STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 01 B. WING	09/30/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
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 483.70(a). Survey Date: 09/30/16 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Life Safety Code survey, Lawrence Manor Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has	K 0000	000 Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and or executed in compliance with State and Federal laws. This POC is to serve as the Lawrence Manor's credible allegation of compliance.	

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

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	a capacity of 55 and had a census of 52 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.			
K 0017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation, the facility failed to ensure the corridor walls within the facility were sealed to prevent the passage of smoke. This deficient practice could affect 6 of 52 residents, as well as staff and visitors within the facility.	K 0017	**K – 017** It is the policy of Lawrence Manor to ensure the walls within the facility are sealed to prevent the passage of smoke. **What corrective action(s) will be accomplished for those residents found to**	10/30/2016

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	Findings include: Based on observation with the Administrator during a tour of the facility from 9:20 a.m. to 11:05 a.m. on 09/30/16, the following was noted: a) there was a one half inch hole in the corridor wall directly into resident room # 22 b) there was a one half inch hole in the corridor wall directly into resident room # 1 Based on interview at the time of the observation, the Administrator acknowledged the holes, and that they should be sealed to prevent the passage of smoke into other areas of the facility. 3.1-19(b)		**have been affected by the deficient practice:** The one half inch hole in the corridor wall directly into resident room #22 has now been repaired and sealed. The one half inch hole in the corridor wall directly into resident room #1 has been repaired and sealed. Both arears has been sealed with the flame proof sealant. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All other resident rooms were inspected and continue to be inspected regularly. There are no additional residents affected by the findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** To prevent a re – occurrence, the maintenance director will document the monthly inspection of resident rooms and resident corridor walls for compliance and repair any holes in walls. Work orders documented in the work order repair book and reviewed by the administrator for monitoring and compliance.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The administrator or designee will review the facility preventative maintenance binder each month and report to the Quality Assurance Committee, monthly, ongoing to ensure compliance for a minimum of 6 months.	
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			

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	Based on observation, the facility failed to ensure doors protecting corridor openings did not have an impediment to the closing of the doors in 1 of 25 resident room doors. This deficient practice could affect approximately 13 of 52 residents. Findings include: Based on observations made with the Administrator on 09/30/2016 at 9:24 a.m., the door to Resident room #18 had a door wedge holding the door open to the corridor. Based on interview at the time of observation, the Administrator acknowledged the door should not be propped open, and removed the door wedge from the door. 3.1-19(b)	K 0018	**K018** It is the policy of Lawrence Manor to ensure there is no impediment to door closure and corridor doors. All doors must have a means for suitable closure and a positive latch. Room #18 wedge was removed from the resident's room. No other resident room doors were affected. To prevent a re-occurrence, the maintenance director will document monthly inspection of the resident room doors closing in the frames. All staff were in serviced on this federal requirement that no doors can be propped open. Housekeeping staff were given rounding tools to record any occurrences and instructed to remove any wedges to be used daily. The administrator or designee will review the facility preventative maintenance binder each month and report to the Quality Assurance Committee, monthly, ongoing to ensure compliance for a minimum of 6 months.	10/30/2016
K 0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 7 doors serving hazardous areas such as a laundry or combustible storage room over 50 square feet in size, was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect approximately 24 residents, staff and visitors. Findings include: Based on observations on 09/30/16 with the Administrator during a tour of the	K 0021	**K021** It is the policy of Lawrence Manor to only hold doors open with devices arranged to automatically close all such doors. The laundry barrel was removed to allow the door to close and staff educated. No other doors were found to be held open. No other residents were affected. To prevent a reoccurrence, the maintenance director will conduct a monthly inspection to ensure door stops not being used. All staff were in serviced on this federal requirement that no doors can be propped open.	10/30/2016

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	facility at 9:44 a.m., the door to the "Hopper Room", a room that is open to the corridor, was held open by a 50 gallon container of soiled linens. Furthermore, the room itself contained approximately three more 50 gallon containers of trash, linens, and other assorted trash. Based on interview at the time of observation, the Administrator acknowledged the door should not be propped open. 3.1-19(b)		Housekeeping/laundry were given rounding tools to record any occurrences and instructed to remove any wedges to be used daily. The maintenance director will document on the monthly preventative maintenance log. The administrator or designee will review the facility preventative maintenance binder each month and report to the Quality Assurance Committee, monthly, ongoing, to ensure compliance a minimum of 6 months.	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to contain the passage smoke. LSC Section 8.3.6.1 requires the passage of building service materials	K 0025	**K025** It is the policy of Lawrence Manor to maintain ceiling smoke barriers. Resident room #2, now have the wall repaired and sealed. The wall has been sealed with the flame	10/30/2016

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	such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately 2 residents, staff and/or visitors in or near resident room #2. Findings include: Based on observation with the Administrator at 11:05 a.m. on 09/30/16, a three quarter inch hole was found in the ceiling of resident room # 2. Based on interview at the time of the observation, the Administrator acknowledged the hole and that it should be sealed to prevent the passage of smoke into other areas of the facility. 3.1-19(b)		proof sealant. All other resident rooms were inspected and continue to be inspected regularly. There are no additional residents affected by the findings. All corridor areas were caulked with fire approved product. To prevent a re-occurrence, the maintenance director has been educated to inspect for smoke barrier penetrations following any building work. The maintenance Director will document work performed and visual inspection to ensure no holes in smoke barriers, and submit to administrator for review. The Quality Assurance Committee will be responsible for oversight of maintenance director's compliance with visual inspection following any building work performed, monthly, ongoing for a minimum of 6 months.	
K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with			

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	19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect 16 of 52 residents, as well as staff and visitors within the facility. Findings include: Based on observation with the Administrator during a tour of the facility from 9:20 a.m. to 11:05 a.m. on 09/30/16, the set of smoke barrier doors in the corridor near resident room # 20 did not fully close leaving a four inch gap in between the set of doors. Based on interview at the time of observation, the Administrator stated the smoke barrier door set did not close completely because it looked as if they had been recently painted and one door was catching on the other. 3.1-19(b)	K 0027	**K027** It is the policy of Lawrence Manor to maintain smoke barrier doors partitions. The paint was removed allowing the smoke barrier doors to close fully in the frame. No residents were affected. To prevent a re-occurrence, the maintenance director has been educated on need for self-closure doors to close properly in the frame. The maintenance director will be required to inspect the corridor doors monthly to ensure self-closure of doors and documentation into the monthly maintenance log. The administrator will review and report compliance to the Quality Assurance Committee, who will be responsible for facility compliance, monthly and, ongoing	10/30/2016
K 0050	NFPA 101			

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SS=F Bldg. 01	LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review, the facility failed to insure all fire drills included the transmission of a fire alarm signal in all fire drills conducted over the last 12 months. LSC 19.7.1.2 requires that fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of "Fire Drill Record" with the Administrator at 11:08 a.m. on 9/30/16, the documentation for the drills performed did not indicate the fire alarm	K 0050	**K050** It is the policy of Lawrence Manor to hold fire drills as required by Life Safety standards to include the transmission of a fire alarm signal in all drills over the last twelve months. On 10 /21/15, a fire drill shall be held with fire alarm activation. The direction require the maintenance director or designee to actually pull alarms with documentation to the monitoring company of receiving the transmission. The only exception is a coded announcement, only between hours of 9 PM and 6 AM. No other residents were affected. To prevent a re-occurrence, the administrator or designee will review all fire drills and report to Quality Assurance Committee who will oversee facility compliance, monthly, ongoing.	10/30/2016

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	system had been activated. There was also no phone call made to the facility monitoring company to verify that an alarm signal was ever sent from the facility, or received at the monitoring company. Based on interview at the time of the observation, the Administrator acknowledged that the "Fire Drill Record" did not have a documented transmission of the fire alarm or that phone calls were ever made to verify the monitoring company received a fire signal from the facility within the last twelve months of documented fire drills. 3.1-19(b) 3.1-51(c)			
K 0053 SS=F Bldg. 01	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) Based on record review and interview, the facility failed to ensure 26 of 26	K 0053	**K053** It is the policy of Lawrence Manor to ensure single station	10/30/2016

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	single station battery operated smoke detectors would operate. This deficient practice affects all 52 residents in the facility. Findings include: Based on record review on 9/30/16 at 11:31 a.m. with the Administrator, the Smoke Detector Checklist log did not have documentation indicating that the single station battery operated smoke detectors were checked in the months of August 2016 or September 2016. Based on an interview with the facility Administrator at the time of the observation, the Administrator advised that the single station smoke detector checks for the aforementioned months could not be located. 3.1-19(b)		battery operated smoke detectors are in proper operation. Monthly checks for battery operated smoke detectors completed by the maintenance director and placed the maintenance preventive log book. No other residents were affected. To prevent a re-occurrence, maintenance will do monthly inspection of the battery operated smoke detectors to ensure all smoke detectors are functional. This documentation to occur monthly in the preventive maintenance log book The Quality Assurance Committee will be responsible for oversight of Maintenance director compliance, monthly, ongoing.	
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 7 of over 150	K 0062	**K062** It is the policy of Lawrence Manor to ensure automatic	10/30/2016

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	sprinklers within the facility which had been painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect up to 10 residents, 2 staff, as well as 8 visitors within the facility. Findings include: Based on observation during a tour with the Administrator on 9/30/16 between 9:20 a.m. and 11:05 a.m., the following was noted: a) there was paint on two sprinkler heads in the Kitchen area b) there was paint on a sprinkler head in resident room # 19 c) there was paint of a sprinkler head in the Business Office d) there was paint on a sprinkler head in resident room # 10 e) there was paint on a sprinkler head in resident room # 9 f) there was paint on a sprinkler head in the Housekeeping Office		sprinkler heads are unobstructed. All sprinkler heads in the kitchen area, resident room #9, # 10 # 19, business office and housekeeping office have been replaced. All sprinkler heads have been inspected to ensure to be free of obstruction. No residents were affected. To prevent a re-occurrence, maintenance will do monthly inspection of sprinkler heads to ensure sprinkler heads are functional, administrator or designee will ensure documentation is collected and obtained and placed in Fire Safety Binder. Sprinkler heads will be observed monthly by maintenance director for any obstruction and inspection documented on maintenance log. The administrator will review monthly logs and fire inspections as applicable and report need for any fire safety inspections to the Quality Assurance Committee, who will oversee facility compliance, monthly, ongoing for a minimum of 6 months.	

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	Based on interview with the Administrator at the time of the observations, he stated that they had just hired contractors to paint all the sprinkler pipes within the facility. To him, it looked like that did not tape off a single sprinkler head before they painted leaving his sprinkler heads susceptible to getting paint on them. The Administrator also acknowledged all the painted sprinkler heads at the times they were located within the facility. 3.1-19(b)			
K 0066 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is 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 is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 01 B. WING	09/30/2016

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	(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect any residents smoking, as well as visitors and staff, if they were utilizing the designated smoking area or the patio. Findings include: Based on observations on 9/30/16 at 9:35 a.m. with the Administrator, the smoking area had twenty four cigarette butts strewn about the designated smoking area. Based on interview at the time of the observations, the Administrator acknowledged the facility's employees disposed of cigarette butts on the ground instead of using the approved long neck vessel which was provided. 3.1-19(b)	K 0066	K066 It is the policy of Lawrence Manor to have cigarette butts deposited into a noncombustible container for the designated smoking area. All cigarettes butts were picked up and removed and placed in red butt can from the designated smoking area. The staff has been educated on cigarettes placement into the wedge shape containers provide for the designated smoking area. No residents were affected. To prevent a re-occurrence, the maintenance director/designee will inspect the patio at least 5 x per week to ensure continuous clean up the area designated for the cigarettes butts. Quality Assurance committee to oversee the weekly audit sheets for compliance with the placement of the cigarette butts for a minimum of 6 months.	10/30/2016

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K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 1) Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect any resident, visitor or staff near the mechanical room. Findings include: Based on observation with the administrator during the tour of the facility at 10:18 a.m. on 09/30/16, a 12 inch in diameter electrical junction box for a light, with numerous wire connections jutting out of the box and without a cover, was in the center of the mechanical room. The open junction box and wires were acknowledged by the	K 0147	**K147** It is the policy Lawrence Manor maintain electrical wiring and equipment in accordance with National Electrical Code 9 -1.2 18.9.1 19.9.1, The electrical wiring has been capped and the wire placed inside the junction box with the protective cover placed on the junction. The facility removed the power strip outlet from wall and plug the appliance directly into the outlet. No residents were affected. To prevent a re-occurrence, the maintenance director was educated on keeping electrical boxes and junction boxes wiring connected safely for housing inside the junction box. Facility policy to not use power strips for multiple appliances from a single outlet. Housekeeping staff will be using rounding tools to ensure electrical cords are not used. The maintenance director will check monthly to ensure wiring and junction boxes are safely connected inside the junction. The Quality Assurance Committee will be responsible for	10/30/2016

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	administrator at the time of the observation. 3.1-19(b) 2) Based on observation, the facility failed to ensure extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect approximately 25 residents. Findings include: Based on observation on 9/30/2016 at 10:55 a.m. during the tour of the facility, a TV, a VCR, and a DVD player were all plugged into an extension cord power strip and not directly into the wall in dining room #2. Based on interview at the time of the observation, the Administrator acknowledged the extension cord power strip. 3.1-19(b)		oversight of Maintenance Director's compliance, monthly, ongoing for a minimum of 6 months.	

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