STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	09/08/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/08/15 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 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement was determined to be of Type II (111) construction and was fully sprinklered. 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	K 0000	SEE ATTACHMENTS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	capacity of 188 and had a census of 146 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 09/14/15 - DA			
K 0020 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to enclose 1 of 6 stairwell vertical openings with construction having a fire resistance rating of one hour. This deficient practice could affect 18 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, the two inch annular space surrounding a one inch in diameter sprinkler pipe which penetrated the	K 0020	K020 1.Thetwo inch annular space surrounding the one inch in diameter sprinkler pipewhich penetrated the stairwell vertical opening above the suspended ceilingabove the stairwell entry door by A102 was repaired with “fire caulk” on9/10/15. **(See picture # K020).** Therewere no residents found to have been affected by this deficient practice. 2.Asa result of this Life Safety Code thorough inspection and facility roundscompleted by Hooverwood’s Maintenance Department, there were no additionalsimilar deficient areas	09/10/2015

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	stairwell vertical opening above the suspended ceiling above the stairwell entry door by Room A102 was not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the stairwell wall failed to maintain a fire resistance rating of one hour for the stairwell vertical opening. 3.1-19(b)		identified. Therefore, no other residents were identified as having the potential ofbeing affected by this same deficient practice. 1.AsHooverwood quickly approaches a facility wide renovation project, thisdeficient practice will be communicated to the architect and generalcontractor. The Maintenance Directorwill be responsible for inspecting all new contractor work moving forward toassure that this same deficient practice does not take place. On a quarterly basis, the MaintenanceDirector will inspect all vertical openings to assure that they continue to beenclosed. 2.Anydeficient practices identified in the post-construction and / or quarterlymaintenance inspections will be addressed immediately with repair andcorrection. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. The monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 1.Dateof Completion: 9/10/15	
K 0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 1. Based on observation and interview, the facility failed to ensure openings through 1 of 9 smoke barriers on the second floor were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, a six inch hole in the smoke barrier wall above the suspended ceiling was noted at the corridor door set by Room B223. The six inch hole was for the passage of a two inch in diameter pipe, two electrical cables and over twenty data cables. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening failed to	K 0025	K025 1.Thesix inch hole in the smoke barrier wall above the suspended ceiling noted atthe corridor set by Room B223 was repaired with “fire caulk & fire bricks”on 9/10/15. **(See picture # K025).** Therewere no residents found to have been affected by this same deficient practice. Thefour inch in diameter hole noted in the ceiling of the first floor clean linenroom by Room B116 was repaired with “drywall and joint compound” on 9/10/15. **(See picture #K025-linen closet).** There were no residents found to have beenaffected by this same deficient practice. 2.Asa result of this Life Safety Code thorough inspection and facility roundscompleted by Hooverwood’s Maintenance Department, there were no additional similardeficient areas identified. Therefore,no other residents were identified as	09/10/2015

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	maintain the smoke resistance of the smoke barrier wall. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 3 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 17 residents, staff and visitors in the vicinity of the clean linen room on the first floor. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, a four inch in diameter hole was noted in the ceiling of the first floor clean linen room by Room B116. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the first floor clean linen room would not maintain at least a one half hour fire resistance rating for the ceiling smoke barrier. 3.1-19(b)		having the potential of being affected bythis same deficient practice. 3.AsHooverwood quickly approaches a facility wide renovation project, thisdeficient practice will be communicated to the architect and generalcontractor. The Maintenance Directorwill be responsible for inspecting all new contractor work moving forward toassure that this same deficient practice does not take place. On a quarterly basis, the MaintenanceDirector will inspect all vertical openings to assure that they continue to beenclosed. 1.Anydeficient practices identified in the post-construction and / or quarterlymaintenance inspections will be addressed immediately with repair andcorrection. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. The monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 1.Dateof Completion: 9/10/15	
K 0029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 18 hazardous areas such as combustible storage rooms over 50 square feet were separated from other spaces by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect five staff and visitors in the basement. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, the entry door set to the #1 Sprinkler Riser Room from the corridor was equipped with a self closing device but the north door was stopped from fully closing and latching by hitting the south door in the door set. The aforementioned	K 0029	K029 1.Theentry door set to the #1 Sprinkler Riser Room was repaired on 9/8/15 and is nowcorrectly closing and latching. Therewere no residents, staff, or visitors affected by this same deficient practice. 2.Asa result of this Life Safety Code thorough inspection and facility roundscompleted by Hooverwood's Maintenance Department, there were no additionalsimilar deficient areas identified. Therefore, no other residents were identified as having the potential ofbeing affected by this same deficient practice. 3.TheMaintenance and Environmental Services Directors will monitor the closing andlatching of these doors daily. These doors will be securely locked at the endof each work day. Any observed deficient	09/10/2015

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	hazardous area measured greater than 50 square feet in size and was used to store combustible boxes, supplies and general storage. Based on interview at the time of observation, the Maintenance Director acknowledged the north door in the entry door set to the aforementioned hazardous room failed to fully self close and latch into the south door. 3.1-19(b)		practices will be reported andrepaired immediately to assure continued compliance. 1.Anydeficient practices identified during daily door checks and / or monthlyMaintenance Rounds will be addressed immediately with repair andcorrection. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. The monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 2.Dateof Completion: 9/8/15	
K 0033 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 Based on observation and interview, the facility failed to enclose 1 of 6 stairwell exits with construction having a fire resistance rating of one hour. This deficient practice could affect 18 residents, staff and visitors. Findings include:	K 0033	K033 1.Thetwo inch annular space surrounding a one inch in diameter sprinkler pipe whichpenetrates the stairwell vertical opening above the suspended ceiling above thestairwell entry door by Room A102 was repaired with “fire caulk” on 9/10/15. **(See picture**	09/10/2015

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	Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, the two inch annular space surrounding a one inch in diameter sprinkler pipe which penetrated the stairwell vertical opening above the suspended ceiling above the stairwell entry door by Room A102 was not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the stairwell wall failed to maintain a fire resistance rating of one hour for the stairwell exit. 3.1-19(b)		**#K033)** Therewere no residents found to have been affected by this deficient practice. 2.Asa result of this Life Safety Code thorough inspection and facility roundscompleted by Hooverwood's Maintenance Department, there were no additionalsimilar deficient areas identified. Therefore, no other residents were identified as having the potential ofbeing affected by this same deficient practice. 1.AsHooverwood quickly approaches a facility wide renovation project, thisdeficient practice will be communicated to the architect and generalcontractor. The Maintenance Directorwill be responsible for inspecting all new contractor work moving forward toassure that this same deficient practice does not take place. On a quarterly basis, the MaintenanceDirector will inspect all vertical openings to assure that they continue to beenclosed. 2.Anydeficient practices identified in the post-construction and / or quarterlymaintenance inspections will be addressed immediately with repair andcorrection. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly	

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			basis. The monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 1.Dateof Completion: 9/10/15	
K 0062 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect five staff and visitors in the basement. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility	K 0062	K062 1.Thehangar assembly attached to the sprinkler pipe that was used to support thedomestic water line below the sprinkler pipe was removed from the sprinklerpipe and was reattached to the domestic water line on 9/8/15. **(Seepicture # K062)** The surveyor was present and observed this immediate repair/ correction. There were no residentsfound to have been affected by this dame deficient practice. 2.Asa result of this Life Safety Code thorough inspection and facility roundscompleted by Hooverwood's Maintenance Department, there were no additionalsimilar deficient areas identified. Therefore, no other residents were identified as	09/10/2015

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	from 11:15 a.m. to 2:35 p.m. on 09/08/15, an adjustable swivel ring and all thread rod hanger assembly was affixed to an overhead automatic sprinkler system pipe and a four inch domestic water line which ran beneath the sprinkler pipe but above a boiler in the basement Mechanical Room/Elevator Room. The hanger assembly attached to the sprinkler pipe was used to support the domestic water line below. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components. 3.1-19(b)		having the potential ofbeing affected by this same deficient practice. 1.AsHooverwood quickly approaches a facility wide renovation project, thisdeficient practice will be communicated to the architect and generalcontractor. A new sprinkler system will be installed as part of this renovationproject. The Maintenance Director willbe responsible for inspecting all new contractor work moving forward to assurethat this same deficient practice does not take place. On a quarterly basis, the MaintenanceDirector will inspect this deficient practice to assure that it continues to bein compliance. 2.Anydeficient practices identified in the post-construction and / or quarterlymaintenance inspections will be addressed immediately with repair andcorrection. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. The monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 1.Dateof Completion: 9/10/15	

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K 0071 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82			
	Based on observation and interview, the facility failed to ensure 1 of 2 trash collection rooms from trash chute discharges was not used for any other purpose. LSC 19.5.4.3 states any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with Section 8.4. This deficient practice could affect five staff and visitors in the basement. Findings include:	K 0071	K071 1.Thetwo folding tables and stacked chairs were immediately removed from the southtrash chute collection room in the basement on 9/8/15. This room will never be used for any otherpurpose other than trash collection. There were no residents, staff or visitors found to have been affectedby this same deficient practice. 2.Therewas no other storage	09/10/2015

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	Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, the south trash chute collection room in the basement was used to store over twenty stacked chairs and two folding tables. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned basement trash chute collection room was not being used for any other purpose other than trash collection. 3.1-19(b)		found in any other trash or linen chute rooms in thebasement. As a result, no otherresidents, staff or visitors were found to have the potential of being affectedby this same deficient practice. 1.TheMaintenance and Environmental Services Directors will monitor trash and linenchute rooms in the basement daily to assure that they are never being utilizedfor storage purposes. Any observed deficient practices will be reported andaddressed immediately to assure continued compliance. 1.Anydeficient practices identified during trash / chute room daily inspections and/ or monthly Maintenance Rounds will be addressed immediately. As necessary,disciplinary action, policy development or inservice training will beimplemented. Any trends of deficient practice will be reported to the QualityImprovement / QAPI Committee on a monthly basis. The monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI / QAPICommittee. 2.Dateof Completion: 9/8/15	
K 0072 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or			

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	impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 10 exits means of egress on the first floor. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, beds and furniture from all resident rooms in the C East Wing on the first floor were being stored throughout the corridor of the C East Wing. The corridor smoke barrier door set at the entrance to the C East Wing by Room C119 is marked with a facility exit sign. Based on interview at the time of the observations, the Maintenance Director stated the C East Wing currently is not being used by residents, the C East Wing is marked as a facility exit with an exit sign and acknowledged corridor storage in the means of egress was not continuously maintained free of all	K 0072	K072 1.Thebeds and furniture observed being stored along the C-wing east corridor will bemoved into the resident rooms along this corridor by 9/25/15. This resident corridor is closed inpreparation for upcoming renovation. There were no residents found to have been affected by this deficientpractice. 2.TheC-wing east corridor is the only corridor throughout the facility that isclosed in preparation for upcoming renovation. Therefore, there were no other residents identified as having thepotential of being affected by this same deficient practice. As a continuous safety measure, this eastcorridor is secured and alarmed at all time. Residents, staff and visitors are never permitted to enter this eastcorridor. 1.Thiseast corridor will be completely free of beds, equipment, and furniture by9/25/15. The Directors of Maintenanceand Environmental Services will inspect this east corridor monthly to assurethat the corridor is free from obstructions. Any observed	09/10/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	obstructions or impediments to full instant use in the C East Wing. 3.1-19(b)		obstructions will be moved immediately to assure a clearmeans of egress. 2.Anydeficient practices identified during monthly inspections of the east corridorwill be addressed immediately. As necessary, disciplinary action, policydevelopment or inservice training will be implemented. Any trends of deficientpractice will be reported to the Quality Improvement / QAPI Committee on amonthly basis. The monitoring willcontinue ongoing as a continuous quality improvement measure unless determinedotherwise by the QI / QAPI Committee. 3.Dateof Completion: 9/25/15	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 18 residents, staff and visitors.	K 0147	K147 1.Theoxygen concentrator plugged into a power strip in resident room #B104 wasimmediately unplugged and re-plugged into an appropriate outlet. The microwave oven that was plugged into apower strip in the second floor social services office was immediatelyunplugged and re-plugged into an appropriate outlet. The coffee pot	09/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 01 B. WING	09/08/2015

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	Findings include: Based on observations with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, the following was noted: a. an oxygen concentrator was plugged into a power strip in resident Room B104. b. a microwave oven was plugged into a power strip in the second floor Social Services Office. c. a coffee pot was plugged into a power strip in the first floor office corridor outside the Conference Room. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)		plugged into a power stripalong the first floor office corridor was immediately unplugged and re-pluggedinto an appropriate outlet. There wereno residents, staff or visitors affected by this same deficient practice. 2.Asa result of this Life Safety Code thorough inspection and facility roundscompleted by Hooverwood's Maintenance Department, there were no additionalsimilar deficient areas identified. Therefore, no other residents were identified as having the potential ofbeing affected by this same deficient practice. 3.Ona monthly basis, the Maintenance Staff will conduct a thorough inspection ofthe entire facility including resident rooms, lounges, offices, corridors,etc., to assure that this deficient practice does not continue. An informational sheet on electrical safetywill continue to be distributed to new residents and their families uponadmission. Electrical safety will alsocontinue to be reviewed during new employee orientation and ongoing inserviceeducation. Any deficient practices willbe addressed immediately upon observation. 1.Anydeficient practices identified during monthly inspections of resident rooms,lounges, offices, corridors,	

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			etc. will be addressed immediately. As necessary,disciplinary action, policy development or inservice training will beimplemented. Any trends of deficient practice will be reported to the QualityImprovement / QAPI Committee on a monthly basis. The monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI /QAPI Committee. 2.Dateof Completion: 9/25/15	
K 0211 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623			
	Based on observation and interview, the facility failed to ensure 7 of over 125 alcohol based hand sanitizers were not installed above or adjacent to an ignition source. NFPA 101, in 19.1.1.3 requires	K 0211	K211 1.Thealcohol based hand sanitizer that was observed installed less than once inchfrom an electrical outlet in Room	09/10/2015

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	all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 60 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and Maintenance Assistant during a tour of the facility from 11:15 a.m. to 2:35 p.m. on 09/08/15, an alcohol based hand sanitizer containing butlyene glycol was observed installed less than one inch from an electrical outlet in Room B223 and Room A224. An alcohol based hand sanitizer containing isopropyl alcohol was observed installed directly over a light switch in Room B204 and over a light switch and an electrical outlet in Room B103, A222, B222 and B224. Each of the aforementioned hand sanitizer's contained butylene glycol or isopropyl alcohol as an ingredient as stated on its packaging. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned hand sanitizer locations were alcohol based and were installed directly above or adjacent to an ignition source.		#B223 and #A224 were remounted on 9/18/15 toan acceptable location in the residents' rooms. The alcohol based hand sanitizer observed installed directly over alight switch in Room # B204 and over a light switch and an electrical outlet inRoom #B103, #A222, #B222, and #B224 were all removed on 9/18/15 and soapdispensers were replaced in acceptable locations in these resident rooms. There were no residents found to have beenaffected by this deficient practice. 2.Asa result of this Life Safety Code thorough inspection and an immediate facilityinspection conducted by the Director of Environmental Services, two other similardispensers were identified in resident rooms and were immediately remounted /replaced in an appropriate location. There were no other residents identified as having the potential ofbeing affected by this same deficient practice. In light of Hooverwood's upcoming renovation project, this deficientpractice has been communicated to the architect and general contractor toassure that all future dispensers are mounted in accordance with this standard. 1.Ona monthly basis, the Director of Environmental Services will conduct a	

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	3.1-19(b)		facilityinspection to assure that all alcohol based hand sanitizers are mounted inaccordance with this standard. Anyidentified deficient practices will be addressed immediately. 2.Anydeficient practices identified during monthly facility inspections by theDirector of Environmental Services will be addressed immediately. As necessary,disciplinary action, policy development or inservice training will beimplemented. Any trends of deficient practice will be reported to the QualityImprovement / QAPI Committee on a monthly basis. The monitoring will continue ongoing as acontinuous quality improvement measure unless determined otherwise by the QI /QAPI Committee. 3.Dateof Completion: 9/18/15	