

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2015
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/13/15</p> <p>Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Lakeview Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in rooms 11 through 19 in the C Hall. The facility has battery operated smoke</p>	K010000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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

TITLE

(X6) DATE

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

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K010029 SS=E	<p>detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 109 at the time of this survey.</p> <p>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.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 19 hazardous areas such as combustible storage rooms</p>	K010029	Door closure was installed on Central Supply door on B wing short hall. Residents and Staff in area have a potential to be	01/15/2015			

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K010046 SS=C	<p>greater than 50 square feet in size were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 12 residents, staff and visitors in the B Wing Short Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:30 p.m. on 01/13/15, the B Wing Short Hall Central Supply storage room measured 240 square feet and was used to store combustible boxes and supplies. The corridor door was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned hazardous area was not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 1 battery</p>	K010046	<p>affected. All hazardous areas in facility greater that 50 square were checked for self closing or close automatically upon activation of fire alarm system.As a measure of ongoing compliance the Maintenance Director will complete an monthly audit to insure all storage rooms over 50 square feet have self closing hardware or automatically closing hardware upon activation of fire alarm system. (see attachment A). As a measure of quality assurance the Maintenance Director or designee will review any findings and subsequent corrective action in the facility's Quarterly Quality Assurance Meetings</p> <p>Replaced battery operated light located inside the detached shed at the emergency generator</p>	01/15/2015

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	<p>powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:30 p.m. on 01/13/15, the battery operated emergency light located inside the detached shed at the emergency generator location failed to illuminate when its respective test button was pressed five times. In addition, the Maintenance Director manually tripped the circuit breaker for the aforementioned emergency light in order to initiate activation of the light which failed to illuminate when the breaker was manually tripped three separate times. Based on interview at the time of observation, the Maintenance Director stated a water leak above the light may have caused the light to</p>		<p>location with Allpro Apel 2-Head Emergency Light. Crack in building that let water in has been filled. All Residents , Staff and Visitors have the potential to be affected. As a measure of ongoing compliance the Maintenance Director will complete an audit weekly in accordance with weekly generator load test to ensure all emergency lighting that has rechargeable battery backup are charged properly and in working condition (see attachment B). As a measure of quality assurance the Maintenance Director or Designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting.</p>	

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K010052 SS=E	<p>malfunction and acknowledged the aforementioned battery operated emergency light failed to illuminate.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, observation and interview; the facility failed to document annual functional testing of 2 of 37 fire alarm system smoke detectors. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual functional test of smoke detector initiating devices. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect ten residents, staff and visitors in the vicinity of the Reception area atrium.</p> <p>Findings include:</p> <p>Based on review of General Alarm "Test Report for Fire Devices and Life Safety" documentation dated 10/10/14 during</p>	K010052	<p>Facility had General Alarm Company come out to test the two "high ceiling" smoke detectors and it was then recorded on the facility's test report for fire devices and life safety documentation sheet. Residents, staff and visitors in the area could have been affected. As a measure of ongoing compliance the Maintenance Director will make sure the annual test report of all smoke detectors in the building are checked annually and recorded. The Administrator will review and sign the annual test report annually, (see attachment C). As a measure of quality assurance the Maintenance Director or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting.</p>	01/15/2015

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K010062 SS=C	<p>record review with the Maintenance Director from 9:40 a.m. to 11:30 a.m. on 01/13/15, documentation of annual functional testing for the two smoke detectors identified as "High Ceiling" within the most recent twelve month period was not available for review. The 10/10/14 inspection report stated a total of 37 fire alarm system smoke detectors were located in the facility but annual functional testing results for the two "High Ceiling" smoke detectors was not stated. Based on interview at the time of record review, the Maintenance Director stated no additional fire alarm system functional testing inspection reports for the most recent twelve month period was available for review and acknowledged documentation of annual functional testing for each of two "High Ceiling" fire alarm system smoke detectors within the last twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:30 p.m. on 01/13/15, two smoke detectors were observed installed higher than fifteen feet on the wall of the atrium in the Reception area.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are</p>			

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	<p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:30 p.m. on 01/13/15, no sidewall spare sprinklers were located in the spare sprinkler cabinet at the sprinkler riser in the</p>	K010062	<p>Sidewall sprinklers and storage box were ordered from Datamation Fire Inc. 1-15-15 , delivery date is expected 1-29-15, sidewall sprinklers and box will be installed immediately upon delivery on premises. All residents , staff and visitors have the potential of being affected. As a measure of ongoing compliance the Maintenance Director will complete an audit monthly along side Fire Extinguisher checks. Sprinkler boxes will have a tag that will be dated upon inspection (see attachment E). As a measure of quality assurance the Maintenance Director or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting.</p>	01/15/2015

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K010144 SS=C	<p>Laundry. Sidewall sprinklers were observed installed in the freezer in the kitchen. Based on interview at the time of observation, the Maintenance Director acknowledged sidewall sprinklers were installed in the facility and no spare sidewall sprinklers were located in the spare sprinkler cabinet or on the premises.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around the generator set in accordance with NFPA 101, 2000 Edition, Life Safety Code. Section 19.2.9.1 states emergency lighting shall be provided in accordance with Section 7.9. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered</p>	K010144	Replaced battery operated light located inside the detached shed at the emergency generator location with Allpro Apel 2-Head Emergency Light. Crack in building that let water in has been filled. All Residents , Staff and Visitors have the potential to be affected. As a measure of ongoing compliance the Maintenance Director will complete an audit weekly in accordance with weekly generator load test to ensure all emergency lighting that has rechargeable battery backup are charged properly and in working condition (see attachment B). As a measure of quality assurance the Maintenance Director or Designee will review any findings and subsequent corrective action	01/15/2015

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K010147 SS=E	<p>emergency lighting. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:30 p.m. on 01/13/15, the battery operated emergency light located inside the detached shed at the emergency generator location failed to illuminate when its respective test button was pressed five times. In addition, the Maintenance Director manually tripped the circuit breaker for the aforementioned emergency light in order to initiate activation of the light which failed to illuminate when the breaker was manually tripped three separate times. Based on interview at the time of observation, the Maintenance Director stated a water leak above the light may have caused the light to malfunction and acknowledged the aforementioned battery operated emergency light failed to illuminate.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>		in the facility's quarterly quality assurance meeting.	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, 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 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 2:30 p.m. on 01/13/15, a refrigerator and a microwave oven were plugged into a power strip in the Social Services Office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p>	K010147	<p>Power strip was removed from social service front office immediately upon notification of finding . All staff was immediately in-serviced on electrical equipment pertaining to finding. All residents and staff and visitors have the potential to be affected. As a measure of ongoing compliance the Maintenance Director will preform monthly audits to all rooms in facility to assure compliance. (see attachment D) As a measure of quality assurance the Maintenance Director or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting.</p>	01/15/2015	