

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 05/10/2016
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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: 05/10/16</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 70 and had a census of 53 at</p>	K 0000	<p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please review the audit tools provided with this plan of correction (attached). Please feel free to contact Skylar Stephenson, Executive Director, should you need any additional information to support the desk review at 812-752-3499. Thank you for your consideration.</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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K 0062 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>Quality Review completed on 05/13/16 - DA</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 or clean 3 of over 300 sprinklers in the kitchen covered in corrosion. 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 shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 30 residents who use the main dining room, located adjacent to the kitchen.</p>	K 0062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? P.I.P.E. Inc. installed temporary sprinkler heads in the walk in cooler and above the food preparation table on 5/11/2016. P.I.P.E. Inc. has ordered replacement sprinkler heads and will install them immediately upon arrival. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents that use the facility dining room have the potential to be affected.</p>	05/20/2016

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	<p>Findings include:</p> <p>Based on observations on 05/10/16 during a tour of the kitchen with the maintenance supervisor from 10:00 a.m., the walk in cooler sprinkler and the two sprinklers above the food preparation table were completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/10/16 at 12:00 p.m.</p> <p>3.1-19(b)</p>		<p>P.I.P.E.Inc. installed temporary sprinkler heads in the walk in cooler and above the food preparation table on 5/11/2016. P.I.P.E. Inc. has ordered replacement sprinkler heads and will install them immediately upon arrival. An audit was completed of sprinklers throughout the facility by the Maintenance Director to ensure that no other sprinkler heads were corroded. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An audit was completed of sprinklers throughout the facility by the Maintenance Director to ensure that no other sprinkler heads were corroded. Visual inspections of sprinkler heads throughout facility are performed monthly by the Maintenance Director to ensure that sprinkler heads are maintained in reliable operating condition. 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 To ensure compliance, the Maintenance Director will complete an audit of facility sprinkler heads to ensure that they are in reliable operating condition. This audit will be completed 1 time per month for 12 months. The results of these audits will be reviewed by the CQI committee monthly and action</p>		

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K 0000 Bldg. 02	<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: 05/10/16</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</p>	K 0000	<p>plans will be developed as needed.</p> <p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please review the audit tools provided with this plan of correction (attached). Please feel free to contact Skylar Stephenson, Executive Director, should you need any additional information to support the desk review at 812-752-3499. Thank you for your consideration.</p>	

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K 0011 SS=E Bldg. 02	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 53 at 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>Quality Review completed on 05/13/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 two hour fire rated separation wall between the Therapy addition and the original building was maintained. This deficient practice affects 5 residents who use the therapy room.</p> <p>Findings include:</p>	K 0011	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 3 one half inch gaps around cable bundles were repaired using fire caulk on 5/11/2016. The one half inch open electrical conduit was repaired by sealing it with fire caulk on 5/11/2016. How will you identify other residents</p>	05/20/2016

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	<p>Based on observation on 05/10/16 at 11:35 a.m. with the maintenance supervisor, the fire barrier wall, located in the corridor between the therapy room and the original building, had three, one half inch gaps around cable bundles not fire stopped on both sides of the fire barrier wall and a one half inch open electrical conduit not fire stopped on both sides of the fire barrier wall. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 05/10/16 at 12:00 p.m.</p> <p>3.1-19(b)</p>		<p>having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents using the therapy room have the potential to be affected. The 3 one half inch gaps around cable bundles were repaired using fire caulk on 5/11/2016. The one half inch open electrical conduit was repaired by sealing it with fire caulk on 5/11/2016.</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? An inspection of the 2 hour fire separation wall was completed by the Maintenance Director to ensure that the wall is not compromised. Inspections will be completed any time that modifications are made to the wall. 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? To ensure compliance, the Maintenance Director will complete an audit of facility 2 hour fire separation wall to ensure that the wall is not compromised. This audit will be completed 1 time per month for 12 months. The results of these audits will be reviewed by the CQI committee monthly and action plans will be developed as needed.</p>		