STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/06/2022

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 the Investigation of Complaints IN00382554 and IN00383633. Complaint IN00382554 - Unsubstantiated due to lack of evidence. Complaint IN00383633 - Substantiated. State deficiencies related to the allegations are cited at R055. Survey date: July 6, 2022 Facility number: 013163 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 12, 2022	R 0000	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 and requests Desk Review in lieu a Post Survey Review.	
R 0055	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(y)(1-4)	R 0055	What corrective actions will be accomplished for those residents found to have been	07/29/2022

	(y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on interview and record review, the facility failed to treat a resident as an individual with consideration and respect for their privacy related to permitting an outside service provider access to a resident's room at 10:30 p.m. without the resident's prior knowledge. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/6/22 at 10:17 a.m. Resident B's diagnoses included, but not limited to, hypertension, congestive heart failure, chronic kidney disease, depression, and mild cognitive disorder. Resident B's service plan dated 4/29/22 indicated the following: Resident B wore glasses and had glaucoma with blurry vision and staff to be sure the resident was wearing glasses; required assistance with orientation with		affected by the finding: RVPO had a telephone conversation with the son (POA)RVPO requested to talk with resident concerning event, resident son (POA) requested that resident not be questioned directly about event, did not want resident to talk about itStaff monitored and asked to check on resident's emotional/psychosocial well-beingResident B's service plan will be updated appropriately. An additional resident declined to have x-ray completed that night without incident.How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:All residents that receive outside provider services have potential to be affectedAn additional resident received outside provider services that night and reported declining to have x-ray that night without incident. No other residents reported concerns with outside provider services.What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:Staff and vendor education on "Outside Provider" procedure. Staff and resident education on "Resident Rights" to include knocking and announcing name prior to entering unit. Staff education on "Notification of Change of Condition" which includes new orders from providers. How the corrective action(s) will be monitored to ensure the finding will not recur:Audit vendor log sign in: Weekly x4 weeksBiweekly x4	

	a goal of to remain calm and understand where they are and an intervention for staff to provide encouragement and simple information about the day, time and location; the resident displayed behaviors and a history of hallucinations with a goal for them to remain safe and calm when exhibiting behaviors and staff to intervene accordingly when the resident exhibited behaviors; and the resident's preferences on entry to their room was to be followed and staff to enter the resident's room after knocking with no response. Resident B's service plan did not indicate what behaviors Resident B had exhibited nor did it indicate how the staff was to intervene when behaviors were exhibited. A nurse's note dated 6/17/22 at 5:12 p.m. indicated, "Writer spoke with [name of Nurse Practitioner] NP inquiring on X-ray order. [sic, NP's name] stated one of resident's son's [sic] contacted office stating pain patches aren't working and was inquiring if there [sic] something else they could do. [NP's name] stated before writing an order she wanted to find out if there was something new going on. She was not aware of any recent falls. [NP's name] had requested a stat [sic, immediately] X-ray early that afternoon."		weeksMonthly x4 monthsInterview random sampling of residents receiving outside provider services: 5 residents Weekly x4 weeks5 residents Biweekly x4weeks5 residents Monthly x4monthsBy what date the systemic changes will be completed: 7/29/22	

The clinical record did not indicate if Resident B was notified of an X-ray order.

A nurse's note dated 6/20/22 at 7:39 p.m. indicated, a wellness check was performed while delivering medication. They asked Resident B is she was ok and if she needed anything and Resident B stated she was fine.

A Health Progress note dated 6/21/22 at 1:21 p.m. indicated, Resident B was engaged in the community and not displaying any signs or symptoms of distress.

A Community note dated 6/22/22 at 7 p.m. indicated, FM 3 was updated on the implementation of a process to not allow X-rays to be performed after 8 p.m. It was also noted that Resident B showed no signs of distress.

The clinical record did not contain emotional or psychosocial assessments of Resident B's status in regards to the incident on 6/17/22 other than to state "no signs of distress".

An interview with Resident B's FM (family member) 2 was conducted on 7/6/22 at 9:46 a.m. They indicated, on June 18th Resident B had informed them of an incident that occurred the prior night. They stated, Resident B indicated at

10:30 p.m. the night prior, she was awakened by a man coming into her room. They indicated, Resident B had told the man who was in her room, 'you can't be here' and then the man said he could be because he had an order to do an X-ray. FM 2 stated, Resident B has continued to talk about the incident with them and was still experiencing fear by re-living the experience and no longer feels safe in her apartment. FM 2 indicated, they did not understand why the facility would allow someone into Resident B's room without notifying Resident B first or being accompanied by a staff member.

An interview with ED (Executive Director) was conducted on 7/6/22 at 12:13 p.m. ED indicated, the facility had conducted an internal investigation regarding FM 2's concern. The investigation file contained, but not limited to: a written statement from CNA (Certified Nursing Assistant) 5, who had let the X-ray technician into the facility on 6/17/22; a written statement from RN (Registered Nurse) 6 who walked the X-ray technician from the entrance to the second floor; and a written statement from QMA (Qualified Medication Assistant) 7, who gave the X-ray technician access to Resident B's room. The written statement

from QMA 7 indicated, he had met the X-ray technician in the hallway on the second floor and walked with him to Resident B's door and let him in. In QMA 7's statement he indicated, he had let the resident know an X-ray technician was there to perform an X-ray then stepped out of the room.

An interview with QMA 7 was conducted on 7/6/22 at 2:47 p.m. QMA 7 indicated, he escorted the X-ray technician to Resident B's room. He stated, he knocked on the door, announced who he was, and explained to the resident that there was someone here to take some X-rays. He indicated, the resident said "ok" and he then exited the room. QMA 7 indicated, it was not uncommon for the X-ray technicians to come to the facility late at night.

An interview with Resident B was conducted on 7/6/22 at 3:06 p.m. Resident B indicated, on the night of 6/17/22, she was sleeping when she heard two people talking in the hallway and the next thing she remembered was her apartment door opening and someone "invading my house". She indicated, she only saw one person coming into her room and they were bringing in a big machine. She stated she does not remember hearing anyone knocking on her door, nor

anyone stating who they were or why they were there. She indicated she felt afraid with having had a strange man in her room alone with her. Resident B indicated, she was still fearful especially since she had a history of hallucinations. She stated, "I never know who will be coming into my room. It gives you a fear of what is going to take place and since it's my home and they want me to treat it like my home, I shouldn't have fears."

This state tag relates to complaint IN00383633.

Based on interview and record review, the facility failed to treat a resident as an individual with consideration and respect for their privacy related to permitting an outside service provider access to a resident's room at 10:30 p.m. without the resident's prior knowledge. (Resident B)

Findings include:

The clinical record for Resident B was reviewed on 7/6/22 at 10:17 a.m. Resident B's diagnoses included, but not limited to, hypertension, congestive heart failure, chronic kidney disease, depression, and mild cognitive disorder.

Resident B's service plan dated 4/29/22 indicated the following: Resident B wore glasses and

had glaucoma with blurry vision and staff to be sure the resident was wearing glasses; required assistance with orientation with a goal of to remain calm and understand where they are and an intervention for staff to provide encouragement and simple information about the day, time and location; the resident displayed behaviors and a history of hallucinations with a goal for them to remain safe and calm when exhibiting behaviors and staff to intervene accordingly when the resident exhibited behaviors; and the resident's preferences on entry to their room was to be followed and staff to enter the resident's room after knocking with no response. Resident B's service plan did not indicate what behaviors Resident B had exhibited nor did it indicate how the staff was to intervene when behaviors were exhibited.

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name] had requested a stat [sic, immediately] X-ray early that afternoon."

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	and they were bringing in a big machine. She stated she does not remember hearing anyone knocking on her door, nor anyone stating who they were or why they were there. She indicated she felt afraid with having had a strange man in her room alone with her. Resident B indicated, she was still fearful especially since she had a history of hallucinations. She stated, "I never know who will be coming into my room. It gives you a fear of what is going to take place and since it's my home and they want me to treat it like my home, I shouldn't have fears." This state tag relates to complaint IN00383633.				

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