

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/29/2015
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NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170
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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: 07/29/15</p> <p>Facility Number: 000168 Provider Number: 155267 AIM Number: 100267020</p> <p>At this Life Safety Code survey, Lake Point Village 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 56 at</p>	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Life Safety Survey Revisit on or after.	

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 0038 SS=E Bldg. 01	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has three wooden detached sheds used for storage which were not sprinkled.</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>Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 6 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 16 residents who reside on the Arbor Hall.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 07/29/15 at 2:15 p.m.,</p>	K 0038	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Facility is obtaining quotes and will have concrete slab replaced. This is a one-time repair.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected.</p> <p>Facility is obtaining quotes and will have concrete slab replaced. This is a one-time repair.</p> <p>The maintenance director inspected all other sidewalk surfaces used as exits, to ensure all were in good repair.</p> <p>What measures will be put into place or what systemic changes you</p>	08/31/2015

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K 0062 SS=F Bldg. 01	<p>the Arbor Hall outside exit sidewalk had a one foot by two foot circular area of concrete missing with a two inch depression and a one foot by four inch area of concrete missing with a two inch depression twelve feet from the exit door next to the parking lot. This was acknowledged by the administrator at the time of observation and at the exit conference on 07/29/15 at 2:35 p.m.</p> <p>3.1-19(b)</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 record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems,</p>	K 0062	<p>will make to ensure that the deficient practice does not recur? The maintenance director will check the integrity of the sidewalks weekly to ensure there are no elevation changes. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director will check the sidewalks weekly for 4 weeks, then monthly for 11 months to ensure the integrity of the sidewalks. Results of these inspections will be reported to the CQI committee monthly. If 100% is not achieved, an action plan will be developed.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Vanguard Alarm Services was contacted to schedule hydrostatic flush of sprinkler system. Armor Fire Protection, LLC began sprinkler system flush on Tuesday 8/11/2015. The internal obstruction investigation of the sprinkler system will be completed</p>	08/31/2015

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	<p>10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the administrator on 07/29/15 at 10:50 a.m., the most recent sprinkler system internal pipe inspection from Safecare was dated 04/07/14. Furthermore, the results of the inspection indicated "the system is full of rust and debris. Recommend that fire sprinkler system be flushed!!". Based on an interview with the administrator on 07/29/15 at 11:15 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 04/07/14, the administrator stated the facility did not have any documentation to indicate the complete sprinkler flushing was conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the administrator at the time of record review and interview and acknowledged by the administrator at the</p>		<p>every 5 years.</p> <p>How willyou identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken?</p> <p>Allresidents have the potential to be affected. Vanguard Alarm Services hasbeen contacted to schedule hydrostatic flush of sprinkler system. Armor FireProtection, LLC began sprinkler system flush on Tuesday 8/11/2015. The internalobstruction investigation of the sprinkler system will be completed at leastevery 5 years.</p> <p>Whatmeasures will be put into place or what systemic changes you will make to ensurethat the deficient practice does not recur?</p> <p>The maintenance director will ensure the internalobstruction investigation of the sprinkler system will be completed at leastevery 5 years. Any recommendations made will be followed. ED will reviewrecommendations to ensure that recommendations are completed.</p> <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director will ensure the internalobstruction investigation of the sprinkler system will be completed at leastevery 5 years. Any recommendations made will be followed.</p>	

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K 0069 SS=E Bldg. 01	<p>exit conference on 07/29/15 at 2:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview; the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p>	K 0069	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Documentation of semi-annual hood inspection performed by Vanguard was obtained by facility after surveyor visit. Documentation shows that semi-annual hood inspections were performed on 6/25/2015, 12/19/2014, 6/13/2014, 12/20/2013, and 6/28/2013. Semi-annual hood inspections have taken place and facility will ensure that they continue to do so per regulation.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected. Documentation of semi-annual hood inspection performed by Vanguard was obtained by facility after surveyor visit. Documentation shows that semi-annual hood inspections were performed on 6/25/2015, 12/19/2014, 6/13/2014, 12/20/2013,</p>	07/30/2015

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K 0000 Bldg. 02	<p>Based on review of the facility's Range Hood Inspection Reports on 07/29/15 at 11:15 a.m. with the administrator, the two most recent range hood fire extinguishing equipment inspection reports were dated 06/25/15 and 06/13/14. Furthermore, both inspection reports indicated these were annual inspections. Based on an interview with the administrator at the time of record review, it was stated the contract with Vanguard for the range hood inspection is an annual inspection and not a semi-annual inspection. The lack of semi-annual inspections on the kitchen range hood system was verified by the administrator at the time of record review and interview and acknowledged at the exit conference on 07/29/15 at 2:15 p.m.</p> <p>3.1-19(b)</p>		<p>and 6/28/2013. Semi-annual hood inspections have takenplace and facility will ensure that they continue to do so per regulation. There are no other range hoods in the facility.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Documentation of semi-annual hood inspection performed by Vanguard was obtained by facility after surveyor visit. Documentation show that semi-annual hood inspections were performed on 6/25/2015, 12/19/2014, 6/13/2014, 12/20/2013, and 6/28/2013. Semi-annual hood inspections have takenplace and facility will ensure that they continue to do so per regulation. Executive Director will ensure the hood inspections are maintained and easily found by the maintenance director.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director will report semi annually the result of the semi-annual hood inspection to the CQI committee. If 100% is not achieved, an action plan will be developed.</p>	

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	<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: 07/29/15</p> <p>Facility Number: 000168 Provider Number: 155267 AIM Number: 100267020</p> <p>At this Life Safety Code survey, Lake Point Village 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) and 410 IAC 16.2. The 2010 Therapy Wing addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 addition to the one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 56 at the time of this visit.</p>	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Life Safety Survey Revisit on or after.	

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K 0062 SS=F Bldg. 02	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has three wooden detached sheds used for storage which were not sprinkled.</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and visitors to the 2010 Therapy Room</p>	K 0062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Vanguard Alarm Services was contacted to schedule hydrostatic flush of sprinkler system. Armor Fire Protection, LLC began sprinkler system flush on Tuesday 8/11/2015. The internal obstruction investigation of the sprinkler system will be completed every 5 years.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected. Vanguard Alarm Services has been contacted to schedule hydrostatic flush of sprinkler system.</p>	08/31/2015

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	<p>addition.</p> <p>Findings include:</p> <p>Based on record review with the administrator on 07/29/15 at 10:50 a.m., the most recent sprinkler system internal pipe inspection from Safecare was dated 04/07/14. Furthermore, the results of the inspection indicated "the system is full of rust and debris. Recommend that fire sprinkler system be flushed!!". Based on an interview with the administrator on 07/29/15 at 11:15 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 04/07/14, the administrator stated the facility did not have any documentation to indicate the complete sprinkler flushing was conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the administrator at the time of record review and interview and acknowledged by the administrator at the exit conference on 07/29/15 at 2:15 p.m.</p> <p>3.1-19(b)</p>		<p>Armor FireProtection, LLC began sprinkler system flush on Tuesday 8/11/2015. The internalobstruction investigation of the sprinkler system will be completed at leastevery 5 years.</p> <p>Whatmeasures will be put into place or what systemic changes you will make to ensurethat the deficient practice does not recur?</p> <p>The maintenance director will ensure the internalobstruction investigation of the sprinkler system will be completed at leastevery 5 years. Any recommendations made will be followed. ED will reviewrecommendations to ensure that recommendations are completed.</p> <p>How thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place?</p> <p>The maintenance director will ensure the internalobstruction investigation of the sprinkler system will be completed at leastevery 5 years. Any recommendations made will be followed.</p>		