PRINTED: 04/05/2023

	T OF HEALTH AND H R MEDICARE & MEDI					RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/01/2023	
NAME OF	PROVIDER OR SUPPLII	ER	7001 H	ADDRESS, CITY, STATE, ZIP COD HOOVER RD NAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
E 0000						
Bldg	Preparedness Surve conducted by the accordance with 4 Survey Date: 03/6 Facility Number: Provider Number: 10 At this PSR surve Preparedness survin compliance wit Requirements for Participating Prov	01/23 000001 155001	E 0000	The creation and submission this plan of correction does not constitute an admission by the provider of any conclusions in the statement of deficience of any violation of regulation. This provider respectfully rethat the 2567 plan of correct considered the letter of crediallegation and requests desireview (paper compliance) of after 3/27/2023.	not his et forth ies, or . quests ion be ible	
E 0041 SS=F Bldg	The requirement at MET as evidenced 482.15(e), 483.7 Hospital CAH an §482.15(e) Conc (e) Emergency at The hospital must	ompleted on 03/02/23 at 42 CFR, Subpart 483.73 is NOT d by:				

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

emergency plan set forth in paragraph (a) of

procedures plan set forth in paragraphs (b)(1)

this section and in the policies and

(i) and (ii) of this section.

TITLE (X6) DATE

Jennifer Voss Administrator 03/18/2023

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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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		A. BUILDING B. WING	JNSTRUCTION	COMPLETED 03/01/2023	
NAME OF P	PROVIDER OR SUPPLIEF	<u> </u>	7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD JAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	§483.73(e), §485. (e) Emergency and The [LTC facility as implement emergy systems based or forth in paragraph §482.15(e)(1), §48. Emergency generator must be the location required Care Facilities Coulterim Amendment 12-4, TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §488. Emergency generation, testing requirements four Facilities Code, Normal Code.	R LSC IDENTIFYING INFORMATION 625(e) and standby power systems. and the CAH] must ency and standby power in the emergency plan set in (a) of this section. 83.73(e)(1), §485.625(e)(1) rator location. The is located in accordance with rements found in the Health inde (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA ind TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, ind NFPA 110, when a new in when an existing			IIE
	have a plan for ho power systems op emergency, unles	ow it will keep emergency perational during the s it evacuates.			
	§483.73(g), and C	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	, ,	UILDING	NSTRUCTION	(X3) DATE COMPL 03/01/	ETED
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 TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	reference by the I Federal Register is 552(a) and 1 CFF the material from You may inspect Information Reson Boulevard, Baltim Archives and Rec (NARA). For infor this material at Nago to: http://www.archive_of_federal_regul If any changes in incorporated by redocument in the Fannounce the characterymarch Par Quincy, MA 0216: 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issued (iii) TIA 12-3 to NI 2012. (iv) TIA 12-4 to NI 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NI 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to NI 11, 2011.	Protection Association, 1 k, 9, www.nfpa.org, th Care Facilities Code, ed August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COM			ETED
		155001	B. W	ING		03/01/	2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			OOVER RD		
HOOVEF	RWOOD				IAPOLIS, IN 46260		
	ı				T		
(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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCIT		DATE
	` '	FPA 101, issued October					
	22, 2013.	TDA 404 :					
	' '	FPA 101, issued October					
	22, 2013.	Standard for Emergency and					
		ystems, 2010 edition,					
		chapter 7, issued August 6,					
	2009	onapioi 1, issuou August 0,					
	Based on record review and interview, the facility		E 00	041	What corrective action(s) wil	ı	03/27/2023
	failed to implement the emergency power system inspection, testing and maintenance requirements			V 11	be accomplished for those	-	05/2//2025
					residents found to have been	ı	
	found in the Health Care Facilities Code, NFPA				affected by the deficient		
	110, and Life Safety Code in accordance with 42				practice?		
	CFR 483.73(e)(2). This deficient practice could				On 3/2/23 The emerger	су	
	affect all residents, staff, and visitors.				generator was been inspected	-	
					tested according to maintenan	ice	
	Findings include:				requirements found in the Hea	alth	
					Care Facilities Code, NFPA 1	10,	
		Direct Supply TELS Logbook			and Life Safety Code		
		nergency Power Generators:			How will you identify other		
		er load" documentation dated			residents having the potentia	al	
		Director of Operations, the			to be affected by the same		
	_	g (DON) and the Director of			deficient practice and what	_	
	`	1) during record review from			corrective action will be take		
		a.m. on $03/01/23$, the following			No residents were affect		
	was noted:				by the alleged deficient practi		
	a monthly load tost	ting documentation for the			All residents, visitors, st		
	· ·	ting documentation for the fired emergency generator was			have the potential to be affected by the alleged deficient practice.		
		cool down" time for monthly			by the alleged delicient practic	Æ	
	_	t recorded and was not			What measures will be put in	ıto	
	_	v. In addition, the amperage			place or what systemic	110	
		for the 01/31/23 monthly load			changes you will make to		
		corded and was not available			ensure that the deficient		
		on interview at the time of			practice does not recur?		
		DOM stated the cool down time			· Evapar, completed the		
		emergency generator is a			emergency generator load tes	st on	
		tor, the amperage and voltage			3/2/23 according to the Health		
		used to calculate the load			Care Facilities Code, NFPA 1		
		or monthly load testing and			and Life Safety Code	•	

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u></u>	COMP	E SURVEY LETED 1/2023
NAME OF F	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP HOOVER RD NAPOLIS, IN 46260	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
TAG	agreed documentation amperage and voltas was not available for the beautiful properties with our equivalent complete the requirementation of the facility's die was not available for the facility's die	en and the cool down time, ge for monthly load testing for review. The review of the name plate rating. Based time of record review, the gency generator load testing minimum load of 30% of the nad provided documentation of generator inspection are contractor "attempted to generator inspection are contractor "attempted to generate it due to mechanical impent" and "we will return to rement at our earliest quipment repair". The period emergency generator for four continuous hours seel fired emergency generator for review. Based on interview deriview, the DOM agreed supplemental load testing for the most recent three year lable for review and provided in the emergency generator for stating the contractor of the emergency generator for stating the contractor for the emergency generator for the emergency generator for the emergency generator for the	TAG	The emergency be tested weekly and according to LSC states A Maintenance ensuring emergency completed monthly for with results reported Assurance Performal Improvement (QAPI) Administrator/overify documentation the emergency power has been tested according to LSC states assurance program into place? A Maintenance for The emergency program into place? Assurance Performan into place? Assurance Performan into place according to LSC states be completed monthly with results reported Assurance Performan into place and threshold of 95% is achieved, an action program into place and the surface and the surf	y power will I documented Indards a audit tool, power, will be or one year to the Quality nce Committee designee to is in TELS of er system ording to LSC action(s) ensure the II not lity will be put a audit tool, power system, in tested indards, will y for one year to the Quality nce Committee dinistrator. If inot plan will be compliance, with staff will	DATE
		s cited on 01/19/23. The facility a systemic plan of correction				

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	OF CORRECTION OF CORRECTION 155001	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/01/2023		
NAME OF I	PROVIDER OR SUPPLIER RWOOD	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION to prevent recurrence.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0000						
Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/01/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this PSR 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 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.	K 0000	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 requitated the 2567 plan of correction considered the letter of credible allegation and requests desk review (paper compliance) on after 3/27/2023	of s forth s, or lests n be le		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 03/01/2023	
NAME OF P	PROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP CODHOOVER RDNAPOLIS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 0000	All areas where res were sprinklered an services were sprink detached buildings	idents have customary access d all areas providing facility klered. The facility has no providing facility services.				
Bldg. 02	Code Recertification conducted on 01/19 Indiana Department 42 CFR 483.90(a). Survey Date: 03/01 Facility Number: 09 Provider Number: 100 At this PSR survey in compliance with in Medicare/Medical Life Safety from Finational Fire Protect Life Safety Code (I 03 were surveyed under Care Occupancies at This two story facilithree portions of on determined to be of was fully sprinkler 2017 general renow floor resident sleep memory care wing	00001 155001 275310 Hooverwood was found not Requirements for Participation aid, 42 CFR Subpart 483.90(a), are and the 2012 Edition of the ction Association (NFPA) 101, LSC). Building 02 and Building sing Chapter 18, New Health	K 0000	The creation and submission this plan of correction does constitute an admission by provider of any conclusion in the statement of deficien of any violation of regulation. This provider respectfully r	not this set forth cies, or n. equests ction be dible sk	

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	OF CORRECTION	IDENTIFICATION NUMBER 155001	A. BUILDING B. WING	02	COMPLETED 03/01/2023
NAME OF P	ROVIDER OR SUPPLIER		7001 H	ADDRESS, CITY, STATE, ZIP COD OOVER RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 02	2240 and 2241 on the Building 03 consists main entrance lobby offices, conference is shop. The facility he smoke detection in the open to the corridor detectors hard wired installed in all residuality has a capacital state of the All areas where resist were sprinklered and services were sprinklered and se	dents have customary access d all areas providing facility clered. The facility has no providing facility services. Inpleted on 03/02/23 In - Testing and In - Testing and In is tested and maintained In an approved program In requirements of NFPA 70, In and Signaling Code. In acceptance, maintenance In acceptance, maintenance In additional acceptance and in a control of the code and in acceptance and in	K 0345	What corrective action(s) will be accomplished for those residents found to have been. The Fire alarm system working order according to LS requirements. Parts have be ordered to repair the "trouble"	n is in SC

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	02	COMPLETED	
		155001	B. W	NG		03/01/2	2023
				CTD FET	ADDRESS SITE OF THE SOL		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
1100//55	NACOD				OOVER RD		
HOOVEF	RWOOD			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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	NFPA 72, Section 1	4.2.1.2.2 requires that system			mode" light. Repairs are		
	defects and malfund	etions shall be corrected. This			scheduled for 3/20/23		
	deficient practice co	ould affect all residents, staff,			How will you identify other		
	and visitors.				residents having the potentia	u l	
					to be affected by the same		
	Findings include:				deficient practice and what		
	Č				corrective action will be take	n?	
	Based on observation	ons with the Director of			No residents were affect	1	
		the Director of Maintenance			by the alleged deficient practic		
	• , ,	n. on 03/01/23, the fire alarm			· All residents, visitors, st		
		rol panel at the 1B nurse's			have the potential to be affected	1	
	station was in the trouble mode. Based on				by the alleged deficient practic		
	interview at the time of record review, the DOM						
	said the main fire alarm system control panel has						
	been in the trouble mode for at least a couple				What measures will be put in	to	
		stated the problem is the			place or what systemic		
		e main fire alarm system panel			changes you will make to		
		ry charging system for the fire			ensure that the deficient		
		ol panel batteries is not			practice does not recur?		
		es continuously. The DOM			practice does not recar :		
		rvice call in to a fire alarm			A Maintenance audit too	, l	
		ontractor when the problem			will be completed monthly, to	"	
	was initially noted a	-			ensure the fire alarm system is	s in	
	documentation to th				working order according to LS		
		/12/23 stating "I wanted to			requirements		
		about the services we			· A Maintenance audit too	,	
		erwood. My tech's notes			ensuring the fire alarm system	-	
	-	e going to install a UPS for			will be completed monthly for		
	-	site. Once that is done, my				I	
		ould be able to come in with 2			year with results reported to the		
		your panels. He said this			Quality Assurance Performance	1	
		ix it, but if not, it is a deeper			Improvement (QAPI) Committe		
		•			Administrator/designee	I	
		know if you have completed			verify documentation is in TEL	I	
		would like to move forward			the emergency power system		
	_	ds". The DOM stated the			has been tested according to l	-SC	
	-	parts for repairs but is			standards		
		complete the repairs. The					
	-	as activated at 10:14 a.m. on					
		manual fire alarm box at the 1B					
	nurse's station.				How the corrective action(s)		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155001	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 02	COMI	E SURVEY PLETED 1/2023
NAME OF F	PROVIDER OR SUPPLIER		7001 F	ADDRESS, CITY, STATE, ZII 100VER RD NAPOLIS, IN 46260	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 02	Operations, the DO 3.1-19(b) NFPA 101 Electrical Systems Electrical Systems System Maintenan	s - Essential Electric Syste s - Essential Electric nce and Testing		will be monitored to deficient practice we recur, i.e., what quate assurance program into place? A Maintenance will be completed me ensure the fire alarm working order according requirements and the the monitoring will be during the Quality A Performance Improvemently meeting for QAPI is overseen by Executive Director. Compliance with staff staff education and disciplinary action.	e audit tool onthly, to a system is in ding to LSC eresults of ereviewed assurance rement (QAPI) 6 months, y the Any non if will result in	
	source and assoc of supplying service 10-second criterion monthly test, a proannually confirm the safety and critical and testing of the switches are performed NFPA 110. Generator sets are exercised under low year in 20-40 day once every 36 more services.	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the possess shall be provided to this capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised inthe for 4 continuous hours, der load conditions include thed cold start and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	·		COMPL	ETED
		155001	B. W	ING	_	03/01/	2023
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		MANUFACTOR NAMES OF THE STREET, AND ASSESSED OF THE STREET		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
TAG	automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with North circuit breakers are program for period components is est manufacturer requof maintenance are and readily available and circuits are mand separate from Minimizing the postemergency power consideration for reference of the facility failed to ensure generators was allow period after a load to 110, Standard for Esystems, 2010 Editiminimum time delation for unloaded running Supply (EPS) prior provides additional	ual transfer of all EES inducted by competent inance and testing of stored irces (Type 3 EES) are in inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels arked, readily identifiable, in normal power circuits. ssibility of damage of the is source is a design inew installations. (NFPA 99), NFPA 110,	K 0	918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? On 3/2/23 The emerger generator was been inspected tested according to maintenant requirements found in the Heat Care Facilities Code, NFPA 1 and Life Safety Code How will you identify other residents having the potential	Incy I, Ince alth	DATE 03/27/2023
		Direct Supply TELS Logbook			to be affected by the same deficient practice and what corrective action will be take	.n2	
		nergency Power Generators:			No residents were affective.		
		er load" documentation dated			by the alleged deficient practi		
		Director of Operations, the			· All residents, visitors, st		
		(DON) and the Director of			have the potential to be affect		
	_	I) during record review from			by the alleged deficient practic		
	,	a.m. on 03/01/23, monthly load			by the alleged delicient practic	, c	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>02</u>			COMPLETED	
		155001	B. W	ING	-	03/01/	/2023	
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	₹			OOVER RD			
HOOVER	RWOOD				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	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ion for the facility's diesel fuel			What measures will be put in	nto		
	fired emergency ge	nerator was incomplete. The			place or what systemic			
	"cool down" time for monthly load testing was				changes you will make to			
	not recorded and wa	as not available for review. In			ensure that the deficient			
	addition, the amperage and volts achieved for the				practice does not recur?			
	01/31/23 monthly load test was also not recorded				· Evapar, completed the			
	and was not available for review. Based on				emergency generator load tes	st on		
	interview at the tim	e of record review, the DOM			3/2/23 according to the Health	า		
	stated the cool dow	n time is 10 minutes, the			Care Facilities Code, NFPA 1			
	emergency generate	or is a three-phase generator,			and Life Safety Code	•		
	the amperage and voltage during the test are used				· The emergency power	will		
	to calculate the load percent achieved for monthly				be tested weekly and docume			
	load testing and agreed documentation of the cool				according to LSC standards			
	down time, amperage and voltage for monthly				A Maintenance audit to	ol.		
	load testing was not available for review.				ensuring emergency power, w	•		
	S				completed monthly for one ye			
	This finding was re	viewed with the Director of			with results reported to the Qu			
	Operations, the DO				Assurance Performance			
	,	,			Improvement (QAPI) Committ	tee		
	This deficiency was	s cited on 01/19/23. The facility			Administrator/designee			
		a systemic plan of correction			verify documentation is in TEI			
	to prevent recurrence	•			the emergency power system			
	•				has been tested according to			
	3.1-19(b)				standards			
	2. Based on record	review and interview, the			How the corrective action(s)			
	facility failed to exe	ercise the generator annually to			will be monitored to ensure			
	meet the requirement	nts of NFPA 110, 2010 Edition,			deficient practice will not			
	the Standard for En	nergency and Standby Powers			recur, i.e., what quality			
	Systems, Chapter 8	.4.2. Section 8.4.2 states diesel			assurance program will be p	ut		
	generator sets in ser	rvice shall be exercised at least			into place?			
	once monthly, for a	minimum of 30 minutes, using			· A Maintenance audit to	ol,		
	one of the following	g methods:			for The emergency power sys			
		aintains the minimum exhaust			to ensure it has been tested	•		
		recommended by the			according to LSC standards, v	will		
	manufacturer	-			be completed monthly for one			
	(2) Under operating	g temperature conditions and at			with results reported to the Qu	-		
		cent of the EPS (Emergency			Assurance Performance	,		
	Power Supply) nam	, ,			Improvement (QAPI) Committ	tee		
		es diesel-powered EPS			overseen by the Administrator			
		-					•	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155001	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 03/01/2023		
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD		STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook		a threshold of 95% is not achieved, an action plan will b developed to ensure complian Any non compliance with staff result in staff education and up disciplinary action.	ce. will		
	Documentation "Emergency Power Generators: Test Generator under load" documentation dated 01/31/23 with the Director of Operations, the Director of Nursing (DON) and the Director of Maintenance (DOM) during record review from 9:10 a.m. to 10:00 a.m. on 03/01/23, emergency generator testing documentation indicated emergency generator load testing does not achieve 30% of the name plate rating. Based on interview at the time of record review, the DOM agreed emergency generator load testing does not achieve a minimum load of 30% of the name plate rating and provided documentation from the emergency generator inspection contractor stating the contractor "attempted to complete the required load bankon 02/16/23 but was unable to complete it due to mechanical issues with our equipment" and "we will return to complete this requirement at our earliest opportunity upon equipment repair". This finding was reviewed with the Director of Operations, the DON, and the DOM.					
	This deficiency was cited on 01/19/23. The facility					

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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 03/01/2023					
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			7001 H	STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE COMPLETION				
TAG	failed to implement	•	TAG	DEFELENCE	DATE				
	3.1-19(b)								
	failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 3. Based on record review and interview, the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 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 Director of Operations, the Director of Nursing (DON) and the Director of Maintenance (DOM) from 9:10 a.m. to 10:00 a.m. on 03/01/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the facility's diesel fired								
	Based on interview at the time of record review, the DOM agreed documentation of supplemental								

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>02</u>			COMPLETED		
		155001 B. WING			03/01/2023		
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260				
(X4) ID	CLIMMADY	ETATEMENT OF DEFICIENCIE	T	ID			(V5)
PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
TAG		hours within the most recent	+	IAU			DATE
	_	as not available for review and					
		ation from the emergency					
	_	n contractor stating the					
		ed to complete the required					
	-	6/23 but was unable to					
		nechanical issues with our					
	_	e will return to complete this					
	* *	earliest opportunity upon					
	equipment repair".						
	1 1 1						
	This finding was rev	viewed with the Director of					
	Operations, the DON, and the DOM.						
	This deficiency was	cited on 01/19/23. The facility					
	failed to implement	a systemic plan of correction					
	to prevent recurrence	•					
	3.1-19(b)						
K 0920	NFPA 101						\
SS=E		ent - Power Cords and					
Bldg. 02	Extens	-					
	Electrical Equipme	ent - Power Cords and					
	Extension Cords						
	Power strips in a p	patient care vicinity are only					
	used for compone	nts of movable					
	patient-care-relate	d electrical equipment					
	(PCREE) assembl	es that have been					
	assembled by qua	lified personnel and meet					
	the conditions of 1	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					
	other UL standard	s. All power strips are used					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155001		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 03/01/2023				
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			7001 I	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			
	are not used as a a structure. Extended temporarily are recompletion of the installed and meed 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on observation failed to ensure all lareceptacles in the failed to the structure of the str	substitute for fixed wiring of sion cords used moved immediately upon purpose for which it was to the conditions of 10.2.4. 2), 10.2.4 (NFPA 99), 400-8 2(D) (NFPA 70), TIA 12-5 on and interview, the facility amps containing electrical cility in the patient care sleeping rooms were not used	K 0920	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient				
	requires utilities to 9.1.2 requires electromply with NFPA 2011 Edition. NFP unless specifically peables shall not be a wiring of a structure building service equals 1.2 requires the structure of the structure	xed wiring. LSC 19.5.1 comply with Section 9.1. LSC rical wiring and equipment to 70, National Electrical Code, A 70, Article 400.8 requires that, remitted, flexible cords and used as a substitute for fixed e. LSC Section 4.5.7 states any ripment or safeguard provided		practice? The CPAP in Room 21 has been plugged into an appropriate receptacle Plug covers have been super glued over the outlet plus of the lamps with receptacles them	ugs in			
	approved in accordance standards. NFPA 9 Facilities, 2012 edit as any portion of a lipatients are intended Patient care vicinity location intended for	be designed, installed, and ance with all applicable NFPA 9, Standard for Health Care ion, defines patient care areas health care facility wherein d to be examined or treated. The is defined as a space, within a port the examination and seconds, extending 6 ft (1.8 m)		How other residents having potential to be affected by the same deficient practice will identified and who corrective action(s) will be taken? All residents, visitors, so have the potential to be affected by the alleged deficient practice.	ne be e taff			
	beyond the normal table, treadmill, or opatient during exampatient care vicinity (2.3 m) above the fl states household or commonly equipped in their power cords they are not located	location of the bed, chair, other device that supports the sination and treatment. A extends vertically to 7 ft 6 in. oor. NFPA 99, Section 10.4.2.3 office appliances not d with grounding conductors is shall be permitted provided within the patient care ient practice could affect over		What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will monitor facility to ensure medical equipment is plugged into an appropriate receptacle and pl	the the			

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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>		COMPLETED			
155001		155001	B. W	B. WING		03/01/	03/01/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER					OOVER RD			
HOOVER	RWOOD				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	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	90 residents, staff,	and visitors.			covers are glued over the outl	et		
					plugs of the lamps			
	Findings include:				· A visual inspection by t			
					Maintenance Director/designe	_		
		ons with the Director of			has been completed to ensure			
		d the Director of Maintenance			medical equipment is plugged			
		n. on 03/01/23, the portable lamp			an appropriate receptacle and			
	_	by the resident bed in the			covers are glued over the outl	et		
		in Room 2131 had two			plugs of the lamps			
	_	es installed in the base of the			Staff will be inserviced	•		
	-	AP machine was on the lamp			the Clinical Educator/designed			
	stand but it was not plugged into a receptacle on				medical equipment being plug	-		
	the lamp stand. The electrical cord for the CPAP				into appropriate receptacles, p	oer		
	machine did not have enough length to plug into				LSC requirements			
	a wall mounted receptacle. Based on interview at				The Maintenance			
	the time of the observations, the DON and the DOM stated about 60% of the resident sleeping				Supervisor/designee will make			
					environmental rounds daily to			
	rooms in the facility have the same type of lamp				ensure medical equipment is			
	with receptacles installed in the base of the lamp				being plugged into appropriate			
	which are used in the resident sleeping rooms.				receptacles and plug covers a			
	The estimate of 60% of the resident sleeping				glued over the outlet plugs of	tne		
	rooms would affect about 93 residents per the DON. The UL listing of the receptacles in the				lamps			
	lamp stands could not be determined. Based on interview at the time of the observations, the DON				Have the same attern and and			
		ed the lamp stand receptacles			How the corrective action(s) will be monitored to ensure			
		a substitute for fixed wiring				uie		
	including in the pat	_			deficient practice will not			
	incruding in the pat	ioni care vicinity.			recur, ie., what quality	+		
	This finding was re	viewed with the Director of			assurance program will be p into place?	ul		
	Operations, the DO				A Maintenance audit to	ol		
	Speranons, the BO	in, and the Dom.			will be completed monthly, to	OI .		
	This deficiency was	s cited on 01/19/23. The facility			ensure medical equipment be	ina		
		t a systemic plan of correction			plugged into appropriate	9		
	to prevent recurrence	-			receptacles and the Administr	ator		
	s prevent recurrent	 ·			will monitor the facility to ensu			
	3.1-19(b)				continued compliance with po			
					cords and extension cord	****		
					requirements, for 6 months w	vith		
					results reported to the Quality			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		COMPLETED	
		155001	B. WING		03/01/2023	
NAME OF PROVIDER OR SUPPLIER HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP COD 7001 HOOVER RD INDIANAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				Assurance Performance Improvement (QAPI) Committ overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplina action	e	

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