STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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	This visit was for a Recertification and State Licensure Survey. Survey dates: April 6, 7, 8, 11, and 12, 2016 Facility number: 000168 Provider number: 155267 AIM number: 100267020 Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 9 Medicaid: 42 Other: 8 Total: 59 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on April 15, 2016.	F 0000	Lake Pointe Village is requesting paper IDR review forcitation F329. This Plan of Correction constitutes the facility's writtenallegation of compliance for the deficiencies cited. This submission of thisPlan of Correction is not an admission of or agreement with the deficiencies orconclusions contained in the Department's inspection report. We respectfully request a desk review and ask that youroffice accept this plan as our facility's compliance. Please review theattachments provided with this plan of correction, which include record of re-education and audit tools. Please feel free to contact Skylar Stephenson, ExecutiveDirector, should you need any additional information to support the desk reviewat 812-752-3499. Thank you for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review, observations and interview, the facility failed to ensure the residents' drug regimen was free from duplicate therapy, had adequate monitoring of behaviors and mood symptoms and/or was at the lowest effective dose for 4 of 6 residents reviewed for unnecessary medications. (Residents #51, #63, and #59). Findings included:	F 0329	Resident #51 remains in the facility. Residenthas been assessed by the interdisciplinary team (IDT). Care plans have been updated to reflect the resident's current status. A gradual dose reduction (GDR) was requested for Trazadone and GDR implemented per provider on 4/21/16. A GDR was requested for Lexapro and was contraindicated per provider with supporting documentation. Behavior tracking has been	05/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	1. Review of the clinical record for Resident #51 on 4/8/16 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: depression and insomnia. The 9/2/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident had a BIMS (Brief Interview Mental Status) score of 9 with some long and short term memory issues and required cueing; frequently felt depressed; trouble sleeping; tired and felt bad about self. The 11/26/15 Annual MDS assessment indicated the resident had a BIMS score of 11 - good recall , but poor temporal orientation; had no behaviors; some trouble with sleep, depression; felt tired and bad about self. The 2/19/16 Quarterly MDS assessment indicated the resident had a BIMS score of 11 - good recall with poor orientation to current surroundings; no mood issues, including no problems with sleep, feeling down, depressed or hopelessness; and no behavior issues. The April 2016 Monthly Physician Orders indicated Resident#1 had orders for Lexapro (for depression) 20 mg (milligrams) - 1 tablet every day ordered		implemented. Resident #63 remains in the facility. Resident has been assessed by the interdisciplinaryteam (IDT). Care plans have been updated to reflect the resident's current status. A gradual dose reduction (GDR) was requested for Lexapro and GDR implemented per provider on 4/21/16. Resident #59 remains in the facility. Resident has been assessed by the interdisciplinary team (IDT). Care plans have been updated to reflect the resident's current status. A gradual dose reduction (GDR) was requested for Trazadone and GDR implemented per provider on 4/21/16. A GDR was requested for Paxil and was contraindicated per provider with supporting documentation. Behavior tracking has been implemented. SS and Psychiatric Nurse Practitioner will continue to monitor residents. All residents residing in the facility and using psychotropic medications have the potential to be affected by the alleged deficient practice. An audit was completed by SSD of all current residents using psychotropic medications to ensure that they are being monitored per policy with GDR being requested if applicable. GDR tracking was implemented for all residents using psychotropic medications. SSD will review all pharmacy recommendations related to psychotropic medications and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	on 11/21/13; and for Trazadone (for depression but was ordered to treat insomnia) 50 mg - 1 tablet every night. Progress notes by the Psychiatric Nurse Practitioner and Licensed Certified Social Worker (LCSW) between 8/6/15 and 2/4/16 indicated the following: - " 8/6/15 Quarterly Psychiatric note - sitting up in w/c (wheelchair) in room, social this morning mood has been 'Fine'. No c/os pain/discomfort. Hold on course, no changes in medications." - "11/5/15 Quarterly Psych note - sitting up in w/c, she is pleasant and smiling, talks to me about (family member). Denies feeling sad or nervous, no c/o pain. Hold on course with no medication changes." - "12/3/15 Psychiatric note - informed by staff resident has been more tearful. Found sitting in w/c and does report increased depression and anxiety immediately tearful, unable to specify why she is sad 'I don't know'; notes reviewed, denies suicide ideation, no psychosis, sleep and appetite ok. Refer to LCSW (Social Worker affiliated with Psychiatrist office) for talk therapy." - "12/4/15 LCSW note: resident mentioned she has had several bouts of		complete follow up per policy. Requested GDRs that are declined by the physician will include a written assessment by the physician. SSD in-serviced by SSD consultant regarding tracking/monitoring of psychotropic medications by SSD Consultant on 4/12/16. GDR Tracker implemented by SSD which includes all residents using psychotropic medications. Monthly behavior summaries will be utilized to evaluate behaviors and medications. The GDR Tracker will be monitored by IDT in the monthly behavior meeting. GDRs will be requested as applicable. ED/designee will review results of behavior meeting to ensure GDRs are being requested per policy. SSD in-serviced by SSD consultant regarding tracking/monitoring of psychotropic medications by SSD Consultant on 4/12/16. To ensure compliance, the Psychoactive Management CQI tool will be used by the Social Services Director/designee weekly for 4 weeks, monthly for 6 months, and then quarterly for 2 quarters.The results of these CQI audits will be reviewed by the CQI committee monthly and action plans will be developed as needed. Date of Compliance: May 12, 2016 Lake Pointe Village respectfully requests additional evidentiaryinformation be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	crying because she is depressed. Had a stroke causing her to lose use of right side and make her feel useless. These feelings most likely feeding depression. Feels her children support her which helps to keep the depression at bay. Will work on positive ways to cope." - "1/28/16 LCSW note: (Resident's name) began the session by talking about how she was feeling less depressed than she had in our last session. She engaged more in our conversation...Part of the session also talked about her family coming to visit when they have the opportunity, which she feels is not enough This could be part of which is driving her depression..." - "2/4/16 Psychiatric note: Resident found sitting up in room in w/c, pleasant today, no mood concerns; chronic sleep disturbance on and off, denies pain. Hold on course, no medication changes." Review of the clinical record facility progress notes between 7/2/15 and 4/8/16 failed to locate any documentation of the resident experiencing issues with sleep or depression i.e. crying, tearfulness, sad facial expressions. Interview with the Social Worker on 4/11/16 at 9:10 a.m., indicated: "We do		considered to reduce F 329 in scope from an E level to a D levelin the 2567.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	not track residents who are on anti-depressants, only if anti-anxiety and psychotics. Resident has been pretty stable and doing well, does have some depression and sees psychiatrist quarterly and the talk therapist 2 x month. No Gradual Dose Reductions have been tried on the Lexapro and Trazadone". During an interview with the DON (Director of Nursing) on 4/11/16 at 10:05 a.m., she indicated there were no behavior tracking sheets for this resident. A 9/8/15 Care Plan indicated: "Resident is at risk for adverse side effects r/t (related to) use of psychotropic med." "Goal - Will have no adverse side effects." "Approaches: Administer meds as ordered, observe for effectiveness; MD (physician) to review routinely to attempt gradual dose reductions, unless contraindicated by MD". Review of the MD and Nurse Practitioner progress notes between 7/1/15 and 4/8/16 failed to indicate the resident was experiencing any issues with sleep or depression. 2. Review of the clinical record for Resident #63 on 4/11/16 at 10:30 a.m., indicated the resident had diagnoses			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	which included, but was not limited to: depression and anxiety. The 10/18/15 Quarterly MDS assessment indicated the resident scored a 3 on her BIMS which indicated she had severe impairment of her long and short term memory and cognitive decisionmaking abilities; and occasionally felt depressed and tired. The 1/25/16 Quarterly MDS assessment indicated the resident continued to score a 3 on her BIMS with no change in cognitive functioning and had no mood issues, included symptoms of depression, sleep, appetite issues. A 7/30/15 Social Work note indicated "Resident continues to be restless, agitated with repetitive worries regarding family and statements to go home. Is new admission and is currently being txd (treated) with an ATB (antibiotic). Will request an order for psych (psychiatric services) to eval (evaluate). A 7/30/15 Initial psychiatric evaluation indicated: "Seen re: (regarding) new admission, confused, anxiety. Hx (history) of poor living condition at home and non-adherence to medications x (times) 6 months...Will need time to adjust to new environment but insight			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	and judgement limited due to dementia. Change Namenda XR (for dementia) 28 mg QD (every day) and add Lexapro10 mg QD for anxiety." A 8/5/15 Social Work Note indicated "Continues to have repetitive worries regarding home. Easily re-directed by conversation. Per resident report and chart review, decreased anxiety noted." A 9/3/15 Quarterly Psychiatric visit indicated "Resident found in dining room area smiling, assisting another resident put together a puzzle. She is pleasant & calm today, mood good. D/W (discussed with) staff marked improvement in mood and decreased anxiety. She has been socializing with others and ambulates thru facility. Med changes - hold on course." A 12/3/15 Quarterly Psychiatric evaluation indicated "Resident up in common area, pleasant, tells me she is here because she wants to be and can go home whenever she wants. Mood has been 'OK'. She enjoys the company of a group of female residents they spend most of their waking hours together. Nsg (nursing) reports exit seeking at times. She does go out with family. Add Aricept (for dementia) 5 mg Q (every) hs (night) x 4 weeks then 10 mg Q hs. Current			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	meds Lexapro 10 mg QD - anxiety. Namenda XR 28 mg QD - dementia." A 3/3/16 Psychiatric note indicated "Resident sitting in common area, pleasant smiling oriented as above. 'I'm doing great'. No c/os anxiety, no c/o pain. Continue on course no changes." Review of progress notes between 12/1/15 and 4/11/16 lacked documentation the resident was experiencing depression and anxiety. Interview with the Social Worker on 4/11/16 at 9:10 a.m.,indicated: "No Gradual Dose Reductions have been tried on the Lexapro". Random observations of the resident throughout the day on 4/6/16 and 4/7/16 indicated the resident was very active in all the daily activity events. Interview with LPN #5 on 4/7/16 at 9:05 a.m., indicated that if the resident's door was closed, then her and her roommate were at the activity program and were very difficult to catch. On 4/11/16 at 10:00 a.m., the Director of Nursing (DON) presented a copy of the facility's current policy titled "Psychotropic Management Policy". Review of this policy at this time			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	included, but was not limited to: "Policy: It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practical mental, physical, and psychosocial well-being. These medications are managed in collaboration with the attending physician, pharmacist and facility staff to include behavioral interventions, assessment and reduction as applicable. Procedure:...4, The facility will initiate a request for a Gradual Dose Reduction at least on the following schedule for each drug....c. For residents who use sedative/hypnotic medication a GDR must be initiated per the following guidelines: - For as long as the resident remains on a sedative hypnotic, the facility should attempt a GDR quarterly unless contraindicated by the physician. For a resident who uses antidepressant medications a GDR must be initiated per the following guidelines: During the first year that the resident is admitted to the facility on an antidepressant or after the facility has initiated an antidepressant, a GDR must be attempted in two separate quarters with at least one month in between attempts, unless contraindicated by the physician. After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	3. On 04/07/16 at 2:33 p.m., the review of the MDS (minimum data set) Quarterly review assessment for Resident # 59, dated 02/03/16, indicated a BIMS (Brief Interview for Mental Status) score of 11 (moderately impaired). The Active Diagnosis indicated anemia, heart failure, hypertension, diabetes mellitus, chronic atrial fibrillation, coronary angioplasty implant and graft hypothyroidism, morbid (severe) obesity due to excess calories, insomnia, atherosclerotic heart disease, gastro-esophageal reflux disease with esophagitis, and kidney failure. The review of the MDS Assessment Significant Change In Status, dated 12/02/15, the CAAs and Care Planning indicated Cognitive Loss/Dementia, ADLs [Activities of Daily Living] Functional Status/Rehabilitation Potential, Urinary Incontinence, Falls, Nutritional Status, Dental Care, Pressure Ulcers, and Psychotropic Medication Use. The review of the Care Plan on 04/07/16 at 2:46 p.m., did not indicate antidepressant use or monitoring the resident for antidepressant drugs or for insomnia. The review on 04/08/16 at 9:29 a.m., of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	the admitting diagnosis, indicated chronic atrial fibrillation, coronary angioplasty implant/graft, fracture of shaft of humerus, hypothyroidism, diabetes mellitus, morbid (severe) obesity, hyperlipidemia, insomnia, hypertension, atherosclerotic heart disease, heart failure, kidney failure, retention of urine, and anemia. On 04/08/16 at 10:21 a.m., the review of the latest Psychiatric Follow-Up Evaluation, dated 03/18/16, indicated the facility requested an evaluation for the resident's increased confusion/psychosis/behaviors. The resident was reported to have repeated delusional physical and verbal aggression and mental status changes. The Psychiatric Nurse Practitioner also indicated the resident was admitted to a local hospital and returned the same day with a diagnosis of a UTI (urinary tract infection). The Psychiatric Nurse Practitioner indicated the need for medical stabilization, which was indicated as the likely cause of the delirium. Dialysis was suggested to the resident, but the nephrologist indicated the resident was not appropriate, due to comorbidities. The resident was evaluated by the Psychiatrist every 3 months (09/03/15, 12/03/15, 03/03/16).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	The review of the Pharmacy Medication Regimen Review on 04/08/16 at 10:49 a.m., indicated monthly reviews. No recommendations for GDR (Gradual Dose Reduction) could be located for the Trazadone or Paxil. On 04/08/16 at 2:40 p.m., the DON (Director of Nursing) provided a copy of the Physician's Order for Trazadone 50 mg orally every night for insomnia, written on "05/15/14 at 13:20" [1:20 p.m.]. On the same date a Physician's Order indicated the resident was to be seen and treated by Psychiatric services. A review on 04/08/16 at 2:40 p.m., a Behavior Events.... New/Worsening Behavior Communication Event, dated 03/14/16, documented/indicated the "Resident through out day becoming verbally agitated, resident calling others names and states being upset/angry, unable to express why he is upset/angry." No infections, pain, or psychosocial changes/stressors, were indicated. The Physician and family were not notified. The nursing staff tried interventions of "Reassurance, redirection, conversation, redirection." On 04/11/16 at 9:34 a.m., the review of the MDS Quarterly review assessment, dated 02/03/16, the Mood indicated, but			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	was not limited to, "No" presence of "Feeling down, depressed, or hopeless." "No" presence of "Trouble falling or staying asleep, or sleeping too much." "No Behaviors" were indicated. The review of the MDS Assessment Significant Change in Status, dated 12/02/15, the Mood indicated, but was not limited to, "No" presence of "Feeling down, depressed, or hopeless." "No" presence of "Trouble falling or staying asleep, or sleeping too much." "No Behaviors" were indicated. The review of the MDS Assessment Annual review assessment, dated 08/27/15, indicated but was not limited to, "No" presence of "Feeling down, depressed, or hopeless." No presence of "Trouble falling or staying asleep, or sleeping too much." "No Behaviors" were indicated. The review of the MDS Assessment Quarterly review assessment, dated 06/30/15, but was not limited to, "No" presence of "Feeling down, depressed, or hopeless." "No" presence of "Trouble falling or staying asleep, or sleeping too much." "No Behaviors" were indicated. During an interview on 04/11/16 at 10:11 a.m., the DON indicated there was no tracking at the facility for behaviors of depression or insomnia.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	On 04/11/16 at 1:12 p.m., during an interview with LPN (Licensed Practical Nurse) # 1, she indicated, after looking in the behavior monitoring log, she didn't monitor for any behaviors with Resident # 59. The LPN also indicated the resident sleeps well, but there are times he gets up. During an interview on 04/12/16 at 8:54 a.m., the DON indicated the timeliness for a response back from the physician for a pharmacy recommendation was 60 days. The DON indicated the pharmacist would review the charts, generate recommendations for GDRs, review labs, review medications for interactions, dosage, therapeutic interchanges and files a report within 3 business days. The Pharmacist marks on the yellow sheet (Medication Regimen Review) any recommendations made, and if something needs to be performed, she reports it directly to the her at the exit conference. The DON indicated the facility policy for the pharmacist recommendation, was if a recommendation is made and the physician doesn't follow up, then a second request is made. The DON indicated she interacts with the pharmacist and an exit conference is conducted after the pharmacy review. If an evaluation was not conducted by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	pharmacist, she would bring it up with the pharmacist. We will wait a week if necessary for an evaluation, if not made. The pharmacist follows the same policy for all medication as recommended for antipsychotics. The physician should write a reason for declination/acceptance of a medication on the rational lines of the recommendation. This sheet asks the physician to indicate the reason for declining or acceptance of the medication recommendation. 3.1-48(2) 3.1-48(3) 3.1-48(4) 3.1-48(6)(b)(1) 3.1-48(6)(b)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation and interview, the facility failed to store and serve food under sanitary conditions during 3 of 3 kitchen observations, in that soiled ice cream scoops were stored in the clean drawer; frozen food was stored in the freezer unsealed; and soiled dishes were stacked as being clean after being run through the dish machine. Findings include: 1. During the initial kitchen tour on 4/6/16 between 8:45 a.m., and 9:15 a.m., while accompanied by the Dietary Manager and the Consultant Dietitian, the following was observed: a. 1 of 5 scoops stored in the clean rack had food debris inside and under the slide. b. 1 box of french toast sticks' bag in the walk-in freezer was not fully sealed - no ice/frost was observed on the food. c. 1 box of cubed ham in the walk-in freezer had a plastic bag with a crack/slit in it which exposed the meat.	F 0371	All dishes and scoops were run through dish machine to ensure they were properly sanitized. A new dish machine was installed on 4/15/2016. All food items that were stored improperly in freezer were discarded. All residents residing in the facility have the potential to be affected by the alleged deficient practice. A new low-temperature dish machine was installed on 4/15/2016. Staff were in-serviced by Dietary Manager on 4/15/2016 regarding proper use of the dish machine, including proper pre-cleaning of dishes, changing the dish machine water when needed, and inspecting all dishes after cleaning. All items in freezer were inspected for proper storage by DM; any items not stored properly were discarded. Staff were in-serviced by Dietary Manager on proper frozen food storage techniques on 4/26/16. All dietary staff in-serviced on 4/26/16 on the proper use of a low-temperature dish machine, including pre-cleaning dishes and inspecting dishes once clean. All dietary staff in-serviced on 4/26/16 onproper froze food storage. To ensure compliance, the Dietary Manager/Designee will	05/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	2. During the lunch meal observation on 4/6/16 between 11:40 a.m., and 12:30 p.m., with the Dietary Manager and the Consultant Dietitian also observing, the following was observed: a. 1 of 7 scoops to be used for lunch service was observed with food debris inside the scoop and under the slide. b. 5 of 57 dinner plates used for lunch were observed with food debris on them - these had been stored all stacked together in the clean hot dish holder. c. 1 of 3 divided puree dishes under the steam table had food debris inside. d. 11 of 39 stacked plastic cereal bowls were observed with food debris inside. The cook was observed to have stop serving the meal in order to place these items off to the side before she resumed serving the lunch meal. 3. During the lunch meal observation on 4/8/16 between 11:35 a.m., and 12:30 p.m., with the Dietary Manager also observing, the following was observed: a. 1 box of french toast sticks in the walk-in freezer was half closed but the bag was open to air.		complete the Kitchen Sanitation and Environmental Review CQI tool 5 times a week for 4 weeks, 3 times a week for 4 weeks, and then weekly for 10 months. The Safety and Sanitation Review will be completed monthly by the RD Consultant/Designee. The results of these CQI audits will be reviewed by the CQI committee monthly and action plans will be developed as needed. Date of Compliance: May 12, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	b.1 box of frozen beef patties was open to air. - no freezer burn/ice was observed on the meat. c. 4 of 12 scoops of various sizes stored in the clean drawer had food debris under the slides. d. 6 of 31 dinner plates stacked in the plate warmer and 2 of 28 cereal bowls stacked on clean trays had dried food food debris inside which the cook had to stop the meal service in order to place them over to the side before she resumed to continue serving the meal. She indicated at this time that "The dishwasher has been an issue for awhile." Observation of the dishmachine at 12:30 p.m., noted the water to be cloudy with food particles in the water. The Dietary Manager indicated at this time that "This water was from the morning washing of the breakfast dishes. The water in the dishmachine is changed after every meal and will be changed before they start the lunch dishes today." In an interview with the Administrator on 4/8/16 at 2:00 p.m., she indicated the new dishwasher arrived about a week or 2 ago and was supposed to be installed on 4/6/16, but she canceled its installation due to plastic and paper plates were going			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	to have to be used during the State survey process until the new machine was in place. She also indicated she was unsure when the machine will be installed as the electrician and the plumber now have to re-coordinate their schedules as both have to be present at the same time to do the installation. During an interview with Dietary Aide #1 on 4/11/16 at 9:30 a.m., she indicated that when doing the dishes, the protocol was to stack the dishes in the rack, rinse them off, run them through the machine and then check them for cleanliness before stacking. She also indicated she started scrubbing any dishes which had stuck-on food before running them through the dish machine. In an interview with the Dietary Manager also on 4/11/16 at 9:45 a.m., he indicated that since he was aware of the dishwasher issues, the staff were instructed to thoroughly spray off all the food on the dishes, run them through the machine and check them to ensure they were clean before stacking them for use at the next meal. He also indicated the staff were now soaking and scrubbing any dishes with stuck-on food which was unable to be sprayed off.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	3.1-21(i)(3)			
F 0460 SS=E Bldg. 00	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.			
	Based on observation and interview, the facility failed to ensure resident bedrooms had full visual privacy, in that curtains were too short when pulled around the resident bed, and/or were hanging off the ceiling tracks. This deficient practice affected 16 of 33 resident rooms observed. (Rooms 100A and B, 405B, 403B, 404A, 400B, 601A and B, 603B, 303B,103B, 205B, 101B, 302A, 504B, and 407B). Findings include: 1. During initial room observations on 4/6/16 between 10:30 a.m., and 11:20 a.m., the following was observed: a. Room 403B - the curtain between the beds was 1 foot too short to provide	F 0460	Privacy curtains in rooms 100A, 100B, 405B,403B, 404A, 400B, 601A, 601B, 603B, 303B, 103B, 205B, 101B, 302A, 504B, and 407B were replaced and corrected to provide full visual privacy per regulation. All residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was completed by Housekeeping/Laundry Supervisor of all resident rooms to identify rooms in which curtains were hung incorrectly and/or did not provide full visual privacy. Housekeeping and Laundry staff were in-serviced on Privacy Curtains, including the correct technique for hanging and washing, on 4/7/2016. All staff in-serviced on 4/25/16 to notify ED and/or Housekeeping/Laundry	05/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	privacy when fully extended. Bed B's curtain had an 8 inch gap when fully extended with the first hook hanging down off the track. b. Room 404A - the curtain between the beds and Bed A's curtain were each 1 foot too short to provide privacy when fully extended. c. Room 100B - the curtain between the beds and Bed B's curtain were both 7 inches too short to provide visual privacy when fully extended. 2. During initial room observations on 4/7/16 between 9:15 a.m., and 11:00 a.m., the following was observed: a. Room 405B - Bed B's privacy curtain was 9 inches too short to provide visual privacy when fully extended. b. Room 400B - the curtain between the beds and Bed B's curtain were both 1 foot too short to provide privacy when fully extended. 3. During initial room observations on 04/06/16 between 11:19 a.m., and 11:38 a.m., the following was observed: a. The privacy curtains in room 303B, between the two residents beds, was 2 feet short when extended. Resident # 59 indicated being upset by the lack of		Supervisor immediately if curtains are observed not providing full visual privacy in any resident room. New curtains arrived at facility on 4/12/16 and were hung in resident rooms immediately. Housekeeping and Laundry staff were in-serviced on Privacy Curtains, including the correct technique for hanging and washing, on 4/7/2016. All staff in-serviced on 4/25/16 to notify ED and/or Housekeeping/Laundry Supervisor immediately if curtains are observed not providing full visual privacy in any resident room. New curtains were obtained by facility that meet regulatory guidelines and hung on 4/12/2016. To ensure compliance, the Housekeeping/Laundry Supervisor will complete an audit to ensure that privacy curtains in resident rooms ensure full visual privacy per regulation. This audit will be completed 1 time per week for 4 weeks, then 1 time per month for 11 months. The results of these audits will be reviewed bythe CQI committee monthly and action plans will be developed as needed. Date of Compliance: May 12, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	privacy in the room. The privacy curtains appeared torn at the top right corner, and hooks were missing, leaving the corner of the curtain hanging. b. The privacy curtains in room 100A, between the two residents beds, was 18 inches short when extended. c. The privacy curtains in room 103B, between the two residents beds, was 18 inches short when extended. 4. During initial room observations on 04/07/16 between 8:59 a.m., and 9:20 a.m., the following was observed: a. The privacy curtains in room 303B, between the two residents beds, was 18 inches short when extended. The hooks of the perpendicular privacy curtains were detached from the curtains, preventing the curtains from fully closing, by 20 inches when extended. b. The privacy curtains in room 101B, between the two residents beds, was 18 inches short when extended. c. The privacy curtains in room 302A, between the two residents beds, was 18 inches short when extended. 5. During the initial room observations			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	on 4/6/16 from 11 a.m., to 2 p.m., and 4/7/16 from 9 a.m., to 1 p.m., the following observations were made: a. Observation in room 601 A: The privacy curtain exposed twelve inches on one side of the residents bed. b. Observation in room 504 B: The privacy curtain exposed twelve inches on one side of the residents bed. c. Observation in room 407 B: The privacy curtain exposed twelve inches on both sides of the residents bed. 6. During the intial room observation on 04/11/2016 between 1:33 p.m., and 1:45 p.m., the following was observed: a. In the room 601B the privacy curtain did not extend all the way to the wall leaving an 18 inch gap between the beds which prevented visual privacy. b. In the room 603B the privacy curtain did not extend all the way to the wall leaving an 18 inch gap between the beds which prevented visual privacy. During an observation with the Maintance Director on 04/11/2016 at 1:48 p.m., he indicated "I was not aware the curtains were short in some rooms". During an interview with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155267		04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	Housekeeping Supervisor on 04/12/2016 at 9:17 a.m., she indicated "yes some of the curtains are too short. I see how short the curtains are. The curtains are a work in progress". 3.1-19(l)(6)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a clean, comfortable and functional environment for 8 of 33 resident rooms and 1 of 1 common resident bathroom observed, in that window sills were cracked with missing pieces of wood; ceilings were stained; paint/plaster was chipped and/or missing; and bathroom doors had chipped and missing pieces of wood with edges that were splintered and rough to the touch. (Dining Room Bathroom, Rooms #100B, 405B, 403B, 404A, 601A, 504B, 600A, and 502B). Findings include: 1. During initial room observations on	F 0465	The bathroom door in room 403B was repaired. The window sill, walls, and ceiling stains in room 404A were repaired. The caulking above the air conditioning unit in room 100B was repaired. The window blinds,chipped plaster, and bathroom door in room 405B were repaired. The bathroom tiles in room 601A were repaired. The window sill in room 504B was repaired.The scrape on the wall in room 600A was repaired. The window sill in room 502B was repaired. The facility restroom across the hall from the dining room is a public restroom and is cleaned once daily and more as needed. All residents residing in the facility have the potential to be affected by the alleged deficient	05/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	4/6/16 between 10:30 a.m., and 11:20 a.m., the following was observed: a. Room 403B - the bottom corner edge on the inside inside of the bathroom door had a 1/2 by 1/2 inch chip out of door which was rough to the touch. b. Room 404A - the right edge/corner of the window sill was missing a 3 inch by 2 inch piece of wood which was rough to the touch. The wall to which the wood window sill connected to was missing 4 inch by 3 inch plaster which was also cracking with loose plaster on the window sill. The wall above the window sill had an area of 3 inch by 3 inch missing plaster. The left side of the wall above the window sill had 2 areas of missing plaster. The first area was missing a 1/2 inch by 2 inch piece of plaster. The second area was missing a 2 inch by 4 inch piece of plaster. Multiple brown ceiling stains ranging in sizes from 1 foot by 8 inch, 4 inch by 2 inch, and 6 inches round were observed above Bed B's bed. c. Room 100B - the caulking around the top of the air conditioning unit was cracked 1 foot in length.		practice. An audit/inspection of all resident rooms was completed by Maintenance Director and ExecutiveDirector and all necessary repairs were completed. Inspection included but not limited to window sills, ceilings, bathroom floors, paint and plaster, window blinds, and doors. The facility will be undergoing renovations beginning June of 2016 which will include but not limited to replacing all window sills in resident rooms, repairing and painting of walls in all resident rooms, and replacement of bathroom floor tile in resident bathrooms. All staff were in-serviced on 4/25/2016 to use Work Order forms when any item in a resident room is in need of repair and to submit these forms to the Maintenance Director immediately. Customer Care Representatives will monitor resident rooms on a daily basis and fill out Work Order forms as necessary for any items in need of repair. To ensure compliance, the Maintenance Director/designee will complete an audit of resident rooms to ensure a safe/functional/sanitary/comfortable environment 1 time per week for 8 weeks,then 1 time per month for 10 months. The results of these audits will be reviewed by the CQI committee monthly and action plans will be developed as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	2. During an initial room observation on 4/7/16 at 11:00 a.m., the following was observed:. a. Room 405B - 4 of 20 window blind slats were missing - the window overlooked the patio where chairs, a table and a grill was located. The left side of the wall just above the window sill had a 2 inch by 2 inch area of chipped and missing wall plaster. Both sides of the bathroom door had areas of 2 feet missing and splintered wood which was rough to the touch. 3. During the initial room observations on 4/6/16 from 11 a.m., to 2 p.m., and 4/7/16 from 9 a.m., to 1 p.m., the following observations were made: a. Observations in room 601 A's bathroom: Tiles were a black stained in color measuring 12 inches by 24 inches and the baseboard was pushed in 12 inches. b. Observations in room 504 B's bedroom: Window sill broken measuring 3 inches by 2 inches. Scrape up the wall measuring 2 inches by 3 feet. c. Observations in room 600 A's		Date of Compliance: May 12, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE POINTE VILLAGE	545 W MOONGLO RD SCOTTSBURG, IN 47170

(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
	bedroom: Scrape up the wall measuring 4 inches by 6 inches. d. Observations in room 502 B's bedroom: Window sill broken measuring 8 inches by 1 inch. 4. During the initial tour on 04/06/2016 at 11:57 a.m., the facility restroom across the hall from the dining room, had a strong odor of urine. Three residents were observed going in and out of the bathroom while waiting for lunch to be served. During an observation on 04/07/2016 at 10:30 a.m., the facility restroom across the hall from the dining room, had a strong odor of urine. During an interview with the Housekeeping Supervisor on 04/12/16 at 9:30 a.m., she indicated she checks the bathroom often during the day. There are four residents that use the bathroom, across the hall from the dining room, and it's possible one of them will dribble on the floor. She indicated "I have asked the CNA's (Certified Nursing Assistance) to help me with this". She indicated they mop the floor and make rounds randomly throughout the day. During a tour of the facility with the Maintenance Director on 04/11/2016 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/12/2016
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170	

(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
	1:48 p.m., he indicated he was unaware of the plaster and part of the window sill missing. The Maintenance Director inspected the wooden doors to the bathrooms and indicated the chips and splintered edges would have to be fixed. He indicated there should not be any mold on the tiles in the showers. The Maintaince Director indicated he was unaware that the curtains were too short in some of the resident's rooms. 3.1-19(a)(4) 3.1-19(f)			