STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155751	A. BUILDING -- B. WING	06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/12/23 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750 At this Emergency Preparedness survey, Meadow Lakes was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 137 certified beds. At the time of the survey, the census was 107. Quality Review conducted on 06/14/23	E 0000	The submission of this plan of correction does not indicate an admission by Meadow Lakes that the findings and allegations contained herein are an accurate and true representation of the quality of care and environment provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, this 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 statue only. *This facility respectfully requests from the Department a desk review for paper compliance. The facility has provided attachments as exhibits to coincide with each number. If anything further is needed facility will provide department documentation upon request for paper compliance/desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annette Cheever		06/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/12/23 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750 At this Life Safety Code survey, Meadow Lakes was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 107 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review conducted on 06/14/23	K 0000	The submission of this plan of correction does not indicate an admission by Meadow Lakes that the findings and allegations contained herein are an accurate and true representation of the quality of care and environment provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, this 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 statue only. *This facility respectfully requests from the Department a desk review for paper compliance. The facility has provided attachments as exhibits to coincide with each number. If anything further is needed facility will provide department documentation upon request for paper compliance/desk review.	

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K 0211 SS=D Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 2 cooler/freezer doors in the kitchen were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 states door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could affect staff in the kitchen. Findings include: Based on observations with the Maintenance Director on 06/12/23 during a tour of the facility between 1:05 p.m. and 2:25 p.m., the walk-in cooler and walk-in freezer each had a door that could be locked with a key from the outside and had a turn release handle on the inside to open the door if locked. Additionally, metal hasps that could be locked with a padlock were affixed to both doors above the handles. This condition could trap a person inside the cooler or freezer if locked from the outside. Based on interview at the time of observation, the Maintenance Director agreed that the cooler and freezer could not be opened from the inside if the affixed padlocks were locked. This finding was reviewed with the Executive Director and Maintenance Director during the exit	K 0211	It is the policy of this facility to insure doors within a required means of egress shall not be equipped with a latch or lock that impede the opening for the egress side at all times. POTENTIAL TO BE AFFECTED: Staff for whom have access to kitchen area have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On June 12, 2023 the Maintenance Director removed the the metal hasps that could be locked with a padlock from both doors above the handles. *See attached Exhibit K-0211 MEASURES TO PREVENT REOCCURENCE: The Maintenance Supervisor/or Designee will visually inspect both doors to assure that a hasp or lock is not in place 1 X MONTHLY	06/14/2023

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	conference. 3.1-19(b)		X'S 6 MONTHS. The results of the audit will be presented by the Executive Director monthly for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team. * See attached Exhibit K-0211 Audit Tool	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 6 exit discharges was maintained in accordance with LSC 7.1.10.1 which states that means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect at least 15 residents, staff, visitors in the smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 06/12/23 at 1:25 p.m. the exit by resident room 129 and 130 discharged onto a concrete sidewalk which lead to the parking lot. A large metal dumpster was	K 0271	It is the policy of this facility to insure that that exit discharges are maintained free of all obstructions or impediments to full instant use in case of fire or other emergencies. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS: Area of placement was marked with pavement paint to assure proper placement. Waste	06/14/2023

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	placed on the asphalt parking lot in front of the facility exit, causing an obstructed means of egress. Based on interview at the time of observation, the Maintenance Director agreed that the means of egress was obstructed and would talk with the trash company about not placing the dumpster in front of the exit after they pick up the trash. This finding was reviewed with Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		management was notified via Maintenance Director of area allocated for receptacle. *See attached Exhibit K-0271 MEASURES TO PREVENT REOCCURENCE: The Maintenance Supervisor/designee will inspect outside dumpster area to assure the placement of receptacle's are not impeding the exit and are within painted area 1X WKLY X'S 8 WKS THEN 1 X MONTHLY X'S 4 MONTHS. The results of the audit will be presented by the Maintenance Director monthly for review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed ore recommended by the QA team. *See attached Exhibit K-0271 Audit Tool HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICENT PRACTICE WILL NOT RECUR: The Maintenance Director will forward the inspection results to the Quality Assurance Team monthly. The results of the audit will be reviewed by the QAPI team. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	

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K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure all battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect at least 15 residents and staff in the Auguste's Cottage unit. Findings include: Based on observation with the Maintenance Director at 1:49 p.m. on 06/12/23, the battery operated emergency light at the side exit from Auguste's Cottage Memory Care unit failed to function when its respective test button was pushed three times. Based on interview at the time of the observation, the Maintenance Director confirmed the aforementioned battery operated emergency light failed to function when its respective test button was pushed. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.	K 0291	It is the policy of this facility to ensure all battery powered emergency lighting is maintained in accordance with LSC 7.9. POTENTIAL TO BE AFFECTED: Residents, staff and visitors on Augustus Cottage have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS TAKEN: On 6/14/23 The Exit sign was removed and a new l.e.d. sign was placed. *SEE EXHIBIT K-0291 ATTACHENT MEASURES TO PREVENT REOCCURRENCE: Maintenance Director/or designee will complete K-0291 Audit Tool with WKLY INSPECCTIONS OF EXIT SIGNAGE ON AUGUSTUS COTTAGE X'S 12 WKS THEN 1X MONTH X'S 3 MONTHS to assure the exit signage illuminates with back up battery. *SEE EXHIBIT K-0291 AUDIT TOOL HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT	06/14/2023

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	3.1-19(b)		PRACTICE WILL NOT RECUR: The Maintenance Director will forward the inspection results to the Quality Assurance Team monthly. The results of the audit will be reviewed by the QA team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door			

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	frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 4 residents. Findings include: Based on observations with the Maintenance Director on 06/12/23 during a tour of the facility between 1:05 p.m. and 2:25 p.m., the corridor doors to Resident Rooms 215 and 309 failed to close and latch positively into their door frames. Based on interview at the time of each observation, the Maintenance Director confirmed the two resident room doors did not latch into their door frames. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0363	It is the intent of this facility to assure that all corridor doors to resident rooms close and latch positively into their door frames. POTENTIAL TO BE AFFECTED: Residents in room 215 and 309 have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On 6/13/23 the Maintenance Director made adjustments to the doors of room 215 and 309. After said adjustments door close and latch positively into their door frames. *See attached Exhibit K-0363 MEASURES TO PREVENT REOCCURRENCE: Maintenance Director/or designee will complete K-0363 Audit Tool with INSPECTIONS OF DOORS	06/14/2023

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			215 AND 309 1 X WKLY X'S 12 WKS THEN 1X MONTHLY X'S 3 MONTHS HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR The Maintenance Director will forward the inspection results to the Quality Assurance Team monthly. The results of the audit will be reviewed by the QA team monthly. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC	K 0372	it is the intent of this facility to assure that that penetrations caused by passage through smoke barrier walls are protected to maintain the smoke resistance	06/14/2023

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	Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect as many as 26 residents, 4 staff, and 2 visitors between the two compartments. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 06/12/23 from 1:05 p.m. to 2:25 p.m., the smoke barrier wall above the smoke barrier doors by resident room 116 had two penetrations of water lines through the smoke barrier wall not proper fire stopped. The area around the water pipes had been sealed off with caulk, but the caulk had pulled away from the wall, leaving approximately a half inch of annular space around the water lines passing through the smoke barrier. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned condition and stated that he would seal the penetration as soon as he had time to do so. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		of each smoke barrier. POTENTIAL TO BE AFFECTED: Residents, staff and visitors have the potential to be impacted by this alleged deficient practice, however none were. CORRECTIVE ACTIONS COMPLETED: On 6/14/23 The Maintenance Director reapplied fire caulk to smoke barrier wall above the smoke barrier doors by resident room 116 around the water lines and water pipes. *SEE ATTACHED EXHIBIT K-0372 MEASURES TO PREVENT REOCCURRENCE: Maintenance Director/or designee will complete K-0372 Audit Tool with immediate inspection to any new work area that requires penetration of smoke barrier wall to assure said penetrated area is sealed with fire caulk to assure the smoke barrer wall is protected to maintain the smoke resistance of each smoke barrier. MEASURES TO PREVENT REOCCURENCE: The Maintenance Supervisor/or Designee will visually inspect both doors to assure that a hasp or lock is not in place 1 X MONTHLY X'S 6 MONTHS. The results of the audit will be presented by the Executive Director monthly for	

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			review in the monthly QAPI meeting. Frequency and duration of the audits will be adjusted as needed or recommended by the QA team. * See attached Exhibit K-0211 Audit Tool	