STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155267	A. BUILDING -- B. WING	09/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/20/23 Facility Number: 000168 Provider Number: 155267 AIM Number: 100267020 At this Emergency Preparedness survey, Lake Pointe Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 68 certified beds. At the time of the survey, the census was 64. Quality Review completed on 09/26/23	E 0000	K 0000 This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The 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 paper compliance desk review and ask that your office accept this plan as our facility's compliance with the final compliance date of 10-31-2023. Please review the attachments provided with this plan of correction, which include audit tools, inspection/test results, and photos of work performed. Please feel free to contact Richey Barton, Executive Director, should you need any additional information to support the desk review at 812-752-3499. Thank you for your consideration	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/20/23 Facility Number: 000168	K 0000	K 0000 This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the department's	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richey Barton	Executive Director	10/09/2023

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	Provider Number: 155267 AIM Number: 100267020 At this Life Safety Code survey, Lake Pointe Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors which were connected to the fire alarm system, plus, hard wired smoke alarms in 16 of 36 resident sleeping rooms with battery backup which were not connected to the fire alarm system, but are single station smoke alarms, furthermore, there were hard wired smoke alarms in 20 of 36 resident sleeping rooms with no battery backup, but are single station smoke detectors. The facility has a capacity of 68 and had a census of 64 at the time of this visit. 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. Quality Review completed on 09/26/23		inspection report. We respectfully request a paper compliance desk review and ask that your office accept this plan as our facility's compliance with the final compliance date of 10-31-2023. Please review the attachments provided with this plan of correction, which include audit tools, inspection/test results, and photos of work performed. Please feel free to contact Richey Barton, Executive Director, should you need any additional information to support the desk review at 812-752-3499. Thank you for your consideration	
K 0100 SS=F Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC			

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	Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation; the facility failed to ensure 36 of 36 smoke alarms were tested for sensitivity in accordance with NFPA 72, National Fire Alarm and Signaling Code, 2010 edition in 36 of 36 resident rooms. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, Section 14.4.5.3 requires in other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7, Section 14.4.5.3.1 requires sensitivity shall be checked within 1 year after installation and Section 14.4.5.3.2 requires sensitivity shall be checked every alternate year thereafter. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 09/20/23 between 9:00 a.m. and 11:30 a.m. with the Maintenance Supervisor present, there was no documentation available to show any of the resident room hard wired single station smoke alarms were tested for sensitivity. Based on interview at the time of record review, the Maintenance Supervisor confirmed the lack of documentation for the testing of sensitivity of the single station resident room smoke alarms. Based on observations between 11:30 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, it was confirmed the facility was provided with a	K 0100	K 100 General Requirements 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice. All 36 smoke detectors were replaced with 10-year lithium battery smoke detectors. 2 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 have the potential to be affected by alleged deficient practice, all 36 resident room smoke detectors were replaced with 10-year lithium battery smoke detectors. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A weekly test is done on the smoke detectors to ensure compliance, monthly cleaning is also done. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A weekly test will be completed to	10/31/2023

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	combination of single station smoke alarm in resident rooms that were both battery backup and non-battery backup. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		ensure compliance. If 100% is not achieved an action plan will be implemented. To ensure compliance, the Executive Director will review the results with Quality Assurance Committee for review and recommendations.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to properly install an exit sign at 1 of 10 areas of exit discharge in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 09/20/23 between 11:30	K 0293	K 293 Exit Signage 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice. An exit sign was placed in the main corridor at the intersection. 2 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 have the potential to be affected by alleged deficient practice, exit signage was placed in the main corridor at the	10/31/2023

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	a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was no illuminated EXIT sign located at the intersection of the cross corridors between the 100 and 400 halls and the center front exit corridor that would lead occupants to exit towards the front entrance/exit in the event of an evacuation. Based on interview at the time of observation, the Maintenance Supervisor agreed this cross corridor area was lacking an EXIT sign with a directional arrow towards the front entrance/exit. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		intersection as you enter the building. All other exit signs were reviewed by Maintenance director with no concerns noted. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A 100% audit was completed on all exit signs ensuring compliance, audits to continue weekly for a period of no less than six months to ensure compliance. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: To ensure compliance, the Executive Director will review the results with Quality Assurance Committee for review and recommendations. If 100% is not achieved, an action plan will be implemented.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where			

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	smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were allowed to be smoked by residents. This deficient practice could affect at least 5 residents and staff. Findings include: Based on observations on 09/20/23 between 11:30 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the resident smoking area had at least 10 cigarette butts thrown in the trash can with paper trash. Based on interview at the time of observation, the Maintenance Supervisor agreed there were at least 10 cigarette butts mixed in the trash can with paper trash. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0741	K 741 Smoking Regulations 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice. The area around the building was inspected and all cigarette butts have been picked up and disposed of in the proper container. 2 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 have the potential to be affected by the alleged deficient practice, the building, parking lot, and smoking areas were checked by the maintenance director and no other issues were found. 3 What measures will be put	10/31/2023

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			into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff will be educated on designated smoking areas and how to properly dispose of a cigarette butt. The maintenance supervisor/designee will check the grounds and containers for butts and correct disposal of cigarette butts. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: To ensure compliance, the Executive Director will round with the maintenance supervisor to ensure cigarette butts are disposed of properly. The Executive Director will review the preventative maintenance checks performed by the maintenance supervisor/designee and bring the findings to QA committee for review and recommendation. The maintenance director will round weekly to ensure butts are disposed of properly. If 100% is not achieved, an action plan will be developed.	