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	06/05/2018

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

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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: 06/05/18 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Emergency Preparedness survey, Lawrence Manor Health Care Center was found 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 34.	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 7-5-2018.	
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: 06/05/18 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Life Safety Code survey, Lawrence Manor Health Care Center was found not in compliance with Requirements for Participation in	K 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 7-5-2018.	

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

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	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 55 and had a census of 34 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage which were not sprinklered.			
K 0281 SS=B Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 1 of 6 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect all kitchen staff only.	K 0281	K281 The exterior fixture above the exit leading from the Dietary department will be replaced with a dual bulb light fixture. All exterior fixtures for exits as a means of egress were assessed to ensure a dual bulb light fixture was in use.	07/05/2018

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	Findings include: Based on observation on 06/05/18 at 1:50 p.m. with the Maintenance Supervisor, the exit for the kitchen staff to the outside was equipped with one light fixture with only one bulb. No other light fixtures could be located anywhere nearby which could aid in illumination of the area. Based on interview concurrent with observation it was confirmed by the Maintenance Supervisor the kitchen exit was not provided with a dual bulb light fixture. 3.1-19(b)		The maintenance person was inserviced on 6-13-18 regarding use of dual bulb fixtures so the failure of any single bulb would not leave the area in darkness. The function of exterior lights has been added to the preventative maintenance log. An audit form including the observation of exterior dual bulb fixtures in the areas of egress was implemented. The maintenance person will audit weekly for one month, bi-weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	
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 observation and interview, the facility failed to ensure 1 of 9 battery powered emergency lights were 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	K 0291	K291 The battery-operated emergency light above the door to the dining room is now functioning. All the battery-operated emergency lights were checked for function and were tested for 90	07/05/2018

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	shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observation on 06/05/18 at 1:24 p.m. with the Maintenance Supervisor the battery operated emergency light located above the door opening to the Dining room failed to function when its test button was by the Maintenance Supervisor. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the battery operated light failed to function when tested. 3.1-19(b) 2. Based on record review and interview on 06/05/18 at 12:01 p.m. with the Maintenance Supervisor, the facility failed to ensure 9 of 9 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. Section 7.9.3.1.1 (1) requires 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, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (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 in the facility.		minutes to ensure function during periods of power outages. The maintenance person was inserviced on 6-13-18 regarding the function and testing of the battery-operated emergency lights including the annual 90-minute test. The testing log was modified to include space to document the 90-minute annual test. An audit form including the testing of battery operated emergency lights was implemented. The maintenance person will audit weekly for one month, bi-weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	

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	Findings include: Based on record review on 06/05/18 concurrent with record review with the Maintenance Supervisor, the Battery Operated Emergency Light Test Log indicated all battery operated lights located throughout the facility were not tested annually for ninety minutes. Based on an interview at the time of record review, the Maintenance Supervisor indicated the facility has battery operated emergency lights throughout the facility but they had not been tested for ninety minutes for the past twelve months. 3.1-19(b)			
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			

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	1. Based on observation and interview the facility failed to properly secure 17 of 25 sprinkler armovers observed when initially installed. NFPA 13, 2010 Edition at 9.2.3.5.1 states the cumulative horizontal length of an unsupported armover to a sprinkler head shall not exceed 24 inches for steel pipe. This deficient practice could affect all residents, staff and visitors. Finding include: Based on observation and interview on 06/05/18 during the tour between 12:00 p.m. and 3:15 p.m. with the Maintenance Supervisor there were unsupported steel armovers in the following locations which exceeded twenty four inches in length: 1. Resident room #1 armover measured 32 inches. 2. Resident room #2 armover measured 38 inches. 3. Resident room #3 armover measured 38 inches. 4. Resident room #4 armover measured 38 inches. 5. Resident room #5 armover measured 40 inches. 6. Resident room #6 armover measured 38 inches. 7. Resident room #9 armover measured 38 inches. 8. Resident room #14 armover measured 37 inches. 9. Resident room #15 armover measured 32 inches. 10. Resident room #17 armover measured 32 inches. 11. Resident room #19 armover measured 34 inches. 12. Business office north wall on east hall armover measured 60 inches. 13. Business office south wall on east hall armover measured 47 inches. 14. MDS office armover measured 38 inches. 15. Furnace room west hall armover measured 35 inches.	K 0351	K351 Additional hangers were installed on the steel armovers by certified technicians in the following locations which exceeded 24 inches: Rooms 1, 2, 3, 4, 5, 6, 9, 14, 15, 17, 19, business office north wall, business office south wall, MDS office, furnace room west hall, storage room west hall, and kitchen storage room. The sprinkler heads obstructed by air conditioning units secured to the ceiling of rooms 3, 4, 5, 18, and 19, were modified by certified technicians to allow the spray pattern to fully develop. A sprinkler was installed by certified technicians in the riser closet next to the front entrance. All armovers were examined and hangers were installed on an additional 5 armovers which exceeded 24 inches in length. Sprinkler heads throughout the facility were examined for any sprinkler head obstruction and none were noted. All areas of the facility were examined for the absence of sprinkler protection and none was noted. The maintenance person was inserviced on 6-13-18 regarding the need for supported armovers which exceed 24 inches in length; surveillance of sprinkler heads to	07/05/2018

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	16. Storage room west hall armover measured 35 inches. 17. Kitchen storage room armover measured 32 inches. Based on interview with the Maintenance Supervisor concurrent with the observations it was acknowledged the unsupported armovers exceeded 24 inches in horizontal length and required another sprinkler hanger. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 5 of 25 resident rooms in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff only. Findings include: Based on observations on 06/05/18 during the tour between 12:20 p.m. to 3:00 p.m. with the Maintenance Supervisor, the following resident rooms had sprinkler heads which were obstructed by air conditioning units secured to the ceilings of the rooms: 1. Resident room #3 2. Resident room #4		prevent any obstruction; and the absence of sprinkler protection in required areas. The preventative maintenance log was reviewed to ensure visual inspection of the sprinklers is a part of the preventative maintenance program. An audit form including the surveillance of sprinkler armovers; sprinkler head obstruction; and the absence of sprinkler protection in required areas was implemented. The maintenance person will audit weekly for one month, bi-weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	

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	3. Resident room #5 4. Resident room #18 5. Resident room #19 Based on interview at the time of observations the Maintenance Supervisor acknowledged the aforementioned resident rooms had sprinkler heads blocked by ceiling air conditioning units which would prevent the spray pattern to fully develop. 3. Based on observation and interview the facility failed to ensure all portions of the facility were sprinklered for 1 of 1 riser rooms. Findings include: Based on observation on 06/05/18 at 12:55 p.m. with the Maintenance Supervisor the riser room next to the front entrance was not provided with sprinkler protection. Based on interview concurrent with the observation, the Maintenance Supervisor after carefully inspecting the riser room confirmed was not provided with sprinkler protection. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be			

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	posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview; the facility failed to deposit extinguished cigarette butts into noncombustible containers of safe design for 1 of 1 outdoor patios where smoking is permitted. This deficient practice could affect any resident, staff or visitor who smoke outside. Findings include: Based on review of the facility's written smoking policy on 06/05/18 at at 1:45 p.m. with the Maintenance Supervisor, resident and staff smoking is only permitted in one designated location outside the facility and nonflammable containers were provided to dispose of the used cigarette butts. Based on observation on 06/05/18 at 1:16 p.m. with the Maintenance supervisor over twenty cigarette butts were were deposited in a metal trash can which contained paper products	K 0741	K741 A designated smoking area is established with ashtray/smoking tower receptacles of noncombustible material and safe design provided. A metal container with self-closing cover into which ashtrays can be emptied is readily available in the area. A metal trash can was inadvertently left in the area in which extinguished cigarette butts were comingled with regular trash. The metal trash can was removed from the area and signage prominently displayed with instructions for the disposal of cigarette butts. There are no other designated	07/05/2018

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	and other flammable good. Based on interview at the time of observation, the Maintenance Supervisor observed and confirmed cigarette butts where not disposed of properly in the provided noncombustible containers, but rather in a trash can with other flammable products. 3.1-19(b)		smoking areas. Housekeeping and maintenance have been assigned to empty the ashtrays daily and were inserviced on the procedure. An audit form including compliance with the procedure for disposal of cigarette butts was implemented. The maintenance person will audit daily for one month, weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	
K 0918 SS=F 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.			

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	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 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, readily identifiable, and separate from normal power circuits. 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 record review and interview, the facility failed to exercise the generator for 7 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS	K 0918	K918 The generator was exercised under load for thirty minutes and documented. There is only one generator on the property. The maintenance person was inserviced on 6-13-18 regarding exercising the generator under load monthly for thirty minutes and documenting results. The generator will be inspected weekly and exercised monthly under load for thirty minutes by the maintenance person who will maintain documentation of the tests and exercises. The preventative maintenance log was	07/05/2018

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	nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of generator load testing documentation with the Maintenance Supervisor on 06/05/18 at 11:45 a.m., there was no documentation available to indicate the monthly load test had not been done since October 2017 for the diesel powered generator. Based on interview at the time of record review, the Maintenance Supervisor acknowledged he neglected to run the generator under load on a monthly basis for the past seven months. 3.1-19(b)		reviewed to ensure generator maintenance, including documenting monthly exercise under load, is part of the preventative maintenance program. An audit form including exercising the generator monthly under load for thirty minutes was implemented. The maintenance person will audit monthly for six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where	K 0927	K927 The exhaust fan in the oxygen	07/05/2018

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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
	oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, sprinklered, and have ceramic or concrete flooring This deficient practice could affect up to 21 residents, as well as staff and visitors by the south Nurse's station. Findings include: Based on observation on 06/05/18 at 1:27 p.m. with the Maintenance Supervisor the oxygen transfilling room next to the south Nurse's station was provided with mechanical ventilation, but was not working at the time of inspection. The ceiling exhaust fan was covered in a visible layer of dust which was not moving. Based on interview concurrent with the observation the Maintenance Supervisor noticed the dust on the grill was static and confirmed the exhaust vent was not working. 3.1-19(b)		storage room next to the nurses' station was replaced and is operational. This is the only oxygen storage room in the facility. The maintenance person was inserviced on 6-13-18 regarding the requirement for mechanical ventilation in the oxygen storage room. The visual inspection of the oxygen room, to include checking the function of the exhaust fan, was added to the preventative maintenance log. An audit form including the visual inspection of the exhaust fan in the oxygen storage room for function was implemented. The maintenance person will audit weekly for one month, bi-weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	