NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER CX4 ID SUMMARY STATEMENT OF DEFICIENCIE GEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CO A. BUILDING B. WING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/21/2017		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION E 0000 Bidg 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 COMPLETION CROSS-REFERNED TO THE APPROPRIATE PREFIX TAG COMPLETION CROSS-REFERNED TO THE APPROPRIATE COMPLETION DATE COMPLETION CROSS-REFERNED TO THE APPROPRIATE COMPLETION DATE COMPLETION CROSS-REFERNED TO THE APPROPRIATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION TAG PREFIX TAG COMPLETION TAG PREFIX TAG FREQUENCY TAG PREFIX TAG FROM TAG FREQUENCY TAG PREFIX TAG FROM TAG PREFIX TAG FROM TAG PREFIX TAG FROM TAG PREFIX TAG FROM TAG FROM TAG PREFIX TAG FROM TAG FROM TAG PREFIX TAG FREMICA TAG FREMICA TAG FREMICA TAG FREMICA TAG PREFIX TAG FREMICA TAG PREFIX TAG FREMICA TAG FREMICA TAG PREFIX TAG FREMICA TAG PREFIX TAG FROM TAG				8935 E	46TH ST	
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 E 0000 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.	PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
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 E 0000 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. 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	E 0000					
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:		conducted by the of Health in acce 483.73. Survey Date: 1 Facility Number Provider Number AIM Number: At this Emerger Lawrence Mand found not in corpreparedness Reand Medicaid Pasuppliers, 42 Cl The facility has time of the survey Quality Review DA The requirement	e Indiana State Department ordance with 42 CFR 1/21/17 r: 000383 er: 155721 100289610 recy Preparedness survey, or Healthcare Center was impliance with Emergency equirements for Medicare articipating Providers and FR 483.73 55 certified beds. At the ey, the census was 36. completed on 11/30/17 -	E 0000	Preparation and or execution of thi 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 plar 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	e n

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION	(X3) DATE COMPL 11/21/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0004 SS=C Blda							
Bldg	facility failed to emergency preparedues and up accordance with deficient practice. Findings include Based on record Administrator ar Manager during a.m. to 11:30 a.m. documentation f program reviewed most recent twel available for reviewed the time of record stated the facility preparedness profacility within the period which addended procedures based community base communication approach to assist the needs of their	review with the nd the Maintenance record review from 9:10	E 0	004	1. The facility has developed, established and maintains a comprehensive emergency preparedness program that meets applicable Federal, State and local requirements. A documented revie 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 revie 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	w	12/21/2017
	_	ne facility's ability to local emergency			forwarded to Corporate Compliance by the 15th of each month for	2	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K2LE21 F

Facility ID: 000383

If continuation sheet

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PARTMENT OF HEALTH AND HUMAN SERVICES								
ENTERS FOR MEDICARE & MEDIC		OMB NO. 093						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED					
	155721	B. WING	11/21/2017					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721			A. BUILDING B. WING			COMPLETED 11/21/2017	
	ROVIDER OR SUPPLIER	THCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ricials was not available for		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) review.	ATE	(X5) COMPLETION DATE
E 0013 SS=C Bldg							10/01/001
	facility failed to emergency preparedures. The must be reviewe annually in accordant accordant and accordant accorda	review with the and the Maintenance record review from 9:10	E 00	013	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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Event ID:

K2LE21

Facility ID: 000383

If continuation sheet

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2017	
	PROVIDER OR SUPPLIER	THCARE CENTER	893	EET ADDRESS, CITY, STATE, ZIP COD 5 E 46TH ST IANAPOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
	has not had an e program reviewed most recent twel addresses policie a facility and co	mergency preparedness ed by the facility within the live month period which es and procedures based on mmunity based risk communication plan utilizing		3. The emergency preparedness policies and procedures based on a facility ar 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 QA meeting agenda, with oversight the administrator, and will be reviewed and updated as needed but no less than annually. Minut of the QAPI meeting are forward to Corporate Compliance by the of each month for review.	nd nt g API by d, tes led	
E 0029 SS=C Bldg	facility failed to emergency prep- plan that compli local laws was re least annually in	: :	E 0029	1. The facility has developed and maintains an emergency preparedness communication plus that complies with Federal, State and local laws. A documented review of the emergency preparedness communication plus was conducted to meet the requirement for annual review. all staff inservice on emergency preparedness communication plus was conducted on 12-13-2017.	an e, an An an	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	i '		DNSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155721	B. WI	ILDING NG		COMPLI 11/21/2	
		100.2.		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	1			46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	,TE	COMPLETION DATE
TAG		nd the Maintenance		TAG	and maintains an emergency		DATE
		record review from 9:10			preparedness communication plan		1
					that complies with Federal, State,		1
	a.m. to 11:30 a.m				and local laws. A documented		1
		or a complete emergency			review of the emergency preparedness communication plan		1
		ogram reviewed by the			was conducted to meet the		1
	-	e most recent twelve month			requirement for annual review. An		1
	period was not available for review. Based				all staff inservice on emergency		1
	on interview at t	he time of record review,			preparedness communication plan was conducted on 12-13-2017.		1
	the Administrate	or stated the facility has not					1
	had an emergeno	cy preparedness program			3. The emergency		1
	reviewed by the	facility within the most			preparedness communication plan		1
	_	onth period which includes a			that contains how the facility coordinates patient care within the		1
		plan that contains how the			facility and across health care		1
		tes patient care within the			providers, will be reviewed and		1
	•	•			updated at least annually and no		1
	-	ealth care providers, and			later than December 2018.		1
		h state and local public			4. The emergency		1
	health departmen	nts.			preparedness communication plan		1
					will be added as a standing item to		1
					the monthly QAPI meeting agenda,		1
					with oversight by the administrator and will be reviewed and updated	,	1
					as needed, but no less than		1
					annually. Minutes of the QAPI		1
					meeting are forwarded to Corporate	е	1
					Compliance by the 15th of each month for review.		ı
					monun for review.		1
							1
E 0037 SS=C Bldg							ſ
	Based on record	review and interview, the	E 00)37	E037		12/21/2017
	facility failed to	ensure the emergency			TI 6 1991		1
	-	ining and testing program			The facility has an emergency preparedness training		1
		ng program. The LTC facility			program including all new and		ı

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	,		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155721	B. WI	NG		11/21/	2017
	PROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ	ID	T		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	must do all of th	e following: (i) Initial training			existing staff, individuals providing		
		eparedness policies and			services under arrangement, and		
	" " "	l new and existing staff,			volunteers, consistent with their expected role; documentation of		
	_	iding services under			training; and demonstration of staff		
	_	d volunteers, consistent with			knowledge. An all staff inservice		
	_				meeting on the emergency		
	their expected roles; (ii) Provide emergency				preparedness program was conducted on 12-13-2018.		
	preparedness training at least annually; (iii)				Representatives of the facility		
	Maintain documentation of the training; (iv)				attended a community meeting with	า	
		ff knowledge of emergency			representatives from emergency		
	procedures in ac	cordance with 42 CFR			management present on 7-13-17, at		
	483.73(d)(1). This deficient practice could				which a mock community disaster was simulated using a table top		
	affect all occupa	nts.			exercise and group discussion. The		
	Findings include				facility will conduct an annual internal mock disaster drill on 12-19-17.		
	Based on record	review with the			2. The facility has an		
	Administrator ar	nd the Maintenance			emergency preparedness training		
	Manager during	record review from 9:10			program including all new and existing staff, individuals providing		
	a.m. to 11:30 a.m				services under arrangement, and		
		or a complete emergency			volunteers, consistent with their		
		ogram reviewed by the			expected role; documentation of		
		ne most recent twelve month			training; and demonstration of staff knowledge. An all staff inservice		
	1				meeting on the emergency		
	_	vailable for review. Based			preparedness program was		
		he time of record review,			conducted on 12-8-2018.		
		Maintenance stated the			Representatives of the facility	,	
	1	conducted a community			attended a community meeting with representatives from emergency	'	
	based disaster dr	rill, conducted initial training			management present on 7-13-17, at	į	
	in emergency pro	eparedness policies and			which a mock community disaster		
	procedures or ha	d an emergency			was simulated using a table top		
	preparedness pro	ogram reviewed by the			exercise and group discussion. The facility will conduct an annual		
		e most recent twelve month			internal mock disaster drill on		
	period.				12-19-17.		

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Event ID:

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Facility ID: 000383

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			urvey eted 2017	
	PROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LEG IDENTIFYING DEFORMATION	1	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	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 a 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 month QAPI meeting overseen by the administrator. Minutes of the QAPI meeting are forwarded to Corporat Compliance by the 15thof each month for review.	ıly	DATE
K 0000							
Bldg. 01	State Licensure State Indiana State accordance with Survey Date: 11 Facility Number Provider Number AIM Number: 1	: 000383 r: 155721 00289610	K 00	000	Preparation and or execution of thi plan does not constitute admission or agreement by the provider of th 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.	e 1	
	At this Life Safe	ty Code survey, Lawrence					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K2LE21

Facility ID: 000383

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPL	
		155721	B. W	ING		11/21/	2017
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					46TH ST		
LAWKEN	NOE IVIAINOK HEAL	THCARE CENTER	_	INDIAN	APOLIS, IN 46226		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		are Center was found not in		TAG			DATE
	compliance with Requirements for Participation in Medicare/Medicaid, 42			The facility respectfully requests a			
		·			desk review to demonstrate		
	•	33.90(a), Life Safety from			compliance. Supporting documentation is attached.		
	Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101,						
	1	le (LSC), Chapter 19,					
	_	Care Occupancies and 410					
	IAC 16.2.						
	This one story f	acility was determined to be					
	of Type II (111)	construction and fully					
	sprinklered. Th	e facility has a fire alarm					
	system with smo	oke detection in the corridors					
	and in all areas	open to the corridor. The					
	facility has batte	ery operated smoke					
	detectors install	ed in all resident sleeping					
	rooms. The fac	ility has a capacity of 55 and					
	had a census of	36 at the time of this visit.					
	All areas where	residents have customary					
		inklered. The facility has					
	_	aildings providing facility					
		which were not sprinklered.					
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Quality Review	completed on 11/30/17 -					
	DA	•					
K 0211	NFPA 101						
SS=E	Means of Egress						
Bldg. 01	Means of Egress	- General /ays, corridors, exit					
		ocations, and accesses are					
	_	th Chapter 7, and the means					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155721		l í	UILDING	ONSTRUCTION 01	(X3) DATE COMPL 11/21	LETED		
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR of egress is contin all obstructions to			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	all obstructions to emergency, unles through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observ facility failed to egress was contiall obstructions of use in the case of This deficient procession in the facility. Findings included Based on observed Maintenance M	full use in case of s modified by 18/19.2.2 110.1 ation and interview, the ensure 1 of 6 means of nuously maintained free of or impediments to full instant of fire or other emergency. actice could affect over 20 and visitors if needing to exit	K 0)211	1. The wood table located in the corridor outside the administrator's office was remove 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 continuous 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	d us e ly s	12/21/2017	
	the corridor which the corridor. Bath of the observation Manager agreed of egress was not free of all obstrutions in the emergency.	ch projected one foot into sed on interview at the time ons, the Maintenance the aforementioned means t continuously maintained ctions or impediments to full e case of fire or other			4. The maintenance person will document weekly rounds for smonths and report results at the monthly QAPI meeting overseen be the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	У		
	3.1-19(b)				1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K2LE21

Facility ID: 000383

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/21/2017	
	PROVIDER OR SUPPLIER		8935 E	ADDRESS, CITY, STATE, ZIP COD E 46TH ST NAPOLIS, IN 46226	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0232 SS=E Bldg. 01	unobstructed) sen at least 4 feet and convenient remove on stretchers, exc. 19.2.3.4, exception 19.2.3.4, 19.2.3.5 Based on observe facility failed to requirement for exception per 19.19.2.3.4(5) states is at least 8 feet, required width selfurniture, provide conditions are median the floor or to the	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the all of nonambulatory patients ept as modified by ns 1-5. ation and interview, the meet the clear width 1 of 6 corridors or met an .2.3.4(5). LSC is where the corridor width projections into the nall be permitted for fixed ed that all of the following et: atiture is securely attached to e wall. atture does not reduce the ed corridor width to less ept as permitted by	K 0232	1. The wood table located in the corridor outside the administrator's office was remover 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 continuousl 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 departmen 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	d us e y s ne t

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUIL		NSTRUCTION 01	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155721	B. WING		<u>U I </u>	11/21/	
VII 2 2	DROLUBER OF SUMP			STREET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
	PROVIDER OR SUPPLIEF		8	8935 E	46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		NDIAN	APOLIS, IN 46226		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX ΓAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		niture groupings addressed in			corridors and exits remain free of		
	19.2.3.4(5)(d) ar	re separated from each			obstruction.		
	other by a distan	ice of at least 10 feet.			4. The maintenance person		
	(f) the fixed furniture is located so as to not obstruct access to building service and fire				will document weekly rounds for six	(
					months and report results at the monthly QAPI meeting overseen by		
	protection equipment. (g) corridors throughout the smoke				the administrator and reported to		
					corporate compliance. If the		
	_	e protected by an electrically			threshold of 100% is not achieved, action plans will be revised to		
	supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and				ensure compliance.		
		direct supervision by the					
	_	n a nurse's station or similar					
	space.						
	` ′	ompartment is protected					
	1 ,	approved, supervised					
	with 19.3.5.8.	tler system in accordance					
		ractice could affect over 20					
	residents, staff a						
	1051delito, staff a	110 1101015.					
	Findings include	: :					
	Based on observ	rations with the					
	Maintenance Ma	anager during a tour of the					
	facility from 11:	30 a.m. to 12:40 p.m. on					
	11/21/17, the co	rridor outside the					
	Administrator's	office and by the corner of					
	the south wall of	f the Front Lounge measured					
	eight feet wide.	A wood table was stored in					
	the corridor which	ch projected one foot into					
	the corridor. Th	e table was not securely					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDIN 155721 B. WING		JILDING	CONSTRUCTION (X3) DATE SURVEY 01 COMPLETED 11/21/2017		ETED		
	ROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0291 SS=F Bldg. 01	on interview at the Maintenance was stored in the egress which prowas not affixed to 3.1-19(b) NFPA 101 Emergency Lighting Emergency Lighting Emergency Lighting duration is provide accordance with 7 18.2.9.1, 19.2.9.1 1. Based on record and interview; the monthly testing in accordance with 7.9.3.1.1 states to systems shall be as follows: (1) Functional termonthly, with a maximum of 5 will less than 30 second permitted by 7.9 (2) The test interview extended beyond of the authority in (3) Functional termonal	of at least 1-1/2-hour de automatically in 1.9. Ord review, observation de facility failed to document for all battery backup lights th LSC 7.9. Section desting of emergency lighting permitted to be conducted desting shall be conducted	K 0	291	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	n	12/21/2017

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI		<u>01</u>	COMPL	
		155721	B. WIN	-		11/21/	2017
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
LAWREN	ICE MANOR HEAL	THCARE CENTER			46TH ST APOLIS, IN 46226		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVJDEDIG DI AM OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	powered.				intended use and shall comply with		
	(4) The emergen	cy lighting equipment shall			NFPA 70 NEC.		
	be fully operation	onal for the tests required by			4. The maintenance person		
	7.9.3.1.1(1) and (3).				will provide testing results for six		
	(5) Written recor	rds of visual inspections and			months at the monthly QAPI meetir overseen by the administrator and	ng	
	tests shall be kep	ot by the owner for			reported to corporate compliance.		
	inspection by the authority having				If the threshold of 100% is not		
	jurisdiction.				achieved, action plans will be revised to ensure compliance.		
	This deficient pr	actice could affect all			revised to ensure compilance.		
	residents, staff a	nd visitors in the facility.					
	Findings include	2:					
	Based on review	of "Battery Operated					
	Emergency Ligh	ting Test" documentation for					
	2016 and 2017 a	and "Emergency Lights"					
	documentation f	for 2017 with the					
	Maintenance Ma	anager during record review					
	from 9:10 a.m. to	o 11:30 a.m. on 11/21/17,					
	documentation of	of 30 day interval testing for					
	May 2017 was n	ot available for review. In					
	addition, the afo	rementioned documentation					
	for the most rece	ent twelve month period did					
	not indicate if th	e test was a 30 second test					
	or an annual 90	minute test. Based on					
	interview at the	time of record review, the					
	Maintenance Ma	nnager stated he started					
		acility a few months ago,					
	additional battery light testing documentation						
		e for review and the					
		documentation did not state					
		nonthly testing records.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155721	B. W	ING		11/21/	2017
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN	APOLIS, IN 46226		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	Based on observ	ations with the		TAG			DATE
		unager during a tour of the					
		30 a.m. to 12:40 p.m. on					
	1	attery powered emergency					
		were noted in the facility.					
	1	-					
		vered light functioned when					
		as pushed except for the					
	light at the exit b	by Room 20.					
	2.1.10(1)						
	3.1-19(b)						
	A D 1 1	. 1:,					
		ervation and interview, the					
	1	ensure 1 of 9 battery					
	1 ^	ncy lights was maintained in					
		LSC 7.9. LSC 7.9.2.6					
	1	erated emergency lights					
		liable types of rechargeable					
	_	ed with suitable facilities for					
	_	n in properly charged					
		ries used in such lights or					
	**	proved for their intended use					
	and shall comply	with NFPA 70 National					
		This deficient practice could					
	affect all residen	ts, staff and visitors.					
	Findings include	:					
	Based on observ	ations with the					
	Maintenance Ma	nager during a tour of the					
	facility from 11:	30 a.m. to 12:40 p.m. on					
	11/21/17, the bat	ttery operated emergency					
	lighting system l	ocated at the exit by Room					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/21/2017
	PROVIDER OR SUPPLIEF		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST JAPOLIS, IN 46226	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION wo lights and only one light	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	was pushed five interview at the Maintenance Ma aforementioned system failed to	n its respective test button separate times. Based on time of the observations, the mager agreed the battery operated lighting illuminate each light when its bushed five separate times.			
K 0293 SS=E Bldg. 01	accordance with 7 illumination also s lighting system. 19.2.10.1 (Indicate N/A in or occupancies with where the line of Based on record facility failed to signage was inst LSC 7.10. LSC	al signs are displayed in 7.10 with continuous erved by the emergency existing less than 30 occupants exit travel is obvious.) review and interview; the ensure 1 of over 5 exit alled in accordance with 7.10.1.2.1 states exits, exterior exit doors that	K 0293	K293 1. The Exit sign near the entrance to the lounge in the area Room 25 was modified to include directional chevrons pointing to t nearest exits.	

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STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
	155721	B. WI	NG		11/21/	2017
NAME OF PROVIDER OR SUPPLE	LTHCARE CENTER		8935 E INDIAN	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		ave.
` '	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
`	ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	clearly are identifiable as		1710			DITTE
	narked by an approved sign			2. The maintenance person		
· ·	that is readily visible from any direction of			visually inspected all mounted exit		
-	SC 7.10.1.2.2 states			signs to ensure they are readily visible including those where the		
				egress path is not obvious. There		
	ponents of the egress path			were no issues noted.		
	within an exit enclosure shall be marked by approved exit or directional exit signs where					
				Maintenance is responsible for making weekly rounds to ensure		
	n of the egress path is not			the exit and directional exit signs		
	leficient practice could affect			are visible and functional and		
over 20 resider	its, staff and visitors.			results documented.		
Based on observations and the description of the observations and the control of the control of the control of the control of the observation of the observation of the control of the observation of the control of the observation of the observation of the observation of the control of the observation of the observati	rvations with the fanager during a tour of the 1:30 a.m. to 12:40 p.m. on intrance to the Lounge from tween Rooms 25 and 26 was a exit sign and had no cator displayed indicating the to exit the facility. The thave an exit to the outside of ised on interview at the time ions, the Maintenance d there is no exit from the outside of the facility and the d not be in place or the cator chevron(s) for the sign			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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155721	B. W	ING		11/21/	2017
	ROVIDER OR SUPPLIER		•	8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, IN 46226		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0300	NFPA 101						
SS=F Bldg. 01	Protection - Other						
ыug. U I	Protection - Other	KS section any LSC					
	Section 18.3 and	•					
		are not addressed by the					
	provided K-tags, b	ut are deficient. This					
		with the applicable Life					
		FPA standard citation,					
		d on Form CMS-2567.	17.0	200	K300		12/21/2017
		review, observation and	K 0	300	K300		12/21/2017
		cility failed to ensure			1. The maintenance person		
	-	ntenance for all battery			tested the battery-operated smoke		
	operated smoke	alarms in resident rooms			detectors in each room and		
	was performed.	NFPA 101 in 4.6.12.3			documented results. There were no concerns reported.)	
	states existing lif	fe safety features obvious to			concerns reported.		
	the public, if not	required by the Code, shall			2. The maintenance person		
	be maintained.	This deficient practice could			tested the battery-operated smoke		
		ts, staff, and visitors.			detectors in each room and documented results. There were no		
		,			concerns reported.	,	
	Findings include						
	i mamas merade	•			3. The maintenance person is		
	Događ om marriarra	of "Smoke Detector			responsible for inspecting the		
					battery-operated smoke detector in resident rooms monthly and	1	
		mentation for 2016 and			documenting results on the smoke	ļ	
		Smoke Detectors"			detector checklist. In the event a		
	documentation for				battery is changed, documentation		
	Maintenance Ma	nager during record review			shall include the room number and date and indication the battery was		
	from 9:10 a.m. to	o 11:30 a.m. on 11/21/17,			changed.		
	battery operated	smoke detector testing					
	documentation for	or the ten month period of			4. The maintenance person		
	November 2016	through September 2017			will provide testing results for six		
		e for review. Based			months at the monthly QAPI meetir overseen by the administrator and	ıg	
		time of record review, the			reported to corporate compliance.		
		nager stated he started			If the threshold of 100% is not		
	iviamitemante ivia	mager stated he started			achieved, action plans will be	ļ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COMPLETED 11/21/2017	
	PROVIDER OR SUPPLIER		8935 E	ADDRESS, CITY, STATE, ZIP CO 46TH ST IAPOLIS, IN 46226	D
				1	770
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	
TAG	``	LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE DATE
	working at the fa	ncility a few months ago,		revised to ensure compliance	e.
	_	y operated smoke detector			
		tation was not available for			
	_	d battery operated smoke			
		documentation for the ten			
	_	November 2016 through			
	•	was not available for			
	-	n observations with the			
	Maintenance Ma	nager during a tour of the			
		30 a.m. to 12:40 p.m. on			
		operated smoke detectors			
	_	ach resident room. A			
	Kidde Model P1	9010 was installed on the			
	wall in Room 6.	Manufacturer's instructions			
	affixed to the ba	ck of the smoke detector			
		detector monthly.			
		J			
	3.1-19(b)				
K 0324	NFPA 101				
SS=D	Cooking Facilities				
Bldg. 01	Cooking Facilities				
	Cooking equipmen				
		IFPA 96, Standard for I and Fire Protection of			
		ing Operations, unless:			
		ng equipment (i.e., small			
		s microwaves, hot plates,			
	•	I for food warming or limited			
	19.3.2.5.2	ance with 18.3.2.5.2,			
		open to the corridor in			
	· ·	ents with 30 or fewer			
	patients comply w	ith the conditions under			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/21/2017 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS, IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0324 K324 12/21/2017 1. Based on record review, observation and interview; the facility failed to ensure 1 The kitchen exhaust system of 1 kitchen exhaust systems was inspected was inspected on 10-18-17 and the in accordance with NFPA 96. NFPA 96, certificate is on file. The previous inspection certificate, unavailable 2011 Edition, Standard for Ventilation at the time of survey, was obtained Control and Fire Protection of Commercial and available for review. Regarding Cooking Operations, Section 11.4 states the the drip tray, the facility respectfully requests a hardship waiver and is entire exhaust system shall be inspected for attaching a waiver application with grease buildup by a properly trained, this response and under separate qualified, and certified person(s) acceptable cover to the Division Long Term Care. to the authority having jurisdiction and in The kitchen exhaust system accordance with Table 11.4. Table 11.4, was inspected on 10-18-17 and the Schedule for Inspection for Grease Buildup, certificate is on file. The previous inspection certificate, unavailable requires systems serving moderate volume at the time of survey, was obtained cooking operations shall be inspected and available for review. Regarding semiannually. Section 11.6.1 states, upon the drip tray, the facility respectfully requests a hardship waiver and is inspection, if the exhaust system is found to attaching a waiver application and be contaminated with deposits from grease supporting documentation with this laden vapors, the contaminated portions of response and under separate cover to the Division Long Term Care. the exhaust system shall be cleaned by a properly trained, qualified, and certified The kitchen exhaust system person(s) acceptable to the authority having is scheduled for inspection/cleaning on a jurisdiction. Hoods, grease removal semi-annual basis or as needed by devices, fans, ducts, and other an approved and certified

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	01	COMPL	
		155721	B. WI	NG		11/21/	2017
NAME OF D	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD	_	
					46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN.	APOLIS, IN 46226		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		a LSC IDENTIFYING INFORMATION nall be cleaned to remove		TAG	company. The certificate of		DATE
	* *	taminants prior to surfaces			inspection/cleaning will be on file		
		•			and available for review. The		
		y contaminated with grease			maintenance person is responsible		
		After the exhaust system is			for ensuring the hood is inspected and cleaned as scheduled and		
	cleaned, it shall not be coated with powder				documentation is available.		
		ce. When an exhaust					
	cleaning service is used, a certificate				 The maintenance person will provide the QAPI Committee 		
	showing the name of the servicing company,				with the next scheduled		
	-	person performing the work,			inspection/cleaning date and it will		
		nspection or cleaning shall			remain on the agenda for the next		
	be maintained on the premises. This				six months to ensure hood is serviced as scheduled. The		
	deficient practice	e could affect three staff and			administrator oversees the QAPI		
	visitors in the kit	tchen.			Committee meetings and minutes of	f	
					the meeting are provided to corporate compliance by the 15th o	f	
	Findings include	i:			each month.	•	
	Based on review	of Hoodz "Job Service					
	Report" docume	ntation dated 10/18/17 with					
	the Maintenance	Manager during record					
	review from 9:10	0 a.m. to 11:30 a.m. on					
	11/21/17, docum	nentation of semiannual					
		system inspection six months					
		was not available for					
	*	n interview at the time of					
		ne Maintenance Manager					
		ation of semiannual kitchen					
		nspection six months prior					
	_	not available for review.					
	Based on observ						
		unager during a tour of the					
	-	30 a.m. to 12:40 p.m. on					
	11/21/1/, only of	ne inspection sticker was					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155721	B. WI	NG		11/21/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>			46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER		INDIAN	APOLIS, IN 46226		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nge hood in the kitchen					
	which documented kitchen exhaust system						
	inspection by Hoodz in October 2017.						
	3.1-19(b)						
	5.1-17(0)						
	2. Based on observation and interview, the						
	facility failed to	install the kitchen range hood					
	system in accordance with the requirements						
		ection 9.2.3 states					
	commercial cooking equipment shall be						
	installed in accordance with NFPA 96,						
		ntilation Control and Fire					
		mmercial Cooking					
	*	PA 96, 2011 edition,					
	Section 6.2.4.1 s	tates kitchen range hood					
	system filters sha	all be equipped with a drip					
	tray beneath thei	r lower edges. The tray					
	shall be kept to the	he minimum size needed to					
	collect grease an	d shall be pitched to drain					
	_	metal container having a					
		eeding 1 gal (3.785 L).					
		actice could affect three staff					
	and visitors in th						
	anu visitois iii th	E KICHEH.					
	Findings include	::					
	<i>5 </i>						
	Based on observa	ations with the					
		nager during a tour of the					
		30 a.m. to 12:40 p.m. on					
	_	•					
	· ·	chen range hood system					
	was missing an e	enclosed metal container for					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 11/21/2017
	PROVIDER OR SUPPLIER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST JAPOLIS, IN 46226	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR grease to drain in the time of the of Maintenance Ma designated locati	on underneath the kitchen m for the drip tray to drain	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.7.5, 9.7.7, 9.7.8, Based on observ facility failed to systems was main the applicable re National Fire Ala 2010 Edition, Seconnections to the shall be on a ded Circuit disconne	n - Testing and m is tested and maintained n an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	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 inservice on the location and access to the circuit on 12-7-17.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2017	
	PROVIDER OR SUPPLIER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, IN 46226	
(X4) ID PREFIX TAG	authorized perso as FIRE ALARM of the circuit dispermanently ider control unit. Secontrol unit	ations with the mager during a tour of the 30 a.m. to 12:40 p.m. on ration of the facility's fire eaker could not be sed on interview at the time ms, the Maintenance he had only been working at the last few months and did the facility's fire alarm	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 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.	DATE d s y

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PRINTED: 12/21/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/21/2017 155721 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8935 E 46TH ST LAWRENCE MANOR HEALTHCARE CENTER INDIANAPOLIS. IN 46226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0353 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 01 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 K 0353 K353 12/21/2017 1. Based on record review, observation and interview; the facility failed to document The wet sprinkler system sprinkler system inspections in accordance gauge inspection and sprinkler with NFPA 25. NFPA 25, Standard for system control valve inspection were conducted and documentation the Inspection, Testing, and Maintenance of of results are available for review. Water-Based Fire Protection Systems, The coax cable was removed from 2011 Edition, Section 5.2.4.1 states gauges the sprinkler pipe in rooms 7, 16 and 18. on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in The wet sprinkler system good condition and that normal water supply gauge inspection and sprinkler

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pressure is being maintained. Section 5.1.2

connections shall be inspected, tested, and

maintained in accordance with Chapter 13.

Section 13.1.1.2 states Table 13.1.1.2 shall

states valves and fire department

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and 18.

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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

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155721	B. WI	NG		11/21/	/2017
NAME OF I	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP COD	•	
					46TH ST		
LAWREN	NCE MANOR HEAL	THCARE CENTER		INDIAN	APOLIS, IN 46226		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG		R LSC IDENTIFYING INFORMATION aspection, testing and		TAG	3. A form was created to		DATE
		valves, valve components			document the results of the gauge		
		on 4.3.1 states records shall			and valve inspections and they will		
		inspections, tests, and			be conducted by the maintenance person monthly. The maintenance		
		•			person was inserviced on 12-7-17		
	maintenance of the system and its				regarding the inspections and		
	components and shall be made available to				results documentation on use of th	e	
		ving jurisdiction upon			new form. A monthly visual inspection of the sprinkler pipes		
	_	eficient practice could affect			and sprinkler heads is in place and		
	all residents, sta	ff, and visitors.			the maintenance person will ensure	e	
					coax cable is not suspended by the sprinkler pipes.		
	Findings include	e:			spinikici pipes.		
					4. The maintenance person		
	Based on review	v of SafeCare's "Report of			will provide gauge and valve		
	Inspection" doc	umentation dated 11/29/16,			inspection and sprinkler pipe/head inspection results for six months at		
	02/06/17, 05/02	/17 and 08/29/17 with the			the monthly QAPI meeting oversee		
	Maintenance Ma	anager during record review			by the administrator and reported		
	from 9:10 a.m. t	to 11:30 a.m. on 11/21/17,			to corporate compliance. If the threshold of 100% is not achieved,		
	monthly wet spi	rinkler system gauge			action plans will be revised to		
	inspection docu	mentation for 8 months of			ensure compliance.		
	_	12 month period was not					
		view. In addition, monthly					
		mentation for all sprinkler					
	1 1	valves for 8 months of the					
	1 -	nonth period was also not					
		view. Based on interview at					
		rd review, the Maintenance					
		the facility frequently checks					
	_						
	sprinkler gauges and valves but sprinkler system gauge and control valve inspection						
	1	•					
		for the aforementioned					
		s was not available for					
	review. Based of	on observations with the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE (COMPL 11/21/	ETED	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	facility from 11:	anager during a tour of the 30 a.m. to 12:40 p.m. on sility has supervised wet s.					
	3.1-19(b)						
	facility failed to systems in accor NFPA 25, Stand Testing, and Ma Fire Protection S Section 5.2.2.2 s not be subjected materials either a from the pipe. T	ervation and interview, the maintain 1 of 1 sprinkler dance with NFPA 25. ard for the Inspection, intenance of Water-Based systems, 2011 edition, tates sprinkler piping shall to external loads by resting on the pipe or hung this deficient practice could sidents, staff and visitors.					
	Findings include Based on observ						
	Maintenance Ma facility from 11: 11/21/17, the fol a. a television ca	anager during a tour of the 30 a.m. to 12:40 p.m. on lowing was noted: ble was wrapped around kler in the closet for Room					
	sprinkler piping and for Room 18	ble was wrapped around in the closet for Room 16 8. ew at the time of the					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 11/21/2017				
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	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.	K 0511	 K511 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. A visual inspection of other closets and similar enclosures revealed no issues with wiring not confined in junction boxes with compatible covers. 	12/21/2017		
	This deficient practice could affect over 20 resident's, staff and visitors in the vicinity of		The maintenance person will monitor existing wiring and			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULT A. BUILE B. WING		nstruction 01	(X3) DATE S COMPL 11/21/	ETED	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the sprinkler rise Lounge. Findings include	er room by the Front			future installations by making rounds throughout the building monthly to ensure wiring is confined in junction boxes with compatible covers.		
	Based on observ Maintenance Ma facility from 11: 11/21/17, two di wiring in the spr Front Lounge we were not confine a cover compatible addition, an elect room for a third wiring did not hat the box. Based of the observations, agreed spliced el- sprinkler riser ro	ations with the mager during a tour of the 30 a.m. to 12:40 p.m. on fferent sets of electrical inkler riser room by the ere spliced together and ad within junction boxes with ole with the box. In trical junction box in the set of spliced electrical ave a cover compatible with on interview at the time of the Maintenance Manager ectrical wiring in the om was not confined within in a junction box with a			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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	COMPLETED	
		155721	B. WING 11/21/2017					
	ROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		DECLIFICATION OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
Bldg. 01	Fire Drills Fire drills include to alarm signal and so conditions. Fire dritimes under varying quarterly on each with procedures at part of established planning and condonly to competent to exercise leaders conducted between coded announcer audible alarms. 18.7.1.4 through 1.19.7.1.7 1. Based on recent the facility failed of a fire drill condon and third shifts for deficient practice and visitors. Findings included Based on review documentation with Manager during a.m. to 11:30 a.m. documentation of the most recent the second and third shifts for the deficient practice and visitors.	the transmission of a fire simulation of emergency fire ills are held at unexpected ag conditions, at least shift. The staff is familiar and is aware that drills are a routine. Responsibility for lucting drills is assigned persons who are qualified ship. Where drills are an 9:00 PM and 6:00 AM, a ment may be used instead of 8.7.1.7, 19.7.1.4 through and review and interview, at to provide documentation aducted on the second shift for 2 of 4 quarters. This are affects all residents, staff The drill Record with the Maintenance are cord review from 9:10 and 11/21/17, are fire drills conducted within the welve month period on the shift for the first and	K 07		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		12/21/2017	
	for review. Base	f 2017 was not available ed interview at the time of the Maintenance Manager			and time the drill was conducted and will be available for review.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/21/2017	
	PROVIDER OR SUPPLIER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, IN 46226	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	day, additional finot available for documentation of second and third	operates three shifts per fire drill documentation was review and agreed f fire drills conducted on the shift for the first and f 2017 was not available		4. The maintenance person will provide fire drill records and results for six months at the monthly QAPI meeting overseen b the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised.	
	3.1-19(b)				
	the facility failed documentation for the third shift for	ord review and interview, I to provide complete or fire drills conducted on 1 of 4 quarters. This e affects all residents, staff			
	Findings include	:			
	documentation we Manager during a.m. to 11:30 a.m. documentation for conducted on 07 time of day the final Based on interview, the Mair additional fire drawailable for revealing day for the third	of "Fire Drill Record" with the Maintenance record review from 9:10 in. on 11/21/17, or the third shift fire drill /31/17 did not include the fire drill was conducted. ew at the time of record intenance Manager stated fill documentation was not fiew and agreed the time of shift fire drill conducted on t documented or available			

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		X1) PROVIDER/SUPPLIER/CLIA				· ′	E SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETE					
		155721	B. WING 11/21/20		2017			
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER				8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	for review. 3.1-19(b)							
K 0911 SS=F Bldg. 01	Chapter 6 Electric that are not addres K-Tags, but are de along with the app	s - Other tKS section any NFPA 99 al Systems requirements ssed by the provided eficient. This information, licable Life Safety Code or eation, should be included						
	facility failed to maintained for 4 Mechanical Root Facilities Code, 2 6.3.2.1 states ele accordance with Electric Code. Narticle 110.26 st space shall be prabout all electric ready and safe of of such equipme equipment operation.	ation and interview, the ensure working space was of 4 electrical panels in the m. NFPA 99, Health Care 2012 Edition, Section ctrical installation shall be in NFPA 70, National NFPA 70, 2011 Edition, ates access and working ovided and maintained al equipment to permit peration and maintenance nt. Working space for ting at 600 volts, nominal, to require examination,	K 0	911	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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/21/2017	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
1.70	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	IAU	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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/21/2017			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	Based on intervious observations, the agreed the aforestored in the work	ew at the time of the e Maintenance Manager mentioned items were rking space for the electrical intenance Room.							
K 0918 SS=C Bldg. 01	System Maintenar The generator or cand associated edsupplying service 10-second criterion monthly test, a proannually confirm the safety and critical and testing of the switches are performed NFPA 110. Generator sets are exercised under loyear in 20-40 day once every 36 moscheduled test under a complete simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with Newson and associated exercised under loyear in 20-40 day once every 36 moscheduled test under the simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with Newson and associated exercised under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled test under loyear in 20-40 day once every 36 moscheduled tes	other alternate power source quipment is capable of within 10 seconds. If the in is not met during the ocess shall be provided to his capability for the life branches. Maintenance generator and transfer ormed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised on the for 4 continuous hours. Indeed the include include in the capability of the life branches. Maintenance generator and transfer ormed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised on the for 4 continuous hours.							

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	· /	JILDING	onstruction 01	(X3) DATE : COMPL 11/21/	ETED	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	components is esimanufacturer requoif maintenance ariand readily availal and circuits are midentifiable. Minimum damage of the emdesign considerate 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on observing facility failed to stops for the facility failed to stops for the facility failed in accordance was labeled in accordance with scode, shall be maintained in accordance system, where results code, shall be maintained in accordance with scode states all remote manual sprevent inadvert operation located the prime mover elsewhere on the mover is located remote manual spread the manual spread to the mover is located remote manual spread to the mover is located to the mover is located to the mover is located remote manual spread to the mover is located to the move	dizing the possibility of sergency power source is a sion for new installations. (NFPA 99), NFPA 110, 0 (NFPA 70) ation and interview, the ensure 1 of 1 remote manual dility's emergency generator ecordance with NFPA 99. The Care Facilities Code, ection 15.5.1.3 states rators and standby power equired for compliance with the installed, tested, and cordance with NFPA 110, ergency and Standby NFPA 110, 2010 edition, installations shall have a top station of a type to ent or unintentional did outside the room housing the premises where the prime outside the building. The top station shall be labeled. Factice could affect all	K 0	918	1. The manual stop, located a 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 simonths at the monthly QAPI meetir overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised.	X.	12/21/2017	

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Event ID:

K2LE21

Facility ID: 000383

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2017 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/21/2017		
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, 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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	facility from 11: 11/21/17, the fac which was locate Room 17 was not 150 kW emerger outside the facilit the building and remote manual s Based on intervi- observations, the stated the facility the spring of 20: for the unit is locate the nurse's statio					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: K2LE21 Facility ID: 000383 If continuation sheet Page 35 of 35