PRINTED: 09/24/2024

DEPARTMENT OF HEALTH AND HUN	FORM APPROVED					
CENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039					
STATEMENT OF DEFICIENCIES	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
	155267	B. WI	ING	08/30/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
			545 W MOONGLO RD			
LAKE BODITE WILLAGE			00077001100 101 47470			

LAKE PO	DINTE VILLAGE		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		
F 0000						
Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 27, 28, 29, and 30, 2024 Facility number: 000168 Provider number: 155267 AIM number: 100267020 Census Bed Type: SNF/NF: 62 Total: 62 Census payor type: Medicare: 2 Medicaid: 42 Other: 18 Total: 62	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 09-30-2024			
F 0690 SS=D Bldg. 00	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 4, 2024. 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to follow appropriate infection control guidelines related to catheter bag and tubing touching the floor for a resident with an indwelling urinary catheter for 1 of 5 residents reviewed for Urinary Tract Infections. (Resident 35) Findings include:	F 0690	It is the policy of this facility to ensure that each resident with indwelling catheters receive appropriate care and services that prevent infections. What corrective action will be done by the facility? All nursing staff were re-educated regarding appropriate care and services for residents who have	09/30/2024		

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

TITLE

(X6) DATE

Richey Barton **Executive Director** 09/17/2024

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VO5I11 Facility ID: 000168 If continuation sheet Page 1 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(Y2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY			
AND PLAN OF CORRECTION				ULTIPLE CC UILDING		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER 155267			00	_			
		155207	D. W	B. WING 08/30/2024					
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD				
					MOONGLO RD				
LAKE PC	DINTE VILLAGE			SCOTTSBURG, IN 47170					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	During the Residen	t Council Meeting			indwelling catheters, including]			
	observation, on 8/2	8/24 at 1:45 p.m., the Resident			assurance that the resident's				
	35's indwelling urin	nary catheter tubing could be			catheter bag and tubing do no	ot			
	heard dragging the	floor as the Activities Director			touch the floor at any time.				
		neelchair the resident was in, to			Resident 35 catheter tubing h	as			
		e wheelchair wheels ran over			been adjusted to ensure tubir	ıg			
	the indwelling urina	ary catheter tubing.			does not touch the floor.				
					How will the facility identify ot	<u>her</u>			
		ident 35 was reviewed on			residents having the potential	to			
		a. The resident's diagnoses			be affected by the same prac	tice_			
		not limited to, dementia,			and what corrective action wil	l be_			
	· ·	e and reflux uropathy, stage 3			taken?				
		ease, anuria and oliguria, and			All residents having catheters	have			
	urinary tract infecti	on.			the potential to be affected. If	any			
					resident with an indwelling				
	_	d 5/2/23, indicated the resident			catheter is observed to have				
	_	ing urinary catheter due to			his/her catheter tubing and/or				
		y. The interventions, dated			catheter drainage bag touchir	ng the			
		avoid obstructions in the			floor, the DNS/designee will				
	_	ot allow tubing or any part of			address the issue with the sta	ıff			
	the drainage system	n to touch the floor.			involved at that time. Once th	е			
					staff reposition the bag and tu	_			
		ated 12/20/23 at 5:16 a.m.,			are in the proper position, the				
		ent's catheter bag was found			DNS/designee will re-train the	staff			
	~	or. A new catheter bag was			involved on the facility policy				
	put in place.				regarding how the drainage b	•			
					and tubing should be placed s				
		ated 1/13/24 at 5:57 p.m.,			that it does not touch the floor	•			
		lwelling urinary catheter was in			Written counseling will be				
	_	resident's complaints of pain			completed for continued				
		w urine was in the BSD			noncompliance.				
	(bedside drain). The resident indicated that it was				What measures will be put int				
	starting to feel better.				place to ensure that this pract	ice			
					does not recur?				
	1	iplinary team) note, dated			DNS will conduct rounds each				
	1/15/24 at 3:50 p.m., indicated the resident was				shift to ensure catheter tubing	g is			
		hospital with diagnoses of			placed appropriately.				
	hypoxia and acute	UTI (urinary tract infection).			How will corrective action be				
					monitored to ensure the pract				
The urine culture results from the urine collection,				does not recur and what QA v	<u>vill</u>				

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED			
		155267	B. WING 08/30/2024			24			
				CTREET	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER									
	NATE VIII A OF			545 W MOONGLO RD					
LAKE PC	DINTE VILLAGE			SCOTTSBURG, 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 C	OMPLETION		
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	on 1/15/24, reported	d results, dated 1/23/24, had			be put into place?				
	greater than 2 organ	nisms recovered. There was			To ensure compliance, the				
	greater than 100,00	0 colony forming units.			DNS/Designee is responsible	for			
					the completion of the Cathete	r			
	The Quarterly MDS	S (Minimum Data Set)			QAPI tool weekly times 4 wee	ks,			
	assessment, dated 4	/18/24, indicated the resident			monthly times 6 and then				
	was cognitively inta	act.			quarterly. The results of these				
					audits will be reviewed by the				
	During an interview	and tour with the DON			QAPI committee overseen by	the			
	(Director of Nursing	g) on 8/30/24 at 8:20 a.m., the			ED. If threshold of 95% is not				
	catheter tubing show	ıld be secured with a clip			achieved an action plan will be	,			
	device when resider	nts were in their wheelchairs.			developed to ensure complian	ce.			
	The tubing should r	not be dragging the floor. Staff			Compliance Date: 09-30-2024	_			
	should check for the	e tubing location when a							
	resident was in their	r wheelchair, to make sure the							
		ing the floor and to make sure							
	the clip device was	holding the tubing.							
	_	on 8/30/24 at 8:44 a.m., the IP							
	1	onist) indicated the indwelling							
	1	ing and bag should be kept off							
	_	pinching and infection. She							
		on catheter monitoring and							
	care in March, Apri	l, July and August 2024.							
	Dunin : .	1 on 9/20/24 of 9:45 1							
		on 8/30/24 at 8:45 a.m., the							
		indicated she would watch for							
		to make sure it was fastened							
		ir. She heard the sound when							
		elchair up to the table for							
		out thought it was just the							
	mindful in the futur	sound. She would be more							
	inmarui in the lutur	e or me morng.							
	During an interview	on 8/30/24 at 9:00 a.m., QMA							
	1	ion Aide) 4 indicated the aides							
	* *	care often during their shift.							
	performed cameter	care often during their sillit.							
	The Nursing policy	, last revised June 2024,							
	included, but was not limited to, " b. Urinary					1			

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Event ID:

VO5I11

Facility ID: 000168

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155267		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ()	(X3) DATE SURVEY COMPLETED 08/30/2024	
	ROVIDER OR SUPPLIER		545 W	ADDRESS, CITY, STATE, ZIP COD MOONGLO RD ISBURG, IN 47170	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0880 SS=D	catheters should have them or a wash basis to prevent catheter the ground" 3.1-41(a)(2) 483.80(a)(1)(2)(4)	ve a catheter bag cover over in underneath them as a barrier pag or tubing from touching			
Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation and interview, the facility failed to ensure that infection control practices were followed related to placement of the indwelling urinary catheter tubing and bag at the bedside for 1 of 3 residents observed for infection control prevention. (Resident 34) Findings include: During an initial observation on 8/27/24 at 8:31 a.m., Resident 34's indwelling urinary catheter bag was in a bath basin, but the tubing was on the floor. During an observation on 8/29/24 at 10:33 a.m., the resident was asleep in bed and her catheter bag was sitting on the floor. During an observation on 8/29/24 at 2:32 p.m., the resident was asleep in bed with her catheter bag folded in half on the fall mat with her bed in its' lowest position. The tubing was on the fall mat. During an observation on 8/30/24 at 8:17 a.m., the resident's tubing was on the floor under the indwelling urinary catheter bag and the bag was scrunched down. There was orange urine backed up in the tubing up to the resident's upper leg.		F 0880	It is the policy of this facility to ensure that each resident with indwelling catheters receives appropriate care and services finfection prevention. What corrective action will be done by the facility? All nursing staff were re-educat regarding infection prevention residents who have indwelling catheters, including assurance that the resident's catheter bag and tubing do not touch the floor at any time. Resident 34 no longer has indwelling catheter. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be at increased risk of infection. All resident with catheters were reviewed to ensure tubing was appropriately placed. If any resident with an indwelling catheter is observed to have his/her catheter tubing and/or	ed //t or er o_ ce oe ave are

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Event ID:

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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. B	A. BUILDING <u>00</u>			COMPLETED	
		155267	B. WING 08/30/2024			/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			MOONGLO RD		
LAKE POINTE VILLAGE					SBURG, IN 47170		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		.ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	n. The diagnoses included, but			catheter drainage bag touchin	g the	
		, type 2 diabetes mellitus with			floor, the DNS/designee will		
		ny, anemia, obstructive and			address the issue with the sta		
		rsonal history of urinary tract			involved at that time. Once the		
		BL (extended spectrum beta			staff reposition the bag and tu	bing	
	· ·	need for assistance with			are in the proper position, the		
	personal care.				DNS/designee will re-train the	staff	
					involved on the facility policy		
		S (Minimum Data Set)			regarding how the drainage ba	-	
		3/8/24, indicated the resident			and tubing should be placed s		
		act. She required substantial			that it does not touch the floor		
	assistance with toil	eting.			Written counseling will be		
	771 1 1 1	14/16/04: 1: 4.14			completed for continued		
	_	d 4/16/24 indicated the resident			noncompliance.		
	_	ling urinary catheter related to			What measures will be put into		
		lux uropathy. The intervention,			place to ensure that this pract	<u>ice</u>	
		uded, but was not limited to, do			does not recur?		
		g or any part of the drainage		DNS/designee will conduct rounds			
	system to touch the	: Hoor.			each shift to ensure tubing is		
	The	-4-1 4/20/24 -4 11:12			placed appropriately.		
		ated 4/30/24 at 11:13 p.m.,			How will corrective action be	:	
		ent's Foley catheter to the n place and patent with dark			monitored to ensure the practi		
	brown colored urin	-			does not recur and what QA w	<u>/III</u>	
	brown colored urin	е.			be put into place?		
	The nurse's note de	ated 5/5/24 at 1:38 p.m.,			To ensure compliance, the DNS/Designee is responsible	for	
		(Certified Nurse Aide) notified			the completion of the Infection		
		in the resident's indwelling			Control QAPI tool weekly time		
		g. The urine was assessed with			weeks, monthly times 6 and th		
		of hematuria and a small clot in			quarterly. The results of these		
		ident denied burning or pain to			audits will be reviewed by the		
	-				QAPI committee overseen by	the	
	the area. Hospice was notified and the nurse waited for a return call.				ED. If threshold of 95% is not		
					achieved an action plan will be		
	The nurse's note. da	ated 5/5/24 at 2:57 p.m.,			developed to ensure compliar		
		laced a new order to					
		quis and continue to monitor			Compliance Date: 09-30-2024	Į	
	for hematuria or wo				<u> </u>	_	
		-0-					
	The nurse's note, dated 5/8/24 at 11:06 n m						

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

PRINTED: 09/24/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155267		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/30/2024	
NAME OF PROVIDER OR SUPPLIER LAKE POINTE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP COD 545 W MOONGLO RD SCOTTSBURG, IN 47170					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWIDERIC BLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		\TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
TAG .	indicated the hemat resident showed no discomfort. During an interview DON (Director of Nindwelling urinary of in the position it was infections. The cath placed in a bath base catheter bag and tubersident's room. During an interview (Infection Prevention urinary catheter tuber the floor to prevent last educated staff of care in March, April	uria was resolving. The signs or symptoms of y on 8/30/24 at 8:20 a.m., the Jursing) indicated the catheter bag did not need to be as in. This could cause leter bag was supposed to be sin. Staff should check the bing every time they go into a y on 8/30/24 at 8:44 a.m., the IP bonist) indicated the indwelling ing and bag should be kept off pinching and infection. She on catheter monitoring and 1, July and August 2024. , last revised June 2024, ot limited to, " b. Urinary					DATE
	catheters should have a catheter bag cover over						
		in underneath them as a barrier bag or tubing from touching					
	3.1-18(1)						

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