

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 07/24/2026
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 Intakes IN00469087 and IN00470611. Intake IN00469087 - No deficiencies related to the allegation(s) are cited. Intake IN00470611 - State deficiencies related to the allegation(s) are cited at R240. Survey Date: July 23, 2026 Facility Number: 014910 Census Bed Type: Residential: 99 Total: 99 Census Payor Type: Other: 99 Total: 99 These State Residential Findings are cited in accordance	R 0000	<i>The submission of this plan of correction does not indicate an admission by Lake Meadows Senior 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 Living.</i> <i>The facility hereby maintains it is in substantial compliance with the requirements of participation for Assisted Living Facilities. This plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. This facility hereby maintains it is in substantial compliance with the requirements of participation for Assisted Living Facilities.</i> <i>The facility respectfully requests</i>		

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	with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on July 27, 2026.		<i>a desk review in lieu of onsite visit for substantial compliance.</i>	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to implement a resident's agreed upon shower verification procedure for 1 of 3 residents reviewed for bathing. (Resident D) Findings include: The clinical record for Resident D was reviewed on 7/23/26 at 1:37 p.m. Resident D's diagnoses included, but were not limited to, dementia. The progress note, dated 4/5/26 at 1:45 p.m., indicated Resident D's Power of Attorney (POA) was "not very happy about him skipped [sic] the shower." The progress note, dated 4/8/26, and written by the Director of Nursing (DON,) indicated the DON consulted with Resident D's POA	R 0240	R 240 - It is the consistent practice of this Provider to ensure that each resident's service plan is implemented, followed and documented. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? <i>Resident D's service plan, shower schedule, and bathing documentation were reviewed. The resident's assigned shower day and time were verified. Staff were re-educated on following the resident's agreed-upon bathing schedule. Staff will document each completed shower,</i>	07/31/2026

regarding Resident D's care and scheduled a care plan meeting for 4/9/26 at 12:00 p.m.

The progress note, dated 4/9/26, and written by the DON, indicated a care plan meeting was held with Resident D's POA and another family member in the private dining room. They discussed Resident D's care and that how he refused showers three times with different approaches. Resident D's POA agreed if Resident D denied a shower, for staff to call Resident D's POA for assistance. Resident D's POA requested a shower log binder to be kept in Resident D's room.

The service plan, dated, 4/9/26, indicated Resident D required minimal assistance with bathing on Friday day shift and Wednesday evening shift.

Resident D's shower binder from his room and Care History for Bathing from the electronic health record were reviewed with the DON on 7/23/26 at 1:40 p.m. They indicated Resident D received showers on the following dates: 4/10/26, 4/15/26, 4/24/26, 5/1/26, 5/6/26, 5/8/26, 5/14/26, 5/15/26, 5/22/26, 5/27/26, 5/29/26, 6/5/26, 6/12/26, 6/19/26, 6/24/26, 6/26/26, 7/3/26, 7/10/26, 7/17/26, 7/21/26, 7/22/26, and 7/23/26.

as well as any refusal. Any refusal will be promptly assessed by the Director of Nursing (DON) or designee to determine the need for follow-up interventions.

How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?

An audit of all residents requiring bathing assistance as identified in their service plans was completed to verify that each resident has an assigned shower schedule consistent with their preferences and assessed needs. Documentation practices were reviewed to ensure bathing services are accurately recorded and refusals are appropriately documented.

What measures will be put into place, or what systemic changes will the facility make, to ensure

An interview was conducted with the DON on 7/23/26 at 1:40 p.m. The DON indicated they held a care plan meeting with Resident D's POA in April, 2026 and agreed to keep a shower binder in his room to log his showers. They also discussed having his POA or another family member come in to assist with showers, if Resident D refused assistance from staff, as he often did. The DON indicated she thought Resident D likely refused showers between 4/15/26 to 4/24/26, 4/24/26 to 5/1/26, 5/15/26 to 5/22/26, 5/29/26 to 6/5/26, 6/5/26 to 6/12/26, 6/12/26 to 6/19/26, 6/26/26 to 7/3/26, 7/3/26 to 7/10/26, and 7/10/26 to 7/17/26. They had no verification there were refusals or that staff requested Resident D's POA or family to come in to assist between the above referenced time frames. If this was the case, staff should have documented such in his shower binder or electronic health record.

the alleged deficient practice does not recur?

The facility reviewed and revised its bathing process to ensure residents receive bathing assistance according to their individualized service plans and agreed-upon schedules.

The following measures have been implemented:

- *A shower schedule has been established for all residents requiring bathing assistance, assigning each resident a designated shower day and time.*
- *Nursing staff were educated by the DON/designee on the revised shower scheduling process, documentation expectations, and procedures for documenting completed showers and resident refusals.*
- *Staff will document each completed shower on the*

The Assistance/Service Plan Procedure was provided by the Executive Director on 7/23/26 at 12:41 p.m. It indicated, "The Resident Services Coordinator will establish a schedule for services based on the assistance/service plan and inform the Resident Assistants of assistance needs."

This Citation relates to Intake IN00470611.

shower tracking log and in the electronic medical record (ECP).

- *Any shower refusal will be documented immediately and reported to the DON or designee for assessment, intervention, and follow-up as appropriate.*

How will the corrective action be monitored to ensure the deficient practice does not recur?

The DON, or designee, will conduct weekly audits for four (4) weeks, followed by monthly audits for three (3) months, to verify:

- *Residents requiring bathing assistance have an assigned shower schedule.*
- *Scheduled showers are completed*

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			<i>and documented appropriately.</i> • <i>Shower refusals are documented and followed up timely.</i> <i>Audit findings will be reviewed through the community's monthly Quality Assurance (QA) process. Any identified deficiencies will result in immediate corrective action, including additional staff education, competency validation, and progressive disciplinary action when warranted.</i>	
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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 SIGNATUREDavid Benson	TITLEExecutive Director	(X6) DATE08/07/2026
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