STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 00 B. WING	01/10/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00425771, IN00425646, and IN00423581. Complaint IN00425771 - Federal/State deficiencies related to the allegations are cited at F658. Complaint IN00425646 - Federal/State deficiencies related to the allegations are cited at F744. Complaint IN00423581 - No deficiencies related to the allegations are cited. Survey dates: January 9 and 10, 2024. Facility number: 004831 Provider number: 155751 AIM number: 200809750 Census Bed Type: SNF/NF: 96 SNF: 10 Residential: 43 Total: 149 Census Payor Type: Medicare: 11 Medicaid: 72 Other: 23 Total: 106 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 19, 2024.	F 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. If anything further is needed facility will provide department documentation upon request for paper compliance/desk review.	
F 0658 SS=D	483.21(b)(3)(i) Services Provided Meet Professional			

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

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Bldg. 00	Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review, the facility failed to provide services in accordance with professional standards for 1 of 3 residents reviewed. Staff administered another resident's medication without a physician's order. (Resident E) Findings include: During an interview on 1/9/24 at 11:28 A.M., the Director of Nursing (DON) indicated on 1/8/24 around 3:00 A.M., Registered Nurse 1 (RN 1) accidentally administered an oral dose of morphine concentrate to Resident E, who was not prescribed the medication. RN 1 was placed on suspension pending the results of the investigation. On 1/9/24 at 11:30 A.M., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, senile degeneration of brain and Alzheimer's disease with late onset. The resident began hospice care on 1/4/24 for senile degeneration of the brain. The January 2024, Medication Administration Record (MAR) did not indicate the resident was administered morphine. During an interview on 1/9/24 at 3:06 P.M., the DON indicated a physician's order for a one-time administration of a 10 milligram (mg) dosage of morphine concentrate solution was obtained after	F 0658	**F658** **Services Provided Meet Professional Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident E is receiving the correct medications per MD order. . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents who receive medications have the potential to be affected by the alleged deficient practice. A 1x audit of the last 30 days will be completed by 2/2/24 to review medications given by RN1 to ensure the correct medications were given All licensed nursing staff will be in-serviced by DNS/designee on or before 2/2/24 on 5 rights of medication administration.	02/02/2024

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	it was discovered RN 1 had administered the medication to Resident E. The resident was not prescribed morphine prior to the accidental administration of the medication. During an interview on 1/10/24 at 12:35 P.M., RN 1 indicated Resident E was on hospice care. She was getting out of bed a lot and complained of pain. RN 1 indicated most residents on hospice care were ordered both Ativan and morphine, so she gave the resident Ativan, and around 3:00 A.M. gave her morphine without checking to verify if the resident was prescribed morphine. The morphine was in the medication drawer but it did not have Resident E's name on it. It was an accident and she should have checked to see if the resident had an order for the morphine. She normally charted when a medication was administered in the MAR on the computer. However, she had become busy and forgot to chart the medication administration. Around 11:00 A.M., the DON called her to tell her Resident E did not have an order for the morphine and should not have received it. She did not intend to give a medication that was not prescribed but was concerned with the resident's comfort and did not check to see if the resident was prescribed morphine. On 1/10/24 at 2:45 P.M., the DON provided the facility's Medication Administration Medication Pass Procedure, with the original date of 2/2010 and a revised date of 7/2023 and indicated this was the procedure currently utilized by the facility. A review of the procedure indicated, "...Nursing Skills Competency...verify order with label...Perform the 5 rights of medication: Right Resident, Right Medication, Right Dose, Right Route, Right Time...Medication administration will be recorded on the MAR [Medication		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All licensed nursing staff will be in-serviced by DNS/designee on or before 2/2/24 on 5 rights of medication administration. The DNS/designee will conduct observations to ensure medications are given per the 5 rights of medication administration. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/designee will be responsible for the delivery of scope of practice to all nurses and supervised medication pass. Medication passes will be completed x 1weekly times 4 weeks, bi-monthly times 2months, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this	

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	Administration Record]/EMAR [Electronic Medication Administration Record] or TAR [Treatment Administration Record]...Administration and inventory of controlled substances were documented according to facility policy..." On 1/10/24 at 2:46 P.M., the DON provided RN 1's training and in-service transcript. A review of the transcript indicated RN 1 successfully completed the Oral Medication Administration course on 11/3/23 at 10:24 P.M. and successfully completed the facility in-service on charting on 11/21/23. This citation relates to Complaint IN00425771. 3.1-35(g)(1)		practice will result in disciplinary action up to and including termination of responsible employee. Date of Compliance 02/02/2024	
F 0744 SS=G Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure services were provided to residents with dementia to prevent resident-to-resident altercations for 2 of 3 residents reviewed for dementia. (Resident C, Resident D) This deficient practice resulted in Resident D experiencing a fall and sustaining an acute fracture of the right upper arm bone with moderate displacement and rotation. Finding includes: During an interview on 1/9/24 at 10:30 a.m., the	F 0744	F744 It is the policy of Meadow Lakes to ensure that there are adequate interventions to provide proper intervention to prevent resident to resident altercations. **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Resident D expired due to unrelated cause. Resident C has been evaluated at Psych Hospital with new orders	02/02/2024

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	Director of Nursing (DON) and Executive Director indicated a physical altercation occurred on 1/5/24 between Resident D and Resident C on a secured unit. The DON indicated a stop sign was positioned across the threshold to the bedroom of Resident C and usually was effective to prevent Resident D from entering the room. The DON indicated Resident D, the victim, entered the bedroom of Resident C by traveling underneath the stop sign. The DON indicated Resident C was pulling on the right upper arm of Resident D to get Resident D out of her room when a physical therapist walked by and told Resident C not to pull on the arm of Resident D. The DON indicated Resident C let go of Resident D and Resident D fell to the floor. The DON indicated Resident D was sent to the hospital and a right arm fracture was identified; however, surgery was not performed because Resident D was receiving hospice services. During an interview on 1/10/24 at 9:50 a.m., a family friend of Resident D indicated she was aware of the altercation between the two women. The resident was observed sleeping, at that time, and had her right arm folded up against her chest with no splint in place. The friend indicated it was unlike the resident to be so lethargic. She indicated the resident's daughters were flying in today to see their mother because she believed the fracture would cause a more rapid decline in her health and death would be soon. During an interview on 1/10/24 at 11:57 a.m., PT 1 indicated he was walking up towards the nurses station when he heard someone yelling, "Don't! Stop it!" He looked around and happened to be right outside of Resident C's room and saw her actively pulling Resident D onto the floor. She was pulling at her by her waist area which caused		received. The behavior care plan has been reviewed and updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents with the diagnosis of dementia have the potential to be affected by the alleged deficient practice however, none were. A 1x audit was completed for residents with dementia to review care plans and behavioral interventions to ensure resident to resident altercations are addressed with appropriate interventions. An all staff Inservice will be conducted by SSD/designee on or before 2/2/24 on dementia services and behavioral interventions being followed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An all staff Inservice will be conducted by SSD/designee on or before 2/2/24 on dementia services and behavioral interventions being followed. SSD/designee will review facility activity report and behavior monitoring events to ensure behavioral interventions are being implemented and utilized. Care plans to be reviewed and updated as needed.	

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	Resident D to fall between the bed and the front of the wheelchair. Resident C continued to yell at the patient while she was on the floor. He further indicated that he did know through communication with staff that Resident C had a tendency to wander and he knew to approach Resident C carefully because she can be foul-tempered. 1 On 1/9/24 at 11:30 a.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with agitation, dementia with psychotic disturbance, dementia with mood disturbance, unspecified dementia with psychotic disturbance, psychotic disorder with delusions, mood disorder, pseudobulbar affect, unspecified dementia with behavioral disturbance, and cognitive communication deficit. The Annual Minimum Data Set (MDS) assessment, dated 8/25/23, indicated the resident was severely cognitively impaired and had Alzheimer's disease and psychotic disorder. The assessment indicated there were no physical behaviors during the assessment period. The most current care plan for agitation, dated 9/25/23, indicated Resident C exhibited aggressive behaviors when other residents entered her bedroom without permission and included the following interventions: -staff will do rounds on the unit to ensure all of the residents are in the correct rooms and beds to assist residents not becoming agitated when peers enter into the wrong room, -staff to check resident's room often to ensure peers are not wandering into her room, -a stop sign is to be placed on the resident doorway to prevent others from entering into her		**How the corrective action will be monitored to ensure the deficient practice will not recur?** To ensure compliance the SSD/Designee will complete a Behavior Management CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The Behavior Management CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee. Facility respectfully request IDR for this deficiency for a lower scope and severity. The facility had adequate interventions and supervision.	

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	room, -the resident was moved to a room closer to the nursing station to increase supervision, and -the resident preferred her door to be closed at all times and this would deter peers from entering her room. The Quarterly MDS assessment, dated 11/18/23, indicated the resident was severely cognitively impaired, utilized a wheelchair for locomotion, and had Alzheimer's disease, dementia, and psychotic disorder. The assessment indicated there were no physical behaviors during the assessment period. Resident C's progress notes, dated from 6/30/23 through 1/3/24, indicated Resident C was the perpetrator in three resident-to-resident altercations. A nursing progress note, dated 1/3/24 at 9:37 a.m., indicated the stop sign did not effectively prevent an unknown resident from entering the room of Resident C without permission, a resident-to-resident verbal altercation occurred, and Resident C attempted to make physical contact with the arm of the unknown resident. The progress note did not include documentation to show new, effective interventions were implemented to prevent further resident-to-resident altercations. A nursing progress note, dated 1/5/24 at 3:59 p.m., indicated the stop sign did not effectively prevent Resident D from entering the room of Resident C without permission, Resident C perpetrated a resident-to-resident physical altercation with Resident D that resulted in Resident D falling to the floor and sustaining a right upper arm fracture with dislocation and rotation. The progress note did not include documentation to show new,			

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	effective interventions were implemented to prevent further resident-to-resident altercations. The progress notes and plans of care, dated between 1/5/24 and 1/7/24 at 4:27 p.m., did not include documentation to show new, effective interventions were implemented to prevent further resident-to-resident altercations. 2. On 1/9/24 at 11:25 a.m., Resident D was observed sleeping in her bed with her right arm folded up and over her chest. On 1/9/23 at 11:32 a.m., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, displaced fracture of upper end of right humerus (bone in the upper arm), severe unspecified dementia, low back pain, unspecified pain, and cognitive communication deficit. A Significant Changed MDS assessment, dated 9/20/23, indicated severe cognitive impairment to make decisions regarding tasks of daily life, had wandering behaviors 1-3 days during the assessment period that significantly intruded on the privacy of others, and the resident had 1 fall with no injuries since the prior assessment. A Quarterly MDS assessment, dated 12/13/23, indicated Resident D experienced severe cognitive impairment to make decisions regarding tasks of daily life, utilized a wheelchair for locomotion, and had 1 fall since the prior assessment with no injury. A Facility Observation Detail List Report, dated 1/6/24 at 4:37 p.m., indicated the resident was transferred to the emergency room due to having a fracture of the head of the humerus.			

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	A Radiology Report, dated 1/6/24, indicated there was an acute fracture involving the neck of the right humerus with moderate displacement of greater than 1 cm (centimeter), with humeral head rotation. The boney structures appear osteopenia. On 1/10/24 at 2:45 p.m., the DON provided the facility policy, "Fall Management", revised 8/2022, and indicated it was the policy currently being used. A review of the policy included, but was not limited to, it is the policy that residents residing within the facility receive adequate supervision. On 1/10/24 at 2:45 p.m., the DON provided the facility policy, "Resident Rights," updated on 3/15/17, and indicated it was the policy currently being used. A review of the policy indicated, "... Safe Environment ... You have the right to a safe ... environment ... including but not limited to receiving treatment for daily living safely ... " This citation relates to Complaint IN00425646. 3.1-37(a)			