

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 11/17/2015
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00186507.</p> <p>Complaint IN00186507 - Substantiated. Federal/State deficiencies related to the allegations are cited at F223, F225 and F226.</p> <p>Survey dates: November 16 and 17, 2015</p> <p>Facility number: 000168 Provider number: 155267 AIM number: 100267020</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 11 Medicaid: 44 Other: 5 Total: 60</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 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 would like to request a desk review. 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>	

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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F 0223 SS=D Bldg. 00	<p>QR completed by 34849 on November 25, 2015.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review the facility failed to ensure residents were protected from abuse, in the form of gestured language, by a staff member. This deficient practice affected 1 of 3 residents reviewed for abuse. (Resident B).</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 11/16/15 at 11:00 a.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, racing thoughts,</p>	F 0223	<p>Social Service and Psych follow-up were completed with resident and resident did not display any signs or symptoms of distress. SS and Psych NP will continue to monitor resident. All staff in-serviced on abuse policy and procedure and reporting by management staff;this was completed 11/30/2015. Resident encouraged by Social Services to voice concerns immediately to staff.</p> <p>All residents residing in the facility have the potential to be affected by the alleged deficient practice. All staff in-serviced on abuse</p>	12/16/2015

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	<p>muscle weakness, and osteoporosis.</p> <p>The MDS (Minimum Data Set) assessment, dated 9/24/15, indicated a BIMS (Brief Interview for Mental Status) score of 10, which indicated Resident B was cognitively impaired.</p> <p>During an interview with CNA (Certified Nursing Assistant) #1, on 11/16/15 at 12:00 p.m., she indicated she overheard LPN (Licensed Practical Nurse) #1 and LPN #2 talking about LPN #1 dressing up as Resident B for the facility-ran Halloween costume contest held on 10/30/15.</p> <p>Resident B was not in the facility at the time of the employee Halloween costume contest on 10/30/15.</p> <p>During an interview with CNA #2, on 11/16/15 at 12:50 p.m., she indicated she saw LPN #1 wearing Resident B's blouse and mimicking Resident B's actions on 10/30/15. CNA #2 indicated LPN #1 was using a walker in a jerking manner and asked CNA #2, "Will you get my pop". CNA #2 indicated these are the gestures that Resident B displays on a daily basis.</p> <p>During an observation on 11/16/15 at 1:15 p.m., Resident B was observed using a walker in a jerking type motion.</p>		<p>policy and procedure and reporting; this was completed 11/30/2015. All alert and oriented residents in facility were interviewed by Social Services Director with no concerns voiced using the QIS abuse questions. All staff in-serviced on abuse policy and procedure and reporting by management staff and a post test was completed by all staff including what to do if abuse if witnessed; this was completed 11/30/2015. Staff was in-serviced that they are not to borrow items from residents, even with consent. Staff was also in-serviced regarding gestured language/verbal abuse. In-service will be conducted for all facility new hires regarding Abuse Policy and Procedure during general orientation. In-service will be conducted for all staff on Abuse Policy and Procedure quarterly. All alert and oriented residents in facility interviewed by Social Services Director with no concerns voiced. Executive Director and Social Services Director to request invitation to Resident Council on 12/28/2015 to provide education on importance of reporting concerns, utilizing grievance forms, and the use of the ASC Hotline number. An Abuse Prohibition and Investigation CQI tool will be used by the Executive Director/designee weekly x4 weeks, monthly x6months, and</p>		

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	<p>During an interview at the time of observation, Resident B asked, "Will you get my pop". Resident B indicated she did not remember if she allowed LPN #1 to borrow her clothes or if she had a conversation with LPN #1 about dressing up as twins for the employee Halloween contest, as LPN #1 had indicated.</p> <p>During an interview with LPN #2 on 11/16/15 at 1:30 p.m., she indicated she saw LPN #1 mimicking Resident B's actions on the day of the Halloween costume contest. LPN #2 indicated LPN #1's outfit was supposed to resemble Resident B. LPN #2 indicated she overheard a conversation when LPN #1 asked to borrow Resident B's clothing.</p> <p>During an interview with LPN #1 on 11/16/15 at 1:40 p.m., she indicated she did borrow Resident B's blouse after having a conversation with Resident B about dressing up as twins for the employee Halloween contest. She indicated she wore Resident B's blouse on the day of the employee Halloween contest. She indicated she "wanted a piece of the resident to be there with her" to participate in the day since Resident B was not in the facility. She indicated her name badge was changed to, "Master of Mayhem". She indicated she caused "a little havoc on the unit" and she was</p>		<p>then quarterly thereafter. The results of these CQI audits will be reviewed by the CQI committee monthly and action plans will be developed as needed if threshold of 100% is not met.</p> <p>Lake Pointe Village respectfully requests additional evidentiary information be considered to delete the following deficiencies F 223, F 225, and F 226, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.</p>	

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	<p>"doing pranks to other employees". She indicated she brought the blouse home, washed the clothing, and returned it to the resident's room, after the event.</p> <p>During an interview with the SSD (Social Services Director), the ED (Executive Director) and the DON (Director of Nursing) on 11/16/15 at 3:12 p.m., the SSD indicated she alerted the ED and DON on 10/30/15 at 9:00 a.m. that LPN #1 was wearing Resident B's blouse. The ED indicated she was unaware and "must have forgotten" the conversation with the SSD, that it was Resident B's blouse that LPN #1 was wearing on the day of the employee Halloween contest. The DON indicated she observed LPN #1 wearing Resident B's blouse and the name tag, "Master of Mayhem". The DON indicated she spoke with LPN #1, on 10/30/15, about not using a walker in the facility and indicated she instructed LPN #1 to be careful because LPN #1's actions may be seen as offensive.</p> <p>During an interview with the AD (Activities Director) on 11/17/15 at 9:30 a.m., she indicated LPN #1 had told her she was dressed up as Resident B on the day of the Halloween employee costume contest (10/30/15). The AD indicated she observed LPN #1 using Resident B's gestures, such as, using a walker in a</p>			

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	<p>jerking motion, and asking others to get her a pop.</p> <p>The current policy and procedure titled, "Abuse Prohibition, Reporting, and Investigation", and dated July, 2015, was received from the Director of Nursing on 11/16/15 at 1:30 p.m. This policy included, but was not limited to, the following: "1. ...will not permit our residents to be subjected to abuse by anyone, including employees... ..5. All abuse allegations/abuse must be reported to the Executive Director immediately and to the resident's representative (spouse, responsible party) within 24 hours of the report. Failure to report will result in disciplinary action... 6. The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed..."</p> <p>This Federal tag relates to complaint IN00186507.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>				

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F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>			

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	<p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure a staff reported allegation of abuse was reported to the Indiana State Department of Health (ISDH) for 1 of 3 residents reviewed for abuse. (Resident B)</p> <p>Findings include:</p> <p>During an interview with CNA (Certified Nursing Assistant) #1, on 11/16/15 at 12:00 p.m., she indicated she overheard LPN (Licensed Practical Nurse) #1 and LPN #2 talking about how LPN #1 dressed up and imitated Resident B, by wearing the resident's clothing and gesturing/mimicking the resident's daily mannerisms, for a facility-ran Halloween event that was held on 10/30/15. CNA #1 indicated she reported this incident to the corporate hotline on 10/31/15. CNA</p>	F 0225	<p>An investigation and report was submitted to ISDH on 11/20/2015 by Executive Director. Social Service and Psych follow-up were completed with resident and resident did not display any signs or symptoms of distress. SS and Psych NP will continue to monitor resident. All staff in-serviced on abuse policy and procedure and reporting; this was completed 11/30/2015. All residents residing in the facility have the potential to be affected by the alleged deficient practice. All staff in-serviced on abuse policy and procedure and reporting; this was completed 11/30/2015. All alert and oriented residents in facility were interviewed by Social Services Director with no concerns voiced. All staff in-serviced on abuse policy and procedure and reporting; this was completed 11/30/2015. Executive Director given one-on-one</p>	12/16/2015

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	<p>#1 also indicated she discussed the incident with the SSD (Social Services Director) on 10/31/15 and the SSD indicated she had notified both, the DON (Director of Nursing) and the ED (Executive Director), on 10/30/15, the day of the incident, about LPN #1 wearing Resident B's clothing.</p> <p>Resident B's clinical record was reviewed on 11/16/15 at 11:00 a.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, racing thoughts, muscle weakness, and osteoporosis.</p> <p>The MDS (Minimum Data Set) assessment, dated 9/24/15, indicated a BIMS (Brief Interview for Mental Status) score of 10, which indicated Resident B was cognitively impaired.</p> <p>Resident B was not in the facility on 10/30/15, the date of the incident (facility-ran Halloween costume contest).</p> <p>During an interview, with the SSD, the ED and the DON present, on 11/16/15 at 3:12 p.m., the ED indicated she was notified by an email from corporate office on 11/01/2015, that a staff member had reported an incident involving Resident B, on the corporate hotline on 10/31/15. The ED indicated this was when she first received notification of the</p>		<p>education by Director of Operations on abuse policy and procedure and to immediately report then investigate all allegations of abuse. In-service will be conducted for all facility new hires regarding Abuse Policy and Procedure during general orientation. In-service will be conducted for all staff on Abuse Policy and Procedure quarterly. All alert and oriented residents in facility were interviewed by Social Services Director with no concerns voiced using the QIS abuse questions. Executive Director and Social Services Director to request invitation to Resident Council on 12/28/2015 to provide education on importance of reporting concerns, utilizing grievance forms, and the use of the ASC Hotline number. The Executive Director will ensure that all allegations of abuse, neglect, or misappropriation of residents funds/property will be reported and thoroughly investigated immediately per the abuse policy and procedure, including but not limited to: suspension of employee(s), immediate reporting to ISDH, notification of family and physician, and initiation of investigation to gather further information. The Director of Operations will review grievances/incidents with the Executive Director to ensure proper reporting and investigation was completed. An Abuse – Staff</p>	

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	<p>allegations. The ED indicated she did not think of the allegations as "abuse" and did not report the incident to the Indiana State Department of Health. The ED also indicated the facility started an investigation into the allegations at the request of the corporate office. During the interview, the SSD indicated she had alerted the ED and DON on 10/30/15 at 9:00 a.m. that LPN #1 was wearing Resident B's blouse. The ED indicated she was unaware and must have forgotten this conversation with the SSD. The DON indicated she observed LPN #1 wearing Resident B's blouse and the name tag, "Master of Mayhem". The DON indicated she spoke with LPN #1 on the date of the incident (10/30/15) about not using a walker in the facility, and cautioned her that her actions may be seen as offensive.</p> <p>The current policy and procedure dated, July 2015 and titled, "Abuse Prohibition, Reporting, and Investigation", was received from the Director of Nursing on 11/16/15 at 1:30 p.m. This document included, but was not limited to the following: "...The Executive Director/designee will report all unusual occurrences, which include allegations of abuse, neglect, misappropriation of property... immediately to the Long Term Care Division of the Indiana State</p>		<p>Interview CQI tool will be used by the Executive Director/designee weekly x4 weeks, monthly x6 months, and then quarterly thereafter. This CQI tool monitors staff knowledge of abuse and abuse reporting. The results of these CQI audits will be reviewed by the CQI committee monthly and action plans will be developed as needed if threshold of 100% is not met. Lake Pointe Village respectfully requests additional evidentiary information be considered to delete the following deficiencies F 223, F 225, and F 226, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.</p>				

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F 0226 SS=D Bldg. 00	<p>Department of Health..."</p> <p>A copy of an email dated 11/01/15 at 7:09 a.m. was provided by the Administrator on 11/17/15 at 11:30 a.m. This email indicated that the corporate home office was aware of the allegations regarding Resident B, reported by a staff member on 10/31/15.</p> <p>This Federal tag relates to complaint IN00186507.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure written policies and procedures prohibiting the mistreatment, neglect and abuse of residents were implemented for 1 of 3</p>	F 0226	Social Service and Psych follow-up were completed with resident and resident did not display any signs or symptoms of distress. SS and Psych NP will continue to monitor resident. All	12/16/2015

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	<p>residents reviewed for abuse. (Resident B).</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 11/16/15 at 11:00 a.m. Diagnoses included, but were not limited to, schizophrenia, anxiety, racing thoughts, muscle weakness, and osteoporosis. The MDS (Minimum Data Set) assessment, dated 9/24/15, indicated a BIMS (Brief Interview for Mental Status) score of 10, which indicated Resident B was cognitively impaired.</p> <p>During an interview with CNA (Certified Nursing Assistant) #1, on 11/16/15 at 12:00 p.m., she indicated she overheard LPN (Licensed Practical Nurse) #1 and LPN #2 talking about LPN #1 being dressed up as Resident B for the facility-ran Halloween costume contest held on 10/30/15.</p> <p>During an interview with CNA #2, on 11/16/15 at 12:50 p.m., she indicated she saw LPN #1 mimicking Resident B's actions. CNA #2 indicated LPN #1 was using a walker in a jerking manner and asked CNA #2, "Will you get my pop". CNA #2 indicated that these are gestures that Resident B displays on a daily basis.</p>		<p>staff in-serviced on abuse policy and procedure and reporting; this was completed 11/30/2015.</p> <p>All residents residing in the facility have the potential to be affected by the alleged deficient practice.</p> <p>All staff in-serviced on abuse policy and procedure and reporting; this was completed 11/30/2015. All alert and oriented residents in facility were interviewed by Social Services Director with no concerns voiced using the QIS abuse questions.</p> <p>All staff in-serviced on abuse policy and procedure and reporting; this was completed 11/30/2015. Executive Director given one-on-one education by Director of Operations on abuse policy and procedure and to immediately report then investigate all allegations of abuse. Director of Operations re-educated Executive Director on implementation of abuse policy and procedures when abuse is alleged. All alert and oriented residents in facility interviewed by Social Services Director with no concerns voiced.</p> <p>In-service will be conducted for all facility new hires regarding Abuse Policy and Procedure during general orientation. In-service will be conducted for all staff on Abuse Policy and Procedure quarterly. Executive Director and Social Services Director to request invitation to Resident Council on 12/28/2015 to provide education on importance of</p>	

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	<p>During an interview with LPN #1 on 11/16/15 at 1:40 p.m., she indicated she did borrow Resident B's blouse after having a conversation with Resident B about dressing up as twins for the employee Halloween contest. She indicated she wore Resident B's blouse on the day of the employee Halloween contest, took the blouse home after the event, washed the blouse, and returned it to the resident's room. She also indicated she used a walker on that day and changed her name tag to read, "Master of Mayhem".</p> <p>During an interview with the SSD (Social Services Director), the ED (Executive Director), and the DON (Director of Nursing) on 11/16/15 at 3:12 p.m., the SSD indicated she alerted the ED and DON on 10/30/15 at 9:00 a.m. that LPN #1 was wearing Resident B's blouse. The ED indicated she was unaware and must have forgotten the conversation with the SSD regarding LPN #1 wearing Resident B's blouse. The DON indicated she observed LPN #1 wearing Resident B's blouse and the name tag, "Master of Mayhem". The DON indicated she spoke with LPN #1 about not using a walker in the facility, and cautioned her that her actions may be seen as offensive.</p> <p>During an interview with the Activities</p>		<p>reporting concerns, utilizing grievance forms, and the use of the ASC Hotline number. The Executive Director will ensure that all allegations of abuse, neglect, or misappropriation of residents funds/property will be reported and thoroughly investigated immediately per the abuse policy and procedure, including but not limited to: suspension of employee(s), immediate reporting to ISDH, notification of family and physician, and initiation of investigation to gather further information.</p> <p>An Abuse Prohibition and Investigation CQI tool will be used by the Executive Director/designee weekly x4 weeks, monthly x6months, and then quarterly thereafter. The results of these CQI audits will be reviewed by the CQI committee monthly and action plans will be developed as needed if threshold of 100% is not met.Lake Pointe Village respectfully requests additional evidentiary information be considered to delete the following deficiencies F 223, F 225,and F 226, from the 2567. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care andservices administered by the provider to its residents.</p>		

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 11/17/2015
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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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	<p>Director (AD) on 11/17/15 at 9:30 a.m., she indicated LPN #1 told her she was dressed up as Resident B on the day of the Halloween employee contest. The AD indicated she observed LPN #1 using Resident B's gestures, such as, using a walker in a jerking motion, and asking others to "get her a pop".</p> <p>The policy and procedure dated, July 2015 titled, "Abuse Prohibition, Reporting, and Investigation" was received from the Director of Nursing on 11/16/15 at 1:30 p.m. The policy included, but was not limited to, the following: "...Procedure: If resident abuse is identified or suspected, the following guidelines will be followed: ... 2. Any staff member implicated in the alleged abuse will be removed from the facility at once and will remain suspended until an investigation is completed... 8. An incident report will be initiated... 9. Residents will be questioned about the nature of the incident... 10. An investigation will be done to assure other residents have not been affected by the incident... 14. The Executive Director is responsible for notifying the following agencies immediately...Indiana State Department of Health..."</p> <p>Review of the facility investigation documents, provided by the ED on</p>			

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	<p>11/16/15 at 3:12 p.m., indicated LPN #1 was not removed from the facility at the time of the incident and was not suspended pending the outcome of the investigation. Documentation could not be located, regarding notification to the Indiana State Department of Health about the incident involving LPN #1 on 10/30/15.</p> <p>This federal tag relates to Complaint IN00186507.</p> <p>3.1-28(a)</p>			