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	09/11/2024

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/11/24 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 09/17/24	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 10-18-2024. 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: 09/11/24 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
Richey Barton	Executive Director	09/30/2024

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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	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 alarms in 16 of 36 resident sleeping rooms with battery backup which were not connected to the fire alarm system, but are single station smoke alarms, furthermore, there were hard wired smoke alarms in 20 of 36 resident sleeping rooms with no battery backup, 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 09/17/24		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 10-18-2024. 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 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility	K 0324	1 What corrective action(s) will	10/18/2024

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	failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could impact five residents in the therapy gym. Findings include: During a tour of the facility with the Maintenance Director on 09/11/20210 between 12:00 PM and 2:30 PM, there was a cooktop stove/oven in the therapy area and the emergency shut off was located in the therapy office next door. Based on interview at the time of observation the Maintenance Director agreed the emergency oven/stove shut off was in a different room than the oven/stove. The finding was reviewed with Maintenance Director and Executive Director at the exit		be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by alleged deficient practice. The cooktop shut off switch was relocated from the therapy gym office to the cooktop stove area in the main gym. 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 the same deficient practice, the cooktop shut off switch was relocated to the main therapy gym near the cooktop. 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 cooktop shut off switches to ensure compliance in being in the same room as the cooktop, with all being in correct location now. 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. If 100%	

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	conference. 3.1-19(b)		compliance is not achieved an action plan will be implemented.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 kitchen freezers in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 09/11/2024 between 12:00 PM and 2:30 PM, the kitchen freezer had a container of ice cream 0 inches below the sprinkler head deflector. This was corrected at the time of observation by kitchen staff. Based on interview at the time of observation, the Maintenance Director agreed there was storage less than 18 inches from the sprinkler heads in the aforementioned location and provided the measurements. This finding was reviewed with the Maintenance Director and Executive Director at the exit conference.	K 0351	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 ice cream container on the freezer was immediately removed. 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? 8 staff members have the potential to be affected by alleged deficient practice, the tub of ice cream was moved at time of inspection, signs have been affixed to the shelves. All shelves were inspected in the kitchen to ensure no sprinkler head was deflected by obstructions. 3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Freezer and Fridge will be inspected daily by maintenance man and dietary manager	10/18/2024

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	3.1-19(b)		4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The freezer and fridge will be inspected weekly for 4 weeks and monthly for 6 months. To ensure compliance, the Executive Director will review the results with Quality Assurance Committee for review and recommendations for 6 months. If 100% is not achieved an action plan will be developed.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 rooms 407 was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect up to 2 residents Findings include: Based on observation during a tour of the facility on 09/11/2024 between 12:00 PM and 2:30 PM with the Maintenance Director, room 407 was propped open with a trash can. Upon initial observation, the trash can was removed from propping open the door. During the time the barrier walls were being checked, the trash can had again been placed in front of the door to room 407 at which time the trash can was again removed by the Executive Director. Based on interview at the time of observations, the Maintenance Director agreed there was a trash can propping the door to room 407 open.	K 0363	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. Room 407 the trash can was removed from the door. The hinges on the room have been replaced to keep the door from closing on its own. 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 trashcan propping open room 407 was removed while inspector was on site. All doors were inspected to ensure doors open and close appropriately.	10/18/2024

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	This finding was reviewed with the Executive Director, and Maintenance Director at the exit conference. 3.1-19(b)		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 corridor doors, audits to continue Door will be checked during rounding daily as well. 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 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. If 100% compliance is not achieved an action plan will be developed	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 receptacles in the ladies break room bathroom and 1 of 1 receptacles in the breakroom near the microwave were properly grounded in accordance with NFPA 70. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements	K 0511	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 GFCI receptacle was replaced, but in doing so located that it was tied into the other bathroom's GFCI. The receptacle for the microwave was rewired on 09-12-2024 as well.	10/18/2024

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	shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect primarily staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/11/2024 between 12:00 PM and 2:30 PM, the receptacle in		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? Only staff could have the potential to be affected by alleged deficient practice, a GFCI receptacle was replaced, but in doing so located that it was tied into the other bathroom's GFCI. The receptacle for the microwave was rewired on 09-12-2024 as well. A 100% audit of GCFI was completed to ensure appropriate working order by the maintenance director. 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 GCFI ensuring compliance, audits to continue monthly 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 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. If 100% compliance is not achieved an action plan will be developed.	

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	the ladies break room bathroom was equipped with the GFCI but did not reset after being tested. Additionally, the receptacle near the microwave in the breakroom indicated the outlet was wired as hot reverse when tested with an Etcon UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned receptacles were not operating as intended. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			