

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 05/30/2014
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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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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: 05/30/14</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 (111) construction. The facility has a fire alarm system with smoke detection in the corridors and all</p>	K010000	<p>Preparation and execution of this plan of correction does not constitute an admission to or an 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 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; that this Plan of Correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to 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 opinion that it was in</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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K010015 SS=E	<p>areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 40 and had a census of 38 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 services which are the laundry building and a metal storage shed which were each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/03/14.</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 Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6</p>		participation of or that corrective was necessary.				

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	<p>from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 30 rooms. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Medical Supply Closet.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 11:05 a.m. to 12:30 p.m. on 05/30/14, three walls of the Medical Supply Closet had wood paneling installed from the floor to six feet high on each wall. Based on interview at the time of observation, the Maintenance Manager stated none of the walls had been treated with flame retardant material and acknowledged flame spread rating documentation was not available for review for the wood paneling installed in the Medical Supply Closet.</p> <p>3.1-19(b)</p>	K010015	<p>K015 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The Medical Supply closet paneling has been treated with flame retardant material; as of 6-10-2014. 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? Per survey, this could have affected 10 residents. The Medical Supply closet paneling has been treated with flame retardant material; as of 6-10-2014. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Maintenance will check each patient room, patient common area and other areas of the facility to check for any area that may be of future concern regarding treatment with flame retardant material. This check will be documented. This check will also be added to the maintenance log book and accomplished monthly. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Maintenance will check each patient room, patient common area and other areas of the facility to check for any</p>	06/29/2014			

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K010050 SS=C	<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>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Report of Monthly Fire Drill" and "Fire Drill Report" documentation with the Maintenance Manager during record review from 9:30 a.m. to 11:05 a.m. on 05/30/14, first shift</p>	K010050	<p>area(s) that may be of future concern regarding treatment with flame retardant material.This check will be documented.This check will also be added to the maintenance log book and accomplished monthly. 5) By what date the systemic changes will be completed? June 29th, 2014</p> <p>K050 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Facility fire drills will be conducted quarterly and at unexpected times and under varying conditions as per regulation. 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? Any resident had the potential to be affected by such a deficiency.First shift facility fire drills were conducted at 8:35 am, 9:31am and 9 am., on seperate days.Due to the unique</p>	06/29/2014	

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K010051 SS=D	<p>fire drills conducted on 06/27/13, 09/18/13 and 03/27/14 were conducted at, respectively, 8:35 a.m., 9:31 a.m. and 9:00 a.m. Based on interview at the time of record review, the Maintenance Manager acknowledged first shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path</p>		<p>population of patients in this facility, it was felt that these aforementioned times would suffice and meet regulations. However, the facility was informed that these varying times were not deemed to be sufficient and therefore the facility will alter those times. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Facility fire drills will be conducted quarterly and at unexpected times and under varying conditions as per regulation. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Maintenance will comply with regulations and will document that this has been done in their log book. 5) By what date the systemic changes will be completed? June 29, 2014</p>				

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	<p>of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide manual fire alarm boxes in the basement. NFPA 72, section 2-1.3.3 states initiating devices shall be installed in all areas where required. Section 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. Each installed initiating device shall be accessible for periodic maintenance and testing. This deficient practice affects two staff and visitors in the basement.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 11:05 a.m. to 12:30 p.m. on 05/30/14, manual fire alarm boxes were not installed in the basement. Based on interview at the time of observation, the Maintenance Manager acknowledged the basement was not provided with manual fire alarm boxes hard wired to the fire alarm system.</p>	K010051	<p>K051 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A manual fire alarm box was installed and hard wired to the fire alarm system, by certified contractors, in the basement on approximately, June 9, 2014. 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? Any resident had the potential to be affected by such a deficiency. A manual fire alarm box was installed and hard wired to the fire alarm system, by certified contractors, in the basement on approximately, June 9, 2014. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A manual fire alarm box was installed and hard wired to the fire alarm system, by certified contractors, in the basement on approximately, June 9, 2014. The fire alarm installer/contractor was in the facility and did not note any other areas of concern at this time. The fire alarm</p>	06/29/2014

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K010052 SS=E	<p>3.1-19(b)</p> <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 Based on record review, observation and interview; the facility failed to ensure documentation of annual functional testing for 1 of 6 fire alarm boxes was maintained. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system initiating devices such as fire alarm boxes are tested annually. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Main Hallway.</p>	K010052	<p>installer/contractor will continue to do inspections as per regulations. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? The fire alarm installer/contractor was in the facility and did not note any other areas of concern at this time. The fire alarm installer/contractor will continue to do inspections as per regulations. 5) By what date the systemic changes will be completed? June 29,2014</p> <p>(1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The annual functional test for each facility fire alarm bow has been performed. 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? Any resident had the potential to be affected by such a deficiency. The annual functional test for each facility fire alarm bow has been</p>	06/29/2014

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	<p>Findings include:</p> <p>Based on review of Superior Systems & Supply "Fire Alarms: Periodic Fire Alarm Inspection and Testing Report" documentation dated 12/20/12, 06/27/13 and 03/31/14 with the Maintenance Manager during record review from 9:30 a.m. to 11:05 a.m. on 05/30/14, it could not be assured an annual functional test for each facility fire alarm box within the most recent twelve month period had been performed. Each of the aforementioned fire alarm inspection reports stated the facility has six fire alarm boxes but the fire alarm box identified as "North Center" in the 12/20/12 report was not documented as being tested in the 06/27/13 and 03/31/14 reports. Based on observations with the Maintenance Manager during a tour of the facility from 11:05 a.m. to 12:30 p.m. on 05/30/14, six fire alarm boxes were noted in the facility. Based on interview at the time of record review and of the observations, the Maintenance Manager acknowledged it could not be assured an annual functional test for the North Center fire alarm box within the most recent twelve month period had been performed.</p> <p>3-1.19(b)</p>		<p>performed. Maintenance has spoken with our contractor and has been assured that the testing and documentation for the testing will be completed as per state regulations. 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 functional test for each facility fire alarm box has been performed. Maintenance has spoken with our contractor and has been assured that the testing and documentation for the testing will be completed as per state regulations. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? The Maintenance Manager will be responsible to ensure that testing is done in a timely manner and meets state regulations. 5) By what date the systemic changes will be completed? June 29, 2014</p>		

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K010062 SS=F	<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>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Superior Systems & Supply, Inc. "Invoice" documentation dated 05/06/09 and Superior's fax cover</p>	K010062	<p>K062 (1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The automatic sprinkler system testing was due by May 30,2014.The facility's contractor completed this testing on approximately 6-2-2014.The automatic sprinkler gauges were ordered immediately and have since been replaced by the facility's contractor.The facility's internal pipe inspection has also been accomplished.The eight data cables that were attached to the support hangers, have been removed. This task was completed 6-10-2014.Sidewall spare sprinklers have been ordered as instructed.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? Any resident had the potential to be affected by such a deficiency.The automatic sprinkler system testing was due by May 30,2014.The facility's</p>	06/29/2014

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	<p>sheet dated 04/29/14 during record review from 9:30 a.m. to 11:05 a.m. on 05/30/14, it has been more than five years since the most recent internal pipe inspection for the automatic sprinkler system was performed. Based on interview at the time of record review, the Maintenance Manager stated an internal pipe inspection was due this year but has not yet been scheduled and acknowledged it has been more than five years since the most recent internal pipe inspection for the automatic sprinkler system was performed.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Superior Systems &</p>		<p>contractor completed this testing on approximately 6-2-2014. The automatic sprinkler gauges were ordered immediately and have since been replaced by the facility's contractor. The facility's internal pipe inspection has also been accomplished. The eight data cables that were attached to the support hangers, have been removed. This task was completed 6-10-2014. Sidewall spare sprinklers have been ordered as instructed. 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 fire alarm installer/contractor has since the time of this survey been in the facility and inspected and no other areas of concerns were noted at this time. The fire alarm installer/contractor will continue to do inspections as per regulations. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur/what quality assurance program will be put into place? Log books and documentations from both the facility's maintenance manager and the contractor(s) will be maintained and kept up to date to meet regulations. 5) By what date the systemic changes will be completed? June 29, 2014</p>				

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	<p>Supply "Sprinkler System Inspection Form" documentation with the Maintenance Manager during record review from 9:30 a.m. to 11:05 a.m. on 05/30/14, facility sprinkler system gauges were not stated as being recalibrated or replaced within the most recent five year period. Based on observations with the Maintenance Manager during a tour of the facility from 11:05 a.m. to 12:30 p.m. on 05/30/14, the two gauges at the sprinkler system riser had a manufacture date of 2008. Based on interview at the time of the observations, the Maintenance Manager acknowledged each of the two sprinkler system gauges at the sprinkler system riser had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained. 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 affects all residents, staff and visitors.</p>			

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	<p>Findings include:</p> <p>Based on observations with the Maintenance Manager during a tour of the facility from 11:05 a.m. to 12:30 p.m. on 05/30/14, the following was noted:</p> <p>a. six TV cables and eight data cables were attached to 16 support hangers for a 40 foot length of four inch in diameter sprinkler pipe in the Main Hallway running from the dining room to the nurses station. The aforementioned cables were also attached to a 20 foot adjoining length of four inch in diameter sprinkler pipe ran perpendicular from the Main Hallway from the nurses station into the South Hall.</p> <p>b. eight data cables were attached to two separate six foot lengths of two inch in diameter sprinkler pipe in the Main Hallway.</p> <p>Based on interview at the time of the observations, the Maintenance Manager acknowledged the aforementioned sprinkler pipe locations had cables attached to the sprinkler pipe.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance</p>			
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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 05/30/2014
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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 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
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	<p>with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Manager during a tour of the facility from 11:05 a.m. to 12:30 p.m. on 05/30/14, no sidewall spare sprinklers were located in the spare sprinkler cabinet in the sprinkler riser room. Sidewall sprinklers were observed installed in the Med Room at the nurses station. Based on interview at the time of observation, the Maintenance Manager acknowledged sidewall sprinklers were installed in the facility and no spare sidewall sprinklers were located in the</p>			
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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 05/30/2014
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	<p>spare sprinkler cabinet or on the premises.</p> <p>3.1-19(b)</p>				