

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 01/31/2014
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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: 01/31/14</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</p>	K010000	<p>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.</p>	
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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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	<p>the C Hall. 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 114 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/06/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 21 residents, staff and visitors in the vicinity of the A Wing Housekeeping Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/31/14, a six inch by five inch hole was noted in the ceiling above an electrical box in the A Wing Housekeeping Room which exposed the attic above and did not provide at least a one half hour fire resistance rating. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned</p>	K010025	<p>The hole in the ceiling on "A" wing was repaired with 5/8" dry wall and sealed with 4 hour fire stop rated caulk. The opening in the barrier wall in the Main Shutoff Electrical & Water room was repaired with 4 hour fire stop rated caulk. All openings in the Main Shutoff & Water room were repaired with premixed concrete and 1/2" concrete board then sealed with 4 hour fire stop rated caulk. Residents and staff in the area have the potential to be affected. All areas in the facility were checked to ensure all fire walls are secured and sealed. As a measure of ongoing compliance the Maintenance Director with complete an audit monthly to ensure all fire walls in the facility are secured and sealed, (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</p>	03/02/2014			

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	<p>opening in the ceiling smoke barrier in the A Wing Housekeeping Room did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings in 1 of 3 smoke barrier walls in the Main Shutoff Electrical & Water Room were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 5 staff and visitors near the kitchen pantry.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/31/14, the following openings in the wall of the Main Shutoff Electrical & Water Room which separates this room from the kitchen pantry were noted:</p> <p>a. an eight inch by three inch hole in the concrete block wall for two conduits.</p> <p>b. the two inch annular space surrounding a one inch in diameter pipe and the one quarter inch annular space surrounding a one inch in diameter pipe.</p> <p>Based on interview at the time of the observations, the Maintenance Assistant</p>		assurance meeting.				

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K010029 SS=A	<p>acknowledged the aforementioned openings in the smoke barrier wall of the Main Shutoff Electrical & Water Room exposed the adjoining kitchen pantry and did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</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 Based on observation and interview, the facility failed to ensure 1 of 18 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 5 staff and visitors near the kitchen pantry.</p> <p>Findings include:</p>	K010029	All said openings in the Main Shutoff & Water room and Kitchen pantry were repaired with premixed concrete and ½" concrete board then sealed with 4 hour fire stop rated caulk. Residents and staff in the area have the potential to be affected. All areas in the facility were checked to ensure all fire walls are secured and sealed. As a measure of ongoing compliance	03/02/2014

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K010046 SS=E	<p>Based on observations with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/31/14, the Main Shutoff Electrical & Water Room contained three natural gas fired water heaters and the following openings in the wall of Main Shutoff Electrical & Water Room which separates this room from the kitchen pantry were noted:</p> <p>a. an eight inch by three inch hole in the concrete block wall for two conduits.</p> <p>b. the two inch annular space surrounding a one inch in diameter pipe and the one quarter inch annular space surrounding a one inch in diameter pipe.</p> <p>Based on interview at the time of the observations, the Maintenance Assistant acknowledged the aforementioned openings in the smoke barrier wall did not separate the Main Shutoff Electrical & Water Room from the kitchen pantry with a smoke resistant partition.</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.</p>		the Maintenance Director with complete an audit monthly to ensure all fire walls in the facility are secured and sealed, (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 meeting	

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	<p>Based on observation and interview, the facility failed to provide exterior emergency lighting of at least 1½ hour duration for 1 of 9 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 10 residents, staff and visitors if required to evacuate the facility from the Activities Room exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/31/14, the Activities Room exit discharge to the exterior of the facility was not provided with exterior lighting. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned exit discharge to the exterior of the facility was not provided with exterior lighting.</p> <p>3.1-19(b)</p>	K010046	<p>The door in the Activities room labeled as an exit, is not an evacuation exit (nor is it included in the facility evacuation exit route), therefore the exit sign has been removed. A new sign posted noting "not an exit" has been placed on said door. Residents and staff in the area have the potential to be affected. All designated exit doors in the facility checked to ensure emergency lighting of at least 1 ½ hour duration is provided. As a measure of ongoing compliance the Maintenance Director or designee will complete an audit weekly, (see attachment B) to ensure appropriate emergency lighting of at least 1 ½ hour duration is provided. 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>	03/02/2014	

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K010056 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect two staff in the Main Shutoff Electrical & Water Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/31/14, an 80 inch horizontal</p>	K010056	The sprinkler hangers will be installed by Dalmatian company to meet the standards for not to exceed 24" in length. All residents, visitors and staff have the potential to be affected. All sprinklers checked to ensure standards are met not to exceed 24" in length. As a measure of ongoing compliance the Maintenance Director or designee will complete a sprinkler audit monthly, (see attachment D) to ensure standards are met not to exceed 24" in length. 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.	03/02/2014

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K010062 SS=A	<p>length of steel sprinkler pipe inside the Main Shutoff Electrical & Water Room was unsupported to a sprinkler. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned sprinkler location was an unsupported armover greater than 24 inches in length for a steel pipe.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 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 replace 1 of over 100 sprinklers in the facility which had paint on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler</p>	K010062	The said sprinkler was replaced by Dalmatian company. All residents, visitors and staff have the potential to be affected. All sprinklers checked to ensure they were not painted, corroded, damaged, loaded, or in the improper orientation. As a measure of ongoing compliance the Maintenance Director or designee will complete a sprinkler audit monthly, (see attachment D) to ensure they were not painted,	03/02/2014

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K010144 SS=C	<p>shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 5 kitchen staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/31/14, the automatic sprinkler located on the ceiling in the kitchen near the dry goods storage room was entirely covered with white paint. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned automatic sprinkler was entirely covered with white paint.</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. Based on record review, observation and interview; the facility failed to ensure a monthly load test for the emergency generator was conducted for 12 of 12</p>	K010144	<p>corroded, damaged, loaded, or in the improper orientation. 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> <p>The emergency generator will be monitored via standby amps rather than kilowatts (kw) forthcoming. The generator will be professionally load bank</p>	03/02/2014

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	<p>months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Monthly Test Log" documentation with the Maintenance</p>		<p>tested by Indiana Power Company. Additionally the Maintenance Director will complete an emergency generator load test monthly. All residents, visitors and staff have the potential to be affected. The emergency generator will be professionally load bank tested by Indiana Power Company. Additionally the Maintenance Director will complete an emergency generator load test monthly. As a measure of ongoing compliance the Maintenance Director or designee will complete an emergency generator load test monthly, (see attachment C) to ensure there is an appropriate load test standby amp. 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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	Assistant during record review from 9:10 a.m. to 11:20 a.m. on 01/31/14, the load test log stated "30% of and standby rating = 1250 amps" but monthly load test results for each month of the twelve month period of 02/25/13 through 01/06/14 was recorded as less than 1250 amps. The aforementioned documentation did not include if the emergency generator ran under operating temperature conditions or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on observation with the Maintenance Assistant during a tour of the facility from 11:20 a.m. to 2:45 p.m. on 01/13/14, the nameplate rating of the emergency generator was listed as 600 kW. Based on interview at the time of record review and observation, the Maintenance Assistant stated no additional monthly load testing documentation was available for review, the nameplate rating of the emergency generator is 600 kW and acknowledged monthly load test documentation did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.			

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