STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING -- B. WING	01/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/19/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Emergency Preparedness survey, Hooverwood was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 155 certified beds. At the time of the survey, the census was 138. Quality Review completed on 01/25/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 2/20/2023	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

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

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: a. 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 a.m. to 1:00 p.m. on 01/19/23, weekly emergency generator inspection documentation after 06/30/22 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed weekly inspection documentation after 06/30/22 was not available for review. b. 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 a.m. to 1:00 p.m. on 01/19/23, monthly load testing documentation for the facility's diesel fuel fired emergency generator after 6/30/22 was not available for review. Based on interview at the	E 0041	**E041 Hospital CAH and LTC Emergency Power** **What corrective action(s) will be accomplished for those residents found to have been 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 potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Evapar, our service provider has been contacted to provide preventative maintenance every 6 months; the 90 minute annual load bank test, and the 4 hour load bank test that is required	02/20/2023

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	time of record review, the Director of Maintenance agreed monthly load testing documentation for the facility's diesel fired emergency generator after 6/30/22 was not available for review. c. 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 a.m. to 1:00 p.m. on 01/19/23, weekly emergency generator testing documentation for the six month period prior to 06/30/22 indicated emergency generator load testing does not achieve 30% of the name plate rating. Based on interview at the time of record review, the Director of Maintenance stated the facility performs a weekly load test, agreed emergency generator load testing does not achieve a minimum load of 30% of the name plate rating and agreed documentation of an annual load bank test for the emergency generator conducted within the most recent twelve month period was not available for review. d. Based on record review with the Administrator, the Director of Operations and the Director of Maintenance from 9:15 a.m. to 1:00 p.m. on 01/19/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Director of Operations, the Director of Maintenance and the		every 3 years, with documentation · A Maintenance audit tool, ensuring corridors are continuously maintained free of all obstructions, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the emergency power system has been inspected, tested according to LSC requirements **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, The emergency power system has been inspected, tested according to maintenance requirements, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action	

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	Maintenance Technician during a tour of the facility from 1:00 p.m. to 3:45 p.m. on 01/19/23, the diesel fuel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 800 kW and was manufactured in July 2016. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/19/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 01 was surveyed using Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 01 consists of the	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 2/20/2023	

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	memory care wing which is one story, the former kitchen, the basement and the former dining room on the first floor which is now a special events room. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 138 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 01/25/23			
K 0761 SS=F Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be 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	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 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice	02/20/2023

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	annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents,		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All Fire doors have been inspected, with the appropriate documentation · A Maintenance audit tool, ensuring all doors are inspected, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the doors being inspected according to Life Safety requirements **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, ensuring All Fire doors have been inspected, with the appropriate documentation, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Doors Locks & Alarms: Test Operation of Doors and Locks" dated 12/24/22 and TELS Masters "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 include all fire doors in the facility. The annual inspection documentation dated 12/24/22 only included five fire door locations identified as "1A East, 1B, 1C, 2A and 2B" in the new and renovated areas of the building and did not include fire door locations in the basement or in Building 01. Based on interview at the time of record review, the Director of Maintenance stated the 12/24/22 fire door inspection documentation was meant to include all fire doors inspected in the five general areas and agreed the 12/24/22 fire door inspection documentation was not itemized by location to ensure all fire doors in the facility were inspected within the most recent twelve month period. 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 entry room door to the laundry chute room and the trash chute room in the basement was a fire-rated door with a minimum 90-minute fire resistance rating label affixed to the door. The stairwell door in the basement was also equipped with minimum 45-minute resistance rating label affixed to the door. Based on interview at the time of record review and of the			

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	observations, the Director of Maintenance agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)			
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/19/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this Life Safety Code survey, Hooverwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 02 and Building 03 were surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 02 consists of the	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 2/20/2023	

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	2017 general renovation of all first and second floor resident sleeping room areas not in the memory care wing and the addition of resident sleeping rooms 1238, 1239, 1240 and 1241 on the first floor and resident sleeping rooms 2238, 2239, 2240 and 2241 on the second floor in 2018. Building 03 consists of the renovated first floor main entrance lobby, administrative support offices, conference room, gift shop and beauty shop. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 142 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 01/25/23			
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 11 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice	K 0211	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	02/20/2023

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	could affect over 15 residents, staff and visitors if needing to exit the facility on the second floor by Room 2231. Findings include: 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, a plastic three drawer chest of drawers for isolation supplies was stored in the corridor outside Room 2231 on the second floor. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)		· All means of egress have been addressed and reviewed to ensure compliance with Life Safety Code Standards · The plastic three drawer chest of drawers for isolation supplies has been removed **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · 15 residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Clinical Educator/designee to in-service staff on maintaining means of egress free of all obstructions or impediments to full use in case of fire or other emergency.. · A maintenance audit tool will be completed monthly for one year to ensure all means of egress are being maintained. · A visual inspection by the Maintenance Director/designee has been completed to ensure all means of egress are being maintained **How the corrective action(s)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · A Maintenance audit tool, ensuring all means of egress are being maintained, will be completed monthly for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action	
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,			

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	155001	A. BUILDING 02 B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected			

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	155001	A. BUILDING 02 B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 18.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 18.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors. Findings include: 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 exit door for the facility at the Kraft Commons vestibule on the first floor was marked as a facility exit with as exit sign, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit door. Based on interview at the time of the observations, the Director of Maintenance stated residents with clinical diagnoses to be in a secure wing were housed on the first floor in the C Wing and agreed the code was not posted at the exit door at the Kraft Commons vestibule. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference.	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Door locking arrangements are being permitted, by Sign being affixed to the door stating, "Push until alarm sounds, door can be opened in 15 seconds", ensure compliance with Life Safety Code Standards **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · 20 residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Sign has been affixed to the door stating, "Push until alarm sounds, door can be opened in 15 seconds" · A maintenance audit tool will be completed monthly for one	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

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	3.1-19(b)		year to ensure Door locking arrangements are being permitted, by Sign being affixed to the door stating, “Push until alarm sounds, door can be opened in 15 seconds” · A visual inspection by the Maintenance Director/designee has been completed to ensure Door locking arrangements are being permitted, by Sign being affixed to the door stating, “Push until alarm sounds, door can be opened in 15 seconds” · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, Door locking arrangements are being permitted, Sign being affixed to the door stating, “Push until alarm sounds, door can be opened in 15 seconds” will be completed monthly for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action	

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	155001	A. BUILDING 02 B. WING	01/19/2023

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

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K 0521 SS=E Bldg. 02	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator,	K 0521	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The fire damper has been inspected and tested, with the appropriate documentation **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The fire damper has been inspected and tested, with the appropriate documentation · A Maintenance audit tool, ensuring fire dampers are inspected and tested, will be completed monthly for one year with results reported to the Quality	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

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	the Director of Operations and the Director of Maintenance from 9:15 a.m. to 1:00 p.m. on 01/19/23, fire damper inspection and testing documentation was not available for review. Based on interview at the time of record review, the Director of Maintenance agreed fire damper inspection and testing documentation was not available for review. 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, fire dampers were located in the HVAC system ductwork in the mechanical rooms identified as 2124A and 2224A. Based on interview at the time of the observations, the Director of Maintenance agreed fire damper inspection and maintenance documentation within the most recent four year period was not available for review. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)		Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the fire dampers has been inspected, tested according to Life Safety requirements **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, ensuring fire dampers are inspected and tested, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0531 SS=E Bldg. 02	NFPA 101 Elevators Elevators 2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for			

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	155001	A. BUILDING 02 B. WING	01/19/2023

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

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	Elevators and Escalators, including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3 Based on record review, observation and interview; the facility failed to maintain testing of all elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with firefighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect over six residents, staff and visitors in the facility. Findings include: Based on record review with the Administrator, the Director of Operations and the Director of Maintenance from 9:15 a.m. to 1:00 p.m. on 01/19/23, documentation for monthly elevator firefighter recall testing was not available for review. 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 facility had a total of two elevators with firefighter recall capability. Review of "Fire Fighter's Service Test Log Sheet" documentation located in the elevator machine rooms during a tour of the facility indicated monthly testing for January, April, May, July, September, October and December 2022 was not documented for each elevator. Based on interview at the time of the	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 potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · 6 residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The elevator has been inspected and tested, with the appropriate documentation · A Maintenance audit tool, ensuring elevators are inspected and tested, will be completed monthly for one year with results reported to the Quality Assurance	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

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	observations and during the exit conference, the Director of Operations stated the elevator inspection contractor conducts monthly elevator recall testing but agreed documentation for the monthly elevator firefighter recall testing for the aforementioned seven month period was not available for review. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)		Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the elevators has been inspected, tested according to Life Safety requirements **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, ensuring elevators are inspected and tested, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0761 SS=F Bldg. 02	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 18.1.1.4.1.1. Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire	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 **How will you identify other**	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	protection rating by Table 8.3.4.2 shall be 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 shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf.		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All Fire doors have been inspected, with the appropriate documentation · A Maintenance audit tool, ensuring all doors are inspected, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the doors being inspected according to Life Safety requirements **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, ensuring All Fire doors have been inspected, with the appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

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	(8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Doors Locks & Alarms: Test Operation of Doors and Locks" dated 12/24/22 and TELS Masters "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 include all fire doors in the facility. The annual inspection documentation dated 12/24/22 only included five fire door locations identified as "1A East, 1B, 1C, 2A and 2B". Based on interview at the time of record review, the Director of Maintenance stated the 12/24/22 fire door inspection documentation was meant to include all fire doors inspected in the five general areas and agreed the 12/24/22 fire door inspection documentation was not itemized by location to ensure all fire doors in the facility were inspected within the most recent twelve month period. 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,		documentation, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly meeting for 6 months, QAPI is overseen by the Administrator. Any non compliance with staff will result in staff education and up to disciplinary action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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

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	entry room doors to over 5 hazardous areas such as soiled linen and trash collection rooms and storage rooms larger than 100 square feet used for storing combustible material were noted in the facility. Each entry door to the rooms was a fire-rated door with a minimum 45-minute fire resistance rating label affixed to the door. In addition, the entry door to three separate oxygen storage and transfilling rooms were each equipped with a 45-minute fire resistance rating label affixed to the hinge side of the door. Five stairwells with minimum 45-minute resistance rated stairwell doors were also noted on each floor. Based on interview at the time of record review and of the observations, the Director of Maintenance agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)			
K 0916 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels was in proper operating condition. This deficient practice could affect all the residents, staff and visitors in the facility. Findings include: 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 facility's emergency generator remote annunciator panel located at the 1B nurse's station had the "Low Coolant Temp" (yellow) trouble light illuminated. Based on interview at the time of the observations, the Director of Maintenance stated the emergency generator was not running at the time of the survey but agreed the remote emergency generator annunciator panel at the 1B nurse's station was not in proper operating condition. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)	K 0916	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The emergency annunciator panel has been inspected, and is in proper operating condition **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Evapar, our service provider has been contacted to ensure the emergency annunciator panel is in proper operating condition · A Maintenance audit tool, ensuring the emergency annunciator panel is in proper operating condition, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the emergency annunciator panel	02/20/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 02 B. WING	01/19/2023

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			is in proper operating condition **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, to ensure emergency annunciator panel has been inspected, and is in proper operating condition, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a			

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review, observation and interview; the facility failed to ensure a written record of weekly inspections for the facility's emergency generator was maintained for 28 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The emergency power system has been inspected, tested according to maintenance requirements **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected	02/20/2023

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	Findings include: 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 a.m. to 1:00 p.m. on 01/19/23, weekly emergency generator inspection documentation after 06/30/22 was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed weekly inspection documentation after 06/30/22 was not available for review. 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 diesel fuel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 800 kW and was manufactured in July 2016. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to document emergency generator monthly load testing for six months of the most recent twelve month period to meet the requirements of NFPA 110, Standard for Emergency and Standby Powers Systems, 2010 Edition, Chapter 8.4.2. Section 8.4.2 states diesel generator sets shall be exercised at least once		by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Evapar, our service provider has been contacted to provide preventative maintenance every 6 months; the 90 minute annual load bank test, and the 4 hour load bank test that is required every 3 years, with documentation · The emergency power will be tested weekly and documented according to LSC standards · A Maintenance audit tool, ensuring emergency power, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, The emergency power system has been tested according to LSC standards, will be completed monthly for one year with results	

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	monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "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 a.m. to 1:00 p.m. on 01/19/23, monthly load testing documentation for the facility's diesel fuel fired emergency generator after 6/30/22 was not available for review. Based on interview at the time of record review, the Director of Maintenance agreed monthly load testing documentation for the facility's diesel fired emergency generator after 6/30/22 was not available for review. 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 diesel fired		reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action	

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	emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 800 kW and was manufactured in July 2016. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors.			

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	Findings include: 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 a.m. to 1:00 p.m. on 01/19/23, weekly emergency generator testing documentation for the six month period prior to 06/30/22 indicated emergency generator load testing does not achieve 30% of the name plate rating. Based on interview at the time of record review, the Director of Maintenance stated the facility performs a weekly load test, agreed emergency generator load testing does not achieve a minimum load of 30% of the name plate rating and agreed documentation of an annual load bank test for the emergency generator conducted within the most recent twelve month period was not available for review. 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 diesel fuel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 800 kW and was manufactured in July 2016. These findings were reviewed with the 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 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA			

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	99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator, the Director of Operations and the Director of Maintenance from 9:15 a.m. to 1:00 p.m. on 01/19/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. 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 diesel fired			

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	emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 800 kW and was manufactured in July 2016. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			

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	Based on observation and interview, the facility failed to ensure 2 of 2 lamps containing electrical receptacles were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff and visitors. Findings include: 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 portable lamp on the lamp stand by the resident bed in Room 1104 had two electrical receptacles	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The CPAP in Room 1104 has been plugged into an appropriate receptacle · The Oxygen Concentrator in Room 2131 has been plugged into an appropriate receptacle **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The Maintenance Director/designee will monitor the facility to ensure medical equipment is plugged into an appropriate receptacle · A visual inspection by the Maintenance Director/designee has been completed to ensure medical equipment is plugged into an appropriate receptacle · Staff will be inserviced by the Clinical Educator/designee on medical equipment being plugged into appropriate receptacles, per	02/20/2023

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	installed in the base of the lamp stand. A CPAP machine was plugged into a receptacle on the lamp stand. In addition, an oxygen concentrator was plugged into one of the receptacles in the lamp stand by the resident bed in Room 2131. The UL listing of the receptacles in the lamp stands could not be determined. Based on interview at the time of the observations, the Director of Maintenance agreed the lamp stand receptacles were being used as a substitute for fixed wiring including in the patient care vicinity in the aforementioned two resident sleeping rooms. These findings were reviewed with the Administrator, the Director of Operations, the Director of Maintenance and the Maintenance Technician during the exit conference. 3.1-19(b)		LSC requirements · The Maintenance Supervisor/designee will make environmental rounds daily to ensure medical equipment is being plugged into appropriate receptacles **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure medical equipment being plugged into appropriate receptacles and the Administrator will monitor the facility to ensure continued compliance with power cords and extension cord requirements, for 6 months with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action	