PRINTED: 12/10/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING <u>00</u>			COMPLETED	
		155077	B. WIN	G		11/05	/2021	
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEI	R			CHWAY DR			
LAKEVIE	EW MANOR				APOLIS, IN 46224			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Ε	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE	
F 0000								
Bldg. 00								
Diug. 00	This visit was for the IN00365995 and IN	he Investigation of Complaints N00366036.	F 000	00				
	Complaint IN0036	5995 - Substantiated.						
		iencies related to the						
		d at F684, F689, and F919.						
	Complaint IN0036	6036 - Substantiated.						
	_	iencies related to the						
		d at F684 and F842.						
	Survey dates: November 4 and 5, 2021.							
	Facility number: 00	00032						
	Provider number: 1	55077						
	AIM number: 1002	773330						
	Census Bed Type:							
	SNF/NF: 87							
	Total: 87							
	Census Payor Type	::						
	Medicare: 8							
	Medicaid: 79							
	Total: 87							
	These deficiencies	reflect State Findings cited in						
	accordance with 41							
	Quality review com	npleted on November 15,						
	2021.	1						
F 0684	483.25							
SS=D	Quality of Care							
Bldg. 00	§ 483.25 Quality (	of care						
-		a fundamental principle that						
		ment and care provided to						
	<u> </u>						<u> </u>	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE		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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COI			ETED
		155077	B. W	NG		11/05/	2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	1					
	W MANOR				CHWAY DR APOLIS, IN 46224		
LAKEVIE	W MANUR			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		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	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility residents. E	Based on the					
	comprehensive as	ssessment of a resident, the					
	facility must ensure that residents receive						
	treatment and care	e in accordance with					
	professional stand	lards of practice, the					
	comprehensive pe	erson-centered care plan,					
	and the residents'						
	· ·	, and record review, the	F 0	584	F684 Quality of Care		11/12/2021
	-	sure neurological check			SS=D		
	assessments were co	-					
		a resident who had a history					
		or 1 of 3 residents reviewed			What corrective action(s) will	I	
	for falls (Resident C	G).			be accomplished for those		
					residents found to have beer	1	
	Findings include:				affected by the deficient		
					practice:		
		a.m., Resident G indicated					
		ght and room call lights did		The resident identified was			
		had to go into the hall and			immediately assessed and no	new	
		come help her. Resident G			findings were noted		
		illen before and was afraid					
		vould cause her to fall again.			l:		
		d she was supposed to use the			How other residents having t		
		wanted to get in and out of		potential to be affected by			
		to get ready for the morning,			same deficient practice will b		
	but it did not work.				identified and what corrective	е	
	O 11/5/01 + 10 00	) D:dCl 1' 1			action(s) will be taken:		
		a.m., Resident G's medical			All regidents have the		
	record was reviewed				All residents have the	llo.	
	-	essment was a quarterly			potential to be affected. All fall		
		(MDS) assessment dated indicated Resident G was			moving forward any fall will be reported to DON/On Call Nurs		
		equired minimum assistance			ensure fall policy/process is	e io	
		daily living (ADLS) and was			followed.		
					lonowed.		
	always continent of her bowel and bladder. She had active diagnoses which included, but were						
	not limited to, anxiety, depression, unsteadiness						
	on feet, and muscle						
	on reet, and muscle	WOUNTEDSS.			What Measures will be put in	to	
	She had a comprehe	ensive care initiated on 3/4/21			place and what systemic		
	one had a comprehe	moive care initiated On 3/4/21			piace and what systemic		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155077	B. WI	NG		11/05/	2021
				CED FEE	A DDDDGG GUTU GTATE TID GODE		_
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					CHWAY DR		
LAKEVIE	EW MANOR			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	and revised 9/8/21.	The care plan indicated			changes will be made to ens	ure	
	Resident G was at a	risk for falls due to weakness,			that the deficient practice do		
	decreased mobility,	and Alzheimer's.			not recur:		
	Interventions for th	e plan of care included, but					
	were not limited to,	provide adequate lighting,			All Licensed staff will b	e	
	resident should wear non-skid footwear, and to				educated on reporting all falls	to	
	keep frequently use	ed items within reach.			DON/On Call Nurse, complete	e fall	
					packet, initiative neuros if fall		
	A nursing progress note dated 9/8/21 at 8:15				unwitnessed, make nurse not	e.	
	a.m., indicated Resident G had a fall earlier in the				DON/Designee will bring all fa		
	shift.				packets to Clinical Meeting ne	ext	
					business day		
	A corresponding Accident and Incident Report						
		lated 9/8/21 at 6:30 a.m.,			How will the corrective		
		G was heard yelling out for			action(s) will be monitored to		
	-	d on the floor, laying on her			ensure the deficient practice		
		er bed. No injuries were			will not recur, i.e., what qual	-	
		re was provided, and the			assurance program will be p		
	potential cause indi	cated, "tries to [be]			into place:		
	independent."						
					DON/Designee will audit all fa	•	
		sponding Neurological Check			(Mon- Fri) for four (4) weeks;		
	assessment (neuro	checks).			three times (3x) a week for the		
					following four (4) weeks; two-		
	_	v on 11/5/21 at 12:14 p.m.,		(2x) a week for the following t			
		of Clinical Services (VPCS)			(4) weeks; once a week (1x) f		
	· ·	ecks were not initiated after			the following four (4) weeks; a		
		When the VPCS asked about			two times (2x) per month for t		
	* '	he was told, because the			following eight (8) weeks. The	9	
	_	not hit her head, they took			results of these audits will be		
		it and did not complete neuro			reviewed by the facility Quality	y	
		it was her expectation that			Assurance Performance	20	
	neuro checks should always be initiated for				Improvement (QAPI) committee for patterns, trends and continuous		
	residents after an unwitnessed fall.				1		
	On 11/5/21 at 12:44	n m the VDCS arrayided a			recommendations for process		
	On 11/5/21 at 12:40 p.m., the VPCS provided a copy of current facility policy titled, "Neurological Assessment," dated 10/2014,				monitoring and improvement		
					100% compliance is achieved		
	-				By what date the systemic		
		.Neurological assessment, is			By what date the systemic		
	to be completed in all cases of head injury to the				changes by completed:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 (X3) DATE COMPL					
		155077	B. WING			11/05/	/2021
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	(X5) COMPLETION
TAG	resident (when susp	LSC IDENTIFYING INFORMATION) ected or known)"		TAG	DEFICIENCY)		DATE
	This Federal tag relation IN00365995 and IN 3.1-37(a)	ates to Complaints			November 12, 2021		
F 0689 SS=D Bldg. 00	- ' ' ' ' '	nts.					
	adequate supervisito prevent accidents  Based on observation review, the facility the environment for a refalls with injury, was accidents when her	on, interview, and record	F 00	589	F689 Free of Accidents/Hazards/Supervis /Devices SS=D	sion	11/12/2021
	-	For environment (Resident			What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice:	nts	
	the facility had a lot would never get fixe resident bathrooms	al interview, it was indicated of plumbing issues that ed. There were several with water that leaked from d dripped down the walls.			The resident's room had toilet call light fixed immediately.	and	
	observed in her room	a.m., Resident G was n and indicated she was condition of her bathroom.			How other residents having the potential to be affected by the	е	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL		
		155077	B. WI	NG		11/05/	2021
	PROVIDER OR SUPPLIER			45 BEA	NDDRESS, CITY, STATE, ZIP CODE CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE
	toilet. She indicated the staff had to put a catch the water, but had to go in the hall someone to come er from overflowing be	troom door and pointed to the the toilet always leaked, so a bucket under the tank to never wanted to empty it. She and call for help for mpty the bucket to keep it ecause neither her bathroom call light worked. At this			same deficient practice will be identified and what corrective action(s) will be taken:  All residents have the potent to be affected. 100% audit will	iial	
	time, her bathroom pink, rectangle, bed sat under the tank of flushed her toilet, an sprayed out from un the tank of the toilet buckets, but also sp floor. The bathroom observed, it hung th	was observed. There was a -bath basin on the floor that f the toilet. Resident G and water was observed as it der the lid and dripped down f, into the catch of the lashed on the surrounding f call light pull-chord was rough a metal loop-hook that			be completed on each resident bathroom/toilet to ensure there no leaks and a 100% call light audit will be completed to ensuall call lights are functioning properly.	t e are ure	
	the metal call light for activate the bathroo indicated she had far water would cause had to her bed at light. The light bulb and did not illuming	e wall but was not attached to lip-switch which would m call light. Resident G llen before and was afraid the ner to fall again. Resident G and pushed the call room call above the door was observed ate. Resident G indicated, she			What Measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recur:	ges	
	wanted to get in and get ready for the mo	e the call light when she dout of bed, or needed help to brning, but it did not work.			All staff will be educated on reporting leaks immediately to Executive Director along with education on how to compa work order form and whom to	olete	
	Certified Nursing A Resident G's room v indicated she did no	ssistant (CNA) 8 entered with fresh ice water. CNA 8 t know Resident G's call light e did know the toilet leaked.			turn them into.	Č	
	CNA 8 indicated the at least several weel worked in the build least all the aids kno	e toilet had been leaking for cs, as long as CNA 8 had ing, it had been that way. At ew about it because they were bucket down to collect the			How will the corrective action(swill be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:	; ;	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W	JILDING	00	COMPL	
		155077	B. W	ING		11/05/	2021
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON BOTTELET			45 BEA	CHWAY DR		
LAKEVIE	W MANOR			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	T		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	On 11/4/21 at 11:16	6 a.m., Resident G's					
	roommate indicated	l she often pushed her own			The Executive		
	call light to request	assistance for Resident G			Director/designee will audit al	l	
	when she needed he	elp since Resident G's call			work orders to ensure they		
	light did not work.	She was not sure how long the			are triaged and completed		
	call light had been l	broken. Resident G's			timely. (Mon- Fri) for four		
		l she did not use the room			(4) weeks; then three times		
		she was paralyzed and used			(3x) a week for the following f	our	
		had been broken for a long			(4) weeks; two-time (2x) a		
	time too.				week for the following four (4)		
					weeks; once a week (1x) for t		
	During an interview on 11/4/21 at 2:30 p.m., the				following four (4) weeks; and	two	
		tor indicated he was a new			times (2x) per month for the		
		been at the facility for a little			following eight (8) weeks. Th	е	
		n he got there, the biggest			results of these audits will be		
	concerns that neede				reviewed by the facility Qualit	у	
		he roof, which leaked in			Assurance Performance		
	_	plumbing issues throughout			Improvement (QAPI) committ		
		e could file a maintenance ace it in his mailbox for			for patterns, trends and conting recommendations for process		
		use there were so many			monitoring and improvement		
	-	s the only maintenance staff			100% compliance is achieved		
	_	prioritize the work orders.			100 % compliance is achieved	•	
		be prioritized would be issues					
		a resident's health and safety,					
		hat did not work, bed rails that			By what date the systemic		
	_	plumbing issues that left water			changes by completed:		
	on the floor etc.	F					
	On 11/4/21 at 2:47	p.m., Resident G's bathroom					
		the Maintenance Director and			November 12,2021		
	the Administrator.	The Maintenance Director					
	indicated the bathro	oom call light pull-chord just					
	needed to be tied to	the right mechanism. He					
	threaded the chord through the metal flip-switch						
		ot. When he pulled the chord					
	to test the light, the						
		e resident's door. Next, he					
	flushed the toilet an	nd observed the water that					
					•		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077		(X2) MULTIPI A. BUILDIN B. WING	E CONSTRUCTION  G  00	(X3) DATE SURVEY COMPLETED 11/05/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPRO	O BE COMPLETION		
	to engage the room was pushed, the light on briefly, and did to indicated there may electrical panel at the attached, or in the pube that the bulb nee	der the lid. Then he attempted call light, but when the button in over the door only flicked not stay illuminated. He be something wrong with the ne wall where the chord was anel above the door, or it may ded to be replaced. He would all b first and left to gather his		F689 Free of Accidents/Hazards/Superv evices	rision/D		
	During an interview on 11/4/21 at 2:58 p.m., the Maintenance Director returned to Resident G's room with supplies and began to work on her toilet and call light. He indicated, maintenance orders for issues like the call light and leaking toilet were definitely a priority because, "you don't want water on the floor of an elderly patient's room, that's a big fall risk."  On 11/4/21 at 3:00 p.m., the Maintenance Director provided a large 3-ring binder of work orders and the stack of current outstanding work orders. He indicated there were some incomplete work orders left from the previous Maintenance Director in the 3-ring binder and he was working through them as best as he could to organize, prioritize and complete all outstanding orders.			p paraid="39899059" paraeid="{c3839496-570e- 14d-1f62c1d2ba44}{122}" of work order			
				p paraid="2031827687" paraeid="{c3839496-570e 14d-1f62c1d2ba44}{129}" original			
				given to Maintenance and copy to ED  (Y/N)			
	a.m. which requested in room B-9 (Resident placed by Nursing St completed.	rder, dated 7/21/21 at 10:00 ad the repair of a leaking sink ent G's room). The order was Staff 10 but had not been		p paraid="353485554" paraeid="{c3839496-570e- 14d-1f62c1d2ba44}{154}" work order for leaks			
	requested the repair The order was place	er, dated 7/22/21 at 3:15 p.m., of a leaking sink or toilet. ed by a different staff the signature was illegible.		(Y/N)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPI	
		155077	B. W	ING		11/05	/2021
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	₹		45 BEA	CHWAY DR		
LAKEVIE	W MANOR				IAPOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	I		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1110		not been completed.					5.112
	The order had also	not been completed.			p paraid="718949073"		
	On 11/5/21 at 10:00	a.m., Resident G's medical			paraeid="{c3839496-570e-49	58-h	
	rerecord was reviewed. The most recent				14d-1f62c1d2ba44}{165}" >If		
		essment was a quarterly			leaks was	.01	
		(MDS) assessment dated			ED notified immediately		
		indicated Resident G was					
		required minimum assistance					
	for her activities of daily living (ADLS) and was				(Y/N)		
always continent of her bowel and bladder. She had active diagnoses which included, but were not limited to, anxiety, depression, unsteadiness				, ,			
	on feet, and muscle weakness.						
				p paraid="1511311970"			
	She had a comprehe	ensive care initiated on 3/4/21			paraeid="{c3839496-570e-49	58-b	
	and revised 9/8/21.	The care plan indicated			14d-1f62c1d2ba44}{180}" >W	hat	
	Resident G was at r	risk for falls due to weakness,		was done to protect resident			
	decreased mobility,	, and Alzheimer's.			until leak resolved or N/A		
	Interventions for th	e plan of care included, but					
		provide adequate lighting,					
		ar non-skid footwear, and to			p paraid="1190925767"		
	keep frequently use	ed items within reach.			paraeid="{c3839496-570e-49		
					14d-1f62c1d2ba44}{195}" >Ha	as	
		note, dated 8/31/21 at 11:10			leak been fixed?		
		sident G fell in her room when					
	_	self into bed. She sustained a			0.400		
		hand and also complained of			(Y/N)		
	pain in her lower ba	ack.					
	A corresponding !! A	Accident and Incident Report					
		dated 8/31/2,1 indicated					
	_	en she tried to get into bed.			p paraid="443472365"		
		n tear and complained of pain			paraeid="{c3839496-570e-49	58-b	
		was immediately sent to the			14d-1f62c1d2ba44}{206}"		
	emergency room (E				>Any negative outcome from	anv	
		<del></del> )·			l leak		
	A nursing progress	note dated 9/8/21 at 8:15					
		ident G had a fall earlier in the					
	shift.				(Y/N)		
					<b> </b> ` '		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CC ЛLDING	00	(X3) DATE COMPL			
		155077	B. W	ING		11/05/	2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETION DATE	
	and Investigation, d indicated Resident ( help. She was found side at the foot of he	accident and Incident Report ated 9/8/21 at 6:30 a.m., G was heard yelling out for d on the floor, laying on her er bed. No injuries were was provided, and the cated, "tries to [be]			p paraid="1446127512" paraeid="{c3839496-570e-49914d-1f62c1d2ba44}{217}" >W order completed timely and signs ED	ork		
	On 11/5/21 at 12:40 copy of current faci dated 10/2014 whice	p.m., the VPCS provided a lity policy titled, "Call Light," h indicated, "Residents will summon facility personnel to			p paraid="104313530" paraeid="{c3839496-570e-499 14d-1f62c1d2ba44}{223}" >	58-b		
	ensure the resident's Equipment: function defective, report to				p paraid="567299829" paraeid="{c3839496-570e-499 14d-1f62c1d2ba44}{226}" >	58-b		
	On 11/5/21 at 12:40 copy of current faci Rights," dated 11/20	p.m., the VPCS provided a lity policy titled, "Resident 016 which indicated, "This ach resident with respect and			p paraid="1332856863" paraeid="{c3839496-570e-49914d-1f62c1d2ba44}{229}" >	58-b		
	dignity and care for in an environment t	each resident in a manner an hat promotes maintenance or or her quality of life"			p paraid="1528247082" paraeid="{c3839496-570e-499 14d-1f62c1d2ba44}{232}" >	58-b		
	This Federal tag rel IN00365995.  3.1-14(a)(1) 3.1-45(a)(1) 3.1-45(a)(2)	ates to Complaint			p paraid="605203788" paraeid="{c3839496-570e-49914d-1f62c1d2ba44}{235}" >	58-b		
	. 3.1 <sup>-</sup> +3(a)(2)				p paraid="2072971950" paraeid="{c3839496-570e-499 14d-1f62c1d2ba44}{238}" >	58-b		
					p paraid="966377409" paraeid="{c3839496-570e-49	58-b		

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING 00  B. WING		COMPLETED 11/05/2021		
	ROVIDER OR SUPPLIEI W MANOR	2	STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY 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		
				14d-1f62c1d2ba44}{241}" > p paraid="485992601"	E0 h		
				paraeid="{c3839496-570e-49: 14d-1f62c1d2ba44}{244}" >	58-0		
				p paraid="1753297889" paraeid="{c3839496-570e-49: 14d-1f62c1d2ba44}{248}" >	58-b		
				p paraid="1068514443" paraeid="{c3839496-570e-49 14d-1f62c1d2ba44}{251}" >	58-b		
				p paraid="1729067356" paraeid="{c3839496-570e-49: 14d-1f62c1d2ba44}{254}" >	58-b		
				p paraid="1471129752" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{2}" >	44-9		
				p paraid="149141459" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{5}" >	44-9		
				p paraid="588233893" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{8}" >	44-9		
				p paraid="767875357" paraeid="{ba9cd05d-691b-49	44-9		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155077	B. WIN	NG		11/05/	2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			CHWAY DR		
I AKFVIF	W MANOR				APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL	'	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG			DATE
					756-a67c98964f37}{11}" >		
					p paraid="139344489"		
					paraeid="{ba9cd05d-691b-49	44-9	
					756-a67c98964f37}{14}" >		
					p paraid="643569827"		
					paraeid="{ba9cd05d-691b-49	44-9	
					756-a67c98964f37}{18}" >		
					p paraid="908720246"	44.0	
					paraeid="{ba9cd05d-691b-494	44-9	
					756-a67c98964f37}{21}" >		
					p paraid="53319972"		
					paraeid="{ba9cd05d-691b-49	44-9	
					756-a67c98964f37}{24}" >		
					p paraid="123256446"		
					paraeid="{ba9cd05d-691b-49-	44-9	
					756-a67c98964f37}{27}" >		
					p paraid="1922077960"		
					p paraid= 1922077960   paraeid="{ba9cd05d-691b-49	1.1_Q	
					756-a67c98964f37}{30}" >	<del></del> -3	
					100-40100000+10101000		
					p paraid="800209319"		
					paraeid="{ba9cd05d-691b-49-	44-9	
					756-a67c98964f37}{33}" >		
					p paraid="1666873762"		
					paraeid="{ba9cd05d-691b-494	44-9	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING 00  B. WING		COMPLETED 11/05/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR		
LAKEVIE	W MANOR			IAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES 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	
				756-a67c98964f37}{36}" >		
				p paraid="882577177" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{39}" >	44-9	
				p paraid="268503711" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{43}" >	44-9	
				p paraid="318843831" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{46}" >	44-9	
				p paraid="787920529" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{49}" >	44-9	
				p paraid="1237753129" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{52}" >	44-9	
				p paraid="1669859451" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{55}" >	44-9	
				p paraid="1958365100" paraeid="{ba9cd05d-691b-49- 756-a67c98964f37}{58}" >	44-9	
				p paraid="693931620" paraeid="{ba9cd05d-691b-49	44-9	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077		A. BUII B. WIN	DING	<u>00</u>	COMPL 11/05/	ETED	
	ROVIDER OR SUPPLIER			45 BEA	.DDRESS, CITY, STATE, ZIP CODE CHWAY DR APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					756-a67c98964f37}{61}" > p paraid="48317791" paraeid="{ba9cd05d-691b-494756-a67c98964f37}{64}" >	4-9	
					Name of Person completing at	udit	
F 0842 SS=D Bldg. 00	§483.20(f)(5) Resi information. (i) A facility may no is resident-identification in the facility may is resident-identification accordance with a agent agrees not to information except itself is permitted to \$483.70(i) Medical §483.70(i)(1) In accordessional standard	- Identifiable Information dent-identifiable  of release information that able to the public.  of release information that able to an agent only in contract under which the of use or disclose the sto the extent the facility of do so.  I records.  cordance with accepted ards and practices, the ain medical records on					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY LETED 5/2021	
	PROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP COI ACHWAY DR NAPOLIS, IN 46224	DE <b>a</b>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	(i) Complete; (ii) Accurately door (iii) Readily acces (iv) Systematically §483.70(i)(2) The confidential all information in the records of the formation in the records, excep (i) To the individual representative who law; (ii) Required by Latinian in the records, excep (iii) For treatment, operations, as per compliance with 4 (iv) For public hear abuse, neglect, or oversight activities proceedings, law	facility must keep permation contained in the form or storage method of ot when release isal, or their resident ere permitted by applicable aw; payment, or health care mitted by and in 5 CFR 164.506; alth activities, reporting of a domestic violence, health as, judicial and administrative enforcement purposes, irposes, research proners, medical all directors, and to avert a health or safety as permitted ince with 45 CFR 164.512.  Ifacility must safeguard formation against loss, authorized use.  In the date of discharge requirement in State law; or years after a resident				

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ì ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		155077	B. W	ING		11/05/	2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
					CHWAY DR		
LANEVIE	W MANOR			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	§483.70(i)(5) The	medical record must					
	contain-						
	(i) Sufficient inforr	nation to identify the					
	resident;						
	(ii) A record of the	resident's assessments;					
	(iii) The comprehe	ensive plan of care and					
	services provided	•					
	(iv) The results of	any preadmission					
	screening and res	ident review evaluations					
	and determination	ns conducted by the State;					
	(v) Physician's, nurse's, and other licensed professional's progress notes; and						
(vi) Laboratory, radiology and other							
	diagnostic services reports as required						
	under §483.50.						
			F 0	342	F842 Resident Records		11/12/2021
	Based on interview	and record review, the					
	1	sure documentation of					
	_	eation was accurate for a					
		esidents reviewed for					
	pharmaceutical serv	vices (Resident C).			What corrective action(s) will b		
					accomplished for those reside		
	Findings include:				found to have been affected b	У	
					the deficient practice:		
		al interview, Resident C					
		went without pain medication,					
		for pain medication, the					
	nurses would say th	ney already gave it.			The resident involved was		
		<b>5.11</b>			immediately assessed for pair	-	
		p.m., Resident C medical			Nurse manager and at that tim	ie	
		d. He had diagnoses which			denied any pain		
		not limited to, Chronic pain					
	1 -	olism and thrombosis					
		when a blood clot, develops					
		nd reduces the flow of blood			•		
		embolism occurs when a			Ham all as a side of the side of	_	
	_	ot, foreign object, or other			How other residents having the	е	
		ecomes stuck in a blood vessel			potential to be affected by the		
	and largely obstruc	ts the flow of blood).			same deficient practice will be		
					identified and what corrective		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> COMPLETED			ETED	
		155077	B. WING 11/05/2021			2021	
		100077				11/00/	2021
NAME OF E	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KO VIDER OR SOITELE.	K		45 BEA	CHWAY DR		
LAKEVIE	W MANOR			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN 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 OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	He had a current pl	hysician order for			action(s) will be taken:		
	•	uminophen (a controlled,					
		cation, also known as Norco)					
	_						
		ims) to be given on a schedule			A II : - ! !		
	every 6 hours.				All residents have		
					the potential to be affected. A		
		cation Administration Record			100% audit will		
	(MAR) for his Nor	co was reviewed in tandem			be conducted and if issues		
	with his "Control I	Orug Record" (CDR). The			are found the resident will be		
	following was note	ed from 9/22/21 through			assessed for pain and		
	11/4/21:	<u> </u>			all appropriate parties will be		
					notified.		
	On 0/24/21 the 6:0	00 a.m. dose was neither			nouned.		
	· · · · · · · · · · · · · · · · · · ·						
		stered on the MAR, or					
		OR, which would indicate the					
	medication was no	t administered as Resident C					
	alleged.						
					What Measures will be put into	<b>o</b>	
	On 10/24/21, the 6	:00 a.m. dose was neither			place and what systemic chan	iges	
	initialed as adminis	stered on the MAR, or			will be made to ensure that the	Э	
		OR, which would indicate the			deficient practice does not		
		t administered as Resident C	recur:				
		t administered as resident e			redur.		
	alleged.						
		2:00 p.m. dose was neither					
		stered on the MAR, or			All Licensed staff and QMA's \	will	
	recorded on the CI	OR, which would indicate the			be educated on Five rights of		
	medication was no	t administered as Resident C			medication and appropriate		
	alleged.				documentation for		
					medication administration.		
	On 10/26/21, the 1	2:00 a.m. dose was neither					
	· · · · · · · · · · · · · · · · · · ·	stered on the MAR, or					
		· · ·					
		OR, which would indicate the					
		t administered as Resident C				ļ	
	alleged.						
					How will the corrective action(		
	On 10/30/21, both	the 12:00 a.m., and 6:00 a.m.			will be monitored to ensure the	Э .	
	doses were neither	initialed as administered on			deficient practice will not recur	ſ,	
	the MAR or record	led on the CDR, which would			i.e., what quality assurance		
		ation was not administered as			program will be put into place:		
	I		1		g. a 20 pat into piaco.	Ų.	

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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 00 COMPLETED 155077 B. WING 11/05/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 45 BEACHWAY DR LAKEVIEW MANOR INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ DEFICIENCY) Resident C alleged. September 22-30 a. On 9/22/21 there was one discrepancy: the DON/Designee will audit 12:00 p.m. dose was initialed as administered on all Control Drug Record. (Monthe MAR, but the dose was not recorded on the Fri) for four (4) weeks; then three CDR. times (3x) a week for the b. On 9/23/21, there was one discrepancy: the following four (4) weeks; two-time (2x) a 6:00 .m. dose was not initialed as administered on the MAR, but the dose was counted recorded week for the following four (4) weeks; once a week (1x) for the c. On 9/24/21, there was one discrepancy: the following four (4) weeks; and two 12:00 a.m. dose was not initialed as administered times (2x) per month for the on the MAR, but the dose was recorded on the following eight (8) weeks. The results of these audits will be d. On 9/25/21, there was one discrepancy: the reviewed by the facility Quality 6:00 p.m. dose was initialed as administered on Assurance Performance Improvement (QAPI) committee the MAR, but the dose was not recorded on the CDR. for patterns, trends and continued e. On 9/26/21, there were three discrepancies: recommendations for process the 12:00 a.m. dose was not initialed as monitoring and improvement until administered on the MAR, but the dose was 100% compliance is achieved recorded on the CDR. The 12:00 p.m. dose was not initialed as administered on the MAR, but was recorded on the CDR, and the 6:00 p.m. dose By what date the systemic was initialed as administered on the MAR, but changes by completed: not recorded on the CDR. f. On 9/30/21, there was one discrepancy: the 12:00 p.m. dose was not initialed as administered on the MAR, but was recorded on the CDR. November 12, 2021 October 1-31 a. On 10/3/21 there were two discrepancies: both the 12:00 a.m., and the 12:00 p.m. doses were initialed as administered on the MAR, but not recorded on the CDR. b. On 10/5/21 there was one discrepancy: the 12:00 a.m. dose was initialed as administered on the MAR, but was not recorded on the CDR. c. On 10/9/21 there was one discrepancy: the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/05/2021
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	6:00 p.m. dose was initialed as administered on the MAR, but was not recorded on the CDR. d. On 10/16/21 there were three discrepancies: both the 12:00 a.m., and 12:00 p.m. doses were not initialed as administered on the MAR, but were recorded on the CDR, and the 6:00 p.m. dose was initialed as administered on the MAR, but was not recorded on the CDR. e. On 10/21/21 there were two discrepancies: both the 12:00 a.m., and 6:00 a.m. doses were initialed as administered on the MAR, but were not recorded on the CDR. f. On 10/24/21 there was one discrepancy: the 6:00 p.m. dose was initialed as administered on the MAR, but was not recorded on the CDR. g. On 10/25/21 there were two discrepancies: both the 12:00 a.m., and 6:00 a.m. doses were initialed as administered on the MAR, but were not recorded on the CDR. h. On 10/31/21 there was one discrepancy: the 12:00 p.m. dose was not initialed as administered on the CDR.		p paraid="39899059" paraeid="{37c1eb7a-ad96-4ad1a-ab81de9754f0}{140}" >Res Initials  p paraid="1460450101" paraeid="{37c1eb7a-ad96-4ad1a-ab81de9754f0}{147}" >Nof Narcotic  p paraid="60239861" paraeid="{37c1eb7a-ad96-4ad1a-ab81de9754f0}{154}" >How often is Narcotic to be	0c-9 ame
	November 1-4 On 11/4/21 there was one discrepancy: the 6:00 a.m. dose was initialed as administered on the MAR, but was not recorded on the CDR.  During an interview on 11/5/21 at 9:47 a.m., the above findings were reviewed with the Vice President of Clinical Services (VPCS). In total, 5 of 176 doses were missed, and there were 22 documentation discrepancies out of 176 opportunities, the VPCS indicated she saw the same concern upon review and indicated, controlled substances should be counted accurately, both on the MAR and CDR to avoid the potential for missed doses, and miscounted drugs.		p paraid="1990770212" paraeid="{37c1eb7a-ad96-4ard1a-ab81de9754f0}{169}" >Is narcotic singed off in MAR  (Y/N)  p paraid="1094499190" paraeid="{37c1eb7a-ad96-4ard1a-ab81de9754f0}{178}" >Is narcotic signed off on CDR  (Y/N)	Oc-9

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077  A. BUILDING  00  B. WING			COMPLETED  11/05/2021	
	ROVIDER OR SUPPLIER		45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	copy of current, but titled, "Medication A Guidelines." the pol are administered as with State Regulation principles and pract prepared, administer nursing, medical, pla authorized by state la administer medication initialed by the personedication, in the sp	pace provided under the date that specific medication dose		p paraid="501813616" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{187}" >Wa Narcotic given as ordered  (Y/N)  p paraid="963096347" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{198}" >Wa action needed  (Y/N)  p paraid="1038686255" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{209}" >Is Narcotic count correct  (Y/N)  p paraid="104313530" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{219}" >  p paraid="567299829" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{219}" >  p paraid="567299829" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{222}" >  p paraid="1332856863"	as 0c-9 as

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	OF CORRECTION	IDENTIFICATION NUMBER: 155077	A. BUILDING 00  B. WING		COMPLETED 11/05/2021	
	PROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR IAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{225}" >	Oc-9	
				p paraid="1528247082" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{228}" >	Oc-9	
				p paraid="605203788" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{231}" >	Oc-9	
				p paraid="2072971950" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{234}" >	Эc-9	
				p paraid="966377409" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{237}" >	Ĵc-9	
				p paraid="485992601" paraeid="{37c1eb7a-ad96-4a0d1a-ab81de9754f0}{240}" >	Oc-9	
				p paraid="1753297889" paraeid="{37c1eb7a-ad96-4a0d1a-ab81de9754f0}{244}" >	Oc-9	
				p paraid="1068514443" paraeid="{37c1eb7a-ad96-4a0 d1a-ab81de9754f0}{247}" >	Oc-9	
				p paraid="1729067356"		

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155077	B. WING		11/05/2021		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR				
LAKEVIE	W MANOR		INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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		
				paraeid="{37c1eb7a-ad96-4a d1a-ab81de9754f0}{250}" >	0c-9		
				p paraid="1471129752" paraeid="{37c1eb7a-ad96-4a d1a-ab81de9754f0}{253}" >	0c-9		
				p paraid="149141459" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{1}" >	b-b1		
				p paraid="588233893" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{4}" >	b-b1		
				p paraid="767875357" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{7}" >	b-b1		
				p paraid="139344489" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{10}" >	b-b1		
				p paraid="643569827" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{14}" >	b-b1		
				p paraid="908720246" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{17}" >	b-b1		
				p paraid="53319972"			

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077  A. BUILDING  00  B. WING		COMPLETED 11/05/2021		
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{20}" >	b-b1	
				p paraid="123256446" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{23}" >	b-b1	
				p paraid="1922077960" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{26}" >	b-b1	
				p paraid="800209319" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{29}" >	b-b1	
				p paraid="1666873762" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{32}" >	b-b1	
				p paraid="882577177" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{35}" >	p-b1	
				p paraid="1621387883" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{39}" >	p-b1	
				p paraid="512982787" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{42}" >	p-b1	
				p paraid="461135462"		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2)		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u> COMPLETED			ETED		
		155077	B. W	<u> </u>			2021
NAME OF P	ROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
	WAAANOD				CHWAY DR		
LAKEVIE	W MANOR			INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{45}" >		
					p paraid="222178662"		
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{48}" >		
					p paraid="627071572"		
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{51}" >		
					p paraid="2088111052"		
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{54}" >		
					p paraid="1471124904"		
					paraeid="{dff2b46a-b00e-408	h_h1	
					14-601d72875b2f}{57}" >	U-D I	
					14-0010120130217017		
					p paraid="101528656"		
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{60}" >		
					p paraid="2098318978"		
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{64}" >		
					, , , , , , , , , , , , , , , , , , ,		
					p paraid="791429976"		
					paraeid="{dff2b46a-b00e-408	b-b1	
					14-601d72875b2f}{67}" >		
					p paraid="1344295685"		
			- 1		Ī		

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	OF CORRECTION IDENTIFICATION NUMBER:  155077  A. BUILDING  00  B. WING		COMPLETED 11/05/2021			
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{70}" >	b-b1	
				p paraid="52285100" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{73}" >	o-b1	
				p paraid="697190021" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{76}" >	b-b1	
				p paraid="1379152470" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{79}" >	b-b1	
				p paraid="930868173" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{82}" >	b-b1	
				p paraid="672266792" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{85}" >	p-b1	
				p paraid="953014441" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{89}" >	p-b1	
				p paraid="1274912573" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{92}" >	p-b1	
				p paraid="1540541136"		

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	PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077  A. BUILDING  00  B. WING		COMPLETED 11/05/2021			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{95}" >	b-b1	
				p paraid="1086029243" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{98}" >	o-b1	
				p paraid="1943225740" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{101}" >	b-b1	
				p paraid="186649387" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{104}" >	b-b1	
				p paraid="1733891356" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{107}" >	b-b1	
				p paraid="1602993822" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{110}" >	b-b1	
				p paraid="202957416" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{114}" >	b-b1	
				p paraid="833770853" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{117}" >	b-b1	
				p paraid="562226323"		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	ETED
		155077	B. WIN	NG		11/05/	2021
			<u> </u>	CTD FFT A	ADDRESS OF A STATE TIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP CODE		
	WAANOD				CHWAY DR		
LAKEVIE	W MANOR			INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					paraeid="{dff2b46a-b00e-408l	b-b1	
					14-601d72875b2f}{120}" >		
					p paraid="898084844"		
					paraeid="{dff2b46a-b00e-408l	o-b1	
					14-601d72875b2f}{123}" >		
					p paraid="829736545"	o b1	
					paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{126}" >	J-D I	
					14-0010720730215(120)		
					p paraid="1743471184"		
					paraeid="{dff2b46a-b00e-408l	b-b1	
					14-601d72875b2f}{129}" >		
					p paraid="1197209450"		
					paraeid="{dff2b46a-b00e-408l	o-b1	
					14-601d72875b2f}{132}" >		
					p paraid="774864158"		
					paraeid="{dff2b46a-b00e-408l	b-b1	
					14-601d72875b2f}{135}" >		
					p paraid="92890436"	h h 1	
					paraeid="{dff2b46a-b00e-408l	ו מ-ט	
					14-601d72875b2f}{139}" >		
					p paraid="50242718"		
					paraeid="{dff2b46a-b00e-408l	b-b1	
					14-601d72875b2f}{142}" >		
					p paraid="2113797309"		
					l · ·		

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	OF OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	PROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{145}" >	b-b1
				p paraid="332781945" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{148}" >	b-b1
				p paraid="235189830" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{151}" >	b-b1
				p paraid="1708220816" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{154}" >	b-b1
				p paraid="748202945" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{157}" >	b-b1
				p paraid="2013382605" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{160}" >	b-b1
				p paraid="1548516559" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{164}" >	b-b1
				p paraid="2103240886" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{167}" >	b-b1
				p paraid="1884853328"	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155077  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224  (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224  (X5) PREFIX (EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE  Paraeid="{dff2b46a-b00e-408b-b1} 14-601d72875b2f}{170}" >
NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR   STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR  INDIANAPOLIS, IN 46224  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR  INDIANAPOLIS, IN 46224  (X5)  PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  paraeid="{dff2b46a-b00e-408b-b1}
NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224  (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE  paraeid="{dff2b46a-b00e-408b-b1}
LAKEVIEW MANOR  LAKEVIEW MANOR  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PROVIDERS PLAN OF CORRECTION (CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  paraeid="{dff2b46a-b00e-408b-b1}
LAKEVIEW MANOR  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  paraeid="{dff2b46a-b00e-408b-b1}
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  paraeid="{dff2b46a-b00e-408b-b1}
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG Paraeid="{dff2b46a-b00e-408b-b1}
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  paraeid="{dff2b46a-b00e-408b-b1}
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY)  DATE  paraeid="{dff2b46a-b00e-408b-b1}
14-601d72875b2f}{170}" >
p paraid="289318705"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{173}" >
p paraid="731958389"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{176}" >
p paraid="1389391151"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{179}" >
p paraid="553223490"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{182}" >
14-00 tut 201 0021 ft 102 f
p paraid="528088834"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{185}" >
p paraid="268503711"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{189}" >
p paraid="318843831"
paraeid="{dff2b46a-b00e-408b-b1
14-601d72875b2f}{192}" >
p paraid="787920529"

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00			COMPLETED	
		155077	B. W	ING		11/05	/2021	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIE	IR.						
	W MANOR				CHWAY DR IAPOLIS, IN 46224			
LAKEVIE	W WANCK			INDIAN	IAPOLIS, IN 46224			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					paraeid="{dff2b46a-b00e-408l	b-b1		
					14-601d72875b2f}{195}" >			
					p paraid="1237753129"			
					paraeid="{dff2b46a-b00e-408l	o-b1		
					14-601d72875b2f}{198}" >			
					n noroid="1660050454"			
					p paraid="1669859451" paraeid="{dff2b46a-b00e-408l	n h1		
					paraeid= {di12b46a-b00e-406i   14-601d72875b2f}{201}" >	ו מ-ט		
					14-0010728730213(201)			
					p paraid="1958365100"			
					paraeid="{dff2b46a-b00e-408l	h-h1		
					14-601d72875b2f}{204}" >			
					p paraid="693931620"			
					paraeid="{dff2b46a-b00e-408l	b-b1		
					14-601d72875b2f}{207}" >			
					p paraid="48317791"			
					paraeid="{dff2b46a-b00e-408l	b-b1		
					14-601d72875b2f}{210}" >			
					p paraid="924002340"			
					paraeid="{dff2b46a-b00e-408l	o-b1		
					14-601d72875b2f}{214}" >			
					n noroid="1062200172"			
					p paraid="1962390172"	h_h1		
					paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{217}" >	J-D I		
					17-0010120130213(211)			
					p paraid="1569454615"			
					p paraid= 1000404010			

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED
		155077	B. WING		11/05/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR	
LAKEVIE	W MANOR			IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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 APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
				paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{220}" >	b-b1
				p paraid="1577460247" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{223}" >	b-b1
				p paraid="743878429" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{226}" >	b-b1
				p paraid="344501875" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{229}" >	b-b1
				p paraid="1519987999" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{232}" >	b-b1
				p paraid="1097126581" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{235}" >	b-b1
				p paraid="1265210286" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{239}" >	b-b1
				p paraid="743657320" paraeid="{dff2b46a-b00e-408 14-601d72875b2f}{242}" >	b-b1
				p paraid="320475242"	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	ROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{245}" >	o-b1
				p paraid="1777630940" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{248}" >	p-b1
				p paraid="1672715080" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{251}" >	p-b1
				p paraid="2086207342" paraeid="{dff2b46a-b00e-408l 14-601d72875b2f}{254}" >	p-b1
				p paraid="2102140118" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{2}" >	7-a
				p paraid="1811629040" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{5}" >	7-a
				p paraid="1855126289" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{9}" >	7-a
				p paraid="397848727" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{12}" >	7-a
				p paraid="1453415579"	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	PROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR JAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{15}" >	17-a
				p paraid="124426407" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{18}" >	17-a
				p paraid="527366448" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{21}" >	17-a
				p paraid="2136636148" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{24}" >	17-a
				p paraid="1294720677" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{27}" >	17-a
				p paraid="654922102" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{30}" >	17-a
				p paraid="538043990" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{34}" >	I7-a
				p paraid="1774069073" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{37}" >	17-a
				p paraid="1051359099"	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	ROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{40}" >	7-a
				p paraid="750159992" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{43}" >	7-a
				p paraid="1906193616" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{46}" >	7-a
				p paraid="1566378974" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{49}" >	7-a
				p paraid="1436363437" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{52}" >	7-a
				p paraid="159055699" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{55}" >	7-a
				p paraid="853500068" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{59}" >	7-a
				p paraid="1049315295" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{62}" >	7-a
				p paraid="5315870"	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	PROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{65}" >	7-a
				p paraid="1121368314" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{68}" >	7-a
				p paraid="1115891632" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{71}" >	7-a
				p paraid="1016487202" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{74}" >	7-a
				p paraid="1870644519" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{77}" >	7-a
				p paraid="331048774" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{80}" >	7-a
				p paraid="1703374003" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{84}" >	7-a
				p paraid="392296142" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{87}" >	7-a
				p paraid="608568901"	

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	PROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{90}" >	7-a
				p paraid="762001624" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{93}" >	7-a
				p paraid="91258280" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{96}" >	7-a
				p paraid="1200699539" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{99}" >	7-a
				p paraid="691285793" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{102}" >	7-a
				p paraid="1375781543" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{105}" >	7-a
				p paraid="246378453" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{109}" >	7-a
				p paraid="2070014076" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{112}" >	7-a
				p paraid="1981866085"	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155077	A. BUILDING B. WING	00	COMPLETED 11/05/2021
	ROVIDER OR SUPPLIE	R	45 BEA	ADDRESS, CITY, STATE, ZIP CODE ACHWAY DR IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{115}" >	7-a
				p paraid="1716350096" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{118}" >	7-a
				p paraid="1128973178" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{121}" >	7-a
				p paraid="641335329" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{124}" >	7-a
				p paraid="438550411" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{127}" >	7-a
				p paraid="1752689381" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{130}" >	7-a
				p paraid="1435830610" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{134}" >	7-a
				p paraid="1368616530" paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{137}" >	7-a
				p paraid="536621141"	

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	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUL A. BUIL		NSTRUCTION	(X3) DATE COMPL	
AND PLAN C	OF CORRECTION	155077	B. WING		00	11/05/	
		155077			_	11/05/	2021
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
	M MANOD				CHWAY DR APOLIS, IN 46224		
LAKEVIE	W MANOR			INDIAN	APOLIS, IN 46224		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					paraeid="{ede2fc44-e9e5-434 7bd-eabdaabfb1d1}{140}" >	7-a	
					7 bd-Cabdaabib id i (140)		
					p paraid="685178874"		
					paraeid="{ede2fc44-e9e5-434	7-a	
					7bd-eabdaabfb1d1}{143}" >		
					p paraid="1529273895"		
					paraeid="{ede2fc44-e9e5-434	7 <sub>-</sub> 2	
					7bd-eabdaabfb1d1}{146}" >	7 -u	
					p paraid="2099605806"		
					paraeid="{ede2fc44-e9e5-434	7-a	
					7bd-eabdaabfb1d1}{149}" >		
					p paraid="544467698"		
					paraeid="{ede2fc44-e9e5-434	7-a	
					7bd-eabdaabfb1d1}{152}" >		
					n nanid-114200045701		
					p paraid="436804572" paraeid="{ede2fc44-e9e5-434	7.0	
					7bd-eabdaabfb1d1}{155}" >	1-a	
					rea caedades la lijtrooj		
					Name of Person completing a	udit	
					Traine of Forson completing a	adit	
					Date of Audit		
					<del></del>		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/05/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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		
F 0919 SS=D Bldg. 00	allow residents to through a communical relays the call direct a centralized staff §483.90(g)(2) Toil Based on observation review, the facility call light, and room for a resident who his injury, so that she chassistance as needed reviewed for environ Findings include:  On 11/4/21 at 11:10 her bathroom call light hung through a met into the wall but was call light flip-switch bathroom call light, fallen before and was would cause her to to her bed and push The light bulb above did not illuminate. I supposed to use the	ent Call System e adequately equipped to call for staff assistance nication system which ctly to a staff member or to work area.  et and bathing facilities. on, interview, and record failed to ensure a bathroom call light functioned properly ad a history of falls with ould summon staff for I for 1 of 8 residents nment (Resident G).  a.m., Resident G indicated ght and room call lights did had to go into the hall and come help her. The pull-chord was observed, it al loop-hook that was secured s not attached to the metal a which would activate the Resident G indicated she had as afraid water on the floor fall again. Resident G walked ed the call room call light. e the door was observed and Resident G indicated she was call light when she wanted to d, or needed help to get ready	F 0919	F919 Resident Call System SS=D  What corrective action(s) will I accomplished for those reside found to have been affected be the deficient practice:  The residents call light was immediately fixed  .  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:	ents Dy S		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CC JILDING	ONSTRUCTION 00	(X3) DATE COMPL		
		155077	B. WI		00	11/05/	
		100077				11/03/	72021
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
I AKFVIF	W MANOR		45 BEACHWAY DR INDIANAPOLIS, IN 46224				
	<u> </u>	TATEMENT OF DEFICIENCIES			I		(7/5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		,					
	On 11/4/21 at 11:16	6 a.m., Resident G's					
	roommate indicated	l she often pushed her own			All residents have the		
	call light to request	assistance for Resident G			potential to be affected. 100%	<b>6</b>	
	when she needed he	elp since her call light did not			call light audit will be complete	ed to	
	work. She was not s	sure how long the call light			ensure all call lights are		
	had been broken. R	esident G's roommate			functioning properly.		
		ot use the room bathroom					
	_	ralyzed and used briefs, but					
	the toilet had been l	broken for a long time too.					
	During an interview on 11/4/21 at 2:30 p.m., the						
	_	tor indicated he was a new					
		been at the facility for a little					
		one could file a maintenance			What Measures will be put int	0	
	I -	ace it in his mailbox for			place and what systemic char		
		e he was the only maintenance			will be made to ensure that th	•	
	_	nere were so many requests,			deficient practice does not		
		the work orders. Orders that			recur:		
	would be prioritized	d would be issues that directly					
	impact a resident's l	health and safety, such as call					
	lights that did not w	vork, bed rails that were lose,					
	any plumbing issue	s that left water on the floor.			All staff will be educated on		
					reporting broken call lights		
		p.m., Resident G's bathroom	immediately to Executive Director				
		the Maintenance Director and	along with education on how				
		ADM). The Maintenance		complete a work order form and			
		he bathroom call light			whom to turn them into.		
	l	led to be tied to the right					
		eaded the chord through the					
	_	nd secured the knot. Then he					
		e the room call light, but when					
		ned, the light over the door					
	1	fly, and did not stay					
	illuminated. He ind				Liam will the accordation of the	′-\	
		vith the electrical panel at the			How will the corrective action		
		d was attached, in the panel			will be monitored to ensure th		
		t may be that the bulb needed			deficient practice will not recu	Ι,	
	_	would try to replace the bulb			i.e., what quality assurance		
	first and left to gath	ier nis supplies.			program will be put into place	•	

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NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR  STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR  INDIANAPOLIS, IN 46224	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
During an interview on 11/4/21 at 2:58 p.m., the Maintenance Director returned to Resident G's room with supplies and began to work on her toilet and call light. He indicated maintenance orders for issues like the call light and leaking toilet, were priorities because "you don't want water on the floor of an elderly patient's room, that's a big fall risk."  On 11/5/21 at 10:00 a.m., Resident G's medical rerecord was reviewed. The most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) sassessment dated 7/20/21. The MDS indicated Resident G was cognitively intact, required minimum assistance for her activities of daily living (ADLS) and was always continent of her bowel and bladder. She had active diagnoses which included, but were not limited to, anxiety, depression, unsteadiness on feet, and muscle weakness.  She had a comprehensive care initiated on 3/4/21 and revised 9/8/21. The care plan indicated Resident G was at risk for falls due to weakness, decreased mobility, and Alzheimer's. Interventions for the plan of care included, but were not limited to, provide adequate lighting, resident should wear non-skid footwear, and to keep frequently used items within reach.  A nursing progress note, dated 8/31/21 at 11:10 a.m., indicated, Resident G fell in her room when she tried to get herself into bed. She sustained a skin tear to her left hand and also complained of pain in her lower back.  A corresponding "Accident and Incident Report and Investigation," dated 8/31/21, indicated Resident G fell when she tried to get the tot get into bed.	

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AND PLAN OF CORRECTION IDENTIFE		IDENTIFICATION NUMBER:  155077	A. BUILDING 00  B. WING		COMPLETED  11/05/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	She sustained a skin tear and complained of pain in her back, so she was immediately sent to the emergency room (ER).						
		note, dated 9/8/21 at 8:15 dent G had a fall earlier in the					
	A corresponding Accident and Incident Report and Investigation, dated 9/8/21 at 6:30 a.m., indicated Resident G was heard yelling out for help. She was found on the floor, laying on her side at the foot of her bed. No injuries were noted, bathroom care was provided, and the potential cause indicated, "tries to [be] independent."			F842 Resident Record  p paraid="39899059" paraeid="{c7c0db01-76bc-4ff224-29dc85b7b718}{108}" >Da of work order			
	On 11/5/21 at 12:40 p.m., the VPCS provided a copy of current facility policy titled, "Call Light," dated 10/2014 which indicated, "Residents will have a call light to summon facility personnel to ensure the resident's needs will be met.  Equipment: functioning call light if call light is defective, report to maintenance call lights			p paraid="521998999" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{113}" >Wa original given to Maintenance and cop	as		
	resident"	nal and within reach of each		ED (Y/N)			
	copy of current facil Rights," dated 11/20 facility shall treat ea dignity and care for in an environment the enhancement of his This Federal tag relations 1800365995.	p.m., the VPCS provided a lity policy titled, "Resident 1016 which indicated, "This ach resident with respect and each resident in a manner an nat promotes maintenance or or her quality of life"		p paraid="1017583369" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{130}" >Wa work order for broken call ligh issues	as		
	3.1-19(u)(1) 3.1-19(u)(2)			(Y/N)			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077			A. BUILDING 00 COMPLETED  B. WING 11/05/2021				
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				p paraid="392668376" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{143}" > If for call light was ED notified immediately			
				p paraid="1511311970" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{154}" >Wh was done to protect resident u call light resolved or N/A	at		
				p paraid="445886255" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{159}" >Has call light been fixed?			
				(Y/N)			
				p paraid="1178207144" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{170}" >Any negative outcome from broker light	y		
				(Y/N)			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155077		A. BUILDING  B. WING	00	COMPLETED  11/05/2021			
	ROVIDER OR SUPPLIER W MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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			
				p paraid="1306288081" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{179}" >Wa work order completed timely a signed by ED	as			
				(Y/N)				
				p paraid="104313530" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{189}" >	2-ac			
				p paraid="567299829" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{192}" >	2-ac			
				p paraid="1332856863" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{195}" >	2-ac			
				p paraid="1528247082" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{198}" >	2-ac			
				p paraid="605203788" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{201}" >	2-ac			
				p paraid="2072971950" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{204}" >	2-ac			

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	OF CORRECTION	IDENTIFICATION NUMBER:  155077	A. BUILDING B. WING	00	COMPLETED  11/05/2021		
	ROVIDER OR SUPPLIE W MANOR	R	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				p paraid="966377409" paraeid="{c7c0db01-76bc-4ff; 24-29dc85b7b718}{207}" >	2-ac		
				p paraid="485992601" paraeid="{c7c0db01-76bc-4ff; 24-29dc85b7b718}{210}" >	2-ac		
				p paraid="1753297889" paraeid="{c7c0db01-76bc-4ff; 24-29dc85b7b718}{214}" >	2-ac		
				p paraid="1068514443" paraeid="{c7c0db01-76bc-4ff/ 24-29dc85b7b718}{217}" >	2-ac		
				p paraid="1729067356" paraeid="{c7c0db01-76bc-4ff/ 24-29dc85b7b718}{220}" >	2-ac		
				p paraid="1471129752" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{223}" >	2-ac		
				p paraid="149141459" paraeid="{c7c0db01-76bc-4ff2 24-29dc85b7b718}{226}" >	2-ac		
				p paraid="588233893" paraeid="{c7c0db01-76bc-4ff; 24-29dc85b7b718}{229}" >	2-ac		

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STATEMENT OF DEFICIENCIES X1) PROVIDI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		TRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		155077	B. WING				2021
				PEET ADD	PRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			IWAY DR		
	LAKEVIEWAANOD				OLIS, IN 46224		
LAKEVIEW MANOR			IINL	JIANAP	OLIS, IN 46224		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAC		DEFICIENCY)		DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	p pa 24 p pa 24 p pa 24 p p p p pa 24 p p p p p p p p p p p p p p p p p p	paraid="767875357" araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{232}" >  paraid="139344489" araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{235}" >  paraid="643569827" araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{239}" >  paraid="908720246" araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{242}" >  paraid="53319972" araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{242}" >  paraid="123256446" araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}-	-ac -ac -ac	DATE
				p pa 24 p	4-29dc85b7b718}{248}" >  paraid="1922077960"  araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{251}" >  paraid="800209319"  araeid="{c7c0db01-76bc-4ff2 4-29dc85b7b718}{254}" >		

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155077		A. BUILDING B. WING	00	COMPLETED  11/05/2021			
	ROVIDER OR SUPPLIE W MANOR	R	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				p paraid="1666873762" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{2}" >	d-aa		
				p paraid="882577177" paraeid="{e9878e3f-bf7f-4150 05-277d5ad15396}{5}" >	d-aa		
				p paraid="268503711" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{9}" >	d-aa		
				p paraid="318843831" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{12}" >	d-aa		
				p paraid="787920529" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{15}" >	d-aa		
				p paraid="1237753129" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{18}" >	d-aa		
				p paraid="1669859451" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{21}" >	d-aa		
				p paraid="1958365100" paraeid="{e9878e3f-bf7f-4156 05-277d5ad15396}{24}" >	d-aa		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					ONSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPL	COMPLETED	
		155077	B. WING 11/05/2021					
NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR				45 BEA	ADDRESS, CITY, STATE, ZIP CODE CHWAY DR IAPOLIS, IN 46224	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	BROWNERS N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		IIE.	DATE	
					p paraid="693931620" paraeid="{e9878e3f-bf7f-415c05-277d5ad15396}{27}" >  p paraid="48317791" paraeid="{e9878e3f-bf7f-415c05-277d5ad15396}{30}" >			
					Name of Person completing a  ———————————————————————————————————	udit		

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