PRINTED: 09/06/2022

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2022		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158		EADOW LAKE DR		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
Bldg. 00	Licensure Survey. Residential Licensus Survey dates: Augu 2022 Facility number: 00 Provider number: 1 AIM number: 2008 Census Bed Type: SNF: 14 NF: 98 Residential: 43 Total: 155 Census Payor Type Medicare: 14 Medicaid: 70 Other: 28 Total: 112 These deficiencies accordance with 41	reflect State Findings cited in 10 IAC 16.2-3.1. npleted August 25, 2022.	F 00	000	Please find the attached Plar Corrections for Meadow Lake Annual Survey completed on 8/22/22. The provider respective requests the 2567 plan of correction be considered the of credible allegation and recal a desk review, in lieu of a Posurvey revisit. Sincerely, Phil Ford, MS, ED. The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion see in the statement of deficienci of any violation of regulation.	es ctfully letter quests st of not nis et forth es, or	
F 0561 SS=D Bldg. 00	Self-Determination §483.10(f) Self-determination The resident has must promote and	n					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of

this section.

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA'			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155751	B. W	B. WING 08/22			2022
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158 ID PROVIDER'S PLAN OF CORRECTION (X5)				(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	choose activities, sleeping and waki providers of health with his or her interplan of care and of this part. §483.10(f)(2) The choices about aspfacility that are sig §483.10(f)(3) The interact with mem participate in comand outside the farm outside the farm of interfere with the facility. Based on interview failed to ensure resipreference for 2 of choices. (Resident 2 of choices. (Resident 2 of choices.) I. During an interview failed to ensure resipreference for 2 of choices. (Resident 2 of choices.) Tindings include: 1. During an interview failed to ensure resipreference for 2 of choices. (Resident 2 of choices.) On 8/17/2022 at 2:3	resident has a right to r activities, including social, inmunity activities that do the rights of other residents and record review, the facility dents were showered per their 6 residents reviewed for 20, Resident 26) ew on 8/15/2022 at 10:52 a.m., ed she had not had a shower lin over a week. Her scheduled and Friday but she had not	F 03	561	F561- Shower Preference - what corrective action(s will be accomplished for thoresidents 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 reresident shower preference ar frequency.	se n s flect	09/16/2022
		cerebral infarction affecting and hemiplegia (muscle			- how other residents hav	ina	
	115111 dominiant side	and hemipiegia (musere			- How other residents flav	9	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 08/22/2022 155751 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 MEADOW LAKE DR MEADOW LAKES MOORESVILLE, IN 46158 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE weakness or partial paralysis). the potential to be affected by the same deficient practice will The Quarterly Minimum Data Set (MDS) be identified and what assessment, dated 6/4/2022, indicated Resident 20 corrective action(s) will be had moderately cognitive impairment and required taken. extensive assistance of one with personal hygiene. All residents have the potential to be affected by the alleged deficient A care plan, initiated on 9/14/2016, and current practice. through target date 9/6/2022, for Resident 20 -DNS/Designee will interview all indicated, "... Problem: Resident requires residents for updated preferences assistance with ADL's [activities of daily living] ... for bathing and update care plan related to: DX [diagnosis] of right hemiparesis appropriately. secondary to CVA [cerebral vascular accident] ... Goal: Resident will not further decline in current what measures will be put functional abilities ... Approach: Offer shower two into place and what systemic times per week in the AM or PM, partial bath in changes will be made to between ..." ensure that the deficient practice does not recur. A review of preferences for Resident 20 indicated, "... How important is it for you to choose between DNS/Designee will audit shower a tub bath, shower, bed bath/sponge bath? Very sheets daily during Clinical important ... Do you have a preference as to what Meeting to ensure all scheduled time or how often you bathe? More than twice per showers were given. Any missed week in the PM ... What type of bathing are you showers will be addressed. used to? Shower ..." All nursing staff will be Inservice A review on 8/19/2022 at 2:15 p.m., of Resident by DNS/Designee on Resident 20's "Shower Report" indicated the following: Rights, including ensuring all residents are showered per their -8/5/2022-shower provided. preference by 09/16/2022 -8/16/2022-shower provided. -undated-shower provided. how the corrective action(s) will be monitored to The Shower Report lacked documentation of ensure the deficient practice Resident 20 having had a shower from 8/5/2022 will not recur, i.e., what quality through 8/16/2022. assurance program will be put into place; and During an interview on 8/19/2022 at 2:45 p.m., the Director of Nursing Services indicated there were Accommodation of needs QAPI

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPLETED	
		155751	B. W	B. WING		08/22/2022	
				CTD FFT A	ADDRESS CITY OTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MEADON	N.I. ALCEO				ADOW LAKE DR		
MEADOV	V LAKES			MOORE	ESVILLE, IN 46158		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDER'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	no shower sheets or	documentation to indicate			Tool will be utilized weekly x 4		
	Resident 20 had a shower between 8/5/2022 and				weeks, monthly x 6 months, a		
		g an interview on 8/14/22 at			quarterly thereafter for one year		
		nt 26 indicated she was not			with results reported to the Qu		
	getting bed baths per her preference.				Assurance and Performance		
	88				Improvement Committee overs	seen	
	During an interview	on 8/17/22 at 1:58 p.m			by the Executive Director	50011	
	_	ed she was to have a bed bath			S, ale Excedite Bilector		
	on 8/16/22, but she did not receive it on 8/16/22.				If a threshold of 90% is not		
	on 6/16/22, out sile	and not receive it on o/ 10/22.			achieved, an action plan will b	_	
	On 8/19/22 at 11:33	3 a.m., Resident 26's clinical			developed to ensure complian		
		d. The diagnoses included, but			developed to ensure compilari	CE	
	were not limited to pain, major depression, and				- by what date the system	io	
	osteoarthritis.	pain, major depression, and			changes for each deficiency	IC .	
	osteoartiiritis.				will be completed. After		
	The Quarterly MDS	S assessment, dated 6/7/22,			submitting an acceptable Pla	m	
		26 was cognitively intact and			of Correction, if it is	ll I	
		ent on one staff for the			-		
	bathing.	the on one start for the			determined that the correction	on	
	batiling.				will not be completed by the	ha	
	The Dreferences for	Customary Routine and			date previously submitted, T Division needs to be contact		
		9/22 at 11:06 a.m., indicated it				eu	
					as soon as possible. The	_	
		for her to choose between tub			facility will need to submit ar	1	
		d bath/sponge bath and to			amended plan of correction		
	nave more than twic	ce per week in the AM.			with the updated plan of		
	A 1 - * ***	1 (/21/10 1			correction date.		
	_	ed on 6/21/19 and current					
		9/9/22, indicated Resident 26			Plans will be implemented, an		
	•	with activities of daily living			issues corrected by 09/16/202	2	
		st with bathing as needed per					
	resident preference.						
		Shower and Linen Change					
		Resident 26's shower schedule					
	was on Tuesday and	d Friday evenings.					
	Resident 26's Show						
		ed baths given from					
	8/7/22-8/13/22.						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		A. BUILDING B. WING	<u>00</u>	COMPLETED 08/22/2022				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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			
	Qualified Medication Resident 26's prefer instead of showers. a week in the evening During an interview Director of Nursing clinical record lacket	on 8/18/22 at 10:43 a.m., on Aide (QMA) indicated tence has been bed baths. She was to receive them twice the two services (DNS) indicated the ed documentation of Resident to the or shower for the week of						
	8/7/22-8/13/22. On 8/14/22 at 2:00 provided the facility revised date 1/2022 policy being used be policy indicated," Choose activities, so	p.m., the Administrator y's policy, "Resident Rights," , and indicated it was the y the facility. A review of the A resident has the right to: chedules, and health care or her interests, assessments,						
F 0744 SS=D Bldg. 00	diagnosed with de appropriate treatm	esident who displays or is ementia, receives the nent and services to attain her highest practicable						
	Based on observation review, the facility was diagnosed with appropriate treatment maintain their higher and psychosocial was a second or second o	on, interview, and record failed to ensure a resident who dementia, received the nt and services to attain or est practicable physical, mental, ell-being for 1 of 4 resident tria care. (Resident 34)	F 0744	F 744 Treatment/Service for Dementia - what corrective action(s will be accomplished for tho residents found to have been affected by the deficient practice? Resident 34's care plan has be	se n			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM			TED	
		155751	B. Wl	ING		08/22/20	022	
		_	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u>'</u>		
NAME OF F	PROVIDER OR SUPPLIE	R		200 ME	ADOW LAKE DR			
MEADO	W LAKES			MOORESVILLE, IN 46158				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE (COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					updated to be more person			
	_	as observation on 8/15/22 from			centered and resident specific			
		3 a.m., the following was			regard to behavioral intervent	ions		
	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					_		
					- how other residents have	-		
					the potential to be affected by	-		
					the same deficient practice	/ III		
		way. Resident 34 returned to			be identified and what			
	the exit door and hit the handle three times. The resident appeared staff. No staff were observed				corrective action(s) will be taken.			
	to redirect the resident. Resident 34 propelled				taken.			
		the hall towards the dining			All residents who have a diag	nocie		
		then returned to the exit door			of Dementia have the potentia			
	and aggressively shook the handle. Resident 34				be affected by the alleged def			
		breathing heavily. Multiple			practice.	loiont		
		e observed to be within sight of			practice.			
		ere not observed to redirect the			An Audit of all residents who	are		
		34 was then observed to propel			affected by dementia will have			
		the door and back down the			their care plans audited 1x no			
	hallway.				check for person centered			
					interventions and care.			
	On 8/17/22 at 10:4	5 a.m., the resident was						
	observed self-prope	elling herself up and down the			- what measures will be p	out		
	halls with her eyes	closed.			into place and what systemi	С		
					changes will be made to			
	During a continuou	s observation on 8/18/22 from			ensure that the deficient			
		a.m., the following was			practice does not recur.			
		34 was self-propelling herself						
		in her wheelchair. She went			All nursing staff will be in serv			
	-	and aggressively shook the			related to Dementia, including	· I		
		imes. The resident sat in front			residents with Dementia recei	-		
		w minutes before she propelled			appropriate treatment and sei			
		out the unit. No staff members			to attain and maintain the high			
		edirect her. Resident 34			level of well-being and having			
		door and aggressively shook			person-centered care plan with			
		o times. She sat in front of the			resident specific interventions	-		
		utes before she propelled back			DNS/Designee by 09/16/2022	<u>'</u>		
	_	No staff members were						
		t her. Resident 34 returned to			DNS/Designee will round dail	-		
	the exit door and aggressively shook the door				ensure residents with Demen	tia		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155751	B. W	ING _		08/22/	2022
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L					
MEADOW	W LAKES			200 MEADOW LAKE DR MOORESVILLE, IN 46158			
				WOOK		-	
(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		LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		DATE		
		The resident sat in front of the			are being redirected as		
		ites before she returned to			needed/provided resident spe		
		out the unit. Multiple staff			interventions per their plan of	care	
		erved to be nearby and did not					
	redirect the resident	•			- how the corrective		
					action(s) will be monitored to)	
	_	s observation on 8/18/22 from			ensure the deficient practice		
	11:29 a.m. to 11:47 a.m., the following was				will not recur, i.e., what quali	ty	
		34 was observed to be			assurance program will be p	ut	
		nroughout the unit in her			into place; and		
		nt up to the exit door and					
	aggressively shook the door handle three times.				Comprehensive Care Plan QA	νPI	
	The resident sat in front of the door for a few				Tool will be utilized weekly x 4		
		propelled away. Multiple staff			weeks, monthly x 6 months, a	nd	
	_	d not redirect the resident. The			quarterly thereafter for one yea	ar	
	resident returned to	the exit door and aggressively			with results reported to the Qu	ıality	
	shook the door hand	lle three times. Resident 34 sat			Assurance and Performance		
	in front of the door	for a few minutes before she			Improvement Committee overs	seen	
	propelled away. A	CNA came up to the resident			by the Executive Director		
	and asked her if she	was hungry. Resident 34					
	responded that she	was. The CNA was observed			If a threshold of 90% is not		
		t to the dining table. No food			achieved, an action plan will b	е	
		given to the resident.			developed to ensure complian	ce	
		ed herself away from the			_		
	_	wn the hall. She returned to			- by what date the system	ic	
		gressively shook the door			changes for each deficiency		
		The resident sat in front of the			will be completed. After		
		minutes before she propelled			submitting an acceptable Pla	ın	
		ff members were nearby and			of Correction, if it is		
		o redirect the resident.			determined that the correction	on	
		d to the exit door and			will not be completed by the		
		the door handle three times.			date previously submitted, T		
		o sit in front of the exit door			Division needs to be contact	ed	
	for a few minutes b	efore she propelled way.			as soon as possible. The		
					facility will need to submit ar	າ	
	_	s observation on 8/19/22 from			amended plan of correction		
		a.m., the following was			with the updated plan of		
	observed: Resident				correction date.		
		ughout the unit. She went up					
	to the exit door rand aggressively shook the door				Plans will be implemented, an	d	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIED	R	STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	handle two times. a few minutes. Respropelling through members were near redirect the resident exit door and aggrest three times. She saminutes before she members were obstredirect the resident exit door and aggrest three times. She saminutes before she members were presented redirect the resident on 8/16/22 at 10:3 record was reviewed were not limited to disturbance, mood features, Alzheimed disorder, and cognitated and redirect as bingo, penny pitt. The Progress Notes to: On 6/16/22 at 8:31 indicated "One in resident's life story On 6/22/22 at 8:48	0 a.m., Resident 34's clinical ed. The diagnoses included, but dementia with behavioral disorder with depressive r's disease, major depressive tive communication deficit. 11/19/22 with a target date of the resident was at risk for need by exit seeking. The ded, but were not limited to, intion and conversation as to activities of interest such		TAG	issues corrected by 09/16/202	2	DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		A. BUILDING B. WING	00	COMPLETED 08/22/2022			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	ambulating in whee -On 7/28/22 at 9:56 frequently self-prop throughout the unit. -On 8/2/22 at 5:45 a ambulating in whee During an interview	p.m., the resident was lehair around the unit. a.m., the resident was elling in her wheelchair a.m., the resident was up lehair during the night shift. on 8/18/22 at 10:00 a.m., CNA lent was always self-propelling					
	around the unit and closed. During an interview 4 indicated the residutiside very long become back in before	she usually had her eyes on 8/18/22 at 10:15 a.m., CNA lents do not get to stay ecause most of them want to e some of the others. There are ne unit who would love to sit					
	unit manager indica the move about the resident liked sweet During an interview Director of Health S	on 8/18/22 at 10:30 a.m., the ted the resident was always on unit. She indicated the s so she'll offer her cookies. on 8/19/22 at 2:45 p.m., the Services indicated the facility for managing wandering					
F 0805 SS=D Bldg. 00	§483.60(d) Food a	leet Individual Needs and drink eives and the facility					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751 NAME OF PROVIDER OR SITPLER MEADOW LAKES SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 IN 100 MEADOW LAKE OR MOORESVILLE, IN 46158 TAG SITMET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE OR MOORESVILLE, IN 46158 IN 100 MOORESWILLE, IN 46158 IN 100 MOORESWILLE, IN 46158 IN 100 MOORESWILLE, IN 461	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
MEADOW LAKES (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (LIACH IDENTIFIANCE MIST BE PRECEDED BY PILL) REPETA (LIACH IDENTIFIANCE MIST BE PRECEDED BY PILL) REPUTA (LIACH IDENTIFIANCE MIST BE PRECEDED BY PILL) REPUTA (LIACH IDENTIFIANCE MIST BE REPUTATION FORMATION) RESOLUTION OF THE ACTION ENGRAPHIAN OF COMPLETION (AND IDENTIFIANCE MIST BE PRECEDED BY PILL) REPUTATION OF THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG PRETICAL THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG TAG TAG TAG TAG TAG THE PRICE OF THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG THE PRICE OF THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG TAG THE PRICE OF THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG TAG TAG TAG THE PRICE OF THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG THE PRICE OF THE ACTION ENGRAPMENT COMPLETION (COMPLETION) TAG THE PRICE OF THE ACTION ENGRAPMENT COMPLETION CO	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/22/2022	
	PROVIDER OR SUPPLIE	R	200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR ESVILLE, IN 46158	
PREFIX (EAC TAG REGU On 8/16/ record w were not oral phas	(EACH DEFICIENT REGULATORY OF Note 11 to 12 to 12 to 12 to 12 to 13 to 14 to 14 to 15 to 1	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) preferences and food textures honored at mealtimes by DNS/Designee by 9/16/2022.	DATE S are
	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"			DNS/Designee will round daily during various mealtimes to ensure residents are receiving meals per their preference an required food texture	
	A Speech - Langua Consistency Acknowindicated, "recon	age Pathologist Altered Diet owledgement, dated 7/15/22, nmended diet mechanical soft" w on 8/17/22 at 11:45 A.M., the ndicated each resident had a		- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be p into place; and	e ity
	tray card from whi	ch they choose their meal old staff what to serve the		Food preference QAPI Tool w utilized weekly x 4 weeks, monthly x 6 months, and quar thereafter for one year with re reported to the Quality Assura and Performance Improvement Committee overseen by the Executive Director	terly sults ance
				If a threshold of 90% is not achieved, an action plan will be developed to ensure compliant by what date the system changes for each deficiency will be completed. After submitting an acceptable Platof Correction, if it is determined that the correction will not be completed by the date previously submitted, T	nic an on
				Division needs to be contact as soon as possible. The	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BD6911

Facility ID: 004831

If continuation sheet Page 11 of 12

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

PRINTED: 09/06/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155751	B. WING		08/22/2022		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 MEADOW LAKE DR MOORESVILLE, IN 46158				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				facility will need to submit at amended plan of correction with the updated plan of correction date. Plans will be implemented, an issues corrected by 09/16/202	nd		
R 0000						l	
Bldg. 00							
	Survey. This visit is State Licensure Sur	st 14, 15, 16, 17, 18, 19, and 22,	R 0000	Please find the attached Plan Corrections for Meadow Lake Annual Survey completed on 8/22/22. The provider respect requests the 2567 plan of correction be considered the I of credible allegation and requa desk review, in lieu of a Pos Survey revisit.	s fully letter uests		
				Sincerely, Phil Ford, MS, ED			
		found to be in compliance 5 in regard to the State re Survey.		The creation and submission this Plan of Correction does n constitute an admission by thi provider of any conclusion set in the statement of deficiencie of any violation of regulation.	iot is t forth		

State Form Event ID: BD6911 Facility ID: 004831 If continuation sheet Page 12 of 12