EPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICA	AID SERVICES					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				

	OF CORRECTION	IDENTIFICATION NUMBER 155721	A. BUILDING B. WING			COMPL	COMPLETED 12/04/2018	
	ROVIDER 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		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
E 0000								
Bldg	conducted by the Inc	paredness Survey was diana State Department of e with 42 CFR 483.73.	E 00	000				
	Facility Number: 00 Provider Number: 1002 AIM Number: 1002	00383 155721						
	Medicaid Participati CFR 483.73 The facility has 55 c	rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of						
		npleted on 12/06/18 - DA 42 CFR, Subpart 483.73 is NOT						
E 0006 SS=C Bldg	failed to maintain ar plan that was (1) bas documented, facility	iew and interview, the facility n emergency preparedness sed on and includes a y-based and community-based izing an all-hazards approach,	E 00	006	The facility-based and community-based Risk Assessment utilizing an all-hazards approach, including missing residents and strategic	•	12/05/2018	
	including missing re strategies for addres identified by the risk	esidents and (2) included sing emergency events assessment in accordance 8(a) (1) and 42 CFR 483.73(a) (2).			for addressing emergency eve identified by the risk assessme was reviewed and updated wit review date noted.	nts ent,		

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

TITLE

(X6) DATE

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155721	B. WI	NG		12/04/	2018
	ROVIDER OR SUPPLIER	THCARE 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	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include: Based on review of documentation with record review from 12/04/18, a docume community-based reall-hazards approace. The document state policies and proced on the risk assessment with the emergency but documentation left blank. Based or record review, the Adocumented facility risk assessment, util specific to Lawrence.	"Emergency Operations Plan" In the Administrator during 8:50 a.m. to 1:15 p.m. on Ented facility-based and lisk assessment, utilizing an Inh, was not available for review. Independent of the facility were based lent which was to be included In preparedness documentation In the risk assessment was In interview at the time of Independent of the list approach, It is a seen and a probability of the review at the time of It is a seen and a probability of the list approach, It is a seen and a probability of the list approach, It is a seen and a probability of the list approach, It is a seen and a probability of the list approach, It is a seen and a probability of the list approach, It is a seen and a probability of the list approach, It is a seen and a probability of the list approach approach, It is a seen and a probability of the list approach approach and a probability of the list approach approach approach and a probability of the list approach and a probability of the list approach approach approach approach approach approach and a probability of the list approach app			The deficient practice could af all occupants and to ensure its implementation all staff will be inserviced on the facility-based and community-based risks ar hazard vulnerabilities. The Risk Assessment will be updated annually and as need The administrator and departm leaders were in serviced on 12/5/2018_regarding the facilit Risk Assessment policy. The annual Risk Assessment revie will be added to the TELS calendar. To ensure compliance, the administrator will review the Ri Assessment with department leaders monthly for six months and document results. Popults	ed. nent y w	
E 0013 SS=C Bldg	Pasad on record ro	view and interview, the facility	E 00	112	and document results. Results the monitoring will be reviewed during the facility's QAPI Committee meeting overseen the administrator and reviewed corporate risk management. It compliance threshold of 95% in not achieved an action plan will developed.	by d by f a s	12/05/2019
	failed to develop an preparedness policie policies and proced	view and interview, the facility and implement emergency es and procedures. The ures must be reviewed and anally in accordance with 42	E 00)13	Emergency preparedness poli- and procedures (the Emergen- Operations Plan) were reviewed and updated based upon the current facility-based and	су	12/05/2018

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION	(X3) DATE COMPL 12/04 /	ETED
	PROVIDER OR SUPPLIEF	THCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF CFR 483.73(b). The all occupants. Findings include: Based on review of documentation with record review from 12/04/18, a docume community-based re all-hazards approace The documents state policies and procede on the risk assessme with the emergency but documentation left blank. Based of record review, the search of the search	THCARE CENTER STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION his deficient practice could affect ""Emergency Operations Plan" he Administrator during 8:50 a.m. to 1:15 p.m. on ented facility-based and hisk assessment, utilizing an h, was not available for review. ed emergency preparedness hures for the facility were based hent which was to be included her preparedness documentation for the risk assessment was n interview at the time of Administrator agreed policies hed on a documented hommunity-based risk her manor Healthcare Center her review at the time of the	PR	INDIANA IID REFIX FAG	PROVIDERS PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) community-based Risk Assessment utilizing an all hazards approach, with the revidate noted. The deficient practice affects a occupants and to ensure its implementation all staff will be inserviced on the facility's Emergency Operations Plan. The Emergency Operations Plan. The Emergency Operations Plan. The Emergency Operations Plan will be updated annually and a needed. The administrator and department leaders were in serviced on 12/5/2018 regarding the Emergency Operations Plan review will be added to the TELS calendar. To ensure compliance, the administrator will review the Emergency Operations Plan will depart the eders monthly formonths and document results. Results of the monitoring will be reviewed during the facility's Committee meeting overseen the administrator and reviewed.	view all an s d an tions e ith or six be tAPI by d by	(X5) COMPLETION DATE
K 0000					corporate risk management. I compliance threshold of 95% i not achieved an action plan wi developed.	s	
Bldg. 01	A Life Safety Code	Recertification and State	K 000	00			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	01	COMPLETED		
		155721	B. W	ING		12/04	/2018	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	8			46TH ST			
LAWREN	ICE MANOR HEAL	THCARE CENTER			APOLIS, IN 46226			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		vas conducted by the Indiana						
	_	f Health in accordance with 42						
	CFR 483.90(a).							
	Survey Date: 12/04	4/18						
	Facility Number: 0	000383						
	Provider Number:							
	AIM Number: 100							
		Code survey, Lawrence Manor						
		was found not in compliance						
	with Requirements	-						
		l, 42 CFR Subpart 483.90(a),						
	I -	re and the 2012 Edition of the ction Association (NFPA) 101,						
		LSC), Chapter 19, Existing						
		ancies and 410 IAC 16.2.						
	This one story facil	ity was determined to be of						
	Type II (111) const	ruction and fully sprinklered.						
	_	re alarm system with smoke						
		ridors and in all areas open to						
		acility has battery operated						
		stalled in all resident sleeping						
	I -	has a capacity of 55 and had a						
	census of 28 at the	ume of this visit.						
	All areas where res	idents have customary access						
		The facility has two detached						
		facility storage services						
	which were not spri							
	Quality Review cor	mpleted on 12/06/18 - DA						
K 0223	NFPA 101							
SS=E	Doors with Self-C							
Bldg. 01	Doors with Self-C	•						
	· ·	assageway, stairway						
	enclosure, or horiz	zontal exit, smoke barrier,						

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DEPARTMENT OF HEALT	TH AND HUMAN SERVICES	
CENTERS FOR MEDICAR	E & MEDICAID SERVICES	

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155721	B. W	NG		12/04/2018		
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ı	ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	*	LISC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE	
_		enclosure are self-closing						
		osed position, unless held						
	·	device complying with						
	7.2.1.8.2 that auto	matically closes all such						
	doors throughout	the smoke compartment or						
	entire facility upon							
	•	ll fire alarm system; and						
		ectors designed to detect						
		rough the opening or a						
		etection system; and						
		der system, if installed; and						
	* Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility							
			K 0	223	The kitchen door closing device		12/04/2018	
		f 1 self closing doors in the	I K U	223	has been reconnected making the door fully operational permitting automatic closure upon		12/04/2010	
		close to form a smoke resistant						
		ent practice could affect over						
	10 residents, staff a	nd visitors in the vicinity of			activation. The Dietary staff h	as		
	the kitchen.				been in serviced on 12/4/2018			
					regarding the operation of the			
	Findings include:				kitchen door and the necessity to			
					ensure its functionality when			
		ons with the Administrator			activated.			
		e Manager during a tour of			All polf planing doors hald	_		
		5 p.m. to 2:25 p.m. on 12/04/18, the kitchen was equipped			All self-closing doors held ope with a release device were	"		
		levice but the device was			inspected to ensure they			
		ed which served to prop the			automatically close upon			
		en position. In addition, the			activation and are fully operati	onal.		
	- 1	the door was not affixed to the				- **		
	_	nted magnetic hold open			The kitchen door release device	e		
		Based on interview at the			has been added to the weekly			
		tions, the Maintenance			kitchen environmental inspecti	on		
		self closing device was			check list. Maintenance will			
		ed and the magnetic hold			inspect the function of the kitcl			
	_	t being utilized which failed to			door closure upon activation o			
		ald self close to form a smoke			fire alarm system during regula	•		
	resistant barrier.				scheduled drills and document	I		
	3.1-19(b)				results.			
	5.1-17(0)							

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/04/2018
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				To ensure compliance, the maintenance person will mon the weekly checklist and mon inspections for six months. Results of the monitoring will reviewed during the facility's of Committee meeting overseen the administrator and reviewed corporate risk management. compliance threshold of 95% not achieved an action plan wideveloped.	itor thly be QAPI by d by If a
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, tes accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record rev	supply source RKS information on non-required or partial er system. and NFPA 25 riew, observation and	K 0353	For residents affected by the	12/06/2018
	interview; the facili systems were maint NFPA 25. LSC 9.7	ty failed to ensure all sprinkler ained in accordance with .5 requires all sprinkler systems ested, and maintained in		deficient practice and those potentially affected, Maintena personnel have added the quarterly waterflow alarm dev	nce

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULT A. BUILD B. WING		NSTRUCTION 01	(X3) DATE COMPL 12/04/	ETED
	PROVIDER OR SUPPLIEF		8	935 E 4	DDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Inspection, Testing Water-Based Fire P	FPA 25, Standard for the and Maintenance of rotection Systems. NFPA 25, on 5.2.5 requires that waterflow			inspection to the sprinkler sys preventative maintenance pro on the TELS calendar.		
	verify they are free 5.3.3.1 requires the devices including, t gongs, shall be teste vane-type and press	be inspected quarterly to of physical damage. NFPA 25, mechanical waterflow alarm out not limited to, water motor ed quarterly. 5.3.3.2 requires sure switch-type waterflow be tested semiannually. NFPA			Maintenance person was give inservice education regarding quarterly waterflow alarm devinspections and record keepin using the sprinkler system preventative maintenance log 12/6/2018.	l vice ng	
	25, 4.3.1 requires re inspections, tests, a components and sha authority having jui	ecords shall be made for all and maintenance of the system all be made available to the risdiction upon request. This buld affect all residents, staff			The administrator will review sprinkler system preventative maintenance logs and vendor inspection reports, including quarterly inspection of the		
	Findings include:	SafeCare's "Report of			waterflow alarm device, week six months. The results of the audits will be taken to the mo QAPI committee meeting,	ese	
	Inspection" docume Integrated Electron for Inspection, Test Pipe Fire Sprinkler	entation dated 11/28/17 and ics of Indiana's (I.E.I.) "Form ing & Maintenance of Wet Systems" documentation dated			overseen by the administrato reviewed by corporate risk management. If a threshold of 95% is not achieved an action	of n	
	Maintenance Mana 8:50 a.m. to 1:15 p. waterflow alarm de	administrator and the ger during record review from m. on 12/04/18, quarterly vice testing and inspection			plan will be developed to ens compliance.	ure	
	February, March) 2 review. The aforen	the first quarter (January, 018 was not available for nentioned documentation did 's wet sprinkler system had a					
	alarm device. Base record review, the I the facility switched	re switch-type waterflow d on interview at the time of Maintenance Manager stated d sprinkler system contractors 28/17 and agreed quarterly					
	waterflow alarm de	vice testing and inspection the first quarter 2018 was not					

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CENTERS FOR	R MEDICARE & MEDIC				OMB 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 12/04/2018
	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0355	the Administrator a during a tour of the p.m. on 12/04/18, S hanging tags to the which did not docur alarm device test an quarter 2018. 3.1-19(b)	r. Based on observations with and the Maintenance Manager facility from 1:15 p.m. to 2:25 afeCare and I.E.I. had affixed facility's sprinkler system riserment a quarterly waterflow d inspection for the first			
SS=E Bldg. 01	installed, inspecte accordance with N Portable Fire Extir 18.3.5.12, 19.3.5. Based on observation failed to ensure 1 of	nguishers guishers are selected, d, and maintained in IFPA 10, Standard for nguishers.	K 0355	The fire extinguisher in the lat was inspected by an approve vendor to meet the annual	· I
	accordance with NF portable fire extinguinstalled, inspected with NFPA 10. NF Fire Extinguishers, states fire extinguishers, states fire extinguisher at the time of specifically indicate electronic notification fire extinguisher shatached that indicate maintenance was performing the worthe agency perform	PA 10. LSC 9.7.4.1 states and maintained in accordance PA 10, Standard for Portable 2010 Edition, Section 7.3.1.1.1 there shall be subject to reals of not more than one hydrostatic test, or when ad by an inspection or on. Section 7.3.3 states each all have a tag or label securely tes the month and year the erformed, identifies the person k, and identifies the name of ting the work. This deficient to ver 10 residents, staff and		maintenance requirement. All fire extinguishers were checked to ensure annual maintenance was performed adocumented. The maintenance person was inserviced on 12/6/2018 regard the requirement for annual inspection and maintenance of portable fire extinguishers by approved vendor. The maintenance person will visual inspect the portable fire extinguishers monthly and	ording of the

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visitors in the vicinity of the Laundry.

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document results in the preventative maintenance log.

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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 12/04/2018 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include: The administrator will review the Based on observations with the Administrator fire extinguisher preventative and the Maintenance Manager during a tour of maintenance log and vendor the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, inspection and maintenance the portable ABC fire extinguisher located in the reports weekly for six months. The Laundry had an affixed maintenance tag results of these audits will be documenting the date the most recent annual taken to the monthly QAPI maintenance was performed by Allied Safety committee meeting, overseen by Services in July 2017. Based on interview at the the administrator and reviewed by time of the observations, the Maintenance corporate risk management. If a Manager agreed the aforementioned portable fire threshold of 95% is not achieved extinguisher did not have documented annual an action plan will be developed to maintenance within the most recent twelve month ensure compliance. period. 3-1.19(b) K 0711 **NFPA 101** SS=C Evacuation and Relocation Plan Bldg. 01 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and K 0711 The Emergency Operations Plan 12/06/2018 interview; the facility failed to provide a written was revised to include a policy for plan that addressed all components in 1 of 1 the relocation of wheeled written fire plans. LSC 19.7.2.2 requires a written equipment during a fire or similar health care occupancy fire safety plan that shall emergency; and the location of the

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	T OF HEALTH AND HUN R MEDICARE & MEDIC							12/20/2018 ROVED 938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	COMPLETED		
		155721	B. WI	NG		12/04/	2018	2018	
	PROVIDER OR SUPPLIER			8935 E	ADDRESS, CITY, STATE, ZIP COD 46TH ST IAPOLIS, 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 APPROPRIA	TE	COMP	PLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DA	ATE	
	provide for the follo	owing:			fire doors for evacuation purpo	oses.			
	(1) Use of alarms						İ		
	(2) Transmission of	alarm to fire department			The deficient practice affects a	all	İ		
	(3) Emergency pho	ne call to fire department			occupants and to ensure its		İ		
	(4) Response to alar	rms			implementation all staff will be		İ		
	(5) Isolation of fire				inserviced on the relocation of	:	İ		
	(6) Evacuation of in	nmediate area			wheeled equipment during a fi	re or	İ		
	(7) Evacuation of si	noke compartment			similar emergency; and the		İ		
	(8) Preparation of fl	loors and building for			location of the fire doors for		İ		
	evacuation				evacuation purposes.		İ		
	(9) Extinguishment	of fire					İ		
	Section 19.2.3.4(4)	states any required aisle or			The administrator and departn	nent	1		
		e less than 48 inches in clear			leaders were in serviced on		1		
	width where serving	g as means of egress from			12/6/2018 regarding the		1		
	I	ms Projections into the			Emergency Operations Plan		1		

Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:

i. Equipment in use and carts in use
ii. Medical emergency equipment not in use
iii. Patient lift and transport equipment
This deficient practice could affect all residents,
staff and visitors.

Findings include:

Based on review of "Emergency Operations Plan: Fire Procedure" documentation with the Administrator during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, the written fire safety plan for the facility did not address the relocation of wheeled equipment during a fire or similar emergency. In addition, the written fire safety plan for the facility did not address the location of fire doors for evacuation purposes. The written fire safety plan stated to "remove persons from the room, continue past fire doors with evacuated

The administrator and department leaders were in serviced on 12/6/2018_regarding the Emergency Operations Plan including the relocation of wheeled equipment and the location of fire doors for purposes of evacuation. The annual Emergency Operations Plan review will be added to the TELS calendar.

administrator will review the Emergency Operations Plan with department leaders monthly for six months and document results. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed

To ensure compliance, the

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721		LDING	nstruction 01	(X3) DATE S COMPLI 12/04/	ETED
	PROVIDER OR SUPPLIER			8935 E 4	ADDRESS, CITY, STATE, ZIP COD 46TH ST APOLIS, IN 46226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	persons" but did not doors in the facility time of record revie evacuation routes w floor plans in the counsure if the writter relocation of wheeled during a fire or simi of fire doors for eva observations with the Maintenance Manage from 1:15 p.m. to 2 were stored in the cand 29. Crash carts near nurse's station 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include the alarm signal and seconditions. Fire drand unexpected to conditions, at leass The staff is familia aware that drills alar routine. Where draware that drills are routine. Where draware that drills are audible alarms. 19.7.1.4 through 1 Based on record reversible for 4 of 4 drills shift for 4 of 4	t identify the location of fire T. Based on interview at the ew, the Administrator stated the evere listed on the wall mounted particle but stated she was in fire safety plan addressed the ed equipment from the corridor ilar emergency and the location acuation purposes. Based on the Administrator and the ger during a tour of the facility :25 p.m. on 12/04/18, Hoyer lifts corridor outside Rooms 27, 28 is were stored in the corridor 1 and nurse's station 2. The transmission of a fire fills are held at expected times under varying at quarterly on each shift. For with procedures and is for part of established fills are conducted between to AM, a coded any be used instead of	K 07		For residents affected by the deficient practice and those potentially affected, fire drills in month of December were held second and third shifts at times which varied from the most reciquarterly drills.	on s	12/06/2018

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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 <u>01</u> B. WING			COMPLETED		
		155721	B. WING 12/04/2018				
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, IN 46226				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	documentation with Maintenance Mana 8:50 a.m. to 1:15 p was noted: a. second shift fire 02/12/18, 03/13/18 07/26/18, 08/25/18 were conducted at, p.m., 9:00 p.m., 7:5 p.m., 9:30 p.m., 9:30 b. third shift fire dr 02/12/18, 03/27/18 08/25/18, 09/25/18 conducted at, respe 11:00 p.m., 10:55 p p.m., 11:00 p.m., 1 Based on interview the Maintenance Maforementioned second	cond and third shift fire drills d at unexpected times under			The maintenance person was serviced on 12/6/2018 regardi fire drills to be held at expecte and unexpected times under varying conditions at least quarterly on each shift. The results of fire drills including the times conducted will be documented. Maintenance pewill maintain a rolling calendar indicating the time variances of to drill on each shift. To ensure compliance, the administrator will review the recalendar and fire drill reports monthly for six months and ongoing. Results of the monitoring will be reviewed duthe facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. I compliance threshold of 95% inot achieved an action plan wideveloped	ng d eerson drill olling f a s	
K 0918 SS=F Bldg. 01	Electrical System System Maintena The generator or source and assoc of supplying servi 10-second criteric monthly test, a pr annually confirm safety and critical	s - Essential Electric Syste s - Essential Electric ince and Testing rother alternate power ciated equipment is capable ice within 10 seconds. If the on is not met during the ocess shall be provided to this capability for the life branches. Maintenance generator and transfer					

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01			COMPLETED	
155721		155721	B. W	ING		12/04/	2018
				CTREET	ADDDECC CITY CTATE ZID COD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
LAWDENCE MANOR LICAL TUCARE CENTER					46TH ST IAPOLIS, IN 46226		
LAWRENCE MANOR HEALTHCARE CENTER				INDIAN	MACOLIO, IN 40220		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	_	ormed in accordance with					
	NFPA 110.						
		re inspected weekly,					
		oad 30 minutes 12 times a					
		intervals, and exercised					
	-	onths for 4 continuous hours.					
		nder load conditions include					
		ated cold start and					
		ual transfer of all EES					
		nducted by competent					
		enance 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						
		narked, readily identifiable,					
		n normal power circuits.					
		essibility of damage of the					
		r source is a design					
	consideration for						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.1	•		0.4.0			4.4.0
		I review, observation and	K 0	918	The automatic transfer switch		12/10/2018
		ity failed to ensure 1 of 1			replaced on 12/10/2018. The		
		switches was maintained in			generator was inspected and		
		FPA 110. NFPA 110, Standard			exercised under load on		
		Standby Power Systems, 2010			12/17/2018 and the test/inspe	ection	
	-	3 states the EPSS shall be			documented on the Weekly		
	maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. Section 8.3.4				Generator Inspection Monthly	'	
					Load Test Log.		
					The facility will ensure the		
		ord of the EPSS inspections,			emergency generator is fully		
	tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and				functional, is tested weekly, a		
					load testing occurs monthly w		
					record of the available load, a	ınd a	

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12/20/2018 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 12/04/2018 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE visitors. written record is available for review. Findings include: The maintenance person was in Based on review of Edwards Mechanical "Work serviced on 12/6/2018 regarding Order" documentation dated 07/31/18 with the generator function, weekly Administrator and the Maintenance Manager inspection, and exercising the during record review from 8:50 a.m. to 1:15 p.m. on generator under load monthly; and 12/04/18, the automatic transfer switch controller availability of documentation for does not transfer building power from the normal review by the Authority having source to the generator. Based on interview at the Jurisdiction. A plan of correction time of record review, the Maintenance Manager audit calendar has been stated company policy required bids for the repair implemented. and it is scheduled to be replaced by MacAllister Machinery on 12/10/18 as evidenced by The administrator or designee will

3.1-19(b)

2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 8 of 52 weeks. NFPA 99, Healthcare Facilities Code, 2012 Edition, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available

MacAllister's confirmation e-mail dated 12/04/18.

the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18,

Based on observations with the Administrator

and the Maintenance Manager during a tour of

the "Not in Auto" light was illuminated and an

audible alarm signal was noted at the generator

nurse's station 1 inside the facility.

location and at the remote annunciator located at

monitor emergency generator operation weekly for two months and monthly thereafter with results and documentation forwarded to the regional director of operations to ensure continued compliance. If any component of the emergency generator system fails the minimum test and inspection requirements it shall be repaired or replaced immediately. All test and inspection shall be documented accordingly as well as any necessary repair or replacement activities. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be

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developed.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		A. BUILDING B. WING	01	COMPLETED 12/04/2018	
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
	for inspection by the jurisdiction. This do residents, staff and v	eficient practice could affect all			
	Findings include:				
	Checks Monthly Lo the Administrator an during record review 12/04/18, weekly er documentation for C was not available fo interview at the time Maintenance Manag Mechanical perform switch inspection or transfer switch conte stopped doing week generator after 09/2 emergency generator for October and Nov for review.	"Weekly Generator Inspection ad Test" documentation with and the Maintenance Manager of from 8:50 a.m. to 1:15 p.m. on the maintenance of the main			
	interview; the facility written record of more for 2 months of the In addition, the facility the generator with suppowered EPS install requirements of NFI 99, Health Care Fac Chapter 6.4.4.1.1.4(the generator serving system to be in account of Standard for Emerger 1.5 months of the facility with the suppose of the facility of the generator serving system to be in account of the facility of the	review, observation and try failed to maintain a complete onthly generator load testing most recent 12 month period. Lity failed to annually exercise upplemental loads for diesel lations that do not meet the PA 110, Section 8.4.2. NFPA ilities Code, 2012 Edition, A) requires monthly testing of g the emergency electrical ordance with NFPA 110, the ency and Standby Powers NFPA 110, 2010 Edition,			

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155721	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/04/2018				
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		
	Section 8.4.2 requires diesel generator sets in service to 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% of the 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 load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS 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. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Weekly Generator Inspection Checks Monthly Load Test" documentation with the Administrator and the Maintenance Manager during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, monthly emergency generator load testing documentation for October and November 2018 was not available for review. In addition, review of monthly load testing documentation for June 2018 through September 2018 indicated the monthly load test never exceeded 11%. Based on interview at the time of record review, the Maintenance Manager stated Edwards Mechanical performed an automatic transfer					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155721		 JILDING	nstruction <u>01</u>	(X3) DATE (COMPL 12/04 /	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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		(X5) COMPLETION DATE			
K 0920	switch inspection of transfer switch cont stopped doing mont generator after 09/2 testing documentation 2018 was not availad Maintenance Managetesting for the diese achieve 30% load of perform an annual lifereent twelve month observations with the Maintenance Managefrom 1:15 p.m. to 2: has one diesel fired Manufacturer's name the unit indicated it "Not in Auto" light audible alarm signal	n 07/31/18 which found the roller does not work so he hly load testing on the 8/18 and agreed monthly load on for October and November ble for review. In addition, the ger stated monthly load I fired generator does not a more and the facility did not coad bank test within the most a period. Based on the Administrator and the ger during a tour of the facility emergency generator. The plate information affixed to was rated at 150 kW. The was illuminated and an a was noted at the generator emote annunciator located at	IAG			DAIL		
SS=E Bldg. 01	Electrical Equipment Extens Electrical Equipment Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by quanthe conditions of 1 the patient care vinnon-PCREE (e.g., except in long-terrido not use PCREE	d electrical equipment						

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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 12/04/2018 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 for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 The extension cord and power 12/06/2018 failed to ensure 1 of 1 extension cords including strip cited at the time of survey power strips were not used as a substitute for was removed. fixed wiring. LSC 19.5.1 requires utilities to All resident rooms, offices. comply with Section 9.1. LSC 9.1.2 requires storage areas and common use electrical wiring and equipment to comply with spaces were inspected for the use NFPA 70, National Electrical Code, 2011 Edition. of extension cords and or power NFPA 70, Article 400.8 requires that, unless strips not specifically permitted specifically permitted, flexible cords and cables and used as a substitute for fixed shall not be used as a substitute for fixed wiring of wiring. Any cited were removed. a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life Administrator, maintenance and safety shall be designed, installed and approved department leaders were in in accordance with all applicable NFPA standards. serviced on 12/6/2018 regarding This deficient practice could affect over 10 the prohibition of extension cords residents, staff and visitors in the vicinity of the and or power strips unless Administrator's Office near the main entrance specifically permitted. The lobby. maintenance person will include the prohibition of extension cords Findings include: and or power strips on the regularly scheduled preventative Based on observations with the Administrator maintenance rounds of resident

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and the Maintenance Manager during a tour of

the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18,

a refrigerator, a microwave oven and a coffee pot

Maintenance Manager agreed a power strip was

were plugged into a power strip. Based on interview at the time of the observations, the

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documented.

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rooms, offices, storage areas and

common use spaces and results

To ensure compliance, the

administrator will review

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OMB NO. 0938-039

l '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155721	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2018		
NAME OF PROVIDER OR SUPPLIER LAWRENCE MANOR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 8935 E 46TH ST INDIANAPOLIS, 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		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	•	DATE
	being used as a substitute for fixed wiring at the				preventative maintenance logs		
	aforementioned location.		the presence of extension cords				
	2.1.10(1)				and power strips and ensure the		
	3.1-19(b)				removal weekly for eight week		
					and monthly thereafter. Resul		
					the monitoring will be reviewed	a	
					during the facility's QAPI		
					Committee meeting overseen	•	
					the administrator and reviewed	•	
					corporate risk management. I		
					compliance threshold of 95% i		
				not achieved an action plan wi	III be		
					developed.		
l			l				

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