STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155267		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/20/2023	
	PROVIDER OR SUPPLIER DINTE VILLAGE	545 W	ADDRESS, CITY, STATE, ZIP COD MOONGLO RD ISBURG, IN 47170		
(X4) ID PREFIX TAG E 0000	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
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 submiss of this plan of correction is not admission of or agreement with the deficiencies or conclusions contained in the department's inspection report. We respectfurequest a paper compliance dereview 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. Pleafeel free to contact Richey Bart Executive Director, should you need any additional information support the desk review at 812-752-3499. Thank you for you consideration	esion an n ully esk s a.	
K 0000 Bldg. 01					
2.5g. 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 submiss of this plan of correction is not admission of or agreement with the deficiencies or conclusions contained in the department's	e sion an n	
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

Richey Barton **Executive Director** 10/09/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	01	COMPLETED	
155267		B. WING 09/20/2023			
NAME OF I	DROVIDED OD CUDDI IE	T.	STREE	Γ ADDRESS, CITY, STATE, ZIP COD	l
NAME OF I	PROVIDER OR SUPPLIE	Л		/ MOONGLO RD	
LAKE PO	DINTE VILLAGE		SCOT	TSBURG, IN 47170	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	Provider Number:			inspection report. We respect	
	AIM Number: 100	0267020		request a paper compliance d	
	At this I if Sofate	Codo aument Laba Dainta		review and ask that your office	· · · · · · · · · · · · · · · · · · ·
		Code survey, Lake Pointe not in compliance with		accept this plan as our facility	S
	Requirements for 1	-		compliance with the final compliance date of 10-31-202	,
	_	d, 42 CFR Subpart 483.90(a),		Please review the attachment	
		ire and the 2012 edition of the		provided with this plan of	
		ection Association (NFPA) 101,		correction, which include audi	•
		LSC) and 410 IAC 16.2. The		tools, inspection/test results, a	
		vas surveyed with Chapter 19,		photos of work performed. Ple	
	Existing Health Ca	-		feel free to contact Richey Ba	
		•		Executive Director, should you	l l
	This one story faci	lity was determined to be of		need any additional information	
	Type V (000) cons	struction and fully sprinkled.		support the desk review at	
	The facility has a fire alarm system with hard wired			812-752-3499. Thank you for	your
	smoke detection in	the corridors and spaces open		consideration	
		nich were connected to the fire			
		, hard wired smoke alarms in 16			
		ping rooms with battery backup			
		nnected to the fire alarm			
	_	gle station smoke alarms,			
		were hard wired smoke alarms			
		t sleeping rooms with no battery			
	* '	ngle station smoke detectors.			
		capacity of 68 and had a census			
	of 64 at the time of this visit. All areas where residents have customary access				
		l all areas providing facility			
	_	nkled. The facility has three			
	_	sheds used for storage which			
	were not sprinkled				
	Quality Review co	ompleted on 09/26/23			
K 0100	NFPA 101				
SS=F	General Require	ments - Other			
Bldg. 01	General Require				
		RKS section any LSC			

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Event ID:

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10/12/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 09/20/2023 155267 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 545 W MOONGLO RD LAKE POINTE VILLAGE SCOTTSBURG, IN 47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0100 K 100 General Requirements 10/31/2023 observation; the facility failed to ensure 36 of 36 What corrective action(s) will smoke alarms were tested for sensitivity in be accomplished for those accordance with NFPA 72, National Fire Alarm residents found to have been and Signaling Code, 2010 edition in 36 of 36 affected by the deficient practice? resident rooms. NFPA 101 in 4.6.12.3 states No residents were affected by existing life safety features obvious to the public, alleged deficient practice. All 36 if not required by the Code, shall be maintained. smoke detectors were replaced NFPA 72, Section 14.4.5.3 requires in other than with 10-year lithium battery smoke one- and two-family dwellings, sensitivity of detectors. smoke detectors and single- and multiple-station How will you identify other smoke alarms shall be tested in accordance with residents having the potential to 14.4.5.3.1 through 14.4.5.3.7, Section 14.4.5.3.1 be affected by the same deficient requires sensitivity shall be checked within 1 year practice and what corrective action after installation and Section 14.4.5.3.2 requires will be taken? sensitivity shall be checked every alternate year All residents have the potential to thereafter. This deficient practice could affect all be affected by alleged deficient residents, as well as staff and visitors. practice, all 36 resident room smoke detectors were replaced Findings include: with 10-year lithium battery smoke detectors. Based on record review on 09/20/23 between 9:00 What measures will be put 3 a.m. and 11:30 a.m. with the Maintenance into place or what systemic Supervisor present, there was no documentation changes you will make to ensure available to show any of the resident room hard that the deficient practice does not wired single station smoke alarms were tested for recur? sensitivity. Based on interview at the time of A weekly test is done on the record review, the Maintenance Supervisor smoke detectors to ensure confirmed the lack of documentation for the compliance, monthly cleaning is testing of sensitivity of the single station resident also done. room smoke alarms. Based on observations How the corrective action(s) between 11:30 a.m. and 1:30 p.m. during a tour of will be monitored to ensure the the facility with the Maintenance Supervisor, it deficient practice will not recur: was confirmed the facility was provided with a A weekly test will be completed to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4ZOV21

Facility ID: 000168

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155267		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/20/2023	
	ROVIDER OR SUPPLIER		545 W	ADDRESS, CITY, STATE, ZIP COD MOONGLO RD TSBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 0293 SS=E	resident rooms that non-battery backup. This finding was redirector and Mainte exit conference. 3.1-19(b) NFPA 101	the station smoke alarm in were both battery backup and with the Executive enance Supervisor during the		ensure compliance. If 100% is achieved an action plan will be implemented. To ensure compliance, the Executive Director will review the results Quality Assurance Committee review and recommendations	e with for
SS=E Bldg. 01	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:		K 0293	K 293 Exit Signage 1 What corrective action(s) be accomplished for those residents found to have been affected by the deficient pract No residents were affected by alleged deficient practice. An sign was placed in the main corridor at the intersection. 2 How will you identify other residents having the potential be affected by the same defic practice and what corrective a will be taken? All residents have the potential be affected by alleged deficient practice, exit signage was plant.	exit er to ient action al to nt
	Based on observation	ons on 09/20/23 between 11:30		in the main corridor at the	

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Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155267		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/20/2023	
		545 W	ADDRESS, CITY, STATE, ZIP COD MOONGLO RD ISBURG, IN 47170		
PREFIX	(EACH DEFICIEN REGULATORY OF a.m. and 1:30 p.m. the Maintenance Su	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION during a tour of the facility with pervisor, there was no	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) intersection as you enter the building. All other exit signs	COMPLETION DATE were
	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.			reviewed by Maintenance d with no concerns noted. 3 What measures will be into place or what systemic changes you will make to er that the deficient practice do recur? A 100% audit was complete all exit signs ensuring comp audits to continue weekly fo period of no less than six m to ensure compliance. 4 How the corrective acti will be monitored to ensure deficient practice will not recompliance, the Executive Director will revier results with Quality Assurant Committee for review and recommendations. If 100% achieved, an action plan will implemented.	put nsure pes not d on liance, r a ponths on(s) the cur: w the ce
SS=E	Smoking Regulati Smoking Regulati Smoking regulatic shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib used or stored and location, and such signs that read NO posted with the in- smoking.	ons ons shall be adopted and ess than the following be prohibited in any room,			

IDENTIFICATION NUMBER 155267 NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE SUMMARY STATEMENT OF DETICIENCIE PRETEX TAO SIDUATION OR SUMMARY STATEMENT OF DETICIENCIE TAO SIDUATION OR SUMMARY STATEMENT OF DETICIENCIE TAO SIDUATION TAO SIDUATION OR SUMMARY STATEMENT OF DETICIENCIE TAO SIDUATION TAO SIDUATI	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	(X3) DATE SURVEY	
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SAM MOONGLO RD SCOTTSBURG NATION	155267		B. WING 09/20/2023			/2023		
SAM MOONGLO RD SCOTTSBURG RIPPLIER					STREET A	ADDRESS, CITY, STATE, ZIP COD		
LAKE POINTE VILLAGE SCOTTSBURG, IN 47170 SUMMARY STATEMENT OF DEFICIENCE GACTI DEFICIENCY MINTS BE PRECEDED BY BUIL TAG 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. (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. (8) 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 buts 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 buts 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.	NAME OF P	PROVIDER OR SUPPLIEF	2					
D PREFIX CALL DEFICIENCY JUST BE PRECEDED BY FULL TAG	LAKE PC	INTE VILLAGE						
RECULATORY OR LSC IDENTIFYING INFORMATION 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 prohibited in all areas where smoking is permitted. (8) 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. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference.	WA ID	OLD O CADA	OT A TEN (EVIT OF DEPLOYED LOVE			, I		
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(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 eigarette 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. 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. We fortune the provided in all areas where smoking areas were checked shearly and safe design shall be provided in all areas where smoking areas were checked shall be provided in all areas where smoking areas were shecked shall be provided in all areas where smoking areas were shecked shall be provided in all areas where smoking areas were checked shall be provided in all areas where smoking areas were shecked shall be provided in all areas where smoking areas were shecked shall be provided in all areas where smoking areas were checked shall be provided in all areas where smoking areas were checked shall be provided in all areas where smoking is permitted. K 741 Smoking Regulations 1 (What corrective action(s) will be accomplished for those residents found to have been affected by the adeficient practice. The area around the building was inspected and all cigarette butts have been picked by the		, ,						
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exit conference. and smoking areas were checked								
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3.1-19(b) no other issues were found.		3.1-19(b)				_		
3 What measures will be put						3 What measures will be p	ut	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4ZOV21 Facility ID: 000168

If continuation sheet Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>01</u>		COMPLETED		
155267		B. WI	B. WING		09/20/	2023	
		<u> </u>	—	CTREET	ADDRESS CITY STATE 7ID COD		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD MOONGLO RD		
IAKEDO	DINTE VILLAGE				SBURG, IN 47170		
LANLIC				30011			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(TE	COMPLETION
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					into place or what systemic		
					changes you will make to ens		
					that the deficient practice doe	s not	
					recur?		
					All staff will be educated on		
					designated smoking areas an	d	
					how to properly dispose of a		
					cigarette butt. The maintenan		
					supervisor/designee will chec		
					grounds and containers for bu		
					and correct disposal of cigare butts.	ue	
					4 How the corrective action	2(0)	
					will be monitored to ensure th	` '	
					deficient practice will not recu		
					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 che	ecks	
					performed by the maintenance	e	
					supervisor/designee and bring	the	
					findings to QA committee for		
					review and recommendation.	The	
					maintenance director will rour	nd	
					weekly to ensure butts are		
					disposed of properly. If 100%	is	
					not achieved, an action plan v	vill	
					be developed.		

Event ID: 4ZOV21 Facility ID: 000168 If continuation sheet Page 7 of 7