

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  04/20/2012
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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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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: 04/20/12</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 all areas open to the corridor. The facility has a capacity of 55</p>	K0000	The Creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. The Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation.	

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>and had a census of 46 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 openings in the storage room by Room 10 was maintained to provide at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of the storage room by Room 10.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the</p>	K0025	No residents were directly affected by this deficient practice. Residents in rooms number 10 and 11 had the potential to be affected by this deficient practice. The annular space surrounding the three inch diameter sprinkler pipe which penetrates the interior back wall of the storage room by Room 10 has now been caulked with a "RED FIRE RETARDANT" caulking thus preventing smoke penetration. The Maintenance Supervisor will inspect all pipes to assure they are sealed and report to the Quality Assurance Committee at their quarterly meeting. This will be monitored by the Maintenance Supervisor ongoing.	04/30/2012			

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	<p>facility from 10:15 a.m. to 11:40 a.m. on 04/20/12, the 3/4 inch annular space surrounding a three inch in diameter sprinkler pipe which penetrates the interior back wall of the storage room by Room 10 was not firestopped. Based on interview at the time of observation, the Maintenance Director acknowledged the 3/4 inch annular space surrounding a three inch in diameter sprinkler pipe penetrating the interior back wall of the storage room by Room 10 was not firestopped.</p> <p>3.1-19(b)</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"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <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 Policy and Procedure" during record review with the Administrator at 11:40 a.m. on 04/20/12, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the</p>	K0048	<p>No resident was directly affected by this deficient practice. The residents that would be affected have been identified as all residents near the kitchen which would be Rooms 18 and 19. The facility has developed a written policy which addresses the use of the overhead hood extinguishing system before using the ABC or the K type of fire extinguisher. The policy also details the location of all ABC fire extinguishers located thru out the building.(See Attached)This will be monitored by the Administrator who will address this policy at the quarterly Quality Assurance Committee meeting.</p>	05/02/2012			

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	<p>kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Administrator acknowledged the written fire safety plan for the facility did not include the policy 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>			