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PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

06/23/2023

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/12/2023	
	PROVIDER OR SUPPLIER	3		200 MI	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR RESVILLE, IN 46158		
	1				1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
E 0000	REGULATORT OF	A LISE IDENTIFY TING INFORMATION		IAG			DAIL
Bldg	conducted by the In accordance with 42 Survey Date: 06/12 Facility Number: 0 Provider Number: 2000 At this Emergency Lakes was found in Preparedness Requi Medicaid Participat CFR 483.73	2/23 04831 155751 809750 Preparedness survey, Meadow compliance with Emergency rements for Medicare and ing Providers and Suppliers, 42 Certified beds. At the time of us was 107.	E 00	000	The submission of this plan of correction does not indicate an admission by Meadow Lakes the findings and allegations contained herein are an accur and true representation of the quality of care and environment provided to the residents of the facility. This facility recognizes obligation to provide legally an medically necessary care and service in a safe environment residents in an economic and manner. The facility herby maintains it is in substantial compliance with the requirement of participation for skilled heals care facilities. To this end, this plan of correction shall serve at the credible allegation of compliance with all state and federal requirements governing management of this facility. It thus submitted as a matter of statue only. *This facility respectfully requested for paper compliance. The fact has provided attachments as exhibits to coincide with each number. If anything further is needed facility will provide department documentation up request for paper compliance/review.	n that ate ate at a te ate at a te ate at a te ate a	

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

Cheever

Any defiency statement 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 disclodays 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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
AND FLAIN	or connection	155751	B. WING	<u>01</u>	06/12/2023
	PROVIDER OR SUPPLIER	?	200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR	
MEADO\	W LAKES		MOOR	ESVILLE, IN 46158	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0000					
Bldg. 01	A Life Sefety Code	December and State	W 0000	The submission of this plan at	
	1	Recertification and State	K 0000	The submission of this plan of correction does not indicate a	
			admission by Meadow Lakes		
	483.90(a).	ith in accordance with 42 Cr K		the findings and allegations	ulat
	103.50(u).			contained herein are an accur	ate
	Survey Date: 06/12	2/23		and true representation of the	
				quality of care and environme	
	Facility Number: 0	004831		provided to the residents of th	
	Provider Number: 155751 facility. This facility recognizes its		s its		
	AIM Number: 200	Sangaran to provide regain, and		nd	
	medically necessary care and				
	At this Life Safety Code survey, Meadow Lakes			service in a safe environment	to its
		ompliance with Requirements		residents in an economic and	safe
	_	Medicare/Medicaid, 42 CFR		manner. The facility herby	
		Life Safety from Fire and the		maintains it is in substantial	
		National Fire Protection		compliance with the requirement	
	1	1) 101, Life Safety Code (LSC),		of participation for skilled heal	
	-	g Health Care Occupancies and		care facilities. To this end, this	
	410 IAC 16.2.			plan of correction shall serve	as
	This one-story facil	lity was determined to be of		the credible allegation of compliance with all state and	
	I	truction and fully sprinklered.		federal requirements governir	ng the
		re alarm system with smoke		management of this facility. It	_
		ridors and in all areas open to		thus submitted as a matter of	
		icility has smoke detectors hard		statue only.	
		rm system in all resident			
		e facility has a capacity of 137		*This facility respectfully requi	ests
		f 107 at the time of this visit.		from the Department a desk r	
				for paper compliance. The fac	
	All areas where the	residents have customary		has provided attachments as	
	_	ered and all areas providing		exhibits to coincide with each	
	facility services we	re sprinklered.		number. If anything further is	
				needed facility will provide	
	Quality Review con	nducted on 06/14/23		department documentation up	oon
				request for paper compliance	'desk
	1		1	review	l

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Event ID:

04DX21

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155751	B. WI	NG		06/12/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADOW LAKE DR		
MEADOV	VIAKES				ESVILLE, IN 46158		
IVILADOV	VEARLO			WOON			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0211	NFPA 101						
SS=D	Means of Egress						
Bldg. 01	Means of Egress						
	Aisles, passagewa	-					
	_	cations, 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						
		on and interview, the facility	K 02	211	It is the policy of this facility to		06/14/2023
	failed to ensure 2 of 2 cooler/freezer doors in the				insure doors within a required		
	kitchen were able to open from the inside if				means of egress shall not be		
		2.1 states doors complying with			equipped with a latch or lock t		
	7.2.1 shall be permitted. 7.2.1.5.1 states door				impede the opening for the eg	ress	
	leaves shall be arranged to be opened readily from				side at all times.		
	_	never the building is					
	-	cient practice could affect			POTENTIAL TO BE AFFECTE		
	staff in the kitchen.				Staff for whom have access to		
					kitchen area have the potentia	ıl to	
	Findings include:				be impacted by this alleged		
		ta a section			deficient practice, however no	ne	
		ons with the Maintenance			were.		
		3 during a tour of the facility					
	-	and 2:25 p.m., the walk-in cooler			CORRECTIVE ACTIONS		
		each had a door that could be			COMPLETED:		
		om the outside and had a turn			On June 12, 2023 the	-1 41	
		e inside to open the door if			Maintenance Director remove	d the	
		y, metal hasps that could be			the metal hasps that could be		
	-	ck were affixed to both doors			locked with a padlock from bo		
		This condition could trap a			doors above the handles. *Sec	Ħ	
	_	ooler or freezer if locked from on interview at the time of			attached Exhibit K-0211		
					MEASURES TO DREVENT		
		intenance Director agreed			MEASURES TO PREVENT		
	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				REOCCURENCE:	or	
					The Maintenance Supervisor/o		
					Designee will visually inspect		
			1		doors to assure that a hasp or		
	Director and Mailing	enance Director during the exit			lock is not in place 1 X MONT	I IL I	I

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUIL		CONSTRUCTION (X3) DATE SI O1 COMPLE			
THILD TETH	or condection	155751	B. WINC		<u>01</u>	06/12/		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD ADOW LAKE DR			
MEADOV	W LAKES				SVILLE, IN 46158			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		ΓAG		<i>.</i>	DATE	
	3.1-19(b)				X'S 6 MONTHS. The results of audit will be presented by the Executive Director monthly for review in the monthly QAPI meeting. Frequency and duratt of the audits will be adjusted an needed or recommended by the QA team. * See attached Exhit K-0211 Audit Tool	ion is ne		
K 0271 SS=E Bldg. 01	7.7, provides a level the provisions of 7 changes in elevating free of obstruction discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation failed to ensure 1 of maintained in according states that means of maintained free of a to full instant use in emergency. This deleast 15 residents, so compartment. Findings include: Based on observation with the Maintenance, much the exit by residuscharged onto a contract of the provision o		K 027		It is the policy of this facility to insure that that exit discharges are maintained free of all obstructions or impediments to instant use in case of fire or ot emergencies. POTENTIAL TO BE AFFECTE Residents, staff and visitors has 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	s full ther ED: ave y	06/14/2023	

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

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

A BUILDING D1 NAME OF PROVIDER OR SUPPLIER MEADOW LAKE S X(3) ID SUMMARY STATEMENT OF DEFICIENCIE (LEACH DEPICIENCY MUST BE PRICEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE PREFIX (LEACH DEPICIENCY MUST BE PRICEDED BY PULL TAG PROCESSY PROGRAMMENT OF THE PRICEDED BY PULL TAG PROCESSY PULL TAG PROCESSY PROGRAMMENT OF THE PRICEDED BY PULL TAG PROCESSY PROGRAMMENT OF THE PRICEDED BY PULL TAG PROCESSY PROGRAMMENT OF THE PRICEDED BY PULL TAG PROCESSY PULL CAUSE OF THE PRICEDED BY PULL TAG PROCESSY PULL CAUSE OF THE PRICEDED BY PULL TAG PROCESSY PULL CAUSE OF THE PRICEDED BY PULL TAG PROCESSY PULL CAUSE OF THE PRICEDED BY PULL TAG PROCESSY PULL CAUSE OF THE PRICEDED BY PULL TAG PROCESSY PULL CAUSE OF THE PRICEDED BY PULL TAG PRICED BY PULL TAG PRICEDED BY PULL TAG PRICEDED BY PULL TAG PRICED BY PULL TAG PRICEDED BY PULL	STATEMEN	T OF DEFICIENCIES			(X3) DATE SURVEY	
MEADOW LAKES (X4) ID SUMMARY STATEMENT OF DEFICIENCE PREFIX TAC REGULATORY OR LSC IDENTIFYING INFORMATION TO observation, the Maintenance Director agreed that the means of egress was obstructed and would falk with the trash company about not placing the dumpster in front of the cxit after they pick up the trash. This finding was reviewed with Executive Director and Maintenance Director at the exit conference. 3.1-19(b) MEASURES TO PREVENT RECOCURENCE: The Maintenance Director at the exit conference. 3.1-19(b) MEASURES TO PREVENT RECOCURENCE: 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 (OAP) meeting. Frequency and duration of the audit will be presented by the Maintenance Director monthly for review in the monthly QAP1 meeting. Frequency and duration of the audit will be presented by the QA team. "See attached Exhibit K-0271 Audit Tool HOW THE CORRECTIVE ACTIONS WILL BE RECUEDED BY FULL TYCO TO SULL BE MONITORED TO ENGLISH THE DEFICENT PRACTICE WILL NOT RECUE. The Maintenance Director will forward the inspection results to the Quality Assurance Team monthly. The results of the audit will be reviewed by the QAP1 team.	AND PLAN (OF CORRECTION			01	
MEADOW LAKE B MEADOW LAKES 200 MEADOW LAKE DR MOORESVILLE, IN 46158 10 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FILL) TAG PREFEX TAG PREFE			155751	B. WING		06/12/2023
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(X4) ID PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION 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) MEASURES TO PREVENT REOCURENCE: 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						
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION Proceed on the asphalip 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.	WEADOV	V LAKES		MOORI	ESVILLE, IN 40158	
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 04DX21 Facility ID: 004831 If continuation sheet

AND PLAN OF CORRECTION 155751 NAME OF PROVIDER OR SUPPLIER MEADOW LAKES (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REgulation of a least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1 p. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility glights 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 either be continuously in operation or shall be capable of repeated automatic ceptation with the Maintenance Director at 14.9 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 seen to a function when its respective test button was seen to a function of the proper of the function when its respective test button was seen to a function of the proper of the provided automatic operation without manual intervention. This deficient practice could affect at least 15 residents and staff in the Auguste's Cottage unit. Findings include: MEASURES TO PREVENT RECOCURRENCE: Maintenance Director/or designee will complete K-0291 Audit Tool with WKLY INSPECCTIONS OF EXITS (SIGNAGE ON AUGUSTUS)	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
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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 MEASURES TO PREVENT REOCCURRENCE: Maintenance Director/or designee will complete K-0291 Audit Tool with WKLY INSPECCTIONS OF						ATTACHENT		
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 REOCCURRENCE: Maintenance Director/or designee will complete K-0291 Audit Tool with WKLY INSPECCTIONS OF		Findings include:						
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 Maintenance Director/or designee will complete K-0291 Audit Tool with WKLY INSPECCTIONS OF						MEASURES TO PREVENT		
operated emergency light at the side exit from Auguste's Cottage Memory Care unit failed to will complete K-0291 Audit Tool with WKLY INSPECCTIONS OF						REOCCURRENCE:		
Auguste's Cottage Memory Care unit failed to with WKLY INSPECCTIONS OF		Director at 1:49 p.m	n. on 06/12/23, the battery			Maintenance Director/or desig	nee	
		operated emergency	light at the side exit from			will complete K-0291 Audit To	ol	
function when its respective test button was		Auguste's Cottage N	Memory Care unit failed to			with WKLY INSPECCTIONS ()F	
Tunicuon which its respective test outton was EALL SIGNAGE ON AUGUSTUS		function when its re	spective test button was			EXIT SIGNAGE ON AUGUST	US	
pushed three times. Based on interview at the COTTAGE X'S 12 WKS THEN 1X		pushed three times.	Based on interview at the			COTTAGE X'S 12 WKS THEN	I 1X	
time of the observation, the Maintenance Director MONTH X'S 3 MONTHS to assure		time of the observat	tion, the Maintenance Director			MONTH X'S 3 MONTHS to as	sure	
confirmed the aforementioned battery operated the exit signage illuminates with		confirmed the afore	mentioned battery operated			the exit signage illuminates wi	th	
emergency light failed to function when its back up battery. *SEE EXHIBIT								
respective test button was pushed. K-0291 AUDIT TOOL								
							ļ	
This finding was reviewed with the Executive HOW THE CORRECTIVE		This finding was reviewed with the Executive Director and Maintenance Director at the exit				HOW THE CORRECTIVE	ļ	
							RED	
conference. TO ENSURE THE DEFICIENT		conference.				TO ENSURE THE DEFICIENT	Γ	

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Event ID:

04DX21 Facility ID: 004831

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

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	JILDING	instruction <u>01</u>	(X3) DATE (COMPL 06/12/	ETED
	PROVIDER OR SUPPLIEF	R	200 ME	ADDRESS, CITY, STATE, ZIP COD ADOW LAKE DR ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	3.1-19(b)			PRACTICE WILL NOT RECUIT The Maintenance Director will forward the inspection results the Quality Assurance Team monthly. The results of the aud will be reviewed by the QA team monthly. Frequency and durat of the audits will be adjusted a needed or recommended by the QA team.	to dit m tion s	
K 0363 SS=D Bldg. 01	than required encexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containing combustible mate hardware. Roller I CMS regulation. The apply to auxiliary apply	rials have positive latching atches are prohibited by These requirements do not spaces that do not contain				

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Event ID:

04DX21 Facility ID: 004831

If continuation sheet Page 7 of 11

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155751	B. W	ING		06/12/	2023
	PROVIDER OR SUPPLIER	2		200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR ESVILLE, IN 46158		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG	frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrict resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratic devices, etc. Based on observation failed to ensure 2 or impediment to closs frame and would rear This deficient practic. Based on observation from the devices include: Based on observation from the device in the deficient practic. Based on observation from the deficient practic from 1:05 p.m. and to Resident Rooms latch positively into interview at the time Maintenance Direct room doors did not. This finding was residually and the side of th	beled and made of steel or compliance with 8.3,	K 0		It is the intent of this facility to assure that all corridor doors to resident rooms close and latch positively into their door frame. POTENTIAL TO BE AFFECTI Residents in room 215 and 30 have the potential to be impact by this alleged deficient praction however none were. CORRECTIVE ACTIONS COMPLETED: On 6/13/23 the Maintenance Director made adjustments to doors of room 215 and 309. A said adjustments door close a latch positively into their door frames. *See attached Exhibit K-0363 MEASURES TO PREVENT REOCCURRENCE: Maintenance Director/or designed will complete K-0363 Audit To with INSPECTIONS OF DOOR	ons. ED: 9 ted ce, the fter nd	06/14/2023

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Event ID:

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

PRINTED: 06/26/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI							
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER 155751	A. BU B. WI	ILDING NG	<u>01</u>	COMPL 06/12/	
		100701	B. W1			00/12/	
NAME OF PROV	VIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
MEADOW L	AKES				ESVILLE, IN 46158		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
K 0372 NI SS=E SI Bldg. 01 Ba 20 SI 1/ ba at in sy is to 19 SI	IFPA 101 Subdivision of Builderrie Subdivision of Builderrie Subdivision of Builderrier Construction O12 EXISTING Simoke barriers shall be parriers shall be parriers shall be parriems where are installed for smooth because of the smoke barriers and passed on observation of the sample of the smoke barriers and passed on observation of the sample of wire and passed of wire and moke barrier walls	silding Spaces - Smoke Silding Spaces Silding Spaces - Smoke Silding	K 0:		215 AND 309 1 X WKLY X'S WKS THEN 1X MONTHLY X'S MONTHS HOW THE CORRECTIVE ACTIONS WILL BE MONITOR TO ENSURE THE DEFICIEN' PRACTICE WILL NOT RECU The Maintenance Director will forward the inspection results the Quality Assurance Team monthly. The results of the auwill be reviewed by the QA teamonthly. Frequency and dura of the audits will be adjusted a needed or recommended by the QA team. it is the intent of this facility to assure that that penetrations caused by passage through smoke barrier walls are protect to maintain the smoke resistant of the smoke resistant that the smoke resist	RED T R to dit am tion as ne	06/14/2023

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Event ID:

04DX21

Facility ID: 004831

If continuation sheet

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STATEMEN	i i			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED		
		155751	B. W	ING		06/12/	2023	
		l	I	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	8			EADOW LAKE DR			
MEADON	W LAKES				ESVILLE, IN 46158			
IVIEADOV	VLANES			WOOR	LOVILLE, IN 40130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		quires smoke barriers to be			of each smoke barrier.			
		rdance with LSC Section 8.5						
		nimum ½ hour fire resistive			POTENTIAL TO BE AFFECTE			
	_	nt practice could affect as			Residents, staff and visitors ha			
	1	ts, 4 staff, and 2 visitors			the potential to be impacted by	y		
	between the two co	mpartments.			this alleged deficient practice,			
					however none were.			
	Findings include:				000000000000000000000000000000000000000			
	Dagad on -1	omo modo domino o t£41 -			CORRECTIVE ACTIONS			
		ons made during a tour of the			COMPLETED:			
	facility with the Maintenance Director on 06/12/23 from 1:05 p.m. to 2:25 p.m., the smoke barrier wall				On 6/14/23 The Maintenance			
					Director reapplied fire caulk to			
	above the smoke barrier doors by resident room 116 had two penetrations of water lines through				smoke barrier wall above the	4		
	_	_			smoke barrier doors by reside			
		vall not proper fire stopped.			room 116 around the water lin	es		
		e water pipes had been sealed			and water pipes. *SEE			
		the caulk had pulled away from proximately a half inch of			ATTACHED EXHIBIT K-0372			
		-			MEACURES TO PREVENT			
	_	nd the water lines passing barrier. Based on interview at			MEASURES TO PREVENT			
	_	tion, the Maintenance Director			REOCCURRENCE:			
		ementioned condition and			Maintenance Director/or desig			
		I seal the penetration as soon			will complete K-0372 Audit To			
	as he had time to do				with immediate inspection to a	шу		
	as he had time to de	5 80.			new work area that requires penetration of smoke barrier w	ıall		
	This finding was re	viewed with the Executive			to assure said penetrated area			
		enance Director at the exit			sealed with fire caulk to assure			
	conference.	chance Director at the Cart						
	conterence.				the smoke barrer wall is protect to maintain the smoke resistar			
	3.1-19(b)				of each smoke barrier.	IUC		
	J.1-17(0)				or cach shioke ballier.			
					MEASURES TO PREVENT			
					REOCCURENCE:			
					The Maintenance Supervisor/o	or		
					Designee will visually inspect			
					doors to assure that a hasp or			
					lock is not in place 1 X MONT			
					X'S 6 MONTHS. The results o			
					audit will be presented by the			
					Executive Director monthly for			
	Ī		1		LYCORUS DISCOUL HIGHING IOI			

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	(X2) MUL' A. BUIL B. WINC	DING	nstruction 01	(X3) DATE COMPL 06/12/	ETED
	PROVIDER OR SUPPLIEI N LAKES	₹		200 ME	ADDRESS, CITY, STATE, ZIP COD ADOW LAKE DR ESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
					review in the monthly QAPI meeting. Frequency and durati of the audits will be adjusted as needed or recommended by the QA team. * See attached Exhibit K-0211 Audit Tool	s ie	