenoioni pidotti			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLETED	
		155001	B. W	ING		01/19/2	2023
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>	7001 HOOVER RD				
HOOVEF	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ten record of the inspection			What measures will be put in	ito	
	_	kept for inspection by the			place or what systemic		
	1	.3.1 states functional testing of			changes you will make to		
		w assemblies shall be			ensure that the deficient		
		iduals with knowledge and			practice does not recur?		
	_	e operating components of			· All Fire doors have bee		
		ng subject to testing. NFPA			inspected, with the appropriate	е	
	· ·	e door assemblies shall be			documentation		
		rom both sides to assess the			A Maintenance audit to	ol,	
	overall condition of	door assembly.			ensuring all doors are inspect		
					will be completed monthly for	one	
	NFPA 80, Section 5.2.4.2 states as a minimum, the				year with results reported to the	ne	
	following items shall be verified:				Quality Assurance Performan	ce	
		r breaks exist in surfaces of			Improvement (QAPI) Committ	ee	
	either the door or fr	ame.			· Administrator/designee	to	
	(2) Glazing, vision	light frames, and glazing beads			verify documentation is in TEL	S of	
	are intact and secure	ely fastened in place, if so			the doors being inspected		
	equipped.				according to Life Safety		
	(3) The door, frame	, hinges, hardware, and			requirements		
		eshold are secured, aligned,					
	and in working orde	er with no visible signs of					
	damage.				How the corrective action(s)		
	(4) No parts are mis	_			will be monitored to ensure t	:he	
	()	do not exceed clearances			deficient practice will not		
	listed in 4.8.4 and 6				recur, i.e., what quality		
		device is operational; that is,			assurance program will be p	ut	
		pletely closes when operated			into place?		
		osition.			A Maintenance audit to	ol,	
	(7) If a coordinator	is installed, the inactive leaf			ensuring All Fire doors have b	een	
	closes before the ac	tive leaf.			inspected, with the appropriate	e	
		are operates and secures the			documentation, will be comple	eted	
	door when it is in th	-			monthly for one year with resu	ılts	
	(9) Auxiliary hardw	vare items that interfere or			reported to the Quality Assura	nce	
	prohibit operation a	re not installed on the door or			Performance Improvement (Q	API)	
	frame.				Committee monthly meeting for	or 6	
	(10) No field modif	ications to the door assembly			months, QAPI is overseen by	the	
	have been performe	d that void the label.			Administrator. Any non		
	(11) Gasketing and	edge seals, where required, are			compliance with staff will resu	It in	
	inspected to verify t	their presence and integrity.			staff education and up to		
	This deficient practice could affect all residents,				disciplinary action.		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155001	B. WI	NG		01/19/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OOVER RD		
HOOVER	RWOOD				APOLIS, IN 46260		
	Г		_	L	7.11 02.10, 114 102.00		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	staff and visitors.						
	Findings include:						
		Direct Supply TELS Logbook					
		oors Locks & Alarms: Test					
	_	and Locks" dated 12/24/22					
		"Fire Door Inspections-Code					
	Specifics" documentation dated 12/28/22 with the Administrator, the Director of Operations and the						
	Director of Maintenance during record review						
	from 9:15 a.m. to 1:00 p.m. on 01/19/23, annual						
	inspection documentation of fire door assemblies						
	in the facility within the most recent twelve month						
	period did not inclu	ide all fire doors in the facility.					
	The annual inspecti	ion documentation dated					
	I	ided five fire door locations					
		ast, 1B, 1C, 2A and 2B" in the					
		areas of the building and did					
		or locations in the basement or					
		sed on interview at the time of					
		Director of Maintenance stated					
		oor inspection documentation de all fire doors inspected in					
		as and agreed the 12/24/22 fire					
		cumentation was not itemized					
	_	re all fire doors in the facility					
	_ ·	nin the most recent twelve					
	_	ed on observations with the					
		ons, the Director of					
	_	ne Maintenance Technician					
	during a tour of the	facility from 1:00 p.m. to 3:45					
	p.m. on 01/19/23, t	he entry room door to the					
	laundry chute room	and the trash chute room in					
		fire-rated door with a minimum					
		stance rating label affixed to the					
		door in the basement was also					
		mum 45-minute resistance					
		to the door. Based on					
	interview at the tim	ne of record review and of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155001	B. W	NG		01/19/	2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
K 0000	it could not be ensur the facility were inc annual fire door insp These findings were Administrator, the I	Director of Operations, the nance and the Maintenance					
Bldg. 02	Licensure Survey w Department of Heal 483.90(a). Survey Date: 01/19 Facility Number: 00 Provider Number: 1002 At this Life Safety C found not in complic Participation in Med Subpart 483.90(a), I 2012 Edition of the Association (NFPA) Building 02 and B	00001 155001	K 0	000	The creation and submission of this plan of correction does no constitute an admission by this provider of any conclusion set in the statement of deficiencies of any violation of regulation. This provider respectfully require that the 2567 plan of correction considered the letter of credible allegation and requests desk review (paper compliance) on after 2/20/2023	t s forth s, or ests n be e	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	ETED
		155001	B. WI	NG		01/19/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	1			OOVER RD		
HOOVER	WOOD.				APOLIS, IN 46260		
TIOOVEI	WOOD .			INDIAN	Al OLIO, IIV 40200		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ation of all first and second					
	_	ng room areas not in the					
	memory care wing and the addition of resident						
		8, 1239, 1240 and 1241 on the					
		ent sleeping rooms 2238, 2239,					
		he second floor in 2018.					
		s of the renovated first floor					
	•	y, administrative support					
		room, gift shop and beauty					
		nas a fire alarm system with					
	smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The						
		ty of 155 and had a census of					
	142 at the time of th	nis survey.					
	All areas where resi	idents have customary access					
	were sprinklered an	d all areas providing facility					
	services were sprink	klered. The facility has no					
	detached buildings j	providing facility services.					
	Quality Review con	npleted on 01/25/23					
K 0211	NFPA 101						
SS=E	Means of Egress -	- General					
Bldg. 02	Means of Egress -	- General					
	Aisles, passagewa	ays, corridors, exit					
	discharges, exit lo	cations, and accesses are					
	in accordance with	n Chapter 7, and the means					
	of egress is contin	uously maintained free of					
	all obstructions to	full use in case of					
	emergency, unless	s modified by 18/19.2.2					
	through 18/19.2.1	1.					
	18.2.1, 19.2.1, 7.1	.10.1					
		on and interview, the facility	K 02	211	What corrective action(s) wil	ı	02/20/2023
		f 11 means of egress was			be accomplished for those		
	•	ained free of all obstructions			residents found to have beer	1	
	or impediments to f	full instant use in the case of			affected by the deficient		
	fire or other emerge	ency. This deficient practice			practice?		

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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 <u>02</u>	(X3) DATE SURVEY COMPLETED 01/19/2023	
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		residents, staff and visitors if facility on the second floor by		 All means of egress had been addressed and reviewer 	
	Room 2231.	activity on the second floor by		ensure compliance with Life	
				Safety Code Standards	
	Findings include:			· The plastic three drawe	er
				chest of drawers for isolation	1
		ons with the Director of		supplies has been removed	
	_	ector of Maintenance and the		How will you identify other	
Maintenance Technician during a tour of the			residents having the potenti	al	
facility from 1:00 p.m. to 3:45 p.m. on 01/19/23, a plastic three drawer chest of drawers for isolation			to be affected by the same deficient practice and what		
supplies was stored in the corridor outside Room			corrective action will be take	en?	
2231 on the second floor. Based on interview at			No residents were affer		
the time of the observations, the Director of			by the alleged deficient pract		
	Maintenance agreed	d the aforementioned means of		· 15 residents, visitors,	
	egress was not cont	inuously maintained free of all		have the potential to be affect	ted
	obstructions or imp	ediments to full instant use in ther emergency.		by the alleged deficient practi	ce
		5 ,		What measures will be put i	nto
	These findings were	e reviewed with the		place or what systemic	
		Director of Operations, the		changes you will make to	
		nance and the Maintenance		ensure that the deficient	
	Technician during t	he exit conference.		practice does not recur?	
	3.1-19(b)			· Clinical Educator/desig	
				to in-service staff on maintain	ning
				means of egress free of all	
				obstructions or impediments	to full
				use in case of fire or other	
				emergency A maintenance audit to	.ol
				will be completed monthly for	
				year to ensure all means of e	
				are being maintained.	J -
				A visual inspection by t	he
				Maintenance Director/designe	
				has been completed to ensur	e all
				means of egress are being	
				maintained	
				How the corrective action(s)	

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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 01/19/2023		
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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) ON COMPLETION DATE		
K 0222 SS=E Bldg. 02	be equipped with requires the use of egress side unless special locking are CLINICAL NEEDS LOCKING Where special lockinical security neused, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times.	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: OR SECURITY THREAT king arrangements for the eds of the patient are cking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the 2.2.6, 19.2.2.2.5.1,		will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place? A Maintenance auditensuring all means of egree being maintained, will be completed monthly for 6 m with results reported to the Assurance Performance Improvement (QAPI) Compoverseen by the Administry a threshold of 95% is not achieved, an action plan with developed to ensure compowers Any non compliance with second in staff education and disciplinary action	t tool, ss are onths Quality mittee ator. If fill be		

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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>02</u>	(X3) DATE SURVEY COMPLETED 01/19/2023				
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
PR	4) ID EFIX ΓAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE		
		19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT: Where special loc safety needs of th the Clinical or Sec are being met. In: electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system at an attended loc space); and both is systems are arran upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT: Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supe detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7	LOCKING Sking arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked d by a complete smoke (or is constantly monitored ation within the locked the sprinkler and detection ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING S relayed-egress locking in accordance with permitted on door g low and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 155001 B. WING 01/19/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7001 HOOVER RD **HOOVERWOOD** INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4. 19.2.2.2.4 Based on observation and interview, the facility K 0222 What corrective action(s) will 02/20/2023 failed to ensure the means of egress through 1 of be accomplished for those 10 exits were readily accessible for residents residents found to have been without a clinical diagnosis requiring specialized affected by the deficient security measures. Doors within a required means practice? of egress shall not be equipped with a latch or Door locking arrangements lock that requires the use of a tool or key from the are being permitted, by Sign being affixed to the door stating, "Push egress side unless otherwise permitted by LSC 18.2.2.2.4. Door-locking arrangements shall be until alarm sounds, door can be permitted in accordance with 18.2.2.2.5.2. This opened in 15 seconds", ensure deficient practice could affect over 20 residents, compliance with Life Safety Code staff and visitors. Standards How will you identify other Findings include: residents having the potential to be affected by the same Based on observations with the Director of deficient practice and what Operations, the Director of Maintenance and the corrective action will be taken? Maintenance Technician during a tour of the No residents were affected facility from 1:00 p.m. to 3:45 p.m. on 01/19/23, the by the alleged deficient practice. exit door for the facility at the Kraft Commons 20 residents, visitors, staff vestibule on the first floor was marked as a facility have the potential to be affected exit with as exit sign, was magnetically locked and by the alleged deficient practice could be opened by entering a four digit code but What measures will be put into the code was not posted at the exit door. Based on interview at the time of the observations, the place or what systemic Director of Maintenance stated residents with changes you will make to clinical diagnoses to be in a secure wing were ensure that the deficient housed on the first floor in the C Wing and agreed practice does not recur? the code was not posted at the exit door at the Kraft Commons vestibule. Sign has been affixed to the door stating, "Push until alarm These findings were reviewed with the sounds, door can be opened in 15 Administrator, the Director of Operations, the seconds" Director of Maintenance and the Maintenance A maintenance audit tool Technician during the exit conference. will be completed monthly for one

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	02	COMPL 01/19/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	3.1-19(b)			year to ensure Door locking arrangements are being possibly Sign being affixed to the stating, "Push until alarm door can be opened in 15 seconds" A visual inspection Maintenance Director/deshas been completed to ender Door locking arrangement being permitted, by Sign affixed to the door stating until alarm sounds, door opened in 15 seconds" How the corrective action will be monitored to ensideficient practice will not recur, i.e., what quality assurance program will into place? A Maintenance aud Door locking arrangement being permitted, Sign beint to the door stating, "Push alarm sounds, door can be in 15 seconds" will be commonthly for 6 months with reported to the Quality As Performance Improvement Committee overseen by the Administrator. If a thresh 95% is not achieved, an aplan will be developed to compliance. Any non conwith staff will result in state education and up to discinaction	bermitted, ne door sounds, so by the signee insure its are being if the put if tool, its are ng affixed in tesults issurance in the put if tool is a surance i		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING ()2 COMPLE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			02	COMPLETED 01/19/2023	
		155001	B. W	ING		01/19/	2023
NAME OF P	PROVIDER OR SUPPLIER	t		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0521	NFPA 101						
SS=E	HVAC						
Bldg. 02	HVAC						
	Heating, ventilatio	n, and air conditioning shall					
	comply with 9.2 ar	nd shall be installed in					
	accordance with the	he manufacturer's					
	specifications.						
	18.5.2.1, 19.5.2.1, 9.2						
	Based on record review, observation and			521	What corrective action(s) wil	II	02/20/2023
	interview; the facility failed to ensure all fire				be accomplished for those		
dampers in the facility were inspected and				residents found to have been	n		
	provided necessary maintenance at least every				affected by the deficient		
	four years in accord	lance with NFPA 90A. LSC			practice?		
	9.2.1 requires heating	ng, ventilating and air			· The fire damper has be	en	
	conditioning (HVA	C) ductwork and related			inspected and tested, with the	;	
	equipment shall be	in accordance with NFPA 90A,			appropriate documentation		
		stallation of Air-Conditioning			How will you identify other		
		tems. NFPA 90A, 2012			residents having the potentia	al	
		.8.1 states fire dampers shall be			to be affected by the same		
		dance with NFPA 80, Standard			deficient practice and what		
		Other Opening Protectives.			corrective action will be take	n?	
		ition, Section 19.4.1 states each			 No residents were affe 		
		ted and inspected 1 year after			by the alleged deficient practi		
		st and inspection frequency			· All residents, visitors, st		
		ars. If the damper is equipped			have the potential to be affect		
		the link shall be removed for			by the alleged deficient praction	ce	
		l closure and lock-in-place if					
		amper shall not be blocked			What measures will be put ir	nto	
		way. All inspections and			place or what systemic		
	_	umented, indicating the			changes you will make to		
		damper, date of inspection,			ensure that the deficient		
		nd deficiencies discovered.			practice does not recur?		
		shall have a space to indicate			The fire damper has be		
		leficiencies were corrected.			inspected and tested, with the	;	
	· ·	ice could affect all residents,			appropriate documentation		
	staff and visitors.				A Maintenance audit to	OI,	
	Findings 1 1 1				ensuring fire dampers are		
	Findings include:				inspected and tested, will be		
	D1	at a constant at a A. 1. 1. 1. 2. 2.			completed monthly for one ye		
	Based on record rev	view with the Administrator,	1		with results reported to the Qu	ıalıty	

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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 01/19/2023		
NAME OF I	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D			
	Maintenance from 01/19/23, fire damp documentation was Based on interview the Director of Mai inspection and testi available for review the Director of Ope Maintenance and the	rations and the Director of 9:15 a.m. to 1:00 p.m. on er inspection and testing not available for review. at the time of record review, intenance agreed fire damper ng documentation was not by. Based on observations with rations, the Director of e Maintenance Technician facility from 1:00 p.m. to 3:45		Assurance Performance Improvement (QAPI) Com · Administrator/design verify documentation is in the fire dampers has been inspected, tested accordin Safety requirements How the corrective action will be monitored to easi	nee to TELS of n ng to Life		
	p.m. on 01/19/23, fi HVAC system duct identified as 2124A interview at the tim Director of Mainter inspection and main the most recent four for review. These findings were Administrator, the I Director of Mainter Technician during t	Director of Operations, the nance and the Maintenance		will be monitored to ensu deficient practice will not recur, i.e., what quality assurance program will be into place? A Maintenance aud ensuring fire dampers are inspected and tested, will completed monthly for one with results reported to the Assurance Performance Improvement (QAPI) Commonthly meeting for 6 mor QAPI is overseen by the Administrator. Any non	t be put it tool, be e year e Quality amittee enths,		
	3.1-19(b)			compliance with staff will r staff education and up to disciplinary action.	result in		
K 0531 SS=E Bldg. 02	Elevators are insp specified in ASME Elevators and Esc Service is operate record. New eleva	with the provision of 9.4. ected and tested as £ A17.1, Safety Code for calators. Firefighter's d monthly with a written utors conform to 1, Safety Code for					

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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 01/19/2023			
NAME OF I	PROVIDER OR SUPPLIEI	?	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
IAU	Elevators and Esc Firefighter's Servi firefighter's Phase detector automati Phase II emergen machine room sm lobby smoke dete 18.5.3, 9.4.2, 9.4. Based on record re- interview; the facili- all elevator firefigh 9.4.6, Elevator Tesc elevators with firef- in accordance with monthly operation- findings made and required by ASME for Elevators and E- practice could affect visitors in the facili- Findings include: Based on record re- the Director of Ope- Maintenance from 01/19/23, documen firefighter recall tes- review. Based on of of Operations, the I- the Maintenance To- facility from 1:00 p- facility had a total of recall capability. R Test Log Sheet" do- elevator machine re- facility indicated m	calators, including ce Requirements. (Includes a I key recall and smoke c recall, firefighter's service acy in-car key operation, noke detectors, and elevator actors.) 3 view, observation and ity failed to maintain testing of iter recall in accordance with iting. LSC 9.4.6.2 states that all ighters' 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 at over six residents, staff and ity. View with the Administrator, artions and the Director of 9:15 a.m. to 1:00 p.m. on tation for monthly elevator sting was not available for observations with the Director Director of Maintenance and echnician during a tour of the om. to 3:45 p.m. on 01/19/23, the of two elevators with firefighter deview of "Fire Fighter's Service cumentation located in the booms during a tour of the conthly testing for January,	K 0531	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The elevator has been inspected and tested, with the appropriate documentation How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken. No residents were affect by the alleged deficient practice. 6 residents, visitors, staff have the potential to be affected by the alleged deficient practice. What measures will be put implace or what systemic changes you will make to ensure that the deficient practice does not recur? The elevator has been inspected and tested, with the appropriate documentation. A Maintenance audit too ensuring elevators are inspected.	02/20/2023 I		
		eptember, October and some some some some some some some some		and tested, will be completed monthly for one year with resul	lts		

elevator. Based on interview at the time of the

reported to the Quality Assurance

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE		(X3) DATE S	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	ETED
		155001	B. WI	NG		01/19/	2023
				CTDEET A	DDDEGG CITY CTATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
HOOVED	WOOD			7001 HOOVER RD			
HOOVER	WOOD			INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	observations and du	ring the exit conference, the			Performance Improvement (Q	API)	
	Director of Operation	ons stated the elevator			Committee		
	inspection contracto	or conducts monthly elevator			· Administrator/designee	to	
	recall testing but ag	reed documentation for the			verify documentation is in TEL	S of	
	monthly elevator fir	refighter recall testing for the			the elevators has been inspec	ted,	
	aforementioned seven month period was not				tested according to Life Safety	,	
	available for review	.			requirements		
	These findings were	e reviewed with the					
		Director of Operations, the			How the corrective action(s)		
	Director of Mainten	ance and the Maintenance			will be monitored to ensure t	he	
	Technician during t	he exit conference.			deficient practice will not		
					recur, i.e., what quality		
	3.1-19(b)				assurance program will be put		
					into place?		
					 A Maintenance audit too 		
					ensuring elevators are inspect	ed	
					and tested, will be completed		
					monthly for one year with resu	lts	
					reported to the Quality Assura	nce	
					Performance Improvement (Q	API)	
					Committee monthly meeting for	or 6	
					months, QAPI is overseen by	the	
					Administrator. Any non		
					compliance with staff will resul	t in	
					staff education and up to		
					disciplinary action.		
K 0761							
SS=F							
Bldg. 02							
		riew, observation and	K 0'	761	What corrective action(s) will	l	02/20/2023
		ty failed to ensure annual			be accomplished for those		
	•	ng of all fire door assemblies			residents found to have been	ı	
		accordance of LSC 18.1.1.4.1.1.			affected by the deficient		
		enings in dividing fire barriers			practice?		
		1.1 shall be permitted only in			· All Fire doors have beer		
		be protected by approved			inspected, with the appropriate	•	
		or assemblies. (See also Section			documentation		
	8.3.) LSC 8.3.3.1 O	penings required to have a fire			How will you identify other		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLE	TED
		155001	B. W	ING _		01/19/2	2023
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OOVER RD		
HOOVEF	RWOOD			INDIANAPOLIS, IN 46260			
				וואטואוו	1		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)			DATE	
		Table 8.3.4.2 shall be			residents having the potentia	al	
	protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection				to be affected by the same		
					deficient practice and what		
					corrective action will be take		
					No residents were affe		
					by the alleged deficient practi All residents, visitors, st		
					1		
					have the potential to be affect		
					by the alleged deficient practic	, c	
					What measures will be put in	ıto	
	shall be signed and kept for inspection by the				place or what systemic		
	AHJ. NFPA 80, 5.2.3.1 states functional testing of				changes you will make to		
	fire door and window assemblies shall be				ensure that the deficient		
		iduals with knowledge and			practice does not recur?		
		e operating components of			· All Fire doors have been	n	
	_	ng subject to testing. NFPA	inspected, with the appropriate				
		re door assemblies shall be			documentation		
	·	from both sides to assess the			A Maintenance audit to		
	overall condition of				ensuring all doors are inspected		
					will be completed monthly for	I .	
	NFPA 80, Section 5	5.2.4.2 states as a minimum, the			year with results reported to the		
	following items sha				Quality Assurance Performance	I .	
	_	or breaks exist in surfaces of			Improvement (QAPI) Committ	I .	
	either the door or fr				· Administrator/designee		
	(2) Glazing, vision	light frames, and glazing beads			verify documentation is in TEL		
		ely fastened in place, if so			the doors being inspected		
	equipped.	-			according to Life Safety		
		e, hinges, hardware, and			requirements		
	noncombustible thr	eshold are secured, aligned,					
	and in working orde	er with no visible signs of					
	damage.				How the corrective action(s)		
	(4) No parts are mis	ssing or broken.			will be monitored to ensure t	:he	
	(5) Door clearances	do not exceed clearances			deficient practice will not		
	listed in 4.8.4 and 6				recur, i.e., what quality		
	(6) The self-closing device is operational; that is,				assurance program will be p	ut	
		pletely closes when operated			into place?		
	from the full open p	osition.			· A Maintenance audit to	ol,	
	(7) If a coordinator	is installed, the inactive leaf			ensuring All Fire doors have b	een	
	closes before the ac	tive leaf.			inspected, with the appropriate	е	

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		COMPLETED 01/19/2023	
STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
do mi re Pe Co mi Ao co	cocumentation, will be completed to the Quality Assurated to the Qualit	ted Its nce API) or 6 the	
	ID PREFIX TAG do m re Po C m Ac cx st	7001 HOOVER RD INDIANAPOLIS, IN 46260 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	

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Event ID:

81HW21 Facility ID: 000001

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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	COM	PLETED 9/2023	
HOOVER	PROVIDER OR SUPPLIEF		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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 0916	as soiled linen and a storage rooms large storing combustible facility. Each entry fire-rated door with resistance rating lab addition, the entry of storage and transfill with a 45-minute fire to the hinge side of minimum 45-minute doors were also not interview at the time observations, the Dit could not be ensure the facility were incompanied in the facility w	Director of Operations, the nance and the Maintenance					
K 0916 SS=F Bldg. 02	Electrical Systems System Alarm And A remote annunci powered is provid generating room in observed by opera annunciator is har conditions of the e- centralized compu	ator that is storage battery ed to operate outside of the n a location readily ating personnel. The d-wired to indicate alarm emergency power source. A uter system (e.g., building n) is not to be substituted					
	6.4.1.1.17, 6.4.1.1						

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Event ID: 81HW21 Facility ID: 000001

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>02</u> COMPLETED			TED
		155001	B. W	ING	_	01/19/20	023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			OOVER RD		
HOOVER	RWOOD				IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	_{.TE} (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on and interview, the facility	K 0	916	What corrective action(s) wil	1 (02/20/2023
		f 1 emergency generator			be accomplished for those		
	_	was in proper operating			residents found to have been	n	
		icient practice could affect all			affected by the deficient		
	the residents, staff a	and visitors in the facility.			practice?		
					· The emergency		
	Findings include:				annunciator panel has been		
	Based on observations with the Director of Operations, the Director of Maintenance and the Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 01/19/23, the				inspected, and is in proper		
					operating condition		
					How will you identify other		
					residents having the potentia	al	
					to be affected by the same		
	facility's emergency generator remote annunciator panel located at the 1B nurse's station had the				deficient practice and what		
	-	p" (yellow) trouble light			corrective action will be take		
		on interview at the time of the			No residents were affect by the alleged deficient practi		
		irector of Maintenance stated			by the alleged deficient practi All residents, visitors, st		
		erator was not running at the			have the potential to be affect		
		out agreed the remote			by the alleged deficient practic		
		or annunciator panel at the 1B			by the alleged delicient practic		
		not in proper operating			What measures will be put ir	nto	
	condition.	not in proper operating			place or what systemic		
					changes you will make to		
	These findings were	e reviewed with the			ensure that the deficient		
	_	Director of Operations, the			practice does not recur?		
		nance and the Maintenance			· Evapar, our service pro	vider	
	Technician during t	he exit conference.			has been contacted to ensure		
					emergency annunciator panel	is in	
	3.1-19(b)				proper operating condition		
					A Maintenance audit to	ol,	
					ensuring the emergency		
					annunciator panel is in proper		
					operating condition, will be		
					completed monthly for one year		
					with results reported to the Qu	ıality	
					Assurance Performance		
					Improvement (QAPI) Committ		
					· Administrator/designee		
					verify documentation is in TEL		
					the emergency annunciator p	anel	

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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 <u>02</u> B. WING			COMPLETED 01/19/2023	
		155001	B. WI	ING		01/19/	2023	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
1710	REGULATORT OR	ESC ISLATII TING IN ORWATION		mo	is in proper operating condition	า	DATE	
					How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place? A Maintenance audit to to ensure emergency annunce panel has been inspected, and in proper operating condition, be completed monthly for one with results reported to the Quantum Assurance Performance Improvement (QAPI) Committed overseen by the Administrator a threshold of 95% is not achieved, an action plan will be developed to ensure compliant Any non compliance with staff result in staff education and up disciplinary action	ut ol, iator d is will year iality ee . If e cce. will		
K 0918 SS=F Bldg. 02	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are	a - Essential Electric Syste b - Essential Electric ace and Testing other alternate power ated equipment is capable be within 10 seconds. If the an is not met during the brocess shall be provided to anis capability for the life branches. Maintenance generator and transfer ace generator and transfer ace generator and transfer ace inspected weekly, and 30 minutes 12 times a						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPI	LETED
	155001 B. WING		01/19	/2023			
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIEI	R			OOVER RD		
HOOVE	RWOOD				IAPOLIS, IN 46260		
	1	CTATEMENT OF DEFICIENCIE	ı		· 		(V5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE
TAG				TAG	DELICE!!		DATE
	1 '	intervals, and exercised					
		onths for 4 continuous hours.					
		nder load conditions include					
	1 '	ated cold start and					
		ual transfer of all EES					
		nducted by competent					
		enance and testing of stored					
		urces (Type 3 EES) are in					
		NFPA 111. Main and feeder					
		re inspected annually, and a dically exercising the					
	-	tablished according to uirements. Written records					
		nd testing are maintained					
	-	ble. EES electrical panels					
		narked, readily identifiable,					
	-	n normal power circuits.					
	1	ssibility of damage of the					
	consideration for	r source is a design					
	NFPA 111, 700.1	(NFPA 99), NFPA 110,					
		review, observation and	K ₀	010	What corrective action(s) wi	11	02/20/2023
		ity failed to ensure a written	K 0	710	be accomplished for those		02/20/2023
		aspections for the facility's			residents found to have been	n	
	-	or was maintained for 28 weeks			affected by the deficient		
		52 week period. NFPA 99,			practice?		
		nsite generators shall be			• The emergency power		
	1	rdance with NFPA 110,			system has been inspected,		
		gency and Standby Power			tested according to maintenar	nce	
	1	10, 8.4.1 requires an Emergency			requirements	.50	
	_	em (EPSS) including all			How will you identify other		
		nents, shall be inspected			residents having the potenti	al	
		ed monthly. NFPA 99, 6.4.4.2			to be affected by the same		
	1	ecord of inspection,			deficient practice and what		
	_	ising period, and repairs for the			corrective action will be take	en?	
	_	ularly maintained and available			No residents were affect		
	for inspection by th	•			by the alleged deficient pract		
		leficient practice could affect all			· All residents, visitors, s		
	residents, staff and	-			have the potential to be affect		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS				RVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	02	COMPLETED	
		155001	B. WING		01/19/20	23	
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			OOVER RD		
HOOVER	RWOOD			INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Eindines includes				by the alleged deficient praction	ce	
	Findings include:				What massures will be put in		
	Based on review of	"Emergency/Auxiliary			What measures will be put in place or what systemic	110	
		g Log (Inspection Testing)"			changes you will make to		
	-	the Administrator, the			ensure that the deficient		
		ons and the Director of			practice does not recur?		
	_	g record review from 9:15 a.m.			· Evapar, our service pro	vider	
	_	19/23, weekly emergency			has been contacted to provid		
	generator inspection	n documentation after 06/30/22			preventative maintenance eve		
	was not available fo	or review. Based on interview			months; the 90 minute annua	-	
	at the time of record	d review, the Director of			load bank test, and the 4 hour	•	
	Maintenance stated	the facility has one diesel fuel		load bank test that is required			
	fired emergency gen	nerator and agreed weekly		every 3 years, with documentation			
	-	ntation after 06/30/22 was not			· The emergency power	will	
		. Based on observations with			be tested weekly and docume	nted	
	_	rations, the Director of			according to LSC standards		
		e Maintenance Technician			A Maintenance audit to		
	-	facility from 1:00 p.m. to 3:45			ensuring emergency power, w		
	-	ne diesel fuel fired emergency			completed monthly for one ye		
	-	cility located outside the			with results reported to the Qu	ıality	
	-	xed nameplate indicating the	Assurance Performance				
	-	at 800 kW and was			Improvement (QAPI) Committ		
	manufactured in Jul	ly 2016.			· Administrator/designee		
	These findings were	e reviewed with the			verify documentation is in TEL the emergency power system		
	_	Director of Operations, the	has been tested according to LSC				
		nance and the Maintenance			standards		
	Technician during t				Staridardo		
		•			How the corrective action(s)		
	3.1-19(b)				will be monitored to ensure		
	. ,				deficient practice will not		
	2. Based on record	review, observation and			recur, i.e., what quality		
	interview; the facili	ty failed to document			assurance program will be p	ut	
	emergency generate	or monthly load testing for six			into place?		
		recent twelve month period to			· A Maintenance audit to	ol,	
	meet the requirement	nts of NFPA 110, Standard for			The emergency power syster	n	
		ndby Powers Systems, 2010			has been tested according to	LSC	
	-	4.2. Section 8.4.2 states diesel			standards, will be completed		
	generator sets shall	be exercised at least once			monthly for one year with resu	ılts	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001			ILDING	nstruction 02	(X3) DATE COMPL 01/19/	ETED	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD (Y4) ID SUMMARY STATEMENT OF DEFICIENCIE			-	7001 H	NDDRESS, CITY, STATE, ZIP COD DOVER RD APOLIS, IN 46260		
(X4) ID PREFIX	(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
TAG	monthly, for a mini of the following med (1) Loading that may gas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) nan Section 8.4.2.3 statinstallations that do 8.4.2 shall be exercised a loads at not less than nameplate kW rating and at not less than nameplate kW rating total test duration of hours. This deficient residents, staff and Findings include: Based on review of Generator Operating documentation with Director of Operating to 1:00 p.m. on 01/documentation for emergency generated available for review time of record review of the facility's dieseles (30/22 was not available for of Mainter Technician during a facility of the facility of	mum of 30 minutes, using one ethods: aintains the minimum exhaust recommended by the green tended by the green to the EPS (Emergency neplate kW rating. es diesel-powered EPS on the met the requirements of itsed monthly with the available Power Supply System) load and annually with supplemental in 50 percent of the EPS ag for 30 continuous minutes 75 percent of the EPS ag for 1 continuous hour for a f not less than 1.5 continuous int practice could affect all		TAG	reported to the Quality Assura Performance Improvement (Q. Committee overseen by the Administrator. If a threshold o 95% is not achieved, an action plan will be developed to ensu compliance. Any non complia with staff will result in staff education and up to disciplinar action	API) f n ire nce	DATE

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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 SURVE COMPLETED 01/19/2023			
NAME OF F	PROVIDER OR SUPPLIEF		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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
IAU	emergency generated outside the building indicating the gener was manufactured in these findings were Administrator, the Indirector of Mainter Technician during the state of the process of the state of the EPS nameplar minutes and at not Indicated in the state of the EPS nameplar minutes and at not Indicated in the state of the EPS nameplar minutes and at not Indirect of the EPS nameplar minutes and at not Indicated in the state of the EPS nameplar minutes and at not Indirect of the EPS nameplar minut	or for the facility located (had an affixed nameplate rator was rated at 800 kW and in July 2016. The reviewed with the Director of Operations, the nance and the Maintenance he exit conference. The review, observation and try failed to exercise the to meet the requirements of dition, the Standard for indby Powers Systems, Chapter 2 states diesel generator sets in reised at least once monthly, 0 minutes, using one of the dintains the minimum exhaust recommended by the stemperature conditions and at cent of the EPS (Emergency peplate kW rating. The ses diesel-powered EPS not meet the requirements of itsed monthly with the available expower Supply System) load and innually with supplemental the stemperature of the EPS grown to the test than 50 percent the kW rating for 30 continuous ess than 75 percent of the EPS grown to the test than 1.5 continuous and practice could affect all			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION To statement of deficiencies (X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 155001		ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 01/19/2023
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260	
(X4) ID SUMMARY STATEMENT OF DEFICIENCY PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORM Findings include:	Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTIO! (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) SEE COMPLETION DATE
Based on review of "Emergency/Auxiliary Generator Operating Log (Inspection Testing documentation with the Administrator, the Director of Operations and the Director of Maintenance during record review from 9:15 to 1:00 p.m. on 01/19/23, weekly emergency generator testing documentation for the six magnetic period prior to 06/30/22 indicated emergency generator load testing does not achieve 30% the name plate rating. Based on interview at time of record review, the Director of Maintenance and the facility performs a weekly load testing does achieve a minimum load of 30% of the name rating and agreed documentation of an annual load bank test for the emergency generator conducted within the most recent twelve most period was not available for review. Based of observations with the Director of Operations Director of Maintenance and the Maintenance Technician during a tour of the facility from p.m. to 3:45 p.m. on 01/19/23, the diesel fue emergency generator for the facility located outside the building had an affixed nameplat indicating the generator was rated at 800 kW was manufactured in July 2016. These findings were reviewed with the	of the enance st, es not e plate al nth on s, the ee 1:00 l fired		
Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference.			
3.1-19(b) 4. Based on record review, observation and interview; the facility failed to document 36 period emergency generator testing for 1 of emergency generators in accordance with NI	1		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 01/19/2023			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	Code, 2012 Edition 1 and Type 2 essent sources (EPSS) sha Class X, Level 1 ge NFPA 110, the Star Standby Powers Sy. 8.4.9 states Level 1 once within every 3 states Level 1 EPSS for the duration of i 4.2). Section 8.4.9. class is greater than to terminate the test Section 8.4.9.5 state test shall be specifie 8.4.9.5.3. Section 8 EPS's, loading shall This deficient pract staff and visitors. Findings include: Based on record revelue Director of Ope Maintenance from 9 01/19/23, thirty-six generator testing do continuous hours for emergency generator Based on interview the Director of Maintenance from Genergency generator testing do continuous hours for emergency generator testing do cont	NFPA 99, Health Care Facilities (Section 6.4.1.1.6.1 states Type ial electrical system power all be classified as Type 10, nerator sets per NFPA 110. Ideard for Emergency and stems, 2010 Edition, Section EPSS shall be tested at least 6 months. Section 8.4.9.1 is shall be tested continuously to assigned class (See Section 2 states where the assigned 4 hours, it shall be permitted after 4 continuous hours. It shall be permitted after 4 continuous hours. It shall be the available EPSS load. It is could affect all residents, and the Director of 2.15 a.m. to 1:00 p.m. on month period emergency cumentation for four art the facility's diesel fired for was not available for review. Internance stated the facility has be emergency generator and on of supplemental load are within the most recent three available for review. Based the Director of Operations, intenance and the Maintenance are tour of the facility from 1:00 in 01/19/23, the diesel fired						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED		
		155001	B. W	ING		01/19/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L			OOVER RD		
HOOVERWOOD (YA) ID SUMMARY STATEMENT OF DEFICIENCIE				APOLIS, IN 46260			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		or for the facility located					
	_	had an affixed nameplate					
		rator was rated at 800 kW and					
	was manufactured in	n July 2016.					
	These findings were	e reviewed with the					
	_	Director of Operations, the					
		nance and the Maintenance					
	Technician during the	he exit conference.					
	3.1-19(b)						
K 0920	NFPA 101						
SS=E	Electrical Equipme	ent - Power Cords and					
Bldg. 02	Extens						
	Electrical Equipme	ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
	_ ·	ed electrical equipment					
	` ,	les that have been					
		alified personnel and meet					
		0.2.3.6. Power strips in the					
	_ ·	y may not be used for					
	, -	personal electronics),					
		n care resident rooms that					
		E. Power strips for PCREE * UL 60601-1. Power strips					
		the patient care rooms					
) meet UL 1363. In					
	· ·	ooms, power strips meet					
	-	s. All power strips are used					
		autions. Extension cords					
		substitute for fixed wiring of					
	a structure. Extens	•					
		moved immediately upon					
		purpose for which it was					
		ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	,	(D) (NFPA 70). TIA 12-5					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
155001		155001	B. WING			01/19/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			OOVER RD		
HOOVEF	RWOOD				IAPOLIS, IN 46260		
(VA) ID	OIDBARN	CTATEMENT OF DEPOSITABLE			· 	OVE	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG		on and interview, the facility	K 0		What corrective action(s) wil		
		f 2 lamps containing electrical	I K U	920	be accomplished for those	02/20/2023	
		t used as a substitute for fixed			residents found to have been	n	
	_	requires utilities to comply with			affected by the deficient	'	
	_	.1.2 requires electrical wiring			practice?		
		omply with NFPA 70, National			The CPAP in Room 110	n4	
		11 Edition. NFPA 70, Article			has been plugged into an		
	· · · · · · · · · · · · · · · · · · ·	unless specifically permitted,			appropriate receptacle		
	_	ables shall not be used as a			· The Oxygen Concentra	tor	
	substitute for fixed	wiring of a structure. LSC			in Room 2131 has been plugg		
	Section 4.5.7 states	any building service			into an appropriate receptacle		
	equipment or safegu	uard provided for life safety					
	shall be designed, in	nstalled and approved in			How other residents having	the	
	accordance with all	applicable NFPA standards.			potential to be affected by th	ie	
	NFPA 99, Standard	for Health Care Facilities, 2012			same deficient practice will I	be	
	_	ent care areas as any portion			identified and who corrective	е	
		lity wherein patients are			action(s) will be taken?		
		nined or treated. Patient care			· All residents, visitors, st		
		s a space, within a location			have the potential to be affect		
		umination and treatment of			by the alleged deficient praction	ce	
		6 ft (1.8 m) beyond the normal					
		chair, table, treadmill, or other			What measures will be put ir	nto	
	device that supports	-			place or what systemic		
		eatment. A patient care vicinity			changes will be made to		
		o 7 ft 6 in. (2.3 m) above the			ensure that the deficient		
		ection 10.4.2.3 states household			practice does not recur?		
		not commonly equipped with ors in their power cords shall			The Maintenance	tho	
		led they are not located within			Director/designee will monitor	uie	
		nity. This deficient practice			facility to ensure medical equipment is plugged into an		
	_	residents, staff and visitors.			appropriate receptacle		
	25414 411001 0 101 20	. 125.20110, Suit und visitois.			A visual inspection by the second secon	he	
	Findings include:				Maintenance Director/designe		
					has been completed to ensure		
	Based on observation	ons with the Director of			medical equipment is plugged		
		ector of Maintenance and the			an appropriate receptacle		
	_	ician during a tour of the			Staff will be inserviced I	by	
		.m. to 3:45 p.m. on 01/19/23, the			the Clinical Educator/designed	-	
		e lamp stand by the resident			medical equipment being plug		
		had two electrical recentacles			into appropriate receptacles in	· -	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	02	COMPLETED		
		155001	B. WING	_	01/19/2023		
		<u> </u>	CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIE	₹	7001 HOOVER RD				
HOOVERWOOD SUMMARY STATEMENT OF DEFICIENCIE			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	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		e of the lamp stand. A CPAP		LSC requirements			
		ed into a receptacle on the		· The Maintenance			
	•	ition, an oxygen concentrator		Supervisor/designee will make			
		ne of the receptacles in the		environmental rounds daily to			
		esident bed in Room 2131. The		ensure medical equipment is			
	_	ceptacles in the lamp stands		being plugged into appropriate	e		
		nined. Based on interview at		receptacles			
		ervations, the Director of					
	_	d the lamp stand receptacles					
	_	a substitute for fixed wiring		How the corrective action(s)			
		ient care vicinity in the		will be monitored to ensure	the		
	aforementioned two	o resident sleeping rooms.		deficient practice will not			
				recur, ie., what quality			
	_	e reviewed with the		assurance program will be p	out		
	· ·	Director of Operations, the		into place?			
		nance and the Maintenance		· A Maintenance audit to	ol		
	Technician during	the exit conference.		will be completed monthly, to			
				ensure medical equipment be	ing		
	3.1-19(b)			plugged into appropriate			
				receptacles and the Administr			
				will monitor the facility to ensu			
				continued compliance with po	wer		
				cords and extension cord			
				requirements, for 6 months w			
				results reported to the Quality			
				Assurance Performance			
				Improvement (QAPI) Committ	tee		
				overseen by the Executive			
				Director. Any non compliance	9		
				with staff will result in staff			
				education and up to disciplina	iry		
				action			

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