

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 05/13/2013
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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: 05/13/13</p> <p>Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610</p> <p>Surveyors: Mark Caraher, Life Safety Code Specialist & Robert Sutton, Life Safety Code Specialist Trainee</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</p>	K010000		

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>corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 55 and had a census of 50 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 05/15/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010046 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>1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 8 of 8 battery powered lights for 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 and 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 all residents staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "30 Day Visual Testing of Emergency Lights" and "Annual 1-1/2 Hour Test of Emergency Lighting System" documentation with the Maintenance Director during record review from 9:40 a.m. to 11:10 a.m. on 05/13/13, the following was noted: a. documentation of an annual ninety</p>	K010046	<p>All residents have been identified as being affected by this deficient practice. A 90 minute emergency lighting test was conducted on May 17, 2013 and recorded. Lawrence Manor Healthcare has implemented documentation for recording the monthly emergency light testing. All emergency lights have now been tested and are operational. The outside battery operated light has received a new battery and is fully operational as of May 17, 2013. The Administrator will be responsible for monitoring that Maintenance Supervisor completes the monthly testing. Monitoring will be every month.</p>	06/12/2013			

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	<p>minute test for each of the eight battery operated emergency lights in the facility after 01/30/12 was not available for review.</p> <p>b. functional testing documentation at 30 day intervals for not less than 30 seconds for each of the eight battery powered emergency lights for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record review, the Maintenance Director stated an annual test was performed in January 2013 but acknowledged the most recent documented annual ninety minute testing for each of eight battery operated emergency lights in the facility was dated 01/30/12. In addition, the Maintenance Director stated monthly functional testing as documented in "30 Day Visual Testing of Emergency Lights" is not a minimum 30 second test for each of eight battery operated lights in the facility and acknowledged documentation of monthly functional testing for at least 30 seconds was not available for review for the twelve month period of May 2012 through April 2013. Based on observations with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 05/13/13, seven of the eight battery powered emergency lights located in the facility were working.</p>			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 8 battery operated emergency lights was 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. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect twenty residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:30 p.m. on 05/13/13, the battery operated emergency light at the Outside 2 Exit failed to illuminate when the test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the battery operated emergency light at the Outside 2 Exit failed to illuminate when the test button was pressed five times.</p>			

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K010047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation and interview, the facility failed to ensure 2 of 8 exit signs were provided with emergency lighting. This deficient practice could affect 17 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 05/13/13, the following was noted:</p> <p>a. the exit sign in the corridor by the Physical Therapy room failed to illuminate when the backup battery test button for the exit sign was pushed five times.</p> <p>b. the exit sign in the corridor by Room 5 was hard wired to the facility's electrical power system and was not provided with backup battery power, external illumination, nor was it photoluminescent.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the exit sign in the corridor outside the Physical Therapy room failed to illuminate when the backup battery test button was pushed five times and the exit</p>	K010047	All residents have been identified as having the potential to be affected by this deficient practice. The exit signs have been replaced in the corridor by the Physical Therapy Room and Room #5. These signs have been added to our 30 day emergency lighting inspection sheet and will be tested on a monthly basis along with emergency lighting. The Administrator and Maintenance Supervisor will be responsible to monitor on a monthly basis. Addendum: The exit lights were replaced with led exit lights with battery back up.	06/12/2013

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	<p>sign in the corridor by Room 5 was not provided with emergency lighting.</p> <p>3.1-19(b)</p>			

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K010062 SS=C	<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 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 to protect 50 of 50 residents. 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> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 05/13/13, the following was noted:</p> <p>a. a twenty foot section of four inch sprinkler pipe in the corridor outside Room 6 had five cables attached to the sprinkler pipe.</p> <p>b. a ten foot section of four inch sprinkler pipe in the Main Nurses Station had five</p>	K010062	All residents have the potential to be affected by this deficient practice. 1. We have contacted our sprinkler inspection contractor and an additional sprinkler head has been ordered and will be placed in the sprinkler head box. Our Sprinkler Maintenance Contractor was notified on May 17, 2013 of this deficiency. They now will make sure there are 6 sprinkler heads available at all times. 2. All cables have been detached from sprinker pipes noted. This will be monitored on a quarterly basis by Maintenance Supervisor and Sprinkler Contractor.	06/12/2013			

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	<p>cables attached to the sprinkler pipe.</p> <p>c. a ten foot section of two inch sprinkler pipe in the Pantry had one camera cable attached to the sprinkler pipe.</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>2. Based on observation and interview, the facility failed to provide a supply of at least six spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems to protect 50 of 50 residents. 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>				

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 05/13/13, five spare pendant sprinklers were located in the spare sprinkler cabinet in the sprinkler riser room. Pendant sprinkler heads were observed installed throughout the facility. Based on interview at the time of observation, the Maintenance Director stated additional spare sprinkler heads were not located in any other part of the facility and acknowledged a minimum of six spare sprinklers were not located on the premises in the spare sprinkler cabinet.</p> <p>3.1-19(b)</p>			
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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect twenty residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 05/13/13, each of the four walls of the oxygen storage and transfilling room by the Nurses Station 2 Med Room did not extend above the suspended ceiling to the underside of the metal roof deck. Three of the four walls had a one foot gap between the top of each wall and the roof deck and the fourth wall which is a</p>	K010076	All residents in the back section of the facility have been identified as having the potential to be affected by this deficient practice. The suspended ceiling will be replaced with 5/8 in. drywall. This will provide one hour of fire resistive construction. This will be monitored by Maintenance Supervisor and reported to the Quality Assurance Committee at the next meeting. Addendum: We omitted to say that the drywall ceiling is "double" layered 5/8in. drywall.	06/12/2013	

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	<p>concrete block wall had a six inch gap between the top of the concrete wall and the roof deck. Two four wheeled portable liquefied oxygen containers were observed stored in the oxygen storage and transfilling room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned gaps in the walls above the suspended ceiling in the oxygen storage and transfilling room did not provide separation of at least one hour fire resistive construction.</p> <p>3.1-19(b)</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 4 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 "Certificate of Inspection" documentation from the State of Indiana with the Maintenance Director during record review from 9:40 a.m. to 11:10 a.m. on 05/13/13, the following natural gas fired water heaters had expired Certificate of Inspection documentation from the State of Indiana:</p> <p>a. the water tube boiler identified as IN279870 had a Certificate of Inspection with an expiration date of 03/14/13.</p> <p>b, the service water heater identified as IN314830 had a Certificate of Inspection with an expiration date of 04/25/13.</p> <p>c. the service water heater identified as IN307622 had a Certificate of Inspection with an expiration date of 03/14/13.</p>	K010130	All residents have been identified as having the potential to be affected by this deficient practice. We have contacted our insurance provider, who is responsible for ordering the pressure vessel inspections for the water heaters and boiler. An inspection will be performed on May 21, 2013. In the future, our insurance provider will automatically order inspections so certificates will not expire. This will be monitored by the Maintenance Supervisor on an annual basis.	06/12/2013	

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	<p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 05/13/13, updated Certificate of Inspection documentation from the State of Indiana was not located at each of the three aforementioned service water heater locations. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned natural gas fired water heaters had expired Certificate of Inspection documentation from the State of Indiana.</p> <p>3.1-19(b)</p>			

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect twenty residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 05/13/13, each of the four walls of the oxygen storage and transfilling room by</p>	K010143	All residents in the back of facility have the potential to be affected by this deficient practice. The suspended ceiling has been replaced with 5/8 drywall. This will provide one hour of fire resistive construction. This will be monitored by the Maintenance Supervisor and reported to the Quality Assurance Committee at the next meeting. Addendum: We omitted to say that the drywall ceiling is "double" layered 5/8in. drywall.	06/12/2013	

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 05/13/2013
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	<p>the Nurses Station 2 Med Room did not extend above the suspended ceiling to the underside of the metal roof deck. Three of the four walls had a one foot gap between the top of each wall and the roof deck and the fourth wall which is a concrete block wall had a six inch gap between the top of the concrete wall and the roof deck. Two four wheeled portable liquefied oxygen containers were observed stored in the oxygen storage and transfilling room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned gaps in the walls above the suspended ceiling in the oxygen storage and transfilling room did not provide separation with a fire barrier of one hour fire resistive construction.</p> <p>3.1-19(b)</p>			