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	10/03/2022

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: 10/03/22 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 59. Quality Review completed on 10/05/22	E 0000	E 0000 This plan of correction constitutes the facilities 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 Oct 14 2022. 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: 10/03/22 Facility Number: 000168	K 0000	E 0000 This plan of correction constitutes the facilities 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

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	155267	A. BUILDING 01 B. WING	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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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 detectors in all resident sleeping rooms with battery back up which were not connected to the fire alarm system, but are single station smoke detectors. The facility has a capacity of 68 and had a census of 59 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 10/05/22		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 Oct 14 2022. 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 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of			

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	155267	A. BUILDING 01 B. WING	10/03/2022

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

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	all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egress was continuously maintained free of obstructions. This deficient practice could affect up to 17 residents, as well as staff and visitors in the Meadow Lane. Findings include: Based on observations on 10/03/22 between 12:15 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, there was a wheelchair scale stored in the Meadow Lane corridor outside the shower room. Based on interview at the time of observation, the Maintenance Director acknowledged the wheelchair scale being stored in the Meadow Lane corridor. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0211	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. Wheelchair scales moved from Meadow Hallway 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? 16 Meadow Hallway residents have potential to be affected by alleged deficient practice. Wheelchair scales removed from the hallway upon survey exit. Maintenance Director reviewed all other hallways 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? Visual inspection of corridors will be completely daily during rounding by Maintenance Director or Executive Director designee and issues with the wheelchair scale will be brought to QAPI. 4. How the corrective action(s)	10/14/2022

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			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.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish in 2 of 6 smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes	K 0331	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 attic accesses were all covered with 5/8" drywall. 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, the two attic accesses were replaced with 5/8' drywall	10/14/2022

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	any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect up to 17 residents, staff, and visitors while in the same smoke compartments. Findings include: Based on observations on 10/03/22 between 12:15 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, the two attic access panels located at the South Nurses' Station and in the Conference Room (next to the Physical Therapy gym) were both about two foot by two foot and constructed of painted plywood. This was acknowledged by the Maintenance Director at the time of each observation. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		and upon audit for facility all were made compliant. 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 attic accesses 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 randomly review the audits and check for accuracy a minimum of two times monthly for a period of six months to ensure compliance reporting findings to QA committee for review and recommendation.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet			

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	the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 1 Beauty Shop. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident and staff. Findings include: Based on observations on 10/03/22 between 12:15 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, there were two curling irons and one hand held hair dryer plugged into a power strip in the Beauty Shop. Based on interview at the time of observation, the Maintenance Director acknowledged the use of	K 0920	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 power strip was removed from the beauty salon upon survey exit. 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? 1 staff member had the potential to be affected by alleged deficient practice, the power strip was removed, and new beautician educated by maintenance director and executive director. 3. What measures will be put	10/14/2022

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	the power strip in the Beauty Shop and said the beautician is new to the facility and doesn't know the regulations. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		into place or what systemic changes you will make to ensure that the deficient practice does not recur? Beauty Salon will be inspected weekly by maintenance man or executive director disignee for four weeks and monthly 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 for 6 months.	
K 0000 Bldg. 03	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: 10/03/22 Facility Number: 000168 Provider Number: 155267 AIM Number: 100267020 At this Life Safety Code survey, Lake Pointe Village was found 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	K 0000	E 0000 This plan of correction constitutes the facilities 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 Oct 14 2022. Please review the attachments provided with this plan of correction, which include audit tools, inspection/test results and	

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	2017 Dining room/Activity room addition to the Memory Care Unit was surveyed with Chapter 18, New Health Care Occupancies. This 2017 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 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 detectors in all resident sleeping rooms with battery back up which were not connected to the fire alarm system, but are single station smoke detectors. The facility has a capacity of 68 and had a census of 59 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 10/05/22		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	