STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW BROOK SENIOR LIVING	11011 VILLAGE SQUARE LANE, FISHERS, , 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: August 21 and 22, 2025 Facility number: 013163 Residential Census: 87 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 25, 2025.	R 0000		
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment;	R 0052	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation**	09/08/2025

	(5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from abuse by another resident for 2 of 3 residents reviewed for abuse. (Resident 33 and Resident 42) Findings include: 1. The clinical record for Resident 42 was reviewed on 8/21/25 at 1:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. The resident resided in the memory care unit. 2. The clinical record for Resident 33 was reviewed on 8/21/25 at 1:30 p.m. The diagnoses included, but were not limited to, dementia. The resident resided in the memory care unit. A nursing progress note, dated 7/31/25 at 8:15 a.m., indicated Resident 42 was resistive to staff during care. She was verbally and physically aggressive. A nursing progress note, dated 7/31/25 at 2:45 p.m., indicated Resident 42's Representative was notified that the resident needed a one-on-one companion during the hours she		**and requests Desk Review in lieu a Post Survey Review.** **In response to R 052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights** **Deficiency:** **(V) Residents have the right to be free from:** **(1) Sexual Abuse;** **(2) Physical Abuse;** **(3) Mental Abuse;** **(4) Corporal Punishment;** **(5) Neglect; and** **(6) Involuntary Seclusion.** **What corrective actions will be accomplished for those residents found to have been affected by the finding:** **-Completed 09/08/25** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:** **No residents were adversely affected though the potential**	

	was awake due to experiencing aggressive behaviors. A nursing progress note, dated 8/1/25, indicated staff had reported to the Director of Nursing (DON) Resident 42 had a physical altercation with Resident 33. The residents were assessed with no injuries. Resident 42 was sent to the emergency room for evaluation. A reportable incident to the Indiana Department of Health, dated 8/1/25, indicated "...Resident to resident altercation. Resident [33] was attempting to pull her chair up to the dining table when Resident [42] threw a placemat in her direction. In response, Resident [33] lightly struck Resident [42] with a placemat and verbally told her to stop. Resident [42] then attempted to hit Resident [33] with her hand, and during the staff's immediate intervention, a soft teddy bear held by Resident [42] made contact with Resident [33]'s face...Follow up...Resident who initiated altercation, remains at the ER [emergency room] for further evaluation. Process for psych-stay initiated..."		**for adverse outcome did exist.** **Wellness Director or designess will complete staff education and inservicing about Resident Rights, Abuse and Reporting.** **-To be completed by 09/08/25 and ongoing** **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.** **Monthly resident review of at risk residents will be conducted during QA Meeting.** **-To be completed by 09/03/25 and ongoing monthly** **How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:** Wellness Director or designess will complete monthly resident review of at risk residnets during QA meeting monthly x 6 months.	

The reportable incident investigation was provided by the Regional Clinical Support (RCS) on 8/22/25 at 10:08 a.m. It included, but were not limited to, the following documents:

A summary incident form, dated 8/1/25, indicated "...Resident [42] was sitting at dining room table when Resident [33] pulled up a chair to sit beside her. Resident [33] moved Resident [42]'s dining chair to sit beside her. Resident [42] then threw placemat across table. Resident [33] hit Resident [42] with placemat and said stop it. Resident [42] then pulled chair away and to stop Resident [33] from sitting down. Resident [33] continued to stand by chair. Staff member then approached residents to diffuse situation. Resident [42] grabbed a teddy bear and attempted to hit Resident [33]. Staff grabbed the bear during interaction. While staff were separating residents. Resident [42] hit back of Resident [33] chair with walker. Follow up action taken. Staff re-initiating geri-psych stay. Resident approved to readmit. [Resident 42's Representative] notified 1 on 1 care to be initiated upon return for further safety monitoring..."

An interview was conducted with Executive Director (ED) 1, RCS, DON, and ED 2 on 8/22/25 at 1:15 p.m. ED 1

indicated, on 8/1/25, there was an altercation between Resident 33 and Resident 42 in the dining room. Resident 33 had hit Resident 42 with a placemat. Resident 42 had some aggressive behaviors and was sent out that day for a psych stay. Resident 42 now has a companion.

An abuse policy was provided by the RCS on 8/22/25 at 10:08 a.m. It indicated the residents would be from physical abuse.

Based on interview and record review, the facility failed to ensure a resident was free from abuse by another resident for 2 of 3 residents reviewed for abuse. (Resident 33 and Resident 42)

Findings include:

1. The clinical record for Resident 42 was reviewed on 8/21/25 at 1:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. The resident resided in the memory care unit.

2. The clinical record for Resident 33 was reviewed on 8/21/25 at 1:30 p.m. The diagnoses included, but were not limited to, dementia. The resident resided in the memory care unit.

A nursing progress note, dated 7/31/25 at 8:15 a.m., indicated

Resident 42 was resistive to staff during care. She was verbally and physically aggressive.

A nursing progress note, dated 7/31/25 at 2:45 p.m., indicated Resident 42's Representative was notified that the resident needed a one-on-one companion during the hours she was awake due to experiencing aggressive behaviors.

A nursing progress note, dated 8/1/25, indicated staff had reported to the Director of Nursing (DON) Resident 42 had a physical altercation with Resident 33. The residents were assessed with no injuries. Resident 42 was sent to the emergency room for evaluation.

A reportable incident to the Indiana Department of Health, dated 8/1/25, indicated "...Resident to resident altercation. Resident [33] was attempting to pull her chair up to the dining table when Resident [42] threw a placemat in her direction. In response, Resident [33] lightly struck Resident [42] with a placemat and verbally told her to stop. Resident [42] then attempted to hit Resident [33] with her hand, and during the staff's immediate intervention, a soft teddy bear held by Resident [42] made contact with Resident [33]'s face...Follow up...Resident who

	initiated altercation, remains at the ER [emergency room] for further evaluation. Process for psych-stay initiated..." The reportable incident investigation was provided by the Regional Clinical Support (RCS) on 8/22/25 at 10:08 a.m. It included, but were not limited to, the following documents:			

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An interview was conducted with Executive Director (ED) 1, RCS, DON, and ED 2 on 8/22/25 at 1:15 p.m. ED 1 indicated, on 8/1/25, there was an altercation between Resident 33 and Resident 42 in the dining room. Resident 33 had hit Resident 42 with a placemat. Resident 42 had some aggressive behaviors and was

	sent out that day for a psych stay. Resident 42 now has a companion. An abuse policy was provided by the RCS on 8/22/25 at 10:08 a.m. It indicated the residents would be from physical abuse.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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