

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/03/2022	
NAME OF PROVIDER OR SUPPLIER LAKE MEADOWS SENIOR ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 11570 E 126TH STREET, FISHERS, , 46037					
(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 IN00374433, IN00374688, IN00374709, IN00375181, IN00377517, IN00377582, IN00379452, and IN00379587. This visit included a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00374433 - Unsubstantiated due to lack of evidence. Complaint IN00374688 - Unsubstantiated due to lack of evidence. Complaint IN00374709 - Unsubstantiated due to lack of evidence. Complaint IN00375181 - Unsubstantiated due to lack of evidence. Complaint IN00377517 - Unsubstantiated due to lack of evidence.	R 0000	Disclaimer: The submission of this plan correction does not indicate an admission by Lake Meadows Senior Assisted Living that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Lake Meadows Senior Assisted Living. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for Assisted Living Facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.				

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	Complaint IN00377582 - Unsubstantiated due to lack of evidence. Complaint IN00379452 - Substantiated. No State Residential Findings related to the allegations were cited. Complaint IN00379587 - Substantiated. No State Residential Findings related to the allegations were cited. Unrelated deficiency cited. Survey dates: August 2 and 3, 2022 Facility number: 014910 Residential Census: 122 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 8, 2022			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered.	R 0091	R091 Corrective Actions It is the intent of Lake Meadows to follow all facility policies related to resident rights and facility reporting.	09/02/2022

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FORM APPROVED

OMB NO. 0938-0391

(2) Residents' rights.

(3) Personnel administration.

(4) Facility operations.

The policies shall be made available to residents upon request.

Based on interview and record review, the facility failed to follow their policy by ensuring an allegation of resident-to-resident physical contact was reported to the Indiana Department of Health (IDOH) for 1 of 2 incidents reviewed. (Resident D and Resident E)

Findings include:

An interview conducted with Resident D, on 8/2/22 at 1:38 p.m., indicated in March of 2022 a resident, Resident E, was upset about his medications and she was attempting to calm him down. He proceeded to grab her wrist and twist it. She notified the police, and they came to conduct a report.

An interview conducted with Resident E, on 8/2/22 at 3:20 p.m., indicated he was not aware of any incident involving another resident. He stated to contact his sister because "she would know that stuff".

The clinical record for Resident D were reviewed on 8/3/22 at

The facility's leadership team has reviewed the facility's policies and procedures regarding the policy and procedures for reporting incidents. Current non-compliance was identified, and current practices updated in consideration of this non-compliance and facility protocols. The Facility leadership or Designee will educate all personnel are the proper reporting of incidents to the appropriate team members when incidents and accidents happen.

Identifications of others

All residents have the potential to be affected by this alleged non-compliance.

Measures/Systemic changes

The facility leadership will educate all staff on reporting incidents and accidents. Policy and procedures will be reviewed with all staff, on what items are reportable to ISDH, and who to report to for proper reporting to the gateway. All staff will be educated on

2:15 p.m. The diagnoses included, but were not limited to, anxiety disorder, blindness and low vision, and aphasia (a language disorder that affects a person's ability to communicate).

A Brief Interview for Mental Status (BIMS) assessment, dated 3/10/22, indicated Resident D was cognitively intact.

A progress note, dated 3/6/22 at 10:35 a.m., indicated the following, "...Resident called police and filed report against another resident for grabbing and twisting her arm causing pain. Resident stated that this resident who grabbed her arm is mean and aggressive when he does not get his way...."

The clinical record for Resident E was reviewed on 8/3/22 at 2:20 p.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, hypertension, arthritis, and frontal lobe and executive function deficit.

A BIMS assessment, dated 2/9/22, indicated Resident E was cognitively impaired.

A progress note, dated 3/6/22 at 10:31 a.m., indicated the following, ""...reported to nurse that resident grabbed another resident by the arm and twisted her arm causing pain. Resident

reporting policy and procedure by 09/02/2022

Monitoring

Compliance will be monitored by use of resident interviews, 24-hour report reviews. Facility leadership or designee will conduct random interviews of 10% of the current residents at lake meadows: Weekly for one month; Monthly for 2 months. Interviews will note any concerns shared. Any concerns noted in the interviews will be reviewed at that time to ensure proper process was followed to ensure compliance. Findings will be reported to the QAPI Committee for review and recommendations.

Compliance Date is September 2, 2022

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then went knocking on other residents doors demanding to see the "f*****g nurse!" Resident redirected and told to go to room...The resident who he had the altercation with has filed a police report....""

There was no indication the above incident involving the resident-to-resident altercation was reported to IDOH.

An interview conducted with the Director of Nursing (DON), on 8/3/22 at 3:58 p.m., indicated she wasn't able to find to where the incident involving Resident D and Resident E was reported to IDOH. It would have been the responsibility of the Executive Director (ED) to report such incident.

A policy titled "Incidents/Accidents", undated, was provided by the ED on 8/3/22 at 5:07 p.m. The policy indicated the following, "...Unusual occurrence; reporting...(b) Reportable unusual occurrences include, but are not limited to, the following, as applicable...(1) Alleged, suspected, or actual abuse, neglect, or exploitation of an individual...(2) Alleged, suspected, or actual assault or abuse by an individual...."

Based on interview and record review, the facility failed to follow their policy by ensuring

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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