

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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K0000	<p>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).</p> <p>Survey Date: 02/22/12</p> <p>Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lynhurst Healthcare was found not in compliance with Requirements for Participation in 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.</p> <p>This facility, constructed in two sections, is fully sprinklered: the oldest section, a former two story private residence with a basement and the newer section, a one story addition were both determined to be of Type V (000) construction. The facility has a fire alarm system with smoke detection in the corridors and all</p>	K0000	<p>Preparation and execution of this plan of correction does not constitute as admission to or agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and /or the safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Lynhurst Healthcare asserts that it is and was in substantial compliance with the regulations governing the operation of long term care facilities and this Plan of Correction in its entirety, constitutes this provider's allegation of compliance and thereby we request a re-survey to verify such. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>areas open to the corridor. There are no smoke detectors in the resident rooms. The facility has a capacity of 50 and had a census of 39 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>opinion that it was in compliance with the requirements of participation or that corrective action was necessary.</p>		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to maintain the smoke resistance of the ceiling by firestopping 2 of 2 openings in the Mechanical room, a hazardous area. This deficient practice could affect any resident, staff or visitor in the vicinity of the Mechanical room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:10 p.m. on 12/22/12, the Mechanical room ceiling above the natural gas fired water heater has two holes each measuring two inches in diameter which are not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged there are two holes in the ceiling in the Mechanical room which are not firestopped.</p>	K0029	<p>K029 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by this deficiency. The facility complied with maintaining the the smoke resistance of the mechanical room on 3-3-2012. The areas with holes have been repaired. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this deficiency. The facility complied with maintaining the the smoke resistance of the mechanical room on 3-3-2012. The areas with holes have been repaired. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The areas with holes have been repaired. The</p>	03/23/2012			

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	3.1-19(b)		Maintenance Director will devise and utilize a a check off sheet. Rounds for monitoring to ensure compliance with this tag, will be added to this sheet. The Mainenance Director will perform these rounds once a week for six (6) weeks and then every other week for six (6) weeks. After which the rounds will take place once per month. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The facility complied with maintaining the the smoke resistance of the mechanical room on 3-3-2012. The areas with holes have been repaired. The Maintenance Director will devise and utilize a check off sheet/log. The rounds for monitoring to ensure compliance with this tag, will be added to this sheet. The Mainenance Director will perform these rounds once a week for six (6) weeks and then, every other week for six (6) weeks. After which the rounds will take place once per month. The Administrator is to be given copies of these rounds and is to be notified as soon as possible should any issues be noted. The Maintenance Director will maintain this log and other applicable documentation concerning this tag. 5) What date will the systemic changes be complete? March 23, 2012		

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K0046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observations and interview; the facility failed to ensure 10 of 10 battery powered emergency lights were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the facility.</p> <p>Findings include:</p> <p>Based on a review of "Weekly/Monthly Preventive Maintenance Log" documentation during record review with the Maintenance Director from 9:15 a.m. to 10:45 a.m. on 02/22/12, documentation of an annual test of battery powered emergency lights in the facility was not available for review. Based on observations with the Maintenance Director during a tour of the facility from</p>	K0046	<p>K046 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by this deficiency. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this deficiency. The annual test for 2012 regarding the battery powered emergency lights in the facility has been completed. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The annual test for 2012 regarding the battery powered emergency lights in the facility has been completed. (attached) The annual testing for battery powered will be changed to an every six month test in order to ensure compliance with this tag. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The annual test for 2012 regarding the battery powered emergency lights in the facility has been completed. The annual</p>	03/23/2012			

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	<p>10:45 a.m. to 12:10 p.m. on 02/22/12, ten battery powered emergency lights were observed in the facility. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of annual testing of each battery powered emergency light was not available for review.</p> <p>3.1-19(b)</p>		<p>testing for battery powered will be changed to an every six month test in order to ensure compliance with this tag. The Maintenance Director will be responsible to maintain logs that include (but are not limited to) related documentation to Life Safety. 5) What date will the systemic changes be complete? March 23, 2012</p>				

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K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Fire Disaster Plan" during record review with the Maintenance Director from 9:15 a.m. to 10:45 a.m. on 02/22/12, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire</p>	K0048	<p>K048 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by this deficiency. Facility fire extinguishers are inspected on a regular basis and kept in working order. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this deficiency. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire The facility has a written fire safety plan which did not include the above requirements. The above requirements will be added to the facility's fire safety plan. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The facility has a</p>	03/23/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>written fire safety plan which did not include the above requirements. (#2) The above requirements will be added to the facility's fire safety plan. Dietary (kitchen staff) will be in-serviced / trained to activate the overhead hood extinguishing system to suppress a fire before using either the type ABC or the K class fire extinguishers. The in-service (s) will include pre and post tests. This in-service (s) (as above) will be done now and again in two weeks. After which, the in-service will continue once per month for four (4) months.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The facility has a written fire safety plan which did not include the above requirements. (#2) The above requirements will be added to the facility's fire safety plan. Dietary (kitchen staff) will be in-serviced / trained to activate the overhead hood extinguishing system to suppress a fire before using either the type ABC or the K class fire extinguishers. The in-service (s) will include pre and post tests. This in-service (s) (as above) will be done now and again in two weeks. After which, the in-service will continue once per month for four (4) months.</p> <p>For future employees to the dietary department, the in-service will be documented as given</p>		

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			during their first three days of employment. (orientation). This in-service is then to be done on an annual basis for dietary staff members. The Maintenance Director will monitor and perform all in-services regarding the facility's fire safety plan and the overhead hood extinguishing system. He will in-service using hands on technique and paper documentation. The Maintenance Director will keep these in-services and applicable documentation concerning this tag, in a log. 5) What date will the systemic changes be complete? March 23, 2012	

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could</p>	K0052	<p>F052 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by this deficiency. The facility's fire alarm system management has been contacted. and they have sent over the paperwork. (as of 2-28-2012) 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this deficiency. The facility's fire alarm system management has been contacted. and they have sent over the paperwork. (as of 2-28-2012) (attached) The facility's fire alarm systems will be monitored utilizing paperwork that has been changed to meet the new codes. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The facility's fire alarm systems management will be utilizing paperwork that has been</p>	03/23/2012			

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	<p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:10 p.m. on 02/22/12, access to the fire alarm system breaker located in the Dietary Office was not locked. Based on interview at the time of observation, the Maintenance Director acknowledged access to the fire alarm system breaker located in the Dietary Office was not locked.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure documentation for testing of 11 of 13 smoke detectors and 3 of 6 fire alarm boxes was complete. NFPA 72, 7-5.2.2 requires the location and type of initiating and supervisory device testing as requested in Figure 7-5.2.2 be kept as part of the permanent record all inspections, testing, and maintenance. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Superior System's & Supply "Periodic Fire Alarm Inspection</p>		<p>changed to meet the new codes. (attached) The Administrator has spoken with the facility's fire alarm system management. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The Maintenance Director will be responsible to maintain logs regarding the facility's fire alarm system and these logs will be maintained according to Life Safety code regulations. 5) What date will the systemic changes be complete? March 23, 2012</p>				

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	<p>and Testing Report" documentation dated 06/27/11 and 12/29/11 with the Maintenance Director during record review from 9:15 a.m. to 10:45 a.m. on 02/22/12, the fire alarm system inspection reports did not document the location of all fire alarm boxes, the type of individual smoke detector being tested and the location of all smoke detectors in the facility. Based on interview at the time of record review, the Maintenance Director acknowledged fire alarm system documentation did not include the location of all fire alarm boxes and all smoke detectors and the type of smoke detector tested.</p> <p>3-1.19(b)</p>				

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K0144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:45 a.m. to 12:10 p.m. on 12/22/12, a remote shut off device was not found for the 100 kilowatt natural gas fired emergency generator. The nameplate on the emergency generator stated the unit was manufactured in January 2006. Based on interview at the time of observation, the Maintenance Director stated the emergency generator</p>	K0144	<p>1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to be affected by this deficiency.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by this deficiency. The installation of a remote shut off device for the 100 kilowatt natural gas fired emergency generator is being scheduled with the provider.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The facility is in process of having the remote shut off device scheduled for installation.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place. The Maintenance Director will be responsible to maintain inspections of and documentation logs, regarding the facility's emergency generator and these inspection logs will be</p>	03/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E667	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2012
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NAME OF PROVIDER OR SUPPLIER LYNHURST HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5225 W MORRIS ST INDIANAPOLIS, IN 46241
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>was installed after 2003 and acknowledged there is no remote emergency shut off for the emergency generator.</p> <p>3.1-19(b)</p>		<p>completed/maintained according to Life Safety code regulations. 5) What date will the systemic changes be complete? March 23, 2012</p>	