STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/29/21 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Emergency Preparedness survey, Lakeview Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 184 certified beds. At the time of the survey, the census was 89. Quality Review completed on 08/04/21 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2),			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
	§484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
	preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated	E 0006	E006 Executive Director educated on E006 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon return at a date to be determined EPP updated to reflect HVA by 8/27/21 by COO	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
	"Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Program" documentation with the Administrator and the Director of Environmental Services during record review from 9:15 a.m. to 12:45 p.m. on 07/29/21, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Hazard Vulnerability Analysis (HVA)" and the current "Hazard Vulnerability Analysis (HVA) Summary" for the facility. Based on interview at the time of record review, the Director of Environmental Services agreed emergency preparedness program documentation did not address emerging infectious diseases as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Director of Environmental Services during the exit conference.		Executive Director/designee to monitor EPP 2x/month for 4 months and periodically thereafter to ensure compliance	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
	§485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
	of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID). The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Program" documentation with the Administrator and the Director of Environmental Services during record review from 9:15 a.m. to 12:45	E 0013	Executive Director educated on E013 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon return at a date to be determined EPP updated by COO on 8/27/21 to reflect updated EID review on annual basis.	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	07/29/2021

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
	p.m. on 07/29/21, emergency preparedness policies and procedures for emerging infectious diseases (EID) was not available for review. EID was not included in the current "Hazard Vulnerability Analysis (HVA)" and the current "Hazard Vulnerability Analysis (HVA) Summary" for the facility. Based on interview at the time of record review, the Director of Environmental Services agreed emergency preparedness program policies and procedures did not include EID as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Director of Environmental Services during the exit conference.		Executive Director will audit 2x/ for 4 months and periodically thereafter to ensure compliance	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/29/21 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Life Safety Code survey, Lakeview Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	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 Wing. 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 89 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 08/04/21			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 12 sets of smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the smoke barrier door set by Room A14.	K 0100	Executive Director educated on K100 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon return at a date to be determined	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the latching mechanisms for the corridor door set by Room A14 failed to protrude into the latching plate on the door frame when tested to close multiple times. Each door in the door set was equipped with a 3-hour fire resistance rating label affixed to the hinge side of each door. Based on interview at the time of the observations, the Director of Environmental Services agreed the aforementioned smoke barrier door set's latching hardware failed to latch into the door frame when tested to close multiple times. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)		door to be repaired by 8/27/21 ED/Designee to randomly audit 5 doors/week for 4 weeks then periodically thereafter to ensure compliance	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 7 of 7 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of	K 0211	Executive Director educated on K211 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon	08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	fire or other emergency. This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, a plastic three drawer chest of drawers for the storage of isolation supplies was stored in the corridor up against the corridor wall outside Rooms A20, A21, A22, A23, B4, B10, B14, B17, B20, B25, C15, D9, D21 and D24. Each chest of drawers projected 18 inches into the eight foot wide corridor. A wooden three drawer chest of drawers was stored in the corridor outside Room B1 and projected fifteen inches into the eight foot wide corridor. Four wooden chairs were stored in the corridor up against the corridor wall next to one another outside Room A18. Based on interview at the time of the observations, the Director of Environmental Services stated the isolation supply storage in the corridor was necessary for staff to don isolation supplies prior to entering a resident room but agreed the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)		return at a date to be determined All items referenced in K211 were removed by the ED on 7/30/21 ED/designee to audit all hallways in the facility 3x/week for 4 weeks then periodically thereafter to ensure compliance	
K 0232 SS=E	NFPA 101 Aisle, Corridor, or Ramp Width			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
Bldg. 01	Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space.	K 0232	Executive Director educated on K232 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon return at a date to be determined The 4 wooden chairs removed by ED on 7/30/21. Wooden3 chest of drawers removed by ED on 7/30/21 ED/designee to audit all facility hallways 3x/week for 4 weeks then periodically thereafter to ensure compliance	08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	(h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, four wooden chairs were stored in the corridor up against the corridor wall next to one another outside Room A18 and were not affixed to the floor or to the wall. In addition, a wooden three drawer chest of drawers was stored in the corridor outside Room B1 and projected fifteen inches into the eight foot wide corridor and was also not affixed to the floor or to the wall. Based on interview at the time of the observations, the Director of Environmental Services agreed furniture was stored in the path of egress at the aforementioned locations and was not affixed to the floor or to the wall. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 doors to the outside of the facility in the Fish Pond Lounge were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Fish Pond Lounge by A & B Wings. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the door to the courtyard to the outside of the facility in the the Fish Pond Lounge by the A & B Wings was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the Director of Environmental Services stated the door is not a facility exit and should be equipped with a NO EXIT sign. This finding was reviewed with the the Director of Environmental Services during the exit conference. 3.1-19(b)	K 0293	Executive Director educated on K293 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon return at a date to be determined No exit sign referenced in K293 posted by ED on 7/30/21 ED/designee to audit door 3x/week for 4 weeks then periodically thereafter to ensure compliance	08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 3 of over 11 hazardous areas such as soiled linen and trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions	K 0321	Executive Director educated on K321 by COO on 8/16/2021 Maintenance Director is out on	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, an 18 inch by 24 inch hole was noted in the wall above the sink in the Soiled Utility Room in the B Wing. A separate 12 inch by 18 inch hole was also noted in the wall by the corridor door to the room. A two inch in diameter hole was noted above the wall guard in the C Wing/D Wing short hall "Soiled Linen" room. The corridor door to the C Wing/D Wing short hall "Soiled Linen" room by the D Wing nurse's station was equipped with a self closing device but the latching mechanism on the door would not latch into the door frame when tested to close multiple times. Three soiled linen and trash carts were stored in the room. Based on interview at the time of the observations, the Director of Environmental Services agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 11 hazardous areas such as combustible storage rooms (over 50 square feet in size) were separated from other		leave and will be educated upon return at a date to be determined 18”x24” hole in soiled to be repaired by 8/27/21 12”x18” hole referenced in K321 citation to be repaired by 8/27/21 on C/D corridor will be repaired by 8/27/21 Items in A wing lounge removed by ED on 7/30/21 ED/designee to audit all referenced areas 3x/week for 4 weeks then periodically thereafter to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the A Wing . Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the A Wing lounge near the west exit door to the outside of the facility was being used to store combustible boxes, clear plastic trash bags with excess clothing and excess furniture including two decorative wooden fireplaces. The A Wing lounge is open to the corridor and was not separated from other spaces by smoke resistant partitions and doors. Based on interview at the time of the observations, the Director of Environmental Services stated the lounge was being used as a temporary storage area for two residents who were recently processed by the Admissions Office for the facility this week, the facility has yet to go through the items to see which items can be discarded or kept and agreed the A Wing lounge was being used for storage of combustible storage and was not protected as a hazardous area. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 1 of over 200 sprinkler heads in the facility was installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. Section 6.2.7.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room A10. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on	K 0351	Executive Director educated on K911 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined The escutcheon in the sprinkler in room A10 bathroom will be repaired and will be in compliance by 08/27/2021 ED/Designee to randomly audit 3x/week for 4 weeks and periodically thereafter to ensure compliance	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	07/29/21, one of one ceiling mounted sprinklers in the bathroom for Room A10 was missing its escutcheon. Based on interview at the time of the observations, the Director of Environmental Services agreed the aforementioned sprinkler location was missing its escutcheon. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to ensure 1 of 2 private fire hydrants was continuously maintained in reliable operating condition. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection	K 0353	Executive Director educated on K353 by COO on 8/16/2021 Maintenance Director is out on leave and will be educated upon	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. Table 7.2.2.4 states the corrective action for dry barrel hydrants with improper drainage from the barrel is to repair the drain. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Discrepancy Report" section of "Executive Summary" documentation dated 06/12/20 and 06/22/21 with the Administrator and the Director of Environmental Services during record review from 9:15 a.m. to 12:45 p.m. on 07/29/21, one of two facility fire hydrants did not drain after annual testing. The fire hydrant identified as "west side in island outside" is a dry barrel hydrant and was listed as "did not drain" on the aforementioned two most recent annual testing reports. Based on interview at the time of record review, the Director of Environmental Services contacted the Maintenance Director who was on sick leave for the day. The Maintenance Director stated the drainage problem has been a problem for awhile and did not believe it had to be corrected. Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the facility had two private fire hydrants located on the west side of the facility. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)		return at a date to be determined Fire Hydrant to be repaired and in compliance by 8/27/21 ED/designee to audit monthly for 4 months then periodically thereafter to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure corridor doors to 1 of over 50 resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room A15. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the face of the corridor door to Room A15 hit the door frame near the top of the door and prevented the door from closing and latching into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Director of Environmental Services agreed the corridor door to Room A15 had an impediment to closing and latching into the door frame. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)	K 0363	Executive Director educated on K363 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined Door in room A15 to be repaired by 8/27/21 ED/designee to randomly audit 3 resident room doors/week for 4 weeks then periodically thereafter to ensure compliance	08/27/2021
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the following openings were noted in the ceiling smoke barrier: a. a one inch wide by three foot long hole was noted near the back wall of the A Wing Housekeeping Closet where the back wall meets the ceiling.	K 0372	Maintenance Director is out on leave and will be educated upon return at a date to be determined 1"x3' long hole by housekeeping closet will be repaired and in compliance by 8/27/21 Rooms A18 and B17 sprinkler escutcheons to be replaced by 8/27/21 Sprinkler escutcheon in kitchen paper goods will be fixed and in compliance by 8/27/21 Crack above fire panel by C wing will be repaired and in compliance by 8/27/21 ED/designee to audit all referenced areas 3x/week for 4	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	b. the annular space surrounding the sprinkler escutcheon in the corridor outside Room A15, Room A18 and B17 were not firestopped. In addition, the annular space surrounding the sprinkler escutcheon in the kitchen paper goods supply room was also not firestopped. c. a large 'H' shaped crack was noted on the ceiling of the "Electrical Panel Location" room by the C Wing nurse's station which would not resist the passage of smoke. Based on interview at the time of the observations, the Director of Environmental Services agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)		weeks then periodically thereafter to ensure compliance	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the smoke barrier door set by Room B1. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, each door in the smoke barrier door set by Room B1 swings in the same direction. One of the doors is equipped with an astragal and a door closing coordinator was affixed to the door frame above the door set near the center of the door frame. The coordinator failed to operate correctly and propped the door with the astragal open leaving a large gap in between the meeting edges of the door set. Each door in the door set was held in the fully open position with magnetic holding devices set to release each door to close with fire alarm system activation. Each door in the door set was equipped with a 3-hour fire resistance rating label affixed to the hinge side of each door. Based on interview at the time of the observations, the Director of Environmental Services agreed the smoke barrier door set failed to fully self close to restrict the passage of smoke due to the closing coordinator not functioning correctly.	K 0374	Executive Director educated on K374 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined Fire door on B unit to be repaired by 8/27/21 ED/designee to randomly audit 3 fire doors weekly for 4 weeks then periodically thereafter to ensure compliance	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	This finding was reviewed with the Administrator and the Director of Environmental Services during the exit conference. 3.1-19(b)			
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in the emergency generator shed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the electrical junction box mounted on the support framing for the facility's emergency	K 0511	Executive Director educated on K511 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined Generator E-Box cover to be replaced by 8/27/21 ED/designee to audit new E-Box cover 3x/week for 4 weeks then periodically thereafter to ensure compliance Exposed wire in soiled utility	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	generator in the generator shed was without a cover which exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Director of Environmental Services agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 outlet boxes in the soiled linen room near the D Wing nurse's station was protected. NFPA 70, National Electric Code, 2011 Edition, Article 406.6 Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the D Wing nurse's station. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the wall mounted light switch in the soiled utility room by the D Wing nurse's station was missing its faceplate which exposed the electrical wiring for the switch. Based on interview at the time of the observations, the Director of Environmental Services agreed the faceplate for the aforementioned light switch		room on B unit will be covered and in compliance by 8/27/21 ED/Designee to monitor all referenced areas 3x/week for 4 weeks then periodically thereafter to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	was missing. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure electrical wiring in the B Wing was maintained in safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 300.15 states a box or conduit body shall be installed at each junction point unless otherwise permitted by 300.15(A) through (I). Article 314.28 states boxes and conduit bodies used as pull or junction boxes shall comply with 314.28 (A) through (E). This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the soiled utility room near the B Wing nurse's station. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, exposed electrical wiring was noted in an open ended conduit which penetrated the wall of the soiled utility room near the floor by the B Wing nurse's station. Based on interview at the time of the observations, the Director of Environmental Services agreed the exposed electrical wiring was not contained within a junction box or conduit body. This finding was reviewed with the Executive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to maintain fire-rated door hardware on 1 of 13 fire barrier doors. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives,except as otherwise specified in this Code. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the fire doors by Room D8. Findings include: Based on review of the "Inspection Points" summary section of "NFPA 80 Inspection Points Job Aid" documentation dated 02/12/21 with the Administrator and the Director of Environmental Services during record review from 9:15 a.m. to 12:45 p.m. on 07/29/21, the fire door set identified as #1 had a missing door frame label. The aforementioned documentation stated "#1 door frame missing lable" in response to "Steel Listed and Labeled Products: Is every component labeled?" Based on interview at the time of record review, the Director of Environmental Services stated the facility has 13 fire doors in the facility as identified on "Lakeview Manor	K 0761	Executive Director educated on K761 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined South door by room D8 will be verified for fire resistance and label placed verifying by 8/27/21 ED/Designee to randoml y audit 3 fire doors/week to verify fire resistant stickers in place. These audits will be done for 4 weeks and periodically thereafter to ensure compliance	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Fire Doors" location floor plans and the facility performs its own annual fire door inspections. Fire door deficiencies found during an annual inspection are noted on "NFPA 80 Inspection Points Job Aid" documentation. The Director of Environmental Services stated he was not sure if deficiencies noted for fire door location #1 had been corrected on or after 02/12/21. Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, the south door in the set of fire doors in the corridor identified as #2 on the door frame by Room D8 was not equipped with a fire resistance rating label. The north door in the door set had a 3-hour fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the Director of Environmental Services stated the fire door label deficiency is for the fire door set identified as #2 not location #1 and agreed the south door in the corridor door set by Room D8 was missing its fire resistance rating label. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 employee break rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the employee break room. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, a refrigerator was stored within one foot of the wall mounted electrical panel in the employee break room near the C Wing. Based on interview at the time of the observations, the Director of Environmental Services agreed a refrigerator was stored within the working space in front of the electrical panel at the aforementioned location. This finding was reviewed with the Director of Environmental Services during the exit conference.	K 0911	Executive Director educated on K911 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined Refrigerator referenced in 2567 was moved by ED on 7/30/21 ED/Designee to randomly audit 3x/week for 4 weeks and periodically thereafter to ensure compliance	07/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was kept in reliable operating mode in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 8.3.1 states the Emergency Power Supply Systems (EPSS) shall be maintained to ensure that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. This deficiency could affect all residents, staff and visitors. Findings include: Based on review of the emergency generator inspection contractor's "Inspection Report" documentation dated 10/06/20 with the Administrator and the Director of Environmental Services during record review from 9:15 a.m. to 12:45 p.m. on 07/29/21, the emergency generator for the facility required maintenance. The "Service Notes" section of the 10/06/20 report stated "air filters need replaced" and "engine alternator belts are old and cracked recommend replacement". Based on interview at the time of record review, the Director of Environmental Services contacted the Maintenance Director who was on sick leave for the day. The Maintenance Director stated the facility was planning on making the recommended repairs during the emergency generator inspection contractor's annual visit in October 2021 and agreed the recommended repairs had not been performed on or after 10/06/20. This finding was reviewed with the Director of Environmental Services during the exit	K 0918	Executive Director educated on K918 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined Generator service and areas referenced in K918 will be corrected and in compliance by 8/27/21 ED/designee to monitor for compliance 3x/week for 4 weeks then periodically thereafter to ensure compliance	08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 non-fused multiplug adapters and 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with	K 0920	Executive Director educated on K920 by COO on 8/16/21 Maintenance Director is out on leave and will be educated upon return at a date to be determined Power strips in B24 and C18 removed by ED on	08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, a cell phone charging cable was plugged into a power strip on a table one foot from the head of the resident bed nearest the corridor door in Room B24. The UL listing of the power strip could not be determined. In addition, a television was plugged into an adaptor which was plugged into an electrical receptacle in a wall mounted outlet box in Room C18. The adaptor was also designed as a port for two cell phone charging cables. Based on interview at the time of the observations, the Director of Environmental Services agreed a multiplug adaptor and a power strip were being used as a substitute for fixed wiring in the aforementioned locations. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)		7/30/21 ED/designee to randomly audit 5 resident rooms per week for 4 weeks and periodically thereafter to ensure compliance	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of	K 0923	Executive Director educated on K923 by COO on 8/16/21	08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	07/29/2021

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
	nonflammable gases in the Med Room at the D Wing nurse's station were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the D Wing nurse's station. Findings include: Based on observations with the Director of Environmental Services during a tour of the facility from 12:45 p.m. to 3:40 p.m. on 07/29/21, one of two 'E' type oxygen cylinders was standing upright on a cart near the floor in the Med Room at the D Wing nurse's station and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Director of Environmental Services agreed one of the two 'E' type oxygen cylinders in the D Wing Med Room was standing upright on a cart near the floor and was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Director of Environmental Services during the exit conference. 3.1-19(b)		Maintenance Director is out on leave and will be educated upon return at a date to be determined Both “E-Type” empty cylinders on D wing were properly secured by ED on 7/30/21 ED/Designee to audit all med rooms 3x/week for 4 weeks then periodically thereafter to ensure compliance	