

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00194376.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaint IN00190839 completed on January 13, 2016.</p> <p>Complaint IN00194376 - Substantiated. Federal/State findings cited at F425 and F309.</p> <p>Survey Dates: March 8, 9, &amp; 10, 2016.</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Census bed type: SNF: 15 SNF/NF: 85 Total: 100</p> <p>Census payor type: Medicare: 11</p>	F 0000	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 0309 SS=G Bldg. 00	<p>Medicaid: 63 Other: 26 Total: 100</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review complete 3/14/16 by 29479.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview, and record review the facility failed to ensure pain medication was available and administered timely to a resident who experienced pain resulting in the resident reporting a night of intense pain for 1 of</p>	F 0309	<p>1. Resident C was affected. Resident C was assessed for pain. Resident c was noted to have pain. Her pain medication was taken from the EDK as ordered after pharmacy approval. The nurse was re-educated on</p>	03/22/2016
----------------------------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3 residents reviewed for quality of care related to pain management (Resident C).</p> <p>Finding includes:</p> <p>Resident C's record was reviewed on 3/8/16 at 12:52 p.m. Resident C had diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, hyperlipidemia, atrial fibrillation, type 2 diabetes, neuropathy, left above the knee amputation, right below the knee amputation, asthma, status post coronary artery bypass graft.</p> <p>An admission assessment note, dated 2/27/16 at 5:45 p.m., indicated Resident C was alert and oriented. The note further indicated she was experiencing phantom pain to her right stump and the physician had ordered narcotic pain medication.</p> <p>Physician's orders, dated 2/27/16, included, but were not limited to oxycodone (narcotic pain medication) 5/325 mg (milligrams) two tablets as needed for neuropathic pain up to four times daily.</p> <p>Resident C's Medication Administration Record (MAR), dated February 2016,</p>		<p>timely utilization of the EDK for medications ordered and not yet available. 2. All residents have the potential to be affected. All CNA's will be educated on reporting any resident complaints of pain to the nurse. All nurses will be educated on pain assessment, treatment, and documentation. 3. As a measure for ongoing compliance each resident will be monitored for pain every shift, which will be noted on the MAR. Should pain be noted, treatment will be provided as ordered and the physician and responsible party will be notified as indicated. The DON or designee will review MARs daily on regularly scheduled days to ensure pain is assessed and addressed as ordered. 4. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised, as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>lacked indication oxycodone 5/325 mg, was administered on 2/27/16.</p> <p>The Emergency Drug Kit (EDK) record did not indicate oxycodone had been removed from the kit for administration to Resident C until 2/28/16 at 2:30 a.m.</p> <p>During an interview on 3/8/16 at 1:20 p.m., LPN (Licensed Practical Nurse) #4 indicated she was the nurse on day shift for Resident C on 2/28/16. She indicated Resident C's medication had not been delivered so she called the pharmacy and they advised her to pull what she could from the EDK (Emergency Drug Kit). She indicated she removed pain medication from the kit and administered it.</p> <p>During an interview on 3/9/16 at 10:15 a.m., Resident C indicated she had not received any of her pain medication on 2/27/16. Resident C then became tearful and stated, "That first night was h---!" Resident C indicated she was in "intense" pain and had requested pain medication for the pain in her right knee stump. She indicated she admitted at 5:45 p.m. and didn't see a nurse until 8:00 p.m., at which time she requested her pain medication. She indicated it was not given to her. She indicated she asked again at 10:00 p.m. and the nurse told her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>she would have to get an order to remove it from the Emergency Drug Kit (EDK). Resident C indicated she did not receive the pain medication until 2:50 a.m. Resident C indicated she had received pain medication at the hospital at 5 p.m. prior to being discharged on 2/27/17. She indicated the pain in her right below the knee amputation was very intense that night because of the transfer. She rated it at a 9/10 on a scale of 1-10. She indicated the pain then became unbearable because she went so long without pain medication.</p> <p>A nurse's note, dated 2/27/16 at 5:45 p.m., indicated Resident C was in pain and pain medication was administered.</p> <p>During an interview on 3/9/16 at 10:40 a.m., the Nurse Consultant indicated the clinical record should include an explanation when a prescribed medication was not given and indicated the medication prescribed for Resident C's pain was available from the EDK and should have been retrieved from the EDK.</p> <p>During an interview on 3/9/16 at 11:18 a.m., Unit Manager # 1 indicated documentation indicated Resident C was administered 2 oxycodone 5/325 mg tablets on 2/28/16 at 2:30 a.m. from the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/10/2016	
NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>EDK.</p> <p>During an interview on 3/9/16 at 11:30 a.m., the DON (Director of Nursing) indicated she called LPN #3 to clarify her charting for 2/27/16. She indicated LPN #3 entered the nurse's note at the end of her shift on 2/28/16, and had not administered Resident C pain medication at 5:45 p.m., as indicated in the nurse's note. She indicated the pain medication was not administered until 2:30 a.m. on 2/28/16.</p> <p>A current policy, titled "PAIN MANAGEMENT" received from the Administrator on 3/10/16 at 9:00 a.m. The policy indicated, "...PURPOSE: To identify those residents who utilize routine medications for pain or who utilize frequent PRN pain medications in an effort to ensure pain control is achieved.</p> <p>Policy: Upon admission each resident shall be assessed for presence of complaint of pain and/or lack of pain relief following currently ordered pain medication administration. If ineffective relief is noted, a Pain Assessment shall be completed in an effort to assess location frequency, etc., and notify physician accordingly to ensure currently ordered pain medication is evaluated and revised, as necessary .... "</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 0425 SS=D Bldg. 00	<p>This Federal tag relates to complaint IN00194376.</p> <p>3.1-37(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure medications were acquired and/or administered as ordered by the physician for 3 of 3 residents reviewed for pharmaceutical</p>	F 0425	<p>1. Resident C was affected. Resident C was assessed for pain. Resident C was noted to have pain. Her pain</p>	03/22/2016
----------------------------	---	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>services (Residents C, D, and B).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident C's record was reviewed on 3/8/16 at 12:52 p.m. Physician's admission orders included, but were not limited to:                             <ol style="list-style-type: none"> <li>a. oxycodone (narcotic pain medication) 5/325 mg two tablets as needed for neuropathic pain up to four times daily.</li> <li>b. atorvastatin (cholesterol medication) 40 mg at bedtime</li> <li>c. digoxin (heart medication) 0.125 mg daily</li> <li>d. nicotine patch 21 mg daily</li> <li>e. Gabapentin 400 mg three times a day for diabetic nerve pain</li> <li>f. Lantus (insulin) 14 units subcutaneous at bedtime</li> <li>g. fluticasone propionate (respiratory) 50 mcg (micrograms)/inhalation give 2 puffs daily for shortness of breath</li> <li>h. albuterol (respiratory medication) 0.083% give one 3 mL vial via nebulizer four times a day up to 3 additional doses may be given per day as needed for shortness of breath.</li> <li>i. beclomethasone bipropionate (respiratory medication) 80 micrograms oral inhaler 3 puffs scheduled every 12 hours at 9:00 a.m. and 9:00 p.m.</li> </ol> </li> </ol> <p>The February 2016 Medication</p>		<p>medication wastaken from the EDK as ordered after pharmacy approval. The nurse wasre-educated on timely utilization of the EDK for medications ordered and notyet available. One should note Resident B, C, and D had orders which noted,“Medications may be administered when they become available from pharmacy”. ResidentB received her medications as ordered, the nurse involved documented a lateentry to note this and was re-educated on medication administration anddocumentation. Resident D received her medications when they became availablefrom pharmacy as ordered.</p> <ol style="list-style-type: none"> <li>2. All new admissions have the potentialto be affected. All nurses will be educated on the procedure for obtainingmedications for new admissions and medication administration.</li> <li>3. As a measure for ongoing compliance.The DON or designee will review the medical records</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Administration Record (MAR) did not indicate the bedtime or as needed doses of oxycodone, Lantus, Gabapentin, beclomethasone bipropionate inhaler, atorvastatin, albuterol were administered on 2/27/16. The MAR did not indicate the 9:00 a.m. dose of beclomethasone dipropionate, daily doses of digoxin, nicotine patch, fluticasone inhaler, or the four ordered doses of albuterol was administered on 2/28/16.</p> <p>The Emergency Drug Kit (EDK) record did not indicate oxycodone was removed on 2/27/16 for Resident C. The record indicated 2 oxycodone 5/325 milligram tablets were signed out for Resident C on 2/28/16 at 2:30 a.m.</p> <p>During an interview on 3/8/16 at 1:20 p.m., LPN (Licensed Practical Nurse) #4 indicated she was the nurse on day shift for Resident C on 2/28/16. She indicated Resident C's medication had not been delivered so she called the pharmacy and they advised her to pull what she could from the EDK (Emergency Drug Kit). She indicated she removed pain medication from the kit and administered it but had not administered the nicotine patch, beclomethasone dipropionate, digoxin, or the fluticasone propionate because they were not available.</p>		<p>for all new admissions daily to ensure medications are obtained from the pharmacy/EDK timely and administered to the resident as ordered. Any problems noted will be addressed immediately.</p> <p>4. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised, as warranted.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview on 3/9/16 at 10:15 a.m., Resident C indicated she had not received any of her medications on 2/27/16. Resident C then became tearful and stated, "That first night was h---!" Resident C indicated she was in "intense" pain and had requested pain medication for the pain in her right knee stump. She indicated she admitted at 5:45 p.m. and didn't see a nurse until 8:00 p.m., at which time she requested her pain medication. She indicated it was not given to her. She indicated she asked again at 10:00 p.m. and the nurse told her she would have to get an order to remove it from the Emergency Drug Kit (EDK). Resident C indicated she did not receive the pain medication until 2:50 a.m. Resident C indicated she had received pain medication at the hospital at 5 p.m. prior to being discharged on 2/27/17. She indicated the pain in her right below the knee amputation was very intense that night because of the transfer. She rated it at a 9/10 on a scale of 1-10. She indicated the pain then became unbearable because she went so long without pain medication.</p> <p>During an interview on 3/9/16 at 11:18 a.m., Unit Manager # 1 indicated documentation which indicated Resident C was administered any of her ordered medications on 2/27/16 was not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>available. She further indicated EDK documentation indicated Resident C was administered 2 oxycodone 5/325 mg tablets on 2/28/16 at 2:30 a.m.</p> <p>During an interview on 3/9/16 at 11:30 a.m., the DON (Director of Nursing) indicated she called LPN #3 to clarify her charting for 2/27/16. She indicated LPN #3 entered the nurse's note at the end of her shift on 2/28/16, and had not administered Resident C pain medication at 5:45 p.m., as indicated in the nurse's note. She indicated the pain medication was not administered until 2:30 a.m. on 2/28/16. 2. During an interview on 3/8/2016 at 12:34 p.m., Resident D indicated she did not receive any of her medications on her admission date and had several medications not administered to her the following date, which included her diabetic medications. She indicated the facility informed her the medications were not available for administration because they had not received them from the pharmacy.</p> <p>Resident D's record was reviewed on 3/8/2016 at 12:40 p.m. Diagnoses included, but were not limited to, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, and Restless Leg Syndrome.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An "Admission/Re-Admission Resident Assessment," dated 2/26/2016, indicated Resident D was alert and oriented to person, place, and time.</p> <p>A "Physician's Order" form indicated the following 2/26/2016 admission orders:</p> <ul style="list-style-type: none"> <li>a. levofloxacin (antibiotic) 750 milligram (mg) 1 tablet orally (PO) daily at 9 a.m.</li> <li>b. prednisone (steroid) 10 mg take 4 tablets PO daily for 3 days at 9 a.m.</li> <li>c. Lantus (insulin) inject 30 units at 9 p.m.</li> <li>d. omeprazole (antacid medication) 20 mg take 2 capsules PO twice a day (BID) at 9 a.m. and 9 p.m.</li> <li>e. amitriptyline (antidepressant) 25 mg tablet 1 tablet PO at night (QHS) at 9 p.m.</li> <li>f. budesonide-formoterol (inhaler for asthma and COPD) inhale 2 puffs BID at 9 a.m. and 9 p.m.</li> <li>g. fluoxetine (antidepressant) 10 mg 1 capsule PO daily at 9 a.m.</li> <li>h. furosemide (diuretic) 80 mg take 0.5 tablet daily at 9 a.m.</li> <li>i. glyburide (antidiabetic) 6 mg 1 tablet BID before meals at 7 a.m. and 4 p.m.</li> <li>j. guaifenesin (mucus expectorant) 600 mg 12 hour tablet take 600 mg BID at 9 a.m. and 9 p.m.</li> <li>k. metformin (antidiabetic) 750 mg 24</li> </ul>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>hour tablet take 1 tablet PO at breakfast at 8 a.m.</p> <p>l. nizatidine (antacid) 150 mg 1 capsule PO daily at 9 a.m.</p> <p>m. potassium chloride 10 mellequivalents (meq) 1 tablet PO daily at 9 a.m.</p> <p>n. Pramipexole (restless leg syndrome) 1 tablet PO three times a day (TID) at 9 a.m., 1 p.m., and 9 p.m.</p> <p>o. Evista (osteoporosis medication) 60 mg 1 tablet PO daily at 9 a.m.</p> <p>p. ropinirole (restless leg syndrome medication) 0.25 mg take 0.25 mg PO daily at 9 a.m.</p> <p>Resident D's Medication Administration Record (MAR) for February 2016 was reviewed on 3/8/2016 at 2:00 p.m. The record lacked documentation, with blank charting, of medication administration to Resident D on 2/26/2016. The record lacked documentation, with blank charting, Resident D's furosemide 80 mg was administered on 2/27/2016. The record indicated a circled initial for the medication administration times for Resident D's following medication orders: glyburide 6 mg on 2/27/2016 and 2/28/2016, prednisone 40 mg on 2/27/2016, levofloxacin 750 mg on 2/27/2016, and potassium chloride 10 meq on 2/27/2016.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A document titled, "Consolidated Delivery Sheets," dated 2/26/2016 at 7:36 p.m., and identified as current by the Director of Nursing (DON) on 3/9/2016 at 12:06 p.m., indicated Resident D's Amitriptyline HCL 25 mg tablet order and Pramipexole 0.25 mg tablet order was delivered and received by the facility on 2/26/2016 at 8:40 p.m.</p> <p>Resident D's Medication Administration Record (MAR) for March 2016 was reviewed on 3/8/2016 at 2:10 p.m. The record lacked documentation Resident D's medication orders of Lantus 30 units, Mirapex, Evista 60 mg, ropinirole 0.25 mg, budesonide-formoterol inhaler, and Amitriptyline 25 mg were administered on 3/7/2016. The record lacked documentation of reason medication was not administered.</p> <p>A document titled, "Standard PO [oral]/IM [intramuscular] EDK [emergency drug kit]," identified as current by the DON on 3/9/2016 at 11:30 a.m., indicated the facility had 6 tablets of levofloxacin 250 mg, 4 tablets of furosemide 20 mg, 4 tablets of prednisone 10 mg, and 4 tablets of potassium chloride extended release 10 meq available for administration when resident medications are not in stock.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview on 3/8/2016 at 1:15 p.m., Licensed Practical Nurse (LPN) #90 indicated medication orders within the MAR that contain circled initials at administration time indicated the medication was not administered and the nursing staff did not indicate in the MAR the reason medication was not administered. She indicated that blank documentation in the MAR for Resident D's 2/26/2016 medications indicated the medications had not been administered.</p> <p>During an interview on 3/8/2016 at 2:20 p.m., Resident D indicated she did not receive her ordered medications from the hospital prior to her admission to the facility. She indicated she did not receive all of her night time medications on 3/7/2016 because the nursing staff indicated her medications were out of stock.</p> <p>During an interview on 3/8/2016 at 2:30 p.m., Unit Manager #2 indicated she expected her nursing staff to not have blank charting in the February and March 2016 MARs, and if the medication has a circled initial, she expected her staff to identify the reason medication was not administered. She indicated Resident D did not receive her glyberide from 2/26/2016 to 2/29/2016 because it was not available from pharmacy. She could</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>not provide documentation from pharmacy that indicated the reason the medication was not available.</p> <p>During an interview on 3/9/2016 at 1:48 p.m., the Nurse Consultant indicated Resident D's Amitriptyline and Pramipexole medications were received by the facility and available for administration on 2/26/2016 at 8:40 p.m.</p> <p>3. During a telephone interview on 3/8/16 at 12:15 p.m., Resident B indicated she admitted to the facility on 2/17/16. She indicated she was "short of breath" and had "anxiety" and was not administered her ordered medications. She indicated she was not administered "any" of her "night" medications. She indicated the facility informed her the medications had not been delivered from the pharmacy.</p> <p>Resident B's record was reviewed on 3/8/16 at 1:30 p.m. Resident B had diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD), hypertension, anxiety, asthma, diabetes mellitus type 2, fibromyalgia syndrome, hypertension, anxiety, and chronic pain.</p> <p>A Physician Certification for Long-Term Care Services document, dated 2/17/16, indicated, "...rehab due to weakness and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>SOB [shortness of breath]... very SOB...."</p> <p>An admission assessment note, dated 2/17/16, indicated Resident B admitted to the facility on 2/17/16 at 3:00 p.m. The note indicated she had expiratory "wheezes" and a "non productive cough." The note lacked indication she had been offered/provided medication for her expiratory wheezes or cough.</p> <p>A nurse's note, dated 2/17/16 at 3:00 p.m., indicated Resident B's blood pressure was 152/89, pulse was 100 beats per minute, respirations were 22, and her oxygen saturation was 94% on 4 liters of oxygen. The note indicated she had an increase of shortness of breath upon "exertion and excitability." The note lacked indication she had been offered/provided medication for shortness of breath.</p> <p>A physician's order, dated 2/17/16, indicated orders which included guaifenesin (cough medicine) 10 milliliters (ml) orally every 4 hours as needed for a cough and clonazepam (anti-anxiety medication) 0.5 mg (milligrams) one orally every 6 hours as needed for anxiety.</p> <p>Physician admission recapitulation orders, dated 2/17/16, indicated orders</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>which included:</p> <ul style="list-style-type: none"> <li>a. albuterol (respiratory medication) 0.083 percent inhaler solution 2.5 mg inhaler administered via nebulizer every 6 hours as needed for shortness of breath</li> <li>b. albuterol HFA (hydrofluoroalkane) (respiratory medication) inhaler 18 grains. 2 puffs with a spacer as needed every 4-6 hours for cough/wheezing/shortness of breath</li> <li>c. budesomide (respiratory medication) 160 mcg (micrograms)/inhaler/formaterol 4.5 mcg/ inhaler MDT (metered dose inhaler) 2 puffs every twelve hours scheduled for 9:00 a.m. and 9:00 p.m. daily</li> <li>d. Singulair (allergy medication) 10 mg orally daily in the evening at 9:00 p.m.</li> <li>e. trazadone (anti-depressant) 100 mg take 1/2 tab to 2 tabs every evening at 9:00 p.m.</li> <li>f. metformin (diabetes) 500 mg one tab orally twice a day at 9:00 a.m. and 9:00 p.m.</li> <li>g. theophylline (respiratory medication) 100 mg SR (sustained release) tab twice a day at 9:00 a.m. and 9:00 p.m. for "COPD"</li> <li>h. verapamil (high blood pressure medication) 120 mg orally twice a day at 9:00 a.m. and 5:00 p.m.</li> <li>i, pregabalin (pain medication) 100 mg one capsule twice a day at 9:00 a.m. and 9:00 p.m.</li> </ul>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Resident B's Medication Administration Record (MAR), dated February 2016, were reviewed on 2/8/16 at 1:20 p.m. The MAR lacked indication Resident B was administered ordered medications on 2/17/16.</p> <p>A pharmacy invoice for Resident B, dated 2/17/16 at 19:36 a.m., indicated medications were ordered and prepared for shipment by the pharmacy on 2/17/16 at 7:36 p.m. The record lacked indication of a time and/or date Resident B's medications were delivered to the facility. The invoice lacked indication clonazepam was in the medications delivered to the facility on 2/17/16.</p> <p>A physician's progress note, dated 2/18/16, indicated Resident B was seen at the facility for an "acute/medically necessary visit." The note indicated she was at the facility for rehab with a chief complaint of "SOB." The note further indicated, "...worse in the last week...reports the problem is experienced constantly...reports the severity of the problem as severe... reports the problem is experienced at rest. Exertion is an aggravating factor. Medications are a relieving factor...Anxiety, chronic, constant issue, improved with clonazepam... back pain, chronic,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>continues, currently causing discomfort 6/10, needs medication for management...patient seen for follow up and management of hypertension. She is currently not doing well. Her blood pressure is being monitored... currently stressed at times with SOB and weakness...."</p> <p>During an interview on 3/9/16 at 2:05 p.m., Licensed Practical Nurse (LPN) #1 indicated on 2/17/16, Resident B had exhibited severe anxiety and complained of shortness of breath. She indicated Resident B's medications were available for administration and she had administered all ordered medications when they arrived "around 9:00 p.m." including "inhalers" and "anti-anxiety" medication on 2/17/16. She further indicated she failed to document she administered medications, document Resident B's symptoms of anxiety and respiratory distress, nursing assessments, and/or interventions provided.</p> <p>During an interview on 3/9/16 at 2:48 p.m., Unit Manger #1 indicated Resident B was cognitively intact and was alert and oriented. She indicated the pharmacy had not delivered Resident B's clonazepam on 2/17/16. She indicated clonazepam was available in the EDK but had not been removed from the EDK on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/10/2016	
NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2/17/16. She indicated the pharmacy delivered Resident B's clonazepam on 2/18/16. She indicated documentation was not available which indicated Resident B had been administered clonazepam on 2/17/16.</p> <p>A "New Resident Admissions" policy identified as current by Unit Manager #1 on 3/9/16 at 1:35 p.m., indicated, "A new resident's medication orders must be transmitted by fax as soon as they are available. This includes hospital discharge orders if handwritten orders are not yet complete. New IV orders must be written to be sent, i.e. IV orders will not be sent from hospital orders...If the new admission orders are received after the order cut off time, a pharmacist will review all orders to determine how the initial medications will be supplied. Following the review, a form will be faxed to the facility stating: *which medications can be pulled from the facility EDK for initial dose *which medications will arrive on the next regularly scheduled delivery time *Please note *Controlled substance medications can only be sent to the facility when the pharmacy possesses a valid hardcopy or prescription from the physician. Only medication that is critical will be sent to the facility or called in to back-up pharmacy for late admits. All other</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>medications will be sent on the next scheduled delivery."</p> <p>A Medication Administration policy, identified as current by the Administrator on 3/10/16 at 9:00 a.m., indicated, "Purpose: To safely administer medications as per physicians' orders. Policy: Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders...Always observe the six rights of giving each medication. RIGHT RESIDENT, RIGHT MEDICINE, RIGHT TIME, RIGHT DOSE, RIGHT ROUTE, RIGHT DOCUMENTATION...always record the dose of medication on the MAR after resident consumption.</p> <p>A current policy titled "PAIN MANAGEMENT" received from the Administrator on 3/10/16 at 9:00 a.m., indicated the following: "PURPOSE: To identify those residents who utilize routine medications for pain or who utilize frequent PRN pain medications in an effort to ensure pain control is achieved. Policy: Upon admission each resident shall be assessed for presence of complaint of pain and/or lack of pain relief following currently ordered pain medication administration. If ineffective</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  03/10/2016
NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>relief is noted, a Pain Assessment shall be completed in an effort to assess location frequency, etc., and notify physician accordingly to ensure currently ordered pain medication is evaluated and revised, as necessary...."</p> <p>This Federal tag relates to Complaint #IN00194376.</p> <p>3.1-25(a)</p>				