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	09/20/2021

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

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 07/29/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/20/21 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this PSR survey to the Emergency Preparedness survey, Lakeview Manor was found 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 85. Quality Review completed on 09/22/21	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/29/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/20/21 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 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 85 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 09/22/21			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 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			

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	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 Executive Director during a tour of the facility from 12:10 p.m. to 12:50 p.m. on 09/20/21, one of one ceiling mounted sprinklers in the bathroom for Room A10 was now equipped with its escutcheon but the escutcheon did not completely cover the hole in the ceiling for the sprinkler. The annular space in the ceiling surrounding the escutcheon was filled with foam. Based on interview at the time of the observations, the Executive Director stated he	K 0351	K351(E) The annular space around the sprinkler head has been completely covered and the was done on the 21st of September 2021 The administrator or his designee will be inspecting and monitoring the sprinkler heads weekly for the	09/21/2021

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	was not aware of the fire resistance rating of the foam and agreed the aforementioned escutcheon for the sprinkler location did not completely cover the opening in the ceiling for the sprinkler. This finding was reviewed with the Executive Director during the exit conference. "This deficiency was cited on 07/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence." 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,	K 0353	The fire Hydrant will be maintained, and any deficiency corrected as timely, and the test and maintenance records will be available for review	10/09/2021

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	and Maintenance of Water-Based Fire Protection 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. Based on review of the sprinkler system inspection contractor's "Deficiency Proposal" documentation dated 08/16/21 with the Executive Director during record review from 12:50 p.m. to 1:30 on 09/20/21, the contractor		Ongoing, the Administrator or designee will monitor the sprinkler system inspection, test and maintenance documents to ensure continued compliance. This will be done weekly for the for the first six weeks and monthly thereafter for six months.	

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	submitted a proposal to "repair fire hydrant that failed inspection did not drain". Based on interview at the time of record review, the Executive Director stated the facility approved the proposal but the repair had not yet been performed due to scheduling issues for the contractor and agreed fire hydrant repair or replace documentation on or after 08/16/21 was not available for review at the time of the survey. This finding was reviewed with the Executive Director during the exit conference. "This deficiency was cited on 07/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence." 3.1-19(b)			
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. 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	K 0372	The hold on the wall in the A wing house keeping closet has been covered with approved fire-resistant sealant. The area	09/21/2021

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	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 Executive Director during a tour of the facility from 12:10 p.m. to 12:50 p.m. on 09/20/21, 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. b. the annular space surrounding the sprinkler escutcheon in the corridor outside Room A15 was 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 Executive Director agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier.		was sealed on the 21st of September 2021 The administrator or his designee will be inspecting and monitoring the open areas in the facility weekly for the first six weeks and monthly thereafter for six months.	

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	This finding was reviewed with the Executive Director during the exit conference. "This deficiency was cited on 07/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence." 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on 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 observations with the Executive Director during a tour of the facility from 12:10 p.m. to 12:50 p.m. on 09/20/21, 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 Executive Director agreed	K 0761	The fire door assembly will be marked and with the appropriate hardware or for resistant rating label This will be incompliance on the 10/11/2021 The administrator or his designee will be inspecting and monitoring the doors in the facility weekly for the first six weeks and monthly thereafter for six months.	10/11/2021

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	the south door in the corridor door set by Room D8 was missing its fire resistance rating label. This finding was reviewed with the Executive Director during the exit conference. "This deficiency was cited on 07/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence." 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			

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	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, 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	K 0918	The emergency generator will be maintained to ensure reasonable degree that generator is capable of supplying emergency power within the time specified. The administrator or his designee will be inspecting and monitoring the doors in the facility weekly for the first six weeks and monthly thereafter for six months.	10/14/2021

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	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. Based on record review with the Executive Director from 12:50 p.m. to 1:30 on 09/20/21, emergency generator air filter and alternator belt replacement documentation on or after 10/06/20 was not available for review. Based on interview at the time of record review, the Executive Director stated the emergency generator repair wasn't scheduled and agreed emergency generator air filter and alternator belt replacement documentation on or after 10/06/20 was not available for review at the time of the survey. This finding was reviewed with the Executive Director during the exit conference. "This deficiency was cited on 07/29/21. The facility failed to implement a systemic plan of correction to prevent recurrence." 3.1-19(b)			