

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155751	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/20/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00210248.</p> <p>Complaint IN00210248 - Substantiated. State deficiency related to the allegations is cited at R0144.</p> <p>Survey date: September 20, 2016</p> <p>Facility number: 004831 Provider number: 155751 AIM number: 200809750</p> <p>Census bed type: Residential: 50 Total: 50</p> <p>Sample: 06</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on September 21, 2016.</p>	R 0000	Meadow lakes respectfully request a desk review.	
R 0144  Bldg. 00	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155751		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/20/2016	
NAME OF PROVIDER OR SUPPLIER  MEADOW LAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>residents.</p> <p>Based on observation and interviews, the facility failed to keep gazebo #2 in a clean and good state of repair for the safety of the 50 residents residing in the assisted living section of the facility.</p> <p>Findings include:</p> <p>On 9/20/16 at 10: a.m., an outside tour of the facility indicated 2 gazebos on the facility property. One was located at the entrance of the assisted living facility and gazebo #2 at the Westside entrance of the assisted living facility. Gazebo #2 was noted to be approximately 131 steps from the Westside residential door. There was a no swimming, fishing, or trespassing sign located next to gazebo #2.</p> <p>Observation of gazebo #2 indicated a greenish- blackish color over the glider chairs, the railings, and the baseboards. The railing directly in front of the paved walkway were missing 3 horizontal rails.</p> <p>Interview with the Senior Lifetime Specialist on 9/20/16 at 1:15 p.m., indicated gazebo # 2 has not been used in the past 2-3 years. No resident at the assisted living facility fished, or had indicated to them their desire to do so.</p> <p>Interview with the Clinical Director of</p>	R 0144	<p><b>R144 Sanitation and safety standards</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·No residents were affected by the deficient practice.</li> <li>·<b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></li> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·The gazebo, gliding rockers and chairs was repaired/power washed immediately.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·The gazebo will be inspected monthly for repairs or cleaning. All repairs and cleaning will be scheduled immediately</li> <li>·The maintenance staff was inservice on 9/23/16 on gazebo upkeep.</li> </ul>	09/24/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155751		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2016	
NAME OF PROVIDER OR SUPPLIER  MEADOW LAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the AL (assisted living) area, on 9/20/16 at 1:30 p.m., also indicated no residents in the AL side used the gazebo.</p> <p>Interview with the Maintenance Director on 9/20/2016 at 2:40 p.m., indicated gazebo #2 and the pond were part of the facilities property. They also indicated the facility just hired a new landscaping company that just started the previous week. They also indicated there was a no swimming, no fishing and no trespassing sign near the gazebo.</p> <p>This State tag relates to Complaint IN00210248.</p>				<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>To ensure compliance the ED or designee will monitor monthly x3 for compliance and quarterly thereafter using cqj tool. All finding will be submitted to CQI team for review. If threshold are not met, action plan may be implemented and monitored.</p>		