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	08/22/2022

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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: August 14, 15, 16, 17, 18, 19, and 22, 2022 Facility number: 004831 Provider number: 155751 AIM number: 200809750 Census Bed Type: SNF: 14 NF: 98 Residential: 43 Total: 155 Census Payor Type: Medicare: 14 Medicaid: 70 Other: 28 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 25, 2022.	F 0000	Please find the attached Plan of Corrections for Meadow Lakes Annual Survey completed on 8/22/22. The provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Sincerely, Phil Ford, MS, ED The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.			

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

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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	§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure residents were showered per their preference for 2 of 6 residents reviewed for choices. (Resident 20, Resident 26) Findings include: 1. During an interview on 8/15/2022 at 10:52 a.m., Resident 20 indicated she had not had a shower nor her hair washed in over a week. Her scheduled days were Tuesday and Friday but she had not received any showers the prior week. On 8/17/2022 at 2:30 p.m., Resident 20's clinical record was reviewed. The diagnoses included, but were not limited to cerebral infarction affecting right dominant side and hemiplegia (muscle	F 0561	**F561- Shower Preference** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 20 and 26 will be showered per their preference Resident 20 and Resident 26's care plans were updated to reflect resident shower preference and frequency. - **how other residents having**	09/16/2022

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	weakness or partial paralysis). The Quarterly Minimum Data Set (MDS) assessment, dated 6/4/2022, indicated Resident 20 had moderately cognitive impairment and required extensive assistance of one with personal hygiene. A care plan, initiated on 9/14/2016, and current through target date 9/6/2022, for Resident 20 indicated, "... Problem: Resident requires assistance with ADL's [activities of daily living] ... related to: DX [diagnosis] of right hemiparesis secondary to CVA [cerebral vascular accident] ... Goal: Resident will not further decline in current functional abilities ... Approach: Offer shower two times per week in the AM or PM, partial bath in between ..." A review of preferences for Resident 20 indicated, "... How important is it for you to choose between a tub bath, shower, bed bath/sponge bath? Very important ... Do you have a preference as to what time or how often you bathe? More than twice per week in the PM ... What type of bathing are you used to? Shower ..." A review on 8/19/2022 at 2:15 p.m., of Resident 20's "Shower Report" indicated the following: -8/5/2022-shower provided. -8/16/2022-shower provided. -undated-shower provided. The Shower Report lacked documentation of Resident 20 having had a shower from 8/5/2022 through 8/16/2022. During an interview on 8/19/2022 at 2:45 p.m., the Director of Nursing Services indicated there were		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the alleged deficient practice. -DNS/Designee will interview all residents for updated preferences for bathing and update care plan appropriately. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** DNS/Designee will audit shower sheets daily during Clinical Meeting to ensure all scheduled showers were given. Any missed showers will be addressed. - All nursing staff will be Inservice by DNS/Designee on Resident Rights, including ensuring all residents are showered per their preference by 09/16/2022 - **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; and** Accommodation of needs QAPI	

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	no shower sheets or documentation to indicate Resident 20 had a shower between 8/5/2022 and 8/16/2022. 2. During an interview on 8/14/22 at 12:44 p.m., Resident 26 indicated she was not getting bed baths per her preference. During an interview on 8/17/22 at 1:58 p.m.. Resident 26 indicated she was to have a bed bath on 8/16/22, but she did not receive it on 8/16/22. On 8/19/22 at 11:33 a.m., Resident 26's clinical record was reviewed. The diagnoses included, but were not limited to pain, major depression, and osteoarthritis. The Quarterly MDS assessment, dated 6/7/22, indicated Resident 26 was cognitively intact and was totally dependent on one staff for the bathing. The Preferences for Customary Routine and Activities, dated 6/9/22 at 11:06 a.m., indicated it was very important for her to choose between tub bath, shower, or bed bath/sponge bath and to have more than twice per week in the AM. A care plan, initiated on 6/21/19 and current through target date 9/9/22, indicated Resident 26 required assistance with activities of daily living (ADLs) and to assist with bathing as needed per resident preference. The 100 Back Hall Shower and Linen Change Schedule indicated Resident 26's shower schedule was on Tuesday and Friday evenings. Resident 26's Shower Reports lacked documentation of bed baths given from 8/7/22-8/13/22.		Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** Plans will be implemented, and issues corrected by 09/16/2022	

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	During an interview on 8/18/22 at 10:43 a.m., Qualified Medication Aide (QMA) indicated Resident 26's preference has been bed baths instead of showers. She was to receive them twice a week in the evenings. During an interview on 8/19/22 at 2:45 p.m., the Director of Nursing Services (DNS) indicated the clinical record lacked documentation of Resident 26 receiving a bed bath or shower for the week of 8/7/22-8/13/22. On 8/14/22 at 2:00 p.m., the Administrator provided the facility's policy, "Resident Rights," revised date 1/2022, and indicated it was the policy being used by the facility. A review of the policy indicated,"...A resident has the right to: Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care..." 3.1-3(u)(1)			
F 0744 SS=D 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 a resident who was diagnosed with dementia, received the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being for 1 of 4 resident reviewed for dementia care. (Resident 34) Findings include:	F 0744	**F 744 Treatment/Service for Dementia** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 34's care plan has been	09/16/2022

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	During a continuous observation on 8/15/22 from 11:25 a.m. to 11:48 a.m., the following was observed. Resident 34 was observed to go the exit door adjacent to the TV room and wiggle the handle in an attempt to open the door. Resident 34 appeared frustrated and then propelled herself back down the hallway. Resident 34 returned to the exit door and hit the handle three times. The resident appeared staff. No staff were observed to redirect the resident. Resident 34 propelled herself back down the hall towards the dining room. Resident 34 then returned to the exit door and aggressively shook the handle. Resident 34 was observed to be breathing heavily. Multiple staff members were observed to be within sight of Resident 34 but were not observed to redirect the resident. Resident 34 was then observed to propel herself away from the door and back down the hallway. On 8/17/22 at 10:45 a.m., the resident was observed self-propelling herself up and down the halls with her eyes closed. During a continuous observation on 8/18/22 from 11:19 a.m. to 11:29 a.m., the following was observed: Resident 34 was self-propelling herself throughout the unit in her wheelchair. She went up to the exit door and aggressively shook the door handle three times. The resident sat in front of the door for a few minutes before she propelled back down throughout the unit. No staff members were observed to redirect her. Resident 34 returned to the exit door and aggressively shook the door handle two times. She sat in front of the door for a few minutes before she propelled back through the unit. No staff members were observed to redirect her. Resident 34 returned to the exit door and aggressively shook the door		updated to be more person centered and resident specific in regard to behavioral interventions - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who have a diagnosis of Dementia have the potential to be affected by the alleged deficient practice. An Audit of all residents who are affected by dementia will have their care plans audited 1x now to check for person centered interventions and care. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All nursing staff will be in service related to Dementia, including residents with Dementia receiving appropriate treatment and services to attain and maintain the highest level of well-being and having a person-centered care plan with resident specific interventions by DNS/Designee by 09/16/2022 - DNS/Designee will round daily to ensure residents with Dementia	

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	handle two times. The resident sat in front of the door for a few minutes before she returned to propelling throughout the unit. Multiple staff members were observed to be nearby and did not redirect the resident. During a continuous observation on 8/18/22 from 11:29 a.m. to 11:47 a.m., the following was observed: Resident 34 was observed to be propelling herself throughout the unit in her wheelchair. She went up to the exit door and aggressively shook the door handle three times. The resident sat in front of the door for a few minutes before she propelled away. Multiple staff were present and did not redirect the resident. The resident returned to the exit door and aggressively shook the door handle three times. Resident 34 sat in front of the door for a few minutes before she propelled away. A CNA came up to the resident and asked her if she was hungry. Resident 34 responded that she was. The CNA was observed to assist the resident to the dining table. No food was observed to be given to the resident. Resident 34 propelled herself away from the dining table and down the hall. She returned to the exit door and aggressively shook the door handle three times. The resident sat in front of the exit door for a few minutes before she propelled away. Multiple staff members were nearby and were not observed to redirect the resident. Resident 34 returned to the exit door and aggressively shook the door handle three times. She was observed to sit in front of the exit door for a few minutes before she propelled way. During a continuous observation on 8/19/22 from 10:23 a.m. to 10:47 a.m., the following was observed: Resident 34 was observed self-propelling throughout the unit. She went up to the exit door rand aggressively shook the door		are being redirected as needed/provided resident specific interventions per their plan of care - **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; and** Comprehensive Care Plan QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** Plans will be implemented, and	

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	handle two times. She sat in front of the door for a few minutes. Resident 34 then returned to propelling throughout the unit. Multiple staff members were nearby and were not observed to redirect the resident. Resident 34 returned to the exit door and aggressively shook the door handle three times. She sat in front of the door for a few minutes before she propelled away. Multiple staff members were observed to be nearby and did not redirect the resident. Resident 34 returned to the exit door and aggressively shook the door handle three times. She sat in front of the door for a few minutes before she propelled away. Multiple staff members were present and were not observed to redirect the resident. On 8/16/22 at 10:30 a.m., Resident 34's clinical record was reviewed. The diagnoses included, but were not limited to, dementia with behavioral disturbance, mood disorder with depressive features, Alzheimer's disease, major depressive disorder, and cognitive communication deficit. A care plan, dated 11/19/22 with a target date of 9/22/22, indicated the resident was at risk for elopement as evidenced by exit seeking. The interventions included, but were not limited to, provide 1 on 1 attention and conversation as needed and redirect to activities of interest such as bingo, penny pitch or coffee hour. The Progress Notes included, but were not limited to: -On 6/16/22 at 8:31 a.m., a quarterly assessment indicated "...One important aspect of the resident's life story: Resident loves to garden..." -On 6/22/22 at 8:48 p.m., the resident was ambulating the unit via her wheelchair.		issues corrected by 09/16/2022	

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	-On 7/20/22 at 8:19 p.m., the resident was ambulating in wheelchair around the unit. -On 7/28/22 at 9:56 a.m., the resident was frequently self-propelling in her wheelchair throughout the unit. -On 8/2/22 at 5:45 a.m., the resident was up ambulating in wheelchair during the night shift. During an interview on 8/18/22 at 10:00 a.m., CNA 3 indicated the resident was always self-propelling around the unit and she usually had her eyes closed. During an interview on 8/18/22 at 10:15 a.m., CNA 4 indicated the residents do not get to stay outside very long because most of them want to come back in before some of the others. There are some residents on the unit who would love to sit outside all day long. During an interview on 8/18/22 at 10:30 a.m., the unit manager indicated the resident was always on the move about the unit. She indicated the resident liked sweets so she'll offer her cookies. During an interview on 8/19/22 at 2:45 p.m., the Director of Health Services indicated the facility did not have policy for managing wandering residents. 3.1-37(a)			
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides-			

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	§483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure a resident's menu choice and required texture were met for 1 of 8 residents reviewed for food. (Resident 70). Findings include: During an interview on 8/15/22 at 12:18 P.M., Resident 70 indicated the meals brought to him in his room were frequently not what he requested and were of a texture he was unable to consume. He was to be served a mechanical soft diet due to not being able to chew solid foods. During an interview on 8/16/22 at 12:35 P.M., Resident 70 indicated for that day's lunch he ordered a mechanical soft ground hamburger with cheese sauce, chopped steamed broccoli, cooked soft, pureed wedge fries, ice cream, and 2 servings of diced peaches. On 8/16/22 at 12:46 P.M., the resident's lunch tray was observed to contain a whole baked chicken breast, chopped steamed broccoli, 2 servings of diced pears, and ice cream. There was not a mechanical soft ground hamburger with cheese sauce, diced peaches, or pureed wedge fries. On 8/16/22 at 12:48 P.M., the lunch menu order card dated 8/16/22 was observed on the resident's lunch tray and indicated the resident ordered a mechanical soft ground hamburger with cheese sauce, chopped steamed broccoli, cooked soft, pureed wedge fries, ice cream, and 2 servings of diced peaches.	F 0805	**F 805 Food Preferences** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** - Menu choice and required food texture are met for Resident 70 - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the alleged deficient practice. All residents will be interviewed by Care Companion to ensure that their current food preferences and food textures are accurate. Updates will be made as needed. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All nursing and culinary staff will be in serviced related to Food Preferences and Textures, including ensuring resident	09/16/2022

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	On 8/16/22 at 2:20 P.M., Resident 70's clinical record was reviewed. The diagnoses included, but were not limited to, heart failure and dysphasia, oral phase (a condition in which an individual had difficulties using the mouth, lips and tongue to control food or liquid). A dietary order, dated 8/2/22 and open ended, indicated the resident was to receive "...regular, mechanical, ground meat..." A Speech - Language Pathologist Altered Diet Consistency Acknowledgement, dated 7/15/22, indicated, "...recommended diet mechanical soft..." During an interview on 8/17/22 at 11:45 A.M., the Dietary Manager indicated each resident had a tray card from which they choose their meal requests, and this told staff what to serve the resident for meals. 3.1-21(a)(3)		preferences and food textures are honored at mealtimes by DNS/Designee by 9/16/2022. - DNS/Designee will round daily during various mealtimes to ensure residents are receiving meals per their preference and required food texture - **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; and** Food preference QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The**	

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			facility will need to submit an amended plan of correction with the updated plan of correction date. Plans will be implemented, and issues corrected by 09/16/2022.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: August 14, 15, 16, 17, 18, 19, and 22, 2022 Facility number: 004831 Residential Census: 43 Meadow Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	Please find the attached Plan of Corrections for Meadow Lakes Annual Survey completed on 8/22/22. The provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Sincerely, Phil Ford, MS, ED The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	