DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC.	AID SERVICES		OMB NO. 09			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED			
	155067	D WING	10/02/2022			

IPLETED 10/03/2022 15526*1* 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 PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE E 0000 Bldg. --An Emergency Preparedness Survey was E 0000 E 0000 This plan of correction conducted by the Indiana Department of Health in constitutes the facilities written accordance with 42 CFR 483.73. allegation of compliance for the deficiencies cited. The submission Survey Date: 10/03/22 of this plan of correction is not an admission of or agreement with Facility Number: 000168 the deficiencies or conclusions Provider Number: 155267 contained in the department's AIM Number: 100267020 inspection report. We respectfully request a paper compliance desk At this Emergency Preparedness survey, Lake review and ask that your office Pointe Village was found in compliance with accept this plan as our facility's Emergency Preparedness Requirements for compliance with the final Medicare and Medicaid Participating Providers compliance date of Oct 14 2022. and Suppliers, 42 CFR 483.73. Please review the attachments provided with this plan of The facility has 68 certified beds. At the time of correction, which include audit the survey, the census was 59. tools, inspection/test results and photos of work performed. Please Quality Review completed on 10/05/22 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 K 0000 E 0000 This plan of correction Licensure Survey was conducted by the Indiana constitutes the facilities written allegation of compliance for the Department of Health in accordance with 42 CFR 483.90(a). deficiencies cited. The submission of this plan of correction is not an Survey Date: 10/03/22 admission of or agreement with

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility Number: 000168

TITLE

the deficiencies or conclusions

contained in the department's

(X6) DATE

Any defiency statement 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155267	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	COMI	E SURVEY PLETED 3/2022
	PROVIDER OR SUPPLIEF		545 W	ADDRESS, CITY, STATE, ZIP CO MOONGLO RD TSBURG, IN 47170	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	Provider Number: AIM Number: 100 At this Life Safety Village was found a Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I original building w Existing Health Car This one story facil Type V (000) const The facility has a fi smoke detection in to the corridors whi alarm system, plus, all resident sleeping which were not consystem, but are sing The facility has a co of 59 at the time of All areas where res were sprinkled and services were sprinkled. Quality Review conservations of the safety of	Code survey, Lake Pointe not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, LSC) and 410 IAC 16.2. The as surveyed with Chapter 19, re Occupancies. The occupancies with ard wired the corridors and spaces open the corridors and spaces open the were connected to the fire hard wired smoke detectors in grooms with battery back up meeted to the fire alarm gle station smoke detectors. The apacity of 68 and had a census this visit. The facility has three heds used for storage which		inspection report. We re request a paper compliance with the finate compliance with the finate compliance date of Oct Please review the attack provided with this plane correction, which include tools, inspection/test rephotos of work perform feel free to contact Rich Executive Director, showned any additional information support the desk review 812-752-3499. Thank you consideration	espectfully ance desk ur office facility's al 14 2022. chments of le audit sults and ed. Please ney Barton, uld you ormation to v at	
K 0211 SS=E Bldg. 01	discharges, exit lo in accordance wit					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155267	A. BUILDING 01 COMPLET B. WING 10/03/20			
		133207			10/03/2	2022
NAME OF F	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD MOONGLO RD		
LAKE POINTE VILLAGE				SBURG, IN 47170		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY 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
	emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 or was continuously in This deficient pract residents, as well as Meadow Lane. Findings include: Based on observation p.m. and 2:00 p.m. the Maintenance Discale stored in the Meadow Lane. This finding was re	on and interview, the facility of 5 corridor means of egress maintained free of obstructions. ice could affect up to 17 staff and visitors in the ons on 10/03/22 between 12:15 during a tour of the facility with rector, there was a wheelchair Meadow Lane corridor outside Based on interview at the time Maintenance Director wheelchair scale being stored	K 0211	1. What corrective action(s will be accomplished for those residents found to have been affected by the deficient pract No residents were affected by alleged deficient practice. Wheelchair scales moved from Meadow Hallway 2. How will you identify oth residents having the potential be affected by the same deficient practice and what corrective a will be taken? 16 Meadow Hallway residents have potential to be affected to alleged deficient practice. Wheelchair scales removed for the hallway upon survey exit. Maintenance Director reviewed other hallways with no concernoted. 3. What measures will be printo place or what systemic changes you will make to ensithat the deficient practice doe recur? Visual inspection of corridors be completely daily during rounding by Maintenance Director designer and issues with the wheelchait scale will be brought to QAPI.	ice? ice? ice? ice on the control of the control	10/14/2022

4. How the corrective action(s)

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	A. BUILDING <u>01</u>			COMPLETED	
		155267	B. WING 10/03/2022					
	PROVIDER OR SUPPLIE	R		545 W	ADDRESS, CITY, STATE, ZIP COD MOONGLO RD ISBURG, IN 47170			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					will be monitored to ensure the deficient practice will not recur To ensure compliance, the Executive Director will review results with Quality Assurance Committee for review and recommendations.	r: the		
K 0331 SS=E Bldg. 01	exposed interior s as fixed or moval columns, and hav Class A or Class	Ceiling Finish ceiling finishes, including surfaces of buildings such ple walls, partitions, are a flame spread rating of B. The reduction in class of a sprinkler system as 2.8.1 is permitted.						
	review; the facility as an interior finish had a flame spread LSC 101 10.2.3.4 stested in accordance Method of Test of Characteristics of I grouped in the followith their flame sp (a) Class A Interior spread 0-25; smoke any material classic spread test scale and scale. Any element not continue to pro (b) Class B Interior	Building Materials, shall be owing classes in accordance read and smoke development. Wall and Ceiling Finish. Flame e development 0-450. Includes fied at 25 or less on the flame ad 450 or less on the smoke test t thereof, when so tested, shall	K 03	331	 What corrective action(s will be accomplished for those residents found to have been affected by the deficient practic. No residents were affected by alleged deficient practice. All a accesses were all covered wit 5/8" drywall. How will you identify oth residents having the potential be affected by the same deficient practice and what corrective a will be taken? All residents have the potential be affected by alleged deficient practice, the two attic accesses were replaced with 5/8' drywa 	e attic ch er to ient action al to ent es	10/14/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED		
		155267	B. W	B. WING			10/03/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	<u>t</u>		545 W I	MOONGLO RD			
LAKE PO	INTE VILLAGE			SCOTTSBURG, IN 47170				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	AN OF CORRECTION (X5		
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
	_	ied at more than 25 but not effame spread test scale and			and upon audit for facility all w	ere		
	450 or less on the sr	-			made compliant.			
		Wall and Ceiling Finish. Flame			3. What measures will be p	ut		
	* *	ke development 0-450.			into place or what systemic	ut		
	-	al classified at more than 75			changes you will make to ensu	ıre		
	_	00 on the flame spread test			that the deficient practice does			
		s on the smoke test scale.			recur?			
		ice could affect up to 17			A 100% audit was completed	on		
	residents, staff, and	visitors while in the same			all attic accesses compliance,			
	smoke compartmen	ts.			audits to continue weekly for a	1		
					period of no less than six mon	ths		
	Findings include:				to ensure compliance.			
	Based on observation	ons on 10/03/22 between 12:15			4. How the corrective action	n(s)		
		during a tour of the facility with			will be monitored to ensure the	, ,		
		rector, the two attic access			deficient practice will not recur			
		e South Nurses' Station and in			To ensure compliance, the			
	the Conference Roo	om (next to the Physical			Executive Director will random	ıly		
	Therapy gym) were	both about two foot by two			review the audits and check fo	-		
	foot and constructed	d of painted plywood. This			accuracy a minimum of two tin	nes		
	was acknowledged	by the Maintenance Director			monthly for a period of six mor	nths		
	at the time of each of	observation.			to ensure compliance reporting	g		
					findings to QA committee for			
	_	viewed with the Executive			review and recommendation.			
		enance Director during the exit						
	conference.							
	3.1-19(b)							
K 0920	NFPA 101							
SS=D		ent - Power Cords and						
Bldg. 01	Extens							
-	Electrical Equipme	ent - Power Cords and						
	Extension Cords							
	Power strips in a p	patient care vicinity are only						
	used for compone	nts of movable						
	patient-care-relate	ed electrical equipment						
		les that have been						
	assembled by qua	lified personnel and meet						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155267		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 01 COMPLETED B. WING 10/03/2022			
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		545 W	ADDRESS, CITY, STATE, ZIP COD MOONGLO RD FSBURG, IN 47170		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	the patient care vinon-PCREE (e.g., except in long-terr do not use PCREI meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3	0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE OLL 60601-1. Power strips the patient care rooms meet UL 1363. In pooms, power strips meet is. All power strips are precautions. Extension das a substitute for fixed	K 0920	1. What corrective action(swill be accomplished for those residents found to have been affected by the deficient praction. The power strip was removed from beauty salon upon survey existents having the potential be affected by the same deficients having the potential be affected by the same deficient practice and what corrective awill be taken? 1 staff member had the potent to be affected by alleged deficient practice, the power strip was removed, and new beauticiant educated by maintenance directed and executive director. 3. What measures will be	cice? / ce in the tt. der to cient caction tial cient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO			COMPL	COMPLETED	
		155267	B. WING 10/03/2022			2022		
				·				
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					MOONGLO RD			
LAKE POINTE VILLAGE			SCOTT	SBURG, IN 47170				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	the power strip in th	ne Beauty Shop and said the			into place or what systemic			
	beautician is new to	the facility and doesn't know			changes you will make to ensu	ure		
	the regulations.		that the deficient practice does not					
					recur?			
	This finding was re	viewed with the Executive			Beauty Salon will be inspected	t		
	Director and Mainte	enance Director during the exit			weekly by maintenance man o			
	conference.				executive director disignee for	four		
					weeks and monthly to ensure			
	3.1-19(b)				compliance.			
					4. How the corrective action	n(s)		
					will be monitored to ensure the	Э		
					deficient practice will not recur	:		
					To ensure compliance, the			
					Executive Director will review	the		
					results with Quality Assurance)		
					Committee for review and			
					recommendations for 6 month	S.		
K 0000								
D								
Bldg. 03	1 T C G C . G 1	D. down						
	-	Recertification and State	K 0	000	E 0000 This plan of correctio			
		vas conducted by the Indiana			constitutes the facilities writter			
	-	th in accordance with 42 CFR			allegation of compliance for th			
	483.90(a).				deficiencies cited. The submis			
	a 5 10/0				of this plan of correction is not			
	Survey Date: 10/03	5/22	1		admission of or agreement wit			
	F 312 37 1 ^	00170			the deficiencies or conclusions			
	Facility Number: 0				contained in the department's			
	Provider Number:				inspection report. We respectf	-		
	AIM Number: 100	20/020			request a paper compliance d			
	Audi Tie e e				review and ask that your office			
	-	Code survey, Lake Pointe			accept this plan as our facility'	S		
	Village was found i	•			compliance with the final	20		
	Requirements for P	-			compliance date of Oct 14 202			
		, 42 CFR Subpart 483.90(a),			Please review the attachments	S		
		re and the 2012 edition of the			provided with this plan of			
		ection Association (NFPA) 101,			correction, which include audit			
	Life Safety Code (L	LSC) and 410 IAC 16.2. The			tools, inspection/test results a	nd		

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 03		COMPLETED				
		155267	B. W	ING		10/03/2022				
				CTREET	ADDRESS CITY STATE ZIP COP					
NAME OF P	ROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD 545 W MOONGLO RD						
I AKE PO	INTE VILLAGE				SBURG, IN 47170					
LAKE POINTE VILLAGE			30011	35013, 11 47 170						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	ATE	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE			
	_	Activity room addition to the			photos of work performed. P					
	•	was surveyed with Chapter 18,			feel free to contact Richey B					
	New Health Care C	Occupancies.			Executive Director, should ye					
					need any additional informat	ion to				
		to the one story facility was			support the desk review at					
		f Type V (111) construction and			812-752-3499. Thank you fo	r your				
		ne facility has a fire alarm system			consideration					
		noke detection in the corridors								
		the corridors which were								
		re alarm system, plus, hard								
		tors in all resident sleeping								
		back up which were not								
		re alarm system, but are single								
		ctors. The facility has a								
		had a census of 59 at the time								
	of this visit.									
		sidents have customary access								
	_	all areas providing facility								
	_	kled. The facility has three								
		heds used for storage which								
	were not sprinkled.									
	O 1': D '	1 4 1 10/05/22								
	Quality Review co	mpleted on 10/05/22								
			I		1		I			

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