

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 01/27/2016
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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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K 0000 Bldg. 01	<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: 01/27/16</p> <p>Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330</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 detectors in all other resident sleeping rooms. The facility has a capacity of 184</p>	K 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.

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K 0021 SS=E Bldg. 01	<p>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>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 2 kitchen rolling fire doors in the opening between the kitchen and the Dining Room is held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect 30 residents, staff and visitors in the Dining Room.</p>	K 0021	The kitchen adjoins the dining room with north and south rolling fire doors. These fire doors are equipped with fusible links and were both freed of any obstructions on 1/27/16. Residents, staff and visitors in dining room all have the potential to be affected. As a measure of ongoing compliance the Maintenance Director, or their designee, will complete a daily	01/27/2016

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K 0029 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 01/27/16, the kitchen adjoins the Dining Room and the south serving window from the adjoining kitchen has a rolling fire door equipped with a fusible link. The Dining Room was not separated from the corridor because the entry to the Dining Room is not separated from the corridor by positive latching doors. The south window rolling fire door was propped open with a serving tray. Based on interview at the time of observation, the Maintenance Director acknowledged the south serving window rolling fire door was propped open with a serving tray.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¼ 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</p>		<p>audit check-off sheet confirming both north and south serving window rolling fire doors equipped with a fusible link are free of any obstructions. This will be turned into the Administrator and/or designee daily. (Please see Attachment A.) As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings.</p>	

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	<p>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 16 hazardous areas such as soiled linen rooms were separated from other areas by smoke resistant partitions and doors. This deficient practice could affect 22 residents, staff and visitors in the B 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 1:50 p.m. on 01/27/16, the back wall of the B Hall soiled linen room had a service window opening to an adjoining office at the B Hall nurse's station which did not separate the soiled linen room with smoke resistant partitions. The service window measured two foot high by two foot wide and had a sliding door which was propped open leaving a three inch high opening in the window. The corridor door to the adjoining office at the B Hall nurse's station was not provided with a self-closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the service window</p>	K 0029	<p>The service window of the back wall of B Wing soiled linen room will be permanently closed and sealed with fire resistant caulk (3M Fire Barrier Sealant CP 25WB+) by 2/12/16. Residents, staff and visitors in this area all have the potential to be affected. As a measure of ongoing compliance the Maintenance Director, or their designee, will complete a daily audit check-off sheet confirming that there are no compromised barriers in all storage rooms. (See attachment A) This will be turned into the Administrator and/or designee daily. As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings.</p>	02/12/2016

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K 0038 SS=E Bldg. 01	<p>opening in the back wall of the B Hall soiled linen room did not separate this hazardous area from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 30 residents, staff and visitors in the Dining Room.</p> <p>Findings include:</p>	K 0038	Two magnetically locking dining room doors marked (exit) that can be opened by entering a 4-digit code, were labeled and posted with a 4-digit code to exit on 1/28/16. Residents, staff and visitors in dining room all have the potential to be affected. As a measure of ongoing compliance the Maintenance Director, or their designee, will complete a daily audit check-off sheet to make sure that all exits doors needing a code, that code is posted. (See attachment A). This will be turned into the Administrator and/or designee daily. As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings. The keyed lock on the corridor door leading to the Laundry room was removed on 1/28/16 and the hole was patched. This had the potential to affect 10 residents, staff and visitors in the vicinity of	02/12/2016

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	<p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 01/27/16, the two sets of exit doors in the Dining Room were each marked as a facility exit, the exit doors were magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at the two exit doors in the Dining Room. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide 1 of over 100 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and</p>		<p>the laundry room. As a measure of ongoing compliance the said keyed lock will remain removed, leaving one release operation on the door. All other doors in the facility with one releasing device will be documented on attachment B. (Please see Attachment B) As a measure of quality assurance the Maintenance Director or designee will add any new doors (i.e. new construction) to the audit sheet to ensure compliance with no more than one releasing operation to open the door. Any findings will be addressed in the quarterly quality assurance meetings.</p>	

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K 0062	<p>not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Laundry.</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 1:50 p.m. on 01/27/16, the corridor door to the Laundry by the Maintenance Office has two locks on the door and a key was needed to unlock the deadbolt on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p>			
	NFPA 101			

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are 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 ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.1 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. These deficient practices could affect 10 residents, staff and visitors in the vicinity of the A Hall Storage Room.</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 1:50 p.m. on 01/27/16, a horizontal shelf was installed in the A Hall Storage Room sixteen inches from the ceiling. Cardboard boxes were placed on top of the shelf stacked</p>	K 0062	<p>We removed in A Hall storage room all cardboard boxes on horizontal shelf within 18" of the ceiling which blocked the spray pattern of a ceiling mounted pendant sprinkler on 1/27/16. This could affect 10 residents, staff and visitors in the vicinity of A Hall storage room. We will mark all storage rooms with red tape at 18" from ceiling so there is a visual do not stack above red line. We will post "do not stack above red line" in each of these storage rooms. This will be completed by 2/12/16. (See attachment C) As a measure of ongoing compliance the Maintenance Director, or their designee, will complete daily audit sheet of all storage rooms in the building with shelving storage to ensure no storage above designated red line. (see Attachment A) This sheet will be turned in to the Administrator or designee daily. As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings.</p>	02/12/2016

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K 0066 SS=D Bldg. 01	<p>up to the ceiling which blocked the spray pattern of a ceiling mounted pendant sprinkler. Based on interview at the time of observation, the Maintenance Director acknowledged the A Hall Storage Room pendant sprinkler had obstructions to its discharge.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self-closing lid at 1 of 1</p>	K 0066	We removed all extinguished cigarette butts from the staff smoking area deposited on the ground. We also removed and discarded an open metal bucket	02/26/2016

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K 0069 SS=D Bldg. 01	<p>outside areas where smoking was permitted. This deficient practice could affect five staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 01/27/16, the outdoor staff smoking area located outside the Dining Room had in excess of 50 extinguished cigarette butts deposited on the ground. In addition, the outdoor smoking area had in excess of 100 extinguished cigarette butts deposited in an open top metal bucket. A metal container with a self-closing cover device into which ashtrays can be emptied was not provided for the metal bucket cigarette butts. Based on interview at the time of the observations, the Maintenance Director acknowledged extinguished cigarette butts were not deposited into a metal container with a self-closing cover device into which ashtrays can be emptied at the aforementioned outdoor location where staff smoking was taking place.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in</p>		<p>containing cigarette butts on 1/27/16. There was potential to affect 5 staff members. As a measure of ongoing compliance we will add an ashtray made of noncombustible material and safe design along with a metal container with self-closing cover into which ashtray can be emptied. We will also add signage stating "Please dispose of cigarette butts in designated containers" in the smoking area. (Attachment D) This will be completed by 2/26/16. As a measure of ongoing compliance the Maintenance Director, or their designee, will complete a daily audit sheet of the employee smoking area to check for discarded cigarette butts and audit the smoking containers are in place and being used. (see attachment A) The audit sheet will be turned in to the Administrator or designee daily. As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings.</p>		

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	<p>accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 2 of 4 kitchen range hood fire suppression system nozzles were correctly positioned in relation to moveable cooking equipment. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <ul style="list-style-type: none"> a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 3-6.3 states moveable cooking equipment shall be provided with a means to ensure that it is correctly positioned in relation to the appliance discharge nozzle during cooking operations. This deficient practice could affect five staff in the kitchen.</p>	K 0069	<p>On 2/3/16 Allied Safety Fire Protection visited and adjusted kitchen range hood fire suppression system nozzles. (Please see attachment E) This could affect 5 staff members in kitchen. As a measure of ongoing compliance Allied Safety will complete bi-annual assessments of the range hood suppression system nozzles. The Maintenance Director, or their designee, will do a visual audit monthly check after scheduled cleaning that the range hood suppression system nozzles are facing the correct direction. (Please see attachment F) This will coincide with the Maintenance Directors monthly fire extinguisher checklist. As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings.</p>	02/03/2016

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K 0072 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 01/27/16, two of four kitchen range hood fire suppression system nozzles were incorrectly positioned under the kitchen range hood. The suppression system nozzle at the north end of the kitchen range hood was pointed away from the griddle below and directed towards where kitchen staff would stand if attending the griddle. The south suppression system nozzle was not positioned over any cooking equipment but was directed towards where kitchen staff would stand if attending moveable cooking equipment intended to be positioned below the south nozzle. Based on interview at the time of the observations, the Maintenance Director acknowledged two of four kitchen range hood fire suppression system nozzles were not were correctly positioned in relation to moveable cooking equipment.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of</p>			

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	<p>fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 2 of 6 exits means of egress. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Unit Manager during a tour of the facility from 11:30 a.m. to 1:50 p.m. on 01/27/16, a wooden three drawer chest of drawers containing isolation equipment supplies was stored in the corridor outside Room A5 in the A Hall and projected sixteen inches into the corridor. Based on interview at the time of observation, the Unit Manager stated isolation equipment supplies were needed to be stored outside the room for a resident in the A Hall and acknowledged the chest of drawers was being stored in the corridor. In addition, a six foot tall metal cabinet containing activity room supplies was being stored in the C Hall corridor and projected two feet into the corridor outside the Activity Room. Based on interview at the time of observation, the Maintenance Director</p>	K 0072	<p>We removed a 3 drawer chest containing isolation equipment supplies outside Room A5. We also removed a 6 ft. tall metal cabinet containing activity room supplies in the C Hall corridor on 1/27/16. This has the potential to affect 50 residents, staff and visitors. As a measure of ongoing compliance the Maintenance Director, or their designee, will monitor all egresses verifying they are free of any obstructions or implements using the daily audit check off sheet. (Please see attachment A) This is given to the Administrator or designee daily for review. As a measure of quality assurance the Maintenance Director or designee will review any findings in subsequent corrective action in the facility's quarterly quality assurance meetings.</p>	01/27/2016			

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 01/27/2016
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	<p>stated the metal cabinet is continuously stored in the corridor and acknowledged corridor storage in the means of egress was not continuously maintained free of all obstructions or impediments to full instant use for the aforementioned two means of egress.</p> <p>3.1-19(b)</p>				