

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 09/24/2012
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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(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	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 09/24/12</p> <p>Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Lakeview Manor was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered except for the kitchen freezer located near the back exit of the kitchen. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms 11 through 19 in the C Hall. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 123 at the time of this survey.</p>	K0000	<p>We are requesting that you give us paper compliance. 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.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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	<p>The facility was found not in compliance with state law in regard to sprinkler coverage. The facility was found in compliance with the state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except the kitchen freezer located near the back exit of the kitchen, two detached buildings providing storage and one detached building housing an emergency generator which were each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 walk in freezers in the kitchen were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect any staff or visitor in the vicinity of the kitchen freezer near the back exit door of the kitchen.</p>	K9999	<p>1. The freezer in the kitchen now has a sprinkler installed. Dalmatian Fire Inc installed the sprinkler on 9/25/12 (See attachment A).2. The Maintenance Supervisor inspected all areas of facility to ensure sprinklers were installed appropriately. No other concerns were noted.3. As a measure to ensure ongoing compliance the sprinkler heads are inspected monthly on the preventative maintance sheet. (See attachment B). 4. As a measure of quality assurance the maintance supervisor or designee will review any findings in the facilitys quarterly quality assurance meeting. Any discrepancies will be corrected immediately.</p>	09/25/2012			

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	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:20 p.m. on 09/24/12, the kitchen freezer near the back exit door of the kitchen was not provided with automatic sprinkler coverage. Based on interview at the time of observation, the Maintenance Director acknowledged the kitchen freezer near the back exit door of the kitchen was not provided with automatic sprinkler coverage.</p> <p>3.1-19(ff)</p>			