

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155721	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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NAME OF PROVIDER OR SUPPLIER  LAWRENCE MANOR HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8935 E 46TH ST INDIANAPOLIS, IN 46226
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K010000	<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: 05/02/14</p> <p>Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lawrence Manor Healthcare Center 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.</p> <p>This one story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery</p>	K010000	<p>ID Prefix Tag: Survey Event ID FVWC21 Survey Date: May 2, 2014</p> <p>Please consider this Plan of Correction as the facility credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law.</p> <p>Lawrence Manor Healthcare Center is respectfully requesting a desk review.</p> <p>If there are any further questions or concerns, please feel free to contact me at 317-898-1515.</p> <p>Respectfully,</p> <p>Devon Brewer, HFA, MHA Administrator</p>	
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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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K010046 SS=F	<p>operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 55 and had a census of 46 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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>1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 10 of 10 battery powered lights for 5 of 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds.</p>	K010046	<p><b>K-046Emergency battery backup lighting</b></p> <p><b>(a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>1. All battery backup lighting is now added to a battery test for no less than 30 seconds monthly and annually for 90 minutes and</p>	06/01/2014

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	<p>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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log for 2013" and "30 Day Visual Testing of Emergency Lights" for 2014 with the Maintenance Director during record review from 9:00 a.m. to 10:20 a.m. on 05/02/14, documentation of functional testing at 30 day intervals for at least 30 seconds for each of ten battery powered emergency lights after November 2013 was not available for review. Functional testing in December 2013 was left blank in "Battery Operated Emergency Lights-Test Log for 2013". In addition, January 2014 in "30 Day Visual Testing of Emergency Lights" was left blank and records for February through April 2014 documented testing for five exit signs. Based on interview at the time of record review, the Maintenance Director acknowledged functional testing documentation at 30 day intervals for not less than 30 seconds for all battery powered emergency lights in the facility</p>		<p>will be documented.</p> <p>2. The battery backup lights in the corridor by room 25 at the front nurse's station and the exterior light at the exit by room 17 have been repaired and tested and are functioning properly.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Any resident, visitor, venter or staff member has the potential to be affected, but none were identified.</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b> The inspection of the emergency backup lighting will be a 30 second test monthly and a 90 minute test annually. All emergency lighting will be checked on a monthly maintenance program.(PM). The maintenance director will ensure the PM on all emergency lighting is performed.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place:</b> The monitoring of this will be a joint effort between the HFA and</p>				

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	<p>after November 2013 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 11:35 a.m. on 05/02/14, a total of ten battery powered emergency lights were observed in the facility and each light functioned when their respective test button was pushed except for the light located in the corridor by Room 25, at the front Nurses Station and at the exterior of the building at the exit by room 17.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 10 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 11:35 a.m. on 05/02/14, the battery powered emergency light located in the corridor by Room 25,</p>		<p>the Director of plant operations/designee will checkall documentation of the emergency backup lights to make sure the facilityremains in compliance. This will be an ongoing standard. A report of any issueswill be addressed at the monthly risk management/QA meeting.</p> <p><b>(e)Date of compliance: 6/1/14</b></p>		

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K010050 SS=F	<p>at the front Nurses Station, and at the exterior of the building at the exit by room 17 each failed to illuminate when their respective test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency lights each failed to illuminate when their respective test button was pressed five times.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the first and second shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors.</p>	K010050	<p><b>K-050fire drills</b></p> <p><b>(a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>1. The facility will conduct a</p>	06/01/2014			

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	<p>Findings include:</p> <p>Based on review of "Fire Drill" and "Fire Drill Record" with the Maintenance Director during record review from 9:00 a.m. to 10:20 a.m. on 05/02/14, documentation of a fire drill conducted on the first shift in the third quarter of 2013 and on the second shift for the fourth quarter of 2013 was not available for review. Based on interview at the time of record review, the Maintenance Director stated no other fire drill documentation was available for review and acknowledged documentation of a fire drill conducted on the aforementioned shifts and calendar quarters in 2013 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the first, second and third shift for 2 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00</p>		<p>firedrill one per quarter per shift for a 12 month period.</p> <p>2. The facility shall test theactivation and transmission of the alarm signal the next day between the hoursof 9:00 am to 9:00 pm if a silent drill was performed.</p> <p><b>(b) Howyou will identify other residents having potential to be affected by the samepractice and what corrective action will be taken:</b> Any resident, visitor, vender andstaff member has the potential to be affected, but none were identified.</p> <p><b>(c)What measures will be put into place or what systematic changes you will maketo ensure that the practice does not recur:</b> The standard will reflect that a firedrill will be conducted one per quarter per shift and the testing andtransmission of the alarm will be tested the next day between the hours of 9:00am to 9:00 pm if a silent drill was performed.</p> <p><b>(d) Howthe corrective action(s) will be monitored to ensure the practice will notrecur, i.e. what quality assuranceprogram will be put into place:</b> The monitoring of this tag will be ajoint effort between the HFA and the director of plant operations/designee asthey</p>				

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	<p>a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill" and "Fire Drill Record" with the Maintenance Director during record review from 9:00 a.m. to 10:20 a.m. on 05/02/14, documentation for the first shift fire drill conducted on 03/27/14 at 1:10 p.m., second shift fire drills conducted on 05/17/13 at 4:50 p.m. and on 06/29/13 at 7:15 p.m. and the third shift fire drill conducted on 03/28/14 at 6:30 a.m. each indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal. Each of the aforementioned fire drill documentation stated "No" in response to "Drill initiated by activation of the alarm" and "Activation of Alarm System." Based on interview at the time of record review, the Maintenance Director acknowledged documentation for the aforementioned fire drills each conducted after 6:00 a.m. and before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p>		<p>monitor the monthly fire drills to include the testing and transmission of the signal. A report of the monthly fire drills ( to include each shift quarterly) will be presented at the risk management/QA meeting to maintain that compliance is being met. This will be an ongoing standard.</p> <p><b>(e)Date of compliance: 6/1/14</b></p>		

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K010062 SS=C	<p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained 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</p>	K010062	<p><b>K-062obstruction on sprinkler line</b></p> <p><b>(a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b></p> <p>a). The four cables that were attached to the 4 inch diameter sprinkler pipe in the closet have been removed. The one cable running through the support bracket has been</p>	06/01/2014

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	<p>nonsystem components. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:20 a.m. to 11:35 a.m. on 05/02/14, the following was noted:</p> <p>a. four cables were attached to a four inch in diameter sprinkler pipe in the closet in the Human Resources Office (HR). In addition, one cable was run through a sprinkler pipe support bracket in the HR closet.</p> <p>b. one cable was attached to a two foot section of four inch sprinkler pipe in the Pantry by Room 18.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinkler pipe locations had cables attached to the sprinkler pipe.</p> <p>3.1-19(b)</p>		<p>relocated.</p> <p>b). The one cable that was attached to a two foot section or four inchsprinkler pipe in the pantry by room 18 has been removed.</p> <p><b>(b) Howyou will identify other residents having potential to be affected by the samepractice and what corrective action will be taken:</b> Any resident, visitor, vender andstaff member has the potential to be affected, but none were identified.</p> <p><b>(c)What measures will be put into place or what systematic changes you will maketo ensure that the practice does not recur:</b> Monthly preventive maintenance roundswill include inspection of all sprinkler lines to check for cables or any otherobstruction.</p> <p><b>(d) Howthe corrective action(s) will be monitored to ensure the practice will notrecur, i.e. what quality assuranceprogram will be put into place:</b> The monitoring of this will be thejoint effort of the HFA and the director of plant operations/designee toconduct a monthly visual inspection of the sprinkler lines to maintaincompliance. Any issues identified will be addressed immediately for correction.Any</p>	

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Certification of Inspection" documentation with the Maintenance Director during record review from 9:00 a.m. to 10:20 a.m. on 05/02/14, fuel fired water heaters in the facility had expired Certificate of Inspection documentation from the State of Indiana. The service water heater identified as IN0279870 had an expiration date of 03/14/13 and the service water heater identified as</p>	K010130	<p>findings will be addressed at the monthly risk management/QA meeting.</p> <p><b>(e)Date of compliance: 6/1/14</b></p> <p><b>K-130Certificate of inspection (water heater)</b></p> <p><b>(a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b> The water heaters identified as IN0279870 which inspection certificate expired on 03/14/13, IN0314830 which inspection certificate expired on 4/25/13 and IN321985 which inspection certificate expired on 5/22/13 have been inspected and have passed inspection.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b> Any resident, visitor, venter and staff member has the potential to be affected, but none were identified.</p> <p><b>(c)What measures will be put into place or what systematic changes you will maketo</b></p>	06/01/2014

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	<p>IN0314830 had an expiration date of 04/25/13. Based on observation with the Maintenance Director during a tour of the facility from 10:20 a.m. to 11:35 a.m. on 05/02/14, a third fuel fired water heater was located in the Utility Room by Room 29. This third unit had an affixed tag identifying the unit as IN321985 and had a Certificate of Inspection document from the State of Indiana posted near the water heater with an expiration date of 05/22/13. Based on interview at the time of record review and of the observation, the Maintenance Director stated current Certificate of Inspection documentation was not available for review and acknowledged the aforementioned service water heaters had expired Certificate of Inspection documentation from the State of Indiana.</p> <p>3.1-19(b)</p>		<p><b>ensure that the practice does not recur:</b> The maintenance director will inspect the water heaters monthly per the maintenance PM for any leaks or any noticeable failures and make sure the inspections are completed annually by a licensed inspector. The passed water heater inspections will be present for their view by each vessel.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place:</b> The monitoring of this will be a joint effort between the NHA and the director of plant operations/designee to make sure the water heaters undergo an annual inspection by a licensed water heater inspector. This will be discussed at the monthly risk management/QA meeting to determine that compliance is being met.</p> <p><b>(e) Date of compliance: 6/1/14</b></p>		