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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMP			COMPL	ETED
		155721	B. W	NG		06/05/2018	
				CTDEET /	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD 46TH ST		
	ICE MANOD LIEAL	TUCADE CENTED			APOLIS, IN 46226		
LAWREN	CE MANOR HEAL	INCARE CENTER		INDIAN	APOLIS, IN 46226		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
E 0000							
Bldg							
	An Emergency Prep	paredness Survey was	E 00	000	Preparation and or execution of	of	
		diana State Department of		700	this plan does not constitute		
	Health in accordance with 42 CFR 483.73.				admission or agreement by the	۵	
					provider of the truth of the fact		
	Survey Date: 06/05/18 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610				alleged or conclusions set forth		
					the statement of deficiencies.	. 511	
					This plan of correction is prepa	ared	
					and or executed solely as	arcu	
					required. The facility requests	the	
	7 MINI INGILIOCI. 1002	207010			plan of correction be considered		
	At this Emergency I	Drengredness survey			the allegation of compliance	s u	
	At this Emergency Preparedness survey, Lawrence Manor Health Care Center was found in the allegation of compliance effective 7-5-2018.						
		nergency Preparedness			enective 7-5-2016.		
	-	ledicare and Medicaid					
		lers and Suppliers, 42 CFR					
	483.73.	iers and Suppliers, 42 CFR					
	463.73.						
	The feether has FF						
	-	certified beds. At the time of					
	the survey, the cens	us was 34.					
K 0000							
1. 0000							
Dida 01							
Bldg. 01	A Life Sefet Co. 1	Descrification and State	17.0	000	Description and access (£	
	-	Recertification and State	K 0	UUU	Preparation and or execution of)I	
		as conducted by the Indiana			this plan does not constitute		
	•	Health in accordance with 42			admission or agreement by the		
	CFR 483.90(a).				provider of the truth of the fact		
	0.00	24.0			alleged or conclusions set forth	n on	
	Survey Date: 06/05	/18			the statement of deficiencies.		
	T 110 37 1 2	00000			This plan of correction is prepa	ared	
	Facility Number: 00				and or executed solely as		
	Provider Number: 1				required. The facility requests		
	AIM Number: 1002	289610			plan of correction be considered	ed	
					the allegation of compliance		
		Code survey, Lawrence Manor			effective 7-5-2018.		
		was found not in compliance					
	with Requirements	for Participation in					
			1		<u> </u>		

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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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/05/2018	
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER (X4) ID PREFIX TAG 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 storage which were not sprinklered.			8935 E	ADDRESS, CITY, STATE, ZIP COD E 46TH ST NAPOLIS, IN 46226		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0281 SS=B Bldg. 01	Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupi This one story facil Type II (111) const sprinklered. The fa with smoke detection open to the corridor detectors in all resid facility has a capaci 34 at the time of thi All areas where res were sprinklered. NFPA 101 Illumination of Me Illumination of Me Illumination of Me Illumination of me discharge, is arrai and shall be eithe or capable of auto manual intervention 18.2.8, 19.2.8 Based on observation failed to ensure the egress was arranged lighting fixture (but) darkness. LSC 7.8. be arranged so that lighting unit does in level of less than 0.	re, and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. Antity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, all areas and battery powered smoke dent sleeping rooms. The try of 55 and had a census of survey. And the facility has two detached facility storage which were ans of Egress ans of egress, including exitinged in accordance with 7.8 recontinuously in operation from and interview, the facility lighting for 1 of 6 exit means of a so the failure of any single b) would not leave the area in 1.4 requires illumination shall the failure of any single to tresult in an illumination 2 foot-candle in any is deficient practice could	K 0281	K281 The exterior fixture above the eleading from the Dietary department will be replaced with dual bulb light fixture. All exterior fixtures for exits as means of egress were assessed to ensure a dual bulb light fixtures in use.	th a a ed	

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	T OF HEALTH AND HU! R MEDICARE & MEDIC					RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/05/2018	
NAME OF	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD 46TH ST		
LAWRE	NCE MANOR HEAL	THCARE CENTER		NAPOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF Findings include: Based on observation with the Maintenan kitchen staff to the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION on on 06/05/18 at 1:50 p.m. ce Supervisor, the exit for the outside was equipped with	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The maintenance person was inserviced on 6-13-18 regarding use of dual bulb fixtures so the failure of any single bulb would leave the area in darkness.	ng e d not Γhe	(X5) COMPLETION DATE
	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.			function of exterior lights has added to the preventative maintenance log. An audit for including the observation of exterior dual bulb fixtures in the areas of egress was implementation.	rm ne	
	3.1-19(b)			The maintenance person will a weekly for one month, bi-week for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved ar action plan will be developed. results of these audits will be reviewed monthly by the QAP committee overseen by the administrator and reviewed by corporate risk management.	kly or n The	
K 0291 SS=F Bldg. 01	duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour ed automatically in	K 0291	K291		07/05/2018
	facility failed to ens	sure 1 of 9 battery powered ere maintained in accordance 27.9.2.6 states battery operated		The battery-operated emerger light above the door to the din room is now functioning.	•	27,00,2010

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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

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emergency lights were checked

for function and were tested for 90

All the battery-operated

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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 06/05/2018 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 shall be approved for their intended use and shall minutes to ensure function during comply with NFPA 70 National Electric Code. LSC periods of power outages. 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be The maintenance person was capable of repeated automatic operation without inserviced on 6-13-18 regarding manual intervention. This deficient practice could the function and testing of the affect all residents, staff and visitors in the facility. battery-operated emergency lights including the annual 90-minute Findings include: test. The testing log was modified to include space to document the Based on observation on 06/05/18 at 1:24 p.m. 90-minute annual test. An audit with the Maintenance Supervisor the battery form including the testing of operated emergency light located above the door battery operated emergency lights opening to the Dining room failed to function was implemented. when its test button was by the Maintenance Supervisor. Based on interview at the time of the The maintenance person will audit observation, the Maintenance Supervisor weekly for one month, bi-weekly acknowledged the battery operated light failed to for two months, and monthly for function when tested. three months for a total of six months. If threshold of 95% 3.1-19(b) compliance is not achieved an action plan will be developed. The 2. Based on record review and interview on results of these audits will be 06/05/18 at 12:01 p.m. with the Maintenance reviewed monthly by the QAPI Supervisor, the facility failed to ensure 9 of 9 committee overseen by the battery backup lights were tested annually for 90 administrator and reviewed by minutes over the past year to ensure the light corporate risk management. 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.

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i ´		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155721	B. W	ING		06/05/2	2018
	ROVIDER OR SUPPLIER		<u>•</u>	8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	Findings include:						
K 0351 SS=F Bldg. 01	Based on record review with record review of Supervisor, the Batt Test Log indicated a located throughout the annually for ninety interview at the time Maintenance Supervisor operated em facility but they had minutes for the past 3.1-19(b) NFPA 101 Sprinkler System - Spinkler System - 2012 EXISTING Nursing homes, and by construction type throughout by an asprinkler system in 13, Standard for the Systems. In Type I and II conprotection measure substituted for spring areas where state sprinklers. In hospitals, sprink clothes closets of where the area of 6 square feet and the closet footprint Standard for Instal Systems. 19.3.5.1, 19.3.5.2,	Installation Installation Ind hospitals where required be, are protected approved automatic accordance with NFPA he Installation of Sprinkler Instruction, alternative hes are permitted to be inkler protection in specific or local regulations prohibit ders are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers tas required by NFPA 13,					
I	19.3.5.5, 19.4.2, 1	9.3.5.10, 9.7, 9.7.1.1(1)	I	I		1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155721	B. W	ING		06/05/2018	
		1	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			46TH ST		
LAWREN	ICE MANOR HEAL	THCARE CENTER			IAPOLIS, IN 46226		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ation and interview the facility	K 0	351	K351		07/05/2018
		ecure 17 of 25 sprinkler			Additional hangers were instal		
		when initially installed. NFPA			on the steel armovers by certif	fied	
	13, 2010 Edition at 9.2.3.5.1 states the cumulative				technicians in the following		
	horizontal length of an unsupported armover to a				locations which exceeded 24		
	sprinkler head shall not exceed 24 inches for steel				inches: Rooms 1, 2, 3, 4, 5, 6,		
	pipe. This deficient practice could affect all				14, 15, 17, 19, business office		
	residents, staff and visitors. Finding include:				north wall, business office sou		
					wall, MDS office, furnace roon west hall, storage room west h		
	rinding include.				and kitchen storage room.	iaii,	
	Based on observation	on and interview on 06/05/18			and kitchen storage room.		
		veen 12:00 p.m. and 3:15 p.m.			The sprinkler heads obstructed	d hv	
	with the Maintenance Supervisor there were				air conditioning units secured	-	
	unsupported steel armovers in the following				the ceiling of rooms 3, 4, 5, 18		
		seeded twenty four inches in			and 19, were modified by certi		
	length:				technicians to allow the spray		
	<i>S</i>				pattern to fully develop.		
	Resident room #	1 armover measured 32 inches.			, , , , , , , ,		
	2. Resident room #	2 armover measured 38 inches.			A sprinkler was installed by		
	3. Resident room #	3 armover measured 38 inches.			certified technicians in the rise	er	
	4. Resident room #	4 armover measured 38 inches.			closet next to the front entrance	e.	
	5. Resident room #	5 armover measured 40 inches.					
	6. Resident room #	6 armover measured 38 inches.			All armovers were examined a	and	
		9 armover measured 38 inches.			hangers were installed on an		
	8. Resident room #	14 armover measured 37			additional 5 armovers which		
	inches.				exceeded 24 inches in length.		
		15 armover measured 32			Sprinkler heads throughout the		
	inches.				facility were examined for any		
		#17 armover measured 32			sprinkler head obstruction and		
	inches.	//10			none were noted. All areas of	the	
		#19 armover measured 34			facility were examined for the		
	inches.	month small on cost 1 11			absence of sprinkler protection	า	
		north wall on east hall			and none was noted.		
	armover measured 60 inches. 13. Business office south wall on east hall armover measured 47 inches. 14. MDS office armover measured 38 inches.				The maintenance recessions		
					The maintenance person was		
					inserviced on 6-13-18 regarding	-	
		west hall armover measured 35			the need for supported armove		
	inches.	west half affilovel fileasured 33			which exceed 24 inches in len	-	
	menes.				surveillance of sprinkler heads	S IU	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	A. BUILDING <u>01</u>			COMPLETED	
		155721	B. WING	·		06/05/	2018	
		<u> </u>	l s	TREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			46TH ST			
LAWREN	ICE MANOR HEAL	THCARE CENTER			APOLIS, IN 46226			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE	
	16. Storage room west hall armover measured 35				prevent any obstruction; and the	ne		
	inches.				absence of sprinkler protection	n in		
	17. Kitchen storage room armover measured 32				required areas. The preventati	ve		
	inches.				maintenance log was reviewed	d to		
					ensure visual inspection of the	!		
	Based on interview with the Maintenance				sprinklers is a part of the			
	Supervisor concurrent with the observations it				preventative maintenance			
	was acknowledged the unsupported armovers				program. An audit form includ	ing		
	exceeded 24 inches in horizontal length and				the surveillance of sprinkler			
	required another sp	rinkler hanger.			armovers; sprinkler head			
					obstruction; and the absence of			
	3.1-19(b)				sprinkler protection in required			
	2. Based on observation and interview, the				areas was implemented.			
		sure the spray pattern for			The maintenance person will a			
		re not obstructed in 5 of 25			weekly for one month, bi-week	-		
		ccordance with 19.3.5.1. NFPA			for two months, and monthly for	or		
		ection 8.5.5.1 states sprinklers			three months for a total of six			
		as to minimize obstructions to			months. If threshold of 95%			
	_	d in 8.5.5.2 and 8.5.5.3 or			compliance is not achieved an			
	_	rs shall be provided to ensure			action plan will be developed.	rne		
		of the hazard. Sections 8.5.5.2			results of these audits will be	ı		
		permit continuous or ructions less than or equal to			reviewed monthly by the QAPI	I		
		e sprinkler deflector or in a			committee overseen by the			
		ore than 18 inches below the			administrator and reviewed by			
		that prevent the spray pattern			corporate risk management.			
		ng. This deficient practice						
	could affect staff or							
	Could arroot start of	 j.						
	Findings include:							
	Based on observation	ons on 06/05/18 during the						
		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 #	43						
	2. Resident room #	44						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	ULTIPLE CO	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPLETED B. WING 06/05/2018			
		155721	B. W			06/05	/ZU18
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	ICE MANOD LIEAL:	THEADE CENTED			46TH ST		
LAWRENCE MANOR HEALTHCARE 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	3. Resident room #	LISC IDENTIFYING INFORMATION	+	TAG	DEFICIENC 11		DATE
	4. Resident room #						
	5. Resident room #						
	Based on interview	at the time of observations the					
	Maintenance Supervisor acknowledged the						
		dent rooms had sprinkler					
	heads blocked by ceiling air conditioning units which would prevent the spray pattern to fully develop.						
	develop.						
	3. Based on observ	ation and interview the facility					
failed to ensure all portions of the facility were							
	sprinklered for 1 of 1 riser rooms.						
	Finding to 1 4.						
	Findings include:						
	Based on observation	on on 06/05/18 at 12:55 p.m.					
		ce Supervisor the riser room					
		rance was not provided with					
	sprinkler protection	. Based on interview					
		observation, the Maintenance					
	•						
		s not provided with sprinkler					
	protection.						
	3 1-19(b)						
	3.1 19(0)						
K 0741	NFPA 101						
	Smoking Regulation						
Bldg. 01							
		ess than the following					
	_ ·	he prohibited in any room					
	``'						
	· ·						
	-						
		-					
		SMOKING or shall be					
K 0741 SS=E Bldg. 01	sprinklered for 1 of Findings include: Based on observation with the Maintenance next to the front ent sprinkler protection concurrent with the Supervisor after car room confirmed was protection. 3.1-19(b) NFPA 101 Smoking Regulation Smoking Regulation Smoking Regulation Smoking regulation shall include not be provisions: (1) Smoking shall ward, or compartnown liquids, combustibused or stored and location, and such	on on 06/05/18 at 12:55 p.m. ce Supervisor the riser room rance was not provided with . Based on interview observation, the Maintenance efully inspecting the riser s not provided with sprinkler ons ons ons ons than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/05/2018		
		ROVIDER OR SUPPLIEF	THCARE CENTER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
PR	4) ID EFIX ΓAG	(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)	ιΤΕ	(X5) COMPLETION DATE
		smoking. (2) In health care smoking is prohib prominently place secondary signs was making shall not (3) Smoking by paresponsible shall (4) The requirement apply where the pare supervision. (5) Ashtrays of not safe design shall where smoking is (6) Metal contained devices into which shall be readily as smoking is permit 18.7.4, 19.7.4 Based on record regiment in the same of safe devices into which shall be readily as smoking is permit 18.7.4, 19.7.4 Based on record regiments of safe devices into which shall be readily as smoking is permit 18.7.4, 19.7.4 Based on record regiments of safe devices into whom where smoking is practice could affect who smoke outside. Based on review of policy on 06/05/18 Maintenance Super smoking is only per location outside the containers were procigarette butts. Based at 1:16 p.m. with the twenty cigarette butts. Based at 1:16 p.m. with the twenty cigarette butts.	d at all major entrances, with language that prohibits be required. atients classified as not be prohibited. In the first of 18.7.4(3) shall not atient is under direct atient is under direct anombustible material and be provided in all areas permitted. It is with self-closing cover in ashtrays can be emptied atiliable to all areas where ted. Ariew, observation and ty failed to deposit the butts into noncombustible esign for 1 of 1 outdoor patios ermitted. This deficient any resident, staff or visitor	K 07	741	K741 A designated smoking area is established with ashtray/smoktower receptacles of noncombustible material and design provided. A metal container with self-closing covinto which ashtrays can be emptied is readily available in area. A metal trash can was inadvertently left in the area in which extinguished cigarette twere comingled with regular trash. The metal trash can waremoved from the area and signage prominently displayed with instructions for the disposicigarette butts.	safe ver the outts as	07/05/2018

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

PRINTED: 06/25/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155721	A. BUILDING B. WING	01	COMPLETED 06/05/2018
	ROVIDER 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the time of observat Supervisor observed butts where not disp provided noncombu	e good. Based on interview at ion, the Maintenance I and confirmed cigarette cosed of properly in the stible containers, but rather in er flammable products.		Housekeeping and maintenant have been assigned to empty ashtrays daily and were insert on the procedure. An audit for including compliance with the procedure for disposal of cigar butts was implemented. The maintenance person will adaily for one month, weekly for months, and monthly for three months for a total of six month threshold of 95% compliance not achieved an action plan we developed. The results of the audits will be reviewed month the QAPI committee overseer the administrator and reviewe corporate risk management.	the viced orm rette audit or two e ens. If is will be ese ly by en by
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm the safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under to year in 20-40 day	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the ncess shall be provided to nis capability for the life branches. Maintenance generator and transfer rmed in accordance with e inspected weekly, nad 30 minutes 12 times a intervals, and exercised nths for 4 continuous hours.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED		
		155721	B. WING		06/05/2018
	PROVIDER OR SUPPLIER		893	EET ADDRESS, CITY, STATE, ZIP COD 5 E 46TH ST IANAPOLIS, 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		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG		DATE
	Scheduled test un	der load conditions include			
	a complete simula				
		ual transfer of all EES			
		nducted by competent			
	1 '	nance and testing of stored			
		rces (Type 3 EES) are in			
		NFPA 111. Main and feeder			
		e inspected annually, and a			
	1 ' -	dically exercising the			
		tablished according to			
	· · · · · · · · · · · · · · · · · · ·	uirements. Written records			
	of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable,				
		n normal power circuits.			
	1	ssibility of damage of the			
		source is a design			
	consideration for r	•			
		(NFPA 99), NFPA 110,			
	NFPA 111, 700.10				
		view and interview, the facility	K 0918	K918	07/05/2018
		e generator for 7 of 12 months	11 0510	The generator was exercise	
		ments of NFPA 110, 2010		under load for thirty minutes	
		rd for Emergency and Standby		documented.	
		hapter 8.4.2. Section 8.4.2			
	states diesel genera	tor sets in service shall be		There is only one generator	on the
		nce monthly, for a minimum of		property.	
	_	ne of the following methods:			
		intains the minimum exhaust		The maintenance person wa	s
		recommended by the		inserviced on 6-13-18 regard	-
	manufacturer			exercising the generator und	
		g temperature conditions and at		load monthly for thirty minute	es and
	1	cent of the EPS (Emergency		documenting results. The	
	Power Supply) nam	-		generator will be inspected w	-
		es diesel-powered EPS		and exercised monthly unde	r load
		not meet the requirements of		for thirty minutes by the	
		ised monthly with the available		maintenance person who wi	
		Power Supply System) load and		maintain documentation of the	ne
		nnually with supplemental n 50 percent of the EPS		tests and exercises. The	
1	i Toaus at not less tha	II DO DEICEIR OF THE EPS	1	I preventative maintenance lo	o was i

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	TOF HEALTH AND HU R MEDICARE & MEDIC						IB NO. 0938-039	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/05/2018	
	PROVIDER OR SUPPLIE	R THCARE CENTER		8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, IN 46226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPR DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE	
K 0927	and at not less than nameplate kW ratin total test duration of hours. This deficient occupants. Findings include: Based on review of documentation with on 06/05/18 at 11:4 documentation avaload test had not be for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the discontinuous for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the time Maintenance Superneglected to run the monthly basis for the diesel power interview at the diesel power i	ang for 30 continuous minutes 175 percent of the EPS ang for 1 continuous hour for a of not less than 1.5 continuous ant practice could affect all If generator load testing the Maintenance Supervisor Is a.m., there was no ilable to indicate the monthly ten done since October 2017 ared generator. Based on the of record review, the revisor acknowledged he the generator under load on a the past seven months.			reviewed to ensure generator maintenance, including documenting monthly exercisunder load, is part of the preventative maintenance properties and the generator monthly under for thirty minutes was implemented. The maintenance person will monthly for six months. If threshold of 95% compliance not achieved an action plant developed. The results of the audits will be reviewed mont the QAPI committee oversee the administrator and review corporate risk management.	ogram. cising load I audit e is will be ese hly by en by		
SS=E Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen oc containers over 5 under 11.5.2.3.1 liquid oxygen con containers under	Transfilling Cylinders Transfilling Cylinders Igen from one cylinder to ordance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is ent care rooms. Transfilling ontainers or to portable 0 psi comply with conditions (NFPA 99). Transfilling to tainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99).						

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Based on observation and interview, the facility

failed to ensure 1 of 1 oxygen storage room where

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KUB921

The exhaust fan in the oxygen

K927

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07/05/2018

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED B. WING 06/05/2018	
155721 B. WING 06/05/2018	
	}
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROFIDENCE TO THE APPROPRIATE COMPL	(X5) MPLETION DATE
oxygen transferring takes place, was provided with property 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 replaced and is operational. 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 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. The maintenance person was inserviced on 6-13-18 regarding the requirement for mechanical ventilation in the oxygen storage room in the facility. The maintenance person was inserviced on 6-13-18 regarding the requirement for mechanical ventilation in 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	DATE

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