STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING -- B. WING	11/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAWRENCE MANOR HEALTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/21/17 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Emergency Preparedness survey, Lawrence Manor Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 36. Quality Review completed on 11/30/17 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	E0000 Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 12-21-17, to the Annual Life Safety Survey conducted 11-21-17 . The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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E 0004 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated the facility has not had an emergency preparedness program reviewed by the facility within the most recent twelve month period which addresses policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach to assist the facility in addressing the needs of their patient populations, along with identifying the continuity of business operations and the facility's ability to collaborate with local emergency	E 0004	E004 1. The facility has developed, established and maintains a comprehensive emergency preparedness program that meets applicable Federal, State and local requirements. A documented review of the program was conducted on 12-13-17 to meet the requirement for annual review. 2. The facility has developed, established and maintains a comprehensive emergency preparedness program that meets applicable Federal, State and local requirements. A documented review of the program was conducted on 12-13-17 to meet the requirement for annual review. 3. The emergency preparedness program will be reviewed annually by the interdisciplinary team and will be reviewed no later than December 2018. 4. The emergency preparedness program will be added as a standing item to the monthly QAPI meeting agenda, with oversight by the administrator, and will be reviewed and updated as needed, but no less than annually. Minutes of the QAPI meeting are forwarded to Corporate Compliance by the 15th of each month for	12/21/2017

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	preparedness officials was not available for review.		review.	
E 0013 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. Policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach was not available for review. Based on interview at the time of record review, the Administrator stated the facility	E 0013	E013 1. The facility has implemented emergency preparedness policies and procedures based on a facility and community-based risk assessment and communication plan utilizing an all-hazards approach. A documented review of the emergency preparedness policies and procedures was conducted to meet the requirement for annual review. An all staff inservice on emergency preparedness policies and procedures was conducted on 12-13-2017. 2. The facility has implemented emergency preparedness policies and procedures based on a facility and community-based risk assessment and communication plan utilizing an all-hazards approach. A documented review of the emergency preparedness policies and procedures was conducted to meet the requirement for annual review. An all staff inservice on emergency preparedness policies and procedures was conducted on 12-13-2017.	12/21/2017

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	has not had an emergency preparedness program reviewed by the facility within the most recent twelve month period which addresses policies and procedures based on a facility and community based risk assessment and communication plan utilizing an all-hazards approach.		3. The emergency preparedness policies and procedures based on a facility and community-based risk assessment and communication plan utilizing an all-hazards approach will be reviewed and updated at least annually and no later than December 2018. 4. The emergency preparedness policies and procedures will be added as a standing item to the monthly QAPI meeting agenda, with oversight by the administrator, and will be reviewed and updated as needed, but no less than annually. Minutes of the QAPI meeting are forwarded to Corporate Compliance by the 15th of each month for review.	
E 0029 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on record review with the	E 0029	E029 1. The facility has developed and maintains an emergency preparedness communication plan that complies with Federal, State, and local laws. A documented review of the emergency preparedness communication plan was conducted to meet the requirement for annual review. An all staff inservice on emergency preparedness communication plan was conducted on 12-13-2017. 2. The facility has developed	12/21/2017

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	Administrator and the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated the facility has not had an emergency preparedness program reviewed by the facility within the most recent twelve month period which includes a communication plan that contains how the facility coordinates patient care within the facility, across health care providers, and coordination with state and local public health departments.		and maintains an emergency preparedness communication plan that complies with Federal, State, and local laws. A documented review of the emergency preparedness communication plan was conducted to meet the requirement for annual review. An all staff inservice on emergency preparedness communication plan was conducted on 12-13-2017. 3. The emergency preparedness communication plan that contains how the facility coordinates patient care within the facility and across health care providers, will be reviewed and updated at least annually and no later than December 2018. 4. The emergency preparedness communication plan will be added as a standing item to the monthly QAPI meeting agenda, with oversight by the administrator, and will be reviewed and updated as needed, but no less than annually. Minutes of the QAPI meeting are forwarded to Corporate Compliance by the 15th of each month for review.	
E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility	E 0037	E037 1. The facility has an emergency preparedness training program including all new and	12/21/2017

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	must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has not conducted a community based disaster drill, conducted initial training in emergency preparedness policies and procedures or had an emergency preparedness program reviewed by the facility within the most recent twelve month period.		existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role; documentation of training; and demonstration of staff knowledge. An all staff inservice meeting on the emergency preparedness program was conducted on 12-13-2018. Representatives of the facility attended a community meeting with representatives from emergency management present on 7-13-17, at which a mock community disaster was simulated using a table top exercise and group discussion. The facility will conduct an annual internal mock disaster drill on 12-19-17. 2. The facility has an emergency preparedness training program including all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role; documentation of training; and demonstration of staff knowledge. An all staff inservice meeting on the emergency preparedness program was conducted on 12-8-2018. Representatives of the facility attended a community meeting with representatives from emergency management present on 7-13-17, at which a mock community disaster was simulated using a table top exercise and group discussion. The facility will conduct an annual internal mock disaster drill on 12-19-17.	

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			3. The facility has included initial emergency preparedness program training as a part of general orientation for all new employees and volunteers. Thereafter, the facility will provide emergency preparedness training at least annually. The facility will participate in a coordinated community based disaster drill at least annually. 4. Emergency preparedness training will be added to required employee training which is a standing agenda item at the monthly QAPI meeting overseen by the administrator. Minutes of the QAPI meeting are forwarded to Corporate Compliance by the 15thof each month for review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/21/17 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Life Safety Code survey, Lawrence	K 0000	E0000 Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 12-21-17, to the Annual Life Safety Survey conducted 11-21-17 .	

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	Manor Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 55 and had a census of 36 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 11/30/17 - DA		The facility respectfully requests a desk review to demonstrate compliance. Supporting documentation is attached.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means			

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	of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 6 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the corridor outside the Administrator's office and by the corner of the south wall of the Front Lounge measured eight feet wide. A wood table was stored in the corridor which projected one foot into the corridor. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 3.1-19(b)	K 0211	K211 1. The wood table located in the corridor outside the administrator's office was removed so as not to obstruct the continuous means of egress in an emergency. 2. The maintenance person inspected all corridors, exit discharges and locations, to ensure the means of egress is continuously maintained free of all obstructions to full use in case of emergency. 3. Housekeeping department was inserviced on 12-13-17 regarding maintaining corridors and exits free of obstruction to full use in case of emergency. Maintenance is responsible for making weekly rounds to ensure the corridors and exits remain free of obstruction. 4. The maintenance person will document weekly rounds for six months and report results at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	12/21/2017

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K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 6 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet.	K 0232	K232 1. The wood table located in the corridor outside the administrator's office was removed so as not to obstruct the continuous means of egress in an emergency. 2. The maintenance person inspected all corridors, exit discharges and locations, to ensure the means of egress is continuously maintained free of all obstructions to full use in case of emergency. (Except where the corridor width is at least 8 feet and projections into the required width, e.g. fixed furniture, is securely attached to the floor or wall.) 3. Housekeeping department was inserviced on 12-13-17 regarding maintaining corridors and exits free of obstruction to full use in case of emergency. Maintenance is responsible for making weekly rounds to ensure the	12/21/2017

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	(e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the corridor outside the Administrator's office and by the corner of the south wall of the Front Lounge measured eight feet wide. A wood table was stored in the corridor which projected one foot into the corridor. The table was not securely		corridors and exits remain free of obstruction. 4. The maintenance person will document weekly rounds for six months and report results at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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	attached to the floor or to the wall. Based on interview at the time of the observations, the Maintenance Manager agreed furniture was stored in the aforementioned means of egress which projected into the corridor and was not affixed to the floor or to the wall. 3.1-19(b)			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery	K 0291	K291 1. The maintenance person replaced the battery powered back up light at the exit by room 20. 2. The maintenance person checked all battery operated back up lights and all functioned properly and results documented. 3. Functional testing of battery operated back up lights will be conducted by the maintenance person monthly (test duration 30 seconds) and the results documented and available for inspection. Annually, the functional test will be performed for a duration of 90 minutes with distinguishing documentation of the prolonged test duration. Batteries used in back up lights will be approved for their	12/21/2017

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	powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) 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 in the facility. Findings include: Based on review of "Battery Operated Emergency Lighting Test" documentation for 2016 and 2017 and "Emergency Lights" documentation for 2017 with the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation of 30 day interval testing for May 2017 was not available for review. In addition, the aforementioned documentation for the most recent twelve month period did not indicate if the test was a 30 second test or an annual 90 minute test. Based on interview at the time of record review, the Maintenance Manager stated he started working at the facility a few months ago, additional battery light testing documentation was not available for review and the aforementioned documentation did not state the duration of monthly testing records.		intended use and shall comply with NFPA 70 NEC. 4. The maintenance person will provide testing results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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	Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, nine battery powered emergency lighting systems were noted in the facility. Each battery powered light functioned when its test button was pushed except for the light at the exit by Room 20. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 9 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 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 all residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the battery operated emergency lighting system located at the exit by Room			

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	20 consisted of two lights and only one light illuminated when its respective test button was pushed five separate times. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned battery operated lighting system failed to illuminate each light when its test button was pushed five separate times. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to ensure 1 of over 5 exit signage was installed in accordance with LSC 7.10. LSC 7.10.1.2.1 states exits, other than main exterior exit doors that	K 0293	K293 1. The Exit sign near the entrance to the lounge in the area of Room 25 was modified to include directional chevrons pointing to the nearest exits.	12/21/2017

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	obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the entrance to the Lounge from the corridor between Rooms 25 and 26 was marked with an exit sign and had no directional indicator displayed indicating the path of egress to exit the facility. The Lounge did not have an exit to the outside of the facility. Based on interview at the time of the observations, the Maintenance Manager agreed there is no exit from the Lounge to the outside of the facility and the exit sign should not be in place or the directional indicator chevron(s) for the sign should be displayed. 3.1-19(b)		2. The maintenance person visually inspected all mounted exit signs to ensure they are readily visible including those where the egress path is not obvious. There were no issues noted. 3. Maintenance is responsible for making weekly rounds to ensure the exit and directional exit signs are visible and functional and results documented. 4. The maintenance person will provide exit light inspection results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure preventative maintenance for all battery operated smoke alarms in resident rooms was performed. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Smoke Detector Checklist" documentation for 2016 and "Battery Check Smoke Detectors" documentation for 2017 with the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, battery operated smoke detector testing documentation for the ten month period of November 2016 through September 2017 was not available for review. Based interview at the time of record review, the Maintenance Manager stated he started	K 0300	K300 1. The maintenance person tested the battery-operated smoke detectors in each room and documented results. There were no concerns reported. 2. The maintenance person tested the battery-operated smoke detectors in each room and documented results. There were no concerns reported. 3. The maintenance person is responsible for inspecting the battery-operated smoke detector in resident rooms monthly and documenting results on the smoke detector checklist. In the event a battery is changed, documentation shall include the room number and date and indication the battery was changed. 4. The maintenance person will provide testing results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be	12/21/2017

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	working at the facility a few months ago, additional battery operated smoke detector testing documentation was not available for review and stated battery operated smoke detector testing documentation for the ten month period of November 2016 through September 2017 was not available for review. Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, battery operated smoke detectors are installed in each resident room. A Kidde Model P19010 was installed on the wall in Room 6. Manufacturer's instructions affixed to the back of the smoke detector stated to test the detector monthly. 3.1-19(b)		revised to ensure compliance.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under			

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	18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected in accordance with NFPA 96. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. Section 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other	K 0324	K324 1. The kitchen exhaust system was inspected on 10-18-17 and the certificate is on file. The previous inspection certificate, unavailable at the time of survey, was obtained and available for review. *Regarding the drip tray, the facility respectfully requests a hardship waiver and is attaching a waiver application with this response and under separate cover to the Division Long Term Care.* 2. The kitchen exhaust system was inspected on 10-18-17 and the certificate is on file. The previous inspection certificate, unavailable at the time of survey, was obtained and available for review. *Regarding the drip tray, the facility respectfully requests a hardship waiver and is attaching a waiver application and supporting documentation with this response and under separate cover to the Division Long Term Care.* 3. The kitchen exhaust system is scheduled for inspection/cleaning on a semi-annual basis or as needed by an approved and certified	12/21/2017

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	appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect three staff and visitors in the kitchen. Findings include: Based on review of Hoodz "Job Service Report" documentation dated 10/18/17 with the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation of semiannual kitchen exhaust system inspection six months prior to 10/18/17 was not available for review. Based on interview at the time of record review, the Maintenance Manager stated documentation of semiannual kitchen exhaust system inspection six months prior to 10/18/17 was not available for review. Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, only one inspection sticker was		company. The certificate of inspection/cleaning will be on file and available for review. The maintenance person is responsible for ensuring the hood is inspected and cleaned as scheduled and documentation is available. 4. The maintenance person will provide the QAPI Committee with the next scheduled inspection/cleaning date and it will remain on the agenda for the next six months to ensure hood is serviced as scheduled. The administrator oversees the QAPI Committee meetings and minutes of the meeting are provided to corporate compliance by the 15th of each month.	

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	affixed to the range hood in the kitchen which documented kitchen exhaust system inspection by Hoodz in October 2017. 3.1-19(b) 2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect three staff and visitors in the kitchen. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the kitchen range hood system was missing an enclosed metal container for			

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	grease to drain into. Based on interview at the time of the observations, the Maintenance Manager agreed there was no designated location underneath the kitchen range hood system for the drip tray to drain into an enclosed metal container. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 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, 2010 Edition, Section 10.5.5.1 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	K 0345	K345 1. The circuit disconnecting means was permanently affixed with a red marking, accessible to authorized personnel only, and identified as FIRE ALARM CIRCUIT. The location of the circuit was permanently identified at the fire alarm control panel. The maintenance person was inserviced on the location and access to the circuit on 12-7-17.	12/21/2017

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	authorized personnel, and shall be identified as FIRE ALARM CIRCUIT. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. Section 10.5.5.4 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 dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the location of the facility's fire alarm system breaker could not be determined. Based on interview at the time of the observations, the Maintenance Manager stated he had only been working at the facility for the last few months and did not know where the facility's fire alarm system breaker was located. 3.1-19(b)		2. The circuit disconnecting means was permanently affixed with a red marking, accessible to authorized personnel only, and identified as FIRE ALARM CIRCUIT. The location of the circuit was permanently identified at the fire alarm control panel. The maintenance person was inserviced on the location and access to the circuit on 12-7-17. 3. The identifying feature of the circuit disconnecting means will be added to the monthly fire suppression and alarm system checks to ensure it is clearly labeled. The maintenance person is responsible for the internal monthly inspections. 4. The maintenance person will provide fire alarm and suppression system inspection results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall	K 0353	K353 1. The wet sprinkler system gauge inspection and sprinkler system control valve inspection were conducted and documentation of results are available for review. The coax cable was removed from the sprinkler pipe in rooms 7, 16 and 18. 2. The wet sprinkler system gauge inspection and sprinkler system control valve inspection were conducted and documentation of results are available for review. The coax cable was removed from the sprinkler pipe in rooms 7, 16 and 18.	12/21/2017

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	be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of SafeCare's "Report of Inspection" documentation dated 11/29/16, 02/06/17, 05/02/17 and 08/29/17 with the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, monthly wet sprinkler system gauge inspection documentation for 8 months of the most recent 12 month period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was also not available for review. Based on interview at the time of record review, the Maintenance Manager stated the facility frequently checks sprinkler gauges and valves but sprinkler system gauge and control valve inspection documentation for the aforementioned monthly periods was not available for review. Based on observations with the		3. A form was created to document the results of the gauge and valve inspections and they will be conducted by the maintenance person monthly. The maintenance person was inserviced on 12-7-17 regarding the inspections and results documentation on use of the new form. A monthly visual inspection of the sprinkler pipes and sprinkler heads is in place and the maintenance person will ensure coax cable is not suspended by the sprinkler pipes. 4. The maintenance person will provide gauge and valve inspection and sprinkler pipe/head inspection results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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	Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the facility has supervised wet sprinkler systems. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the following was noted: a. a television cable was wrapped around the upright sprinkler in the closet for Room 7. b. a television cable was wrapped around sprinkler piping in the closet for Room 16 and for Room 18. Based on interview at the time of the			

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	observations, the Maintenance Manager stated he did not affix the wiring to the sprinkler pipe but agreed the aforementioned sprinkler pipe locations were used to support non-system components. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure all electrical wiring in the facility was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314 states exposed terminals and receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect over 20 resident's, staff and visitors in the vicinity of	K 0511	K511 1. The electrical wiring in the sprinkler riser room not confined within junction boxes and the junction box without a compatible cover, were enclosed in junction boxes with compatible covers. 2. A visual inspection of other closets and similar enclosures revealed no issues with wiring not confined in junction boxes with compatible covers. 3. The maintenance person will monitor existing wiring and	12/21/2017

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	the sprinkler riser room by the Front Lounge. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, two different sets of electrical wiring in the sprinkler riser room by the Front Lounge were spliced together and were not confined within junction boxes with a cover compatible with the box. In addition, an electrical junction box in the room for a third set of spliced electrical wiring did not have a cover compatible with the box. Based on interview at the time of the observations, the Maintenance Manager agreed spliced electrical wiring in the sprinkler riser room was not confined within a junction box or in a junction box with a cover compatible with the box. 3.1-19(b)		future installations by making rounds throughout the building monthly to ensure wiring is confined in junction boxes with compatible covers. 4. The maintenance person will document monthly rounds for six months and report results at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second shift and third shifts for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Record" documentation with the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation of fire drills conducted within the most recent twelve month period on the second and third shift for the first and second quarter of 2017 was not available for review. Based interview at the time of record review, the Maintenance Manager	K 0712	K712 1. Fire drills on each of three shifts were conducted on 12-13-17 and 12-14-17 and the date and time of drill were recorded on the fire drill record and are available for review. 2. Fire drills on each of three shifts were conducted on 12-13-17 and 12-14-17 and the date and time of drill were recorded on the fire drill record and are available for review. 3. The maintenance person is responsible for planning and conducting fire drills at unexpected times under varying conditions, at least quarterly on each shift. The fire drill record will include the date and time the drill was conducted and will be available for review.	12/21/2017

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	stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed documentation of fire drills conducted on the second and third shift for the first and second quarter of 2017 was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete documentation for fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Record" documentation with the Maintenance Manager during record review from 9:10 a.m. to 11:30 a.m. on 11/21/17, documentation for the third shift fire drill conducted on 07/31/17 did not include the time of day the fire drill was conducted. Based on interview at the time of record review, the Maintenance Manager stated additional fire drill documentation was not available for review and agreed the time of day for the third shift fire drill conducted on 07/31/17 was not documented or available		4. The maintenance person will provide fire drill records and results for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised.	

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	for review. 3.1-19(b)			
K 0911 SS=F Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure working space was maintained for 4 of 4 electrical panels in the Mechanical Room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination,	K 0911	K911 1. A bag with cubicle curtains and a metal file cabinet were removed from the mechanical room. 2. Other mechanical rooms, and rooms with a specific purpose other than storage were visibly inspected to ensure they were not being used for anything other than their intended purpose. 3. The maintenance person will make weekly rounds of storage, utility, electrical, mechanical and similar type rooms to ensure they are being used for their intended purpose and organized in such a	12/21/2017

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	adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. 110.26(A)(3) states the work space shall be clear and extend from the grade, floor, or platform to a height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, one trash bag filled with cubicle curtains and one metal file cabinet were stored underneath the four electrical panels		way as to allow easy access, and do not contain items comingled or incompatible that would pose a danger. 4. The maintenance person will provide results of weekly round for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised.	

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	in the Maintenance Room by Room 29. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned items were stored in the working space for the electrical panels in the Maintenance Room. 3.1-19(b)			
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation and interview, the facility failed to ensure 1 of 1 remote manual stops for the facility's emergency generator was labeled in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 15.5.1.3 states emergency generators and standby power system, where required for compliance with this code, shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 edition, 5.6.5.6 states all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. The remote manual stop station shall be labeled. This deficient practice could affect all residents, staff and visitors.	K 0918	K918 1. The manual stop, located at the nurses' station, for the facility's emergency generator was labeled. 2. The maintenance person inspected the generator and its ancillary components to ensure items essential to its operation are identified and labeled. 3. The maintenance person is responsible for testing and maintaining the emergency generator within the scope of the responsibilities assigned, and will verify the manual stop is labeled appropriately as a part of the weekly inspection and test. 4. The maintenance person will provide results of weekly generator test and inspection for six months at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised.	12/21/2017

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	Findings include: Based on observations with the Maintenance Manager during a tour of the facility from 11:30 a.m. to 12:40 p.m. on 11/21/17, the facility's remote manual stop which was located at the nurse's station by Room 17 was not labeled. The facility has a 150 kW emergency generator installed outside the facility near the southwest side of the building and it was not equipped with a remote manual stop outside of the building. Based on interview at the time of the observations, the Maintenance Manager stated the facility installed the generator in the spring of 2017, the remote manual stop for the unit is located inside the building at the nurse's station and agreed the remote manual stop station was not labeled. 3.1-19(b)			