STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155267	A. BUILDING 00 B. WING	10/17/2024

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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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00444354. Complaint IN00444354 - Federal/State deficiency related to the allegations is cited at F744. Survey date: October 17, 2024 Facility number: 000168 Provider number: 155267 AIM number: 100267020 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 3 Medicaid: 41 Other: 13 Total: 57 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 23, 2024.	F 0000	***This Plan of Correction constitutes the written allegation of compliance for deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a post survey re-visit on or after 11-08-2024***	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on interview, observation and record review, the facility failed to appropriately handle a resident with a diagnosis of dementia and a behavior of figiting for re-positioning for 1 of 3 residents reviewed for dementia care. (Resident B) Findings include:	F 0744	What corrective action will be done by the facility? Resident B was assessed for pain, skin impairments, and psychosocial distress with no findings, and was not harmed by the alleged deficiency	11/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Richey Barton	Executive Director	11/03/2024

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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	The review of the Reportable Incident to the Indiana Department of Health (IDOH), dated 9/30/24, indicated a family member reported to the Executive Director (ED) that there was rough handling by an aide on the memory care unit (Cottage) which happened on 9/22/24. The record for Resident B was reviewed on 10/17/24 at 3:30 p.m. The resident was admitted to the facility's dementia unit on 8/13/24 from home and was subsequently sent out to a psychiatric facility shortly after admission for behavioral issues. She returned to the facility dementia unit on 9/18/24. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease; mood disorder due to known physiological condition with manic features; dementia in other diseases of moderate with behavioral disturbances; Bipolar disorder of current episode manic with severe psychotic features, delusional disorders, anxiety disorder, depression, syncope and collapse, abnormalities of gait with motility, impulsiveness; and fracture of second thoracic vertebrate. The Admission Minimum Data Set (MDS) assessment, dated 9/25/24, indicated the resident had long and short term memory loss and was severely impaired for cognitive skills for daily decision making. She required two staff for assistance with toileting and ADLs (Activities of Daily Living). A care plan, dated 8/13/24, indicated the resident exhibited cognitive impairment with a BIMS (Brief Interview of Memory) less than 13. The resident's cognition was severely impaired. The long term goal was for the resident to continue to participate in daily decisions as able and will remain alert and		How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? All dementia residents requiring assistance with positioning have the potential to be affected. Residents identified at risk will have skin and pain assessments completed. All nursing staff were re-educated regarding the appropriate positioning of dementia residents. What measures will be put into place to ensure that this practice does not recur? - All staff will be educated on proper positioning of dementia residents that fidget, have poor posture, etc. to ensure proper positioning of dementia residents are being done. Skills validation for positioning for all nursing staff completed. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place? To ensure compliance, the DNS/Designee is responsible for visual observation 5x week for 4 weeks, 3x week for 4 weeks, then weekly for four weeks, then	

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	oriented at current level. The interventions included, but were not limited to, encourage social interaction; give resident choices throughout the day regarding decisions as able; provide resident with prompts and cues as needed; and provide simple instructions and repeat as needed. A care plan, with a start date of 9/19/24, indicated the resident at times prefered to get onto her hands and knees and crawl on the floor/sleep on the floor. The resident experienced the following behaviors: anxiousness, restlessness, repetitive worries related to a diagnosis of anxiety disorder, severe agitation, delusional behaviors, and intrusive wandering related to diagnosis of Bipolar disorder with manic and severe with psychotic features. During an interview on 10/17/24 at 3:13 p.m., the complaiant indicated he on the day of the incident it was very chaotic and hectic back on the dementia unit. There was a COVID outbreak in the facility and on the unit. Staff were trying to keep the residents with COVID in their rooms and the others out of those rooms. He was visiting his family member in his room and he had to go to the bathroom. He walked out to get the key from the nursing station and went to the bathroom. As he was returning the key, he saw two Certified Nurse Aides (CNAs) were trying to get Resident B to sit down as she kept trying to get up. He then saw a CNA walk by the resident who was sitting in a chair by the nursing station. The CNA used her hand and by the resident's head she shoved her back into the chair. The aide did not speak to the resident, she just pushed her back down into the chair. When she pushed the resident down, the resident screamed, but this resident had a habit of screaming out quite frequently for no reason. He was not sure if she actually hurt her. He did not		monthly for 3 months, validating repositioning is being done properly on the cottage. The results of these observations will be reviewed by the QAPI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. Compliance Date: 11-08-2024	

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	report it to anyone until a week later. The record indicated, on 9/30/24, CNA 2 recalled the incident between her and Resident B on 9/22/24. The CNA indicated that the only incident she could recall was when she sat with Resident B on the couch in the dining room. Since the resident had been crying so hard, she held her close and took her hand and gently guided the resident's head to her shoulder, which calmed the resident down a little while later. Review of the progress notes, between 9/22/24 and 9/26/24, did not indicate the resident had bruising to her forehead due to allegation of rough treatment by a CNA nor did she appear fearful with staff when helping her. In a second interview with CNA 2, the ED, and Director of Nursing (DON), dated 10/1/24, the CNA was made aware of the allegation by a resident's family. She denied the incident occurring and was not aware of any other staff, including herself, who could have done that. During an interview with Resident C on 10/17/24 at 10:55 a.m., she was asked what she remembered from that day involving CNA 2 and Resident B. She indicated CNA 2 was sitting on different couches with Resident B talking to her.The CNA appeared to be trying to get Resident B to lay her head on the pillow by placing her hand on her forehead and gently pushing her to lay down and rest. She used her open hand and kind of pushed her head back as if trying to get her to lay back on the pillow. During an interview with RN 7 on 10/17/24 at 2:45 p.m., she indicated Resident B may have been leaning forward so much like she does that CNA 2			

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	just put her hand on the resident's forehead to prevent her from falling forward onto the floor and straighten up so she could lay down. She would have used the resident's arms to re-position her or guided her body back. During an interview with the Scheduler on 10/17/24 at 2:53 p.m., she indicated she was also a CNA. Although she believed it was okay for CNA 2 to use her hand on the resident's forehead to guide her back up, she would have used the resident's arms to help guide her into a better position. During an observation of Resident B at 2:55 p.m., the resident was observed sitting in her high back tilt chair (a chair that provides greater upper and lower back support, as well as taking the strain off your neck and shoulders) at a table with other residents and CNA 6. The resident was observed to be fidgety in her chair occasionally leaning forward. During an interview with Licensed Practical Nurse (LPN) 10 on 10/17/24 at 3:00 p.m., she indicated that she felt like the aide was only trying to re-position the resident by placing her hand on the resident's forehead and pushing her back to prevent falling to the floor. She would not have used her hand on the resident's forehead, she would use the resident's arms or another CNA to help re-position her and tilt her back. During an interview with CNA 11 on 10/17/24 at 3:05 p.m., she indicated she was taught to re-position a resident using their arms or body to prevent them from falling forward. This citation relates to Complaint IN00444354.			

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