STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

(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
K0000	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: 11/09/12 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Lakeview Manor 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 III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in rooms 11 through 19 in the C Hall. The facility has battery operated smoke	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.This plan of correction is prepared and submitted as a requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance.	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 125 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/14/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.	K0052	1. No residents were harmed.2. All residents have the potential to be affected. The breaker box is scheduled to be installed for the fire alarm panel on 11/29/12.3. We are installing a breaker box for our fire alarm panel on November 29, 2012. The panel will be located in the power supply room. 4. The findings of these audits will be reviewed during the facility's quarterly Quality Assurance meeting and the plan of action adjusted accordingly.	11/30/2012

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:00 p.m. on 11/09/12, the fire alarm system breaker could not be identified or located. Based on interview at the time of observation, the Maintenance Director acknowledged the fire alarm system breaker could not be identified or located. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. In addition, NFPA 13, Section 5-6.3.4, "Minimum Distance Between Sprinklers" states sprinklers shall be spaced not less than six feet on center. This deficient practice could affect ten residents, staff and visitors in the vicinity of the Short Hall C Wing Storage Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:00 p.m. on	K0056	1. No residents were harmed.2. The residents on C hall have the potential to be affected. All other sprinklers were inspected to ensure they were 6 feet apart.3. A bulk head was built to seperate the sprinker heads. If any new sprinkler heads are installed we will ensure they are 6 ft apart.4. The findings of these audits will be reviewed during the facility's quarterly quality assurance meeting and the plan of action adjusted accordingly.	11/30/2012

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	11/09/12, two of two sprinklers installed in the Short Hall C Wing Storage Room were installed four feet apart from one another on the ceiling. Based on interview at the time of observation, the Maintenance Director acknowledged the two sprinklers installed in the Short Hall C Wing Storage Room were installed four feet apart from one another on the ceiling. 3.1-19(b)			

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K0061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on record review and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV). LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all residents in the facility as well as staff and visitors, if the water to the sprinkler system was shut off and not detected due to lack of supervision. Findings include: Based on review of Dalmatian Fire Inc. "Comments and Inspection Observations" documentation dated 09/07/12 with the Maintenance Director during record review from 8:50 a.m. to 10:50 a.m. on 11/09/12, the PIV lacked functional electronic supervision. The "Comments to Inspection Report(s)" section of the 09/07/12 documentation stated "PIV Tamper - has broken wire in ground."	K0061	1. No Residents were harmed.2. All residents have the potential to be affected. Fire System checked and no other problems were noted.3. A switch valve was adjusted by Dalmation Fire System. General Alarm came out and found wires that were not connected into the system. General Alarm made repairs to these wires. A relay is now connected into the fire alarm panel system.4. The findings of these audits will be reviewed during the facility's quarterly quality assurance meeting and the plan of action adjusted accordingly.	11/30/2012

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	Based on telephone interview with the Dalmatian Fire Inc. Service Technician who wrote the 09/07/12 inspection report during record review at 10:50 a.m. on 11/09/12, the tamper switch for the PIV was inoperable because of the broken wire in the ground. Based on interview at the time of record review, the Maintenance Director acknowledged the PIV tamper switch wiring had not been repaired or replaced to ensure electronic supervision of the PIV. 3.1-19(b)			

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K0069 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect 6 staff and visitors in the vicinity of the kitchen. Findings include: Based on review of 360 Services "Work Order" documentation dated 01/12/12 and 08/23/12 with the Maintenance Director during record review from 8:50 a.m. to 10:50 a.m. on 11/09/12, semiannual	K0069	1. No residents were harmed.2. All residents have the potential to be affected. See below for corrective measures. 3. Upon review noted, the date on the invoice was dated incorrectly and that 360 services were out on 2/12/12 instead of 1/12/12 this would make it within the time frame (see attachment A). Hood Range cleaning schedule will be added to the preventative maintence log to ensure it is inspected within the 6 months time frame.4. The findings of these audits will be reviewed during the facility's quarterly quality assurance meeting and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 11/30/12.	11/30/2012

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	kitchen range hood cleaning documentation indicated it had been more than six months between the two most recent semiannual range hood cleanings. Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:00 p.m. on 11/09/12, 360 Services had affixed only the 08/23/12 semiannual maintenance cleaning sticker to the kitchen range hood. Based on interview at the time of record review and observation, the Maintenance Director acknowledged it had been more than six months between the two most recent range hood cleanings. 3.1-19(b)			

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K0130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure 4 of 7 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:00 p.m. on 11/09/12, the following natural gas fired water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana: a. the service water heater identified as IN265742 and located in the Short Wing A Hall Housekeeping room had a Certificate of Inspection posted at the unit stating the expiration date was 05/24/12. b. the service water heater identified as IN293159 and located in the Short Wing B Hall Housekeeping room had a Certificate of Inspection posted at the unit stating the expiration date was 05/24/12.	K0130	1. No residents were harmed.2. All residents have the potential to be affected. 3. Zurich insurance will be at lakeview on 11/29/12 to inspect boilers. The bio-hazards containers were removed to another location meeting all guidelines. 4. This will be reviewed during quarterly QA.	11/30/2012

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	c. the service water heater identified as IN265744 and located in the Short Wing C Hall Housekeeping room had no Certificate of Inspection posted at the unit. d. the service water heater identified as IN265745 and located in the Short Wing D Hall Housekeeping room had a Certificate of Inspection posted at the unit stating the expiration date was 05/24/12. Based on interview at the time of the observations, the Maintenance Director stated documentation of current Certificate of Inspection documentation is kept in no other location than at the service water heater locations and acknowledged the aforementioned service water heaters had expired or missing Certificate of Inspection documentation from the State of Indiana. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 16 hazardous rooms with fuel fired water heaters were kept in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.			

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	Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 2:00 p.m. on 11/09/12, each of nine medical waste bins with a 28 gallon capacity were filled with medical waste and were stored up against three natural gas fired water heaters in the Main Shut Off Electrical and Water Room. Based on interview at the time of observation, the Maintenance Director acknowledged combustible medical waste bins were being stored next to natural gas fired water heaters in the Main Shut Off Electrical and Water Room. 3.1-19(b)			