PRINTED: 10/05/2022

	T OF HEALTH AND HUI R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/15/2022	
	PROVIDER OR SUPPLIEF	₹		200 ME	EET ADDRESS, CITY, STATE, ZIP COD MEADOW LAKE DR ORESVILLE, IN 46158		
	1		1		,	<i>a</i> 75	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
E 0000 Bldg E 0039 SS=F	conducted by the In accordance with 42 Survey Date: 09/15 Facility Number: 0 Provider Number: 200 At this Emergency Lakes was found not Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 137 the survey, the cense Quality Review cor 403.748(d)(2), 410, 441.184(d)(2), 485	25/22 204831 205751 209750 Preparedness survey, Meadow of in compliance with edness Requirements for icaid Participating Providers 25FR 483.73 7 certified beds. At the time of sus was 111. Impleted on 09/19/22 26.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2),	E 00	000	/p> /p> /p> /p> ="" p=""> ="" p=""> ="" p=""> ="" p="">		
Bldg	485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					

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

*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:

> 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.

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

Event ID:

BD6921

If continuation sheet

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING		COM	PLETED 5/2022
NAME OF F	PROVIDER OR SUPPLIER		200 ME	ADDRESS, CITY, STATE, ZIP O ADOW LAKE DR ESVILLE, IN 46158	COD	
(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 COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	exercises to test the	acility] must conduct ne emergency plan liity] must do all of the				
	community-based (A) When a commot accessible, confunctional exercises (B) If the [facinatural or man-malactivation of the elis exempt from encommunity-based functional exercise actual event. (ii) Conduct an addevery 2 years, oppor functional exercise (i) of this section is include, but is not (A) A second full-scommunity-based functional exercise (B) A mock disaste (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem starmessages, or prepto challenge an encommunity accession using a clinically-relevant of the confunctional exercise (C) and the confunctional exercise (C) at abletop exelled by a facilitator discussion using a clinically-relevant of the confunctional exercise (C) and the confunctional exercise (C) at abletop exelled by a facilitator discussion using a clinically-relevant of the confunctional exercise (C) at abletop exelled by a facilitator discussion using a clinically-relevant of the confunctional exercise (C) at abletop exelled by a facilitator discussion using a clinically-relevant of the confunctional exercise (C) at abletop exelled by a facilitator discussion using a clinically-relevant of the confunctional exercise (C) at a	nunity-based exercise is induct a facility-based every 2 years; or lity] experiences an actual ide emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale place is conducted, that may limited to the following: scale exercise that is or individual, facility-based exercise that is or individual, facility-based exercise or workshop that is and includes a group in narrated, emergency scenario, and a tements, directed pared questions designed				
	maintain documer exercises, and em	ntation of all drills, tabletop ergency events, and revise rgency plan, as needed.				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 2 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING		COMP	LETED 5/2022
	PROVIDER OR SUPPLIER		200 ME	ADDRESS, CITY, STATE, ZIP COI EADOW LAKE DR ESVILLE, 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 CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	the patient's home conduct exercises plan at least annuate following: (i) Participate in a community based (A) When a command accessible, condubased functional et (B) If the hospice of the emergency exempt from engascale community-facility-based functional exercise of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem star messages, or prepto challenge an endition of the community of the communi	unity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full based exercise or individual tional exercise following the gency event. Iditional exercise every 2 exper the full-scale or exunder paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based exercise or workshop that is and includes a group in narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. Pices that provide inpatient hospice must conduct exercise exercise in patient hospice must do the following: n annual full-scale exercise				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 3 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING	JNSTRUCTION	COM	IPLETED 15/2022
	PROVIDER OR SUPPLIER		200 ME	ADDRESS, CITY, STATE, ZIP EADOW LAKE DR ESVILLE, IN 46158	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	accessible, condular facility-based functions of the emergency exempt from engal full-scale community-based functional exercise emergency event. (ii) Conduct an activation and that may include, following: (A) A second full-community-based functional exercises (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, demergency scenal statements, direct questions designed emergency plan. (iii) Analyze the homaintain document exercises, and emergency scenal for the hospice's emergency scenal for the hospice's emergency plan. (iii) Analyze the hospice's emergency scenal for the hospice's emergency plan. (iii) Analyze the hospice's emergency plan. (iii)	experiences a natural or ency that requires activation plan, the hospice is ging in its next required ity based or facility-based e following the onset of the ditional annual exercise out is not limited to the scale exercise that is or a facility based e; or er drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ed messages, or prepared d to challenge an cospice's response to and station of all drills, tabletop ergency events and revise regency plan, as needed. 41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must to test the emergency r. The [PRTF, Hospital, following: n annual full-scale exercise				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 4 of 28

PRINTED: 10/05/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPI	LETED
		155751	B. W	ING		09/15	/2022
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	R		200 ME	ADOW LAKE DR		
MEADO	W LAKES			MOORE	ESVILLE, 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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based fund	ctional exercise; or					
	(B) If the [PRTF, I	Hospital, CAH] experiences					
	an actual natural	or man-made emergency					
	that requires activ	ation of the emergency					
	plan, the [facility]	is exempt from engaging in					
	its next required f	ull-scale community based					
	or individual, facil	ity-based functional exercise					
	following the onse	et of the emergency event.					
	(ii) Conduct	an [additional] annual					
	exercise or and th	nat may include, but is not					
	limited to the follo	wing:					
	(A) A second full-	-scale exercise that is					
	community-based	l or individual, a					
	facility-based fund	ctional exercise; or					
	(B) A mo	ock disaster drill; or					
	(C) A tableto	p exercise or workshop that					
	is led by a facilitat	tor and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta	atements, directed					
	messages, or pre	pared questions designed					
	to challenge an e	·					
	_	he [facility's] response to					
	and maintain doc	umentation of all drills,					
	tabletop exercises	s, and emergency events					
	-	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60.84(d):]					
		PACE organization must					
	` '	s to test the emergency					
	plan at least annu	0 5					
	organization must	-					
	_	an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	, ,	uct an annual individual,					
	·	ctional exercise; or					
	, ,	,	1				1

(B) If the PACE experiences an actual natural or man-made emergency that requires

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING	ONSTRUCTION	-	LETED 5/2022
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO	DD	
MEADOV	W LAKES			RESVILLE, IN 46158		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		mergency plan, the PACE gaging in its next required				
	· ·	ity based or individual,				
		tional exercise following the				
	onset of the emerg	_				
	l '	n additional exercise every				
	1 ' '	he year the full-scale or				
		e under paragraph (d)(2)(i)				
	of this section is c	onducted that may include,				
	but is not limited to	o the following:				
	(A) A second full-	scale exercise that is				
	community-based	or individual, a facility				
	based functional e	exercise; or				
	(B) A mock disast	ter drill; or				
	1 ' '	ercise or workshop that is				
	led by a facilitator	and includes a group				
	discussion, using	a narrated,				
	I	emergency scenario, and a				
	set of problem sta					
		pared questions designed				
	to challenge an er					
	l ' '	ACE's response to and				
		ntation of all drills, tabletop				
		nergency events and revise				
	the PACE's emerg	gency plan, as needed.				
	*[For LTC Facilitie	s at §483.73(d):]				
	(2) The [LTC facili	ty] must conduct exercises				
	to test the emerge	ncy plan at least twice per				
	year, including una	announced staff drills using				
	the emergency pro	ocedures. The [LTC facility,				
	ICF/IID] must do ti	he following:				
		ın annual full-scale exercise				
	that is community-					
	1 ' '	unity-based exercise is not				
		ct an annual individual,				
	facility-based func					
	l ' '	ility] facility experiences an				
		nan-made emergency that				
	requires activation	of the emergency plan, the				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 6 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751 AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING			COMPI 09/15			
	F PROVIDER OR SUPPLIE	R	200 1	ET ADDRESS, CITY, STATE, ZIP COD MEADOW LAKE DR DRESVILLE, IN 46158		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	LTC facility is exercipated a full-scalindividual, facility-following the onset (ii) Conduct an attent may include, following: (A) A second full-community-based based functional (B) A mock disass (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the [response to and rall drills, tabletop events, and revise emergency plan, *[For ICF/IIDs at § (2) Testing. The lexercises to test to twice per year. The following: (i) Participate in a that is community (A) When a community (A) When a community (B) If the ICF/IID of natural or man-material activation of the elis exempt from er full-scale community.	empt from engaging its next ale community-based or based functional exercise et of the emergency event. In the emergency event of the emergency event. It is not limited to the escale exercise that is the or an individual, facility exercise; or effect of ill; or effect or workshop that is includes a group a narrated, emergency scenario, and a effect of emergency scenario, and a effect of exercise of exercise of exercise of exercise of exercise of effect of emergency scenario, and a effect of emergency plan. In the emergency effect of exercises, and emergency effect of exercises and emergency effect of emergency plan at least the ICF/IID must do the emergency plan at least of exercise of exercise.				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 7 of 28

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/15/2022	
	PROVIDER OR SUPPLIEI	2	200 1	ET ADDRESS, CITY, STATE, ZIP (MEADOW LAKE DR PRESVILLE, IN 46158	COD	
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
	that may include, following: (A) A second full-community-based facility-based function (B) A mock disast (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an elementary (iii) Analyze the IC maintain document exercises, and enthe ICF/IID's emethology (b) Participate in a community-based (A) When a clis not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-materization of the exempt from engal full-scale community-based functions of the emer (ii) Conduct an additional community based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emer (iii) Conduct an additional facility based functions of the emergence of t	ditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a ttements, directed pared questions designed mergency plan. CF/IID's response to and ntation of all drills, tabletop nergency events, and revise rgency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is ; or ommunity-based exercise conduct an annual based functional exercise A experiences an actual ade emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 8 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES IN OF CORRECTION	IDENTIFICATION NUMBER 155751	, ,	ILDING	NSTRUCTION	COMPL 09/15/	ETED
	F PROVIDER OR SUPPLIEI	3		200 ME	DDRESS, CITY, STATE, ZIP COD ADOW LAKE DR SVILLE, 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)	TE	(X5) COMPLETION DATE
	functional exercise of this section is of include, but is not (A) A second community-based facility-based func (B) A mock d (C) A tabletor is led by a facilitar discussion, using clinically-relevant set of problem star messages, or preto challenge an et (iii) Analyze the H maintain documer exercises, and enthe HHA's emerged *[For OPOs at §4 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a papor workshop at lease exercise is led by group discussion, relevant emergen problem statemer prepared question emergency plan. actual natural or requires activation OPO is exempt for required testing exercises, and entered in the emergency (ii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iii) Analyze the Omaintain documer exercises, and entered in the emergency (iiii) Analyze the Omaintain documer exercises, and entered in the emergency (iiii) Analyze the Omaintain documer exercises, and entered in the emergency (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is l or an individual, ctional exercise; or isaster drill; or p exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next xercise following the onset					

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

Event ID:

BD6921 Facility I

Facility ID: 004831

If continuation sheet

Page 9 of 28

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED		
		155751	B. WING		09/15/2022		
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	R		EADOW LAKE DR			
MEADO\	N LAKES		MOORESVILLE, IN 46158				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		DRY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)		DATE			
	needed.						
	exercises to test to RNHCI must do the (i) Conduct a paper at least annually, group discussion narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RI maintain document exercises, and enter the RNHCI's emel Based on record reversialed to conduct explan at least twice punannounced staff of procedures. The LT following: (i) Participate in an is community-based a. When a communaccessible, conduct facility-based funct b. If the LTC facility or man-made emergory promengaging its not community-based of the emergency promengaging its not community-based of the onset of the actual (ii) Conduct an additional conduct and discontinuation of the conduct and discontinuation of the emergency promengaging its not community-based of the conset of the actual conduct and discontinuation of the conset of the actual conduct and discontinuation of the conset of the actual conduct and discontinuation of the conset of the actual conduct and discontinuation of the conset of the actual conduct and discontinuation of the conset of the actual conduct and discontinuation of the conset of the actual conduct and discontinuation of the condu	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise regency plan, as needed. riew and interview, the facility tercises to test the emergency per year, including drills using the emergency TC facility must do the annual full-scale exercise that di; or ity-based exercise is not an annual individual, ional exercise. Ty experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale or individual, facility-based I exercise for I year following titional exercise that may imited to the following:	E 0039	="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""> Please find the attached Plar Corrections for Meadow Lake Safety Survey completed on 9/15/22. The provider respec requests the 2567 plan of correction be considered the lof credible allegation and requ a desk review, in lieu of a Pos Survey revisit. ="" p=""> ="" p=""> ="" p=""> The creation and submission this Plan of Correction does n constitute an admission by thi provider of any conclusion sei in the statement of deficiencie	s Life tfully letter uests st of iot is t forth		
		or an individual, facility-based		of any violation of regulation.	<i>'</i>		

functional exercise.

/p>

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPLETED
		155751	B. WI	NG		09/15/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIE	R		200 ME	EADOW LAKE DR	
MEADO	W LAKES			MOOR	ESVILLE, IN 46158	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	b. A mock disaster					
	•	ise or workshop that is led by a				
	facilitator that includes a group discussion, using				E – 039 - **Required Drills we	
		ly relevant emergency scenario,			completed during the calend	ıar
	_	m statements, directed			year of 2021 (copies	
	challenge an emerg	red questions designed to			uploaded). The next drills an planned to be completed	re
	-	TC facility's response to and			•	
		tation of all drills, tabletop			during the remainder of the calendar year of 2022. Pleas	
		rgency events, and revise the			strike this finding from the	e
		rgency plan, as needed in			2567**	
	1	2 CFR 483.73(d)(2). This			2007	
		ould affect all occupants.				
					- what corrective action(s)
	Findings include:				will be accomplished for tho	·
					residents found to have been	
	Based on record re	view of the facility's Emergency			affected by the deficient	
		entitled "Emergency			practice?	
	Preparedness Progr	ram" with the facility			ļ ·	
	Maintenance Direc	tor and the Maintenance			The Required drills were	
	Assistant on 09/15/	/22 at 12:36 p.m., the facility			completed during the calenda	r
	failed to complete	and document any annual			year of 2021 (copies have bee	en
		or exercises that were			uploaded). 2022 calendar yea	ar
	-	an annual individual,			required drills will be complete	ed
		tional exercise, an actual natural			prior to the end of the calenda	
		gency that requires activation			year of 2022. No residents we	
		olan, a mock disaster drill, or a			identified as having been affe	cted
	_	r workshop that is led by a			by this potentially deficient	
		udes a group discussion, using			practice.	
	•	ly relevant emergency scenario,			h	
	_	m statements, directed			- how other residents have	<u> </u>
		red questions designed to gency plan. Based on an			the potential to be affected by	- I
	-	ne of record review, the			the same deficient practice value be identified and what	VIII
					corrective action(s) will be	
	Maintenance Director advised that the facility had been short staffed and extremely busy and had				taken.	
		me to hold or schedule these			tanen.	
		he exit conference with the			All residents have the potential	al of
	facility Maintenand				being affected if this practice	

BD6921

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/05/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	LETED
		155751	B. WIN	NG		09/15/	/2022
			—		_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ADOW LAKE DR		
MEADOV	V LAKES			MOORE	ESVILLE, IN 46158		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	_	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	Ι,	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
	•		'		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE
		ence could be provided			completed during the calendar		
	contrary to this defi	cient finding.			year of 2021 (copies have bee		
					uploaded). 2022 calendar yea	ır	
					required drills will be complete	d	
					prior to the end of the calenda	r	
					year of 2022. No residents we	ere	
					identified as having been affec		
					by this potentially deficient		
					practice.		
					'		
					- what measures will be p	ut	
					into place and what systemic		
					changes will be made to	•	
					ensure that the deficient		
					practice does not recur.		
					M		
					Management Team has been		
					inserviced on the importance of		
					the performance of these requ	ired	
					drills, and the importance of		
					maintaining these records in a	n	
					organized manner allowing red	cords	
					of the performed drills to be		
					located upon request.		
					- how the corrective		
					action(s) will be monitored to)	
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p	-	
					into place; and	•	
					piace, and		
					Emergency Preparedness Dril	le	
						10	
					QAPI Tool will be utilized by		
					Maintenance Supervisor/Desig	•	
					weekly x 4 weeks, monthly x 6		
					months, and quarterly thereaft		
					for one year with results report	ted	
					to the Quality Assurance and		

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

Event ID:

BD6921

Facility ID: 004831

Performance Improvement

If continuation sheet

Page 12 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING		COMPLETED 09/15/2022	
		100701			09/10/2022	
NAME OF F	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR		
MEADOV	V LAKES			ESVILLE, IN 46158		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
				Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be	e	
				developed to ensure compliant - - by what date the system changes for each deficiency will be completed. After submitting an acceptable Plate of Correction, if it is determined that the correction will not be completed by the date previously submitted, T Division needs to be contact as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. ="" p=""> ="" p=""> ="" p="">	ic an on he ed	
				="" p="">		
K 0000				="" p="">		
Bldg. 01	Licensure Survey v	004831 155751	K 0000	/p> /p> /p> /p> /p> /p> ="" p=""> ="" p=""> ="" p=""> ="" p="">		

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING	01	COMPLETED 09/15/2022
NAME OF P	PROVIDER OR SUPPLIER		200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR ESVILLE, 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
	was found not in co for Participation in I Subpart 483.90(a), I 2012 Edition of the Association (NFPA Chapter 19, Existing 410 IAC 16.2.	Code survey, Meadow Lakes mpliance with Requirements Medicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and lity was determined to be of			
	The facility has a findetection in the corridor. The facility wired to the fire alar sleeping rooms. The	ruction and fully sprinklered. The alarm system with smoke ridors and in all areas open to cility has smoke detectors hard run system in all resident refacility has a capacity of 137 at the time of this visit.			
		-			
K 0211 SS=E Bldg. 01	in accordance with of egress is contin all obstructions to	General ays, corridors, exit cations, and accesses are chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.			
	Based on observation failed to ensure the corridors was conting obstructions. This d	on and interview, the facility means of egress in 1 of 3 amously maintained free of efficient practice could affect ents, 4 staff and 1 visitor.	K 0211	/p> /p> /p> /p>	09/30/2022

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 14 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/15/2022
NAME OF P	PROVIDER OR SUPPLIER	3	200 MI	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR RESVILLE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
PREFIX	Findings include: Based on observation Maintenance Assist the Auguste's Cotta Memory Care unit, wooden dresser stooutside the Activitic interview with the It time of the observation discussed this issue in the past, but they wishes when it composed item was not allowed to corridor. During the facility Maintenance Maintenance Assiste	ons made with the tant on 09/15/22 at 1:16 p.m., tage unit, also known as the unit had a three-drawer red in the corridor immediately es Closet. Based on an Maintenance Assistant at the tion, he stated that he has e with the Memory Care staff or have not respected his nes to keeping the corridor clear as and agreed that the dresser be kept as storage in the exercise exit conference with the tent at 2:45 p.m., no additional lence could be provided		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	on(s) those peen dresser ediately et has having ed by ce will pe ential of cient were facility to egress erein.
				Management Team has be inserviced on the importanthe description of not allow items being stored in area egress.	ice and ving any

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	A. BUILDING <u>01</u> CO		(X3) DATE SURVEY COMPLETED 09/15/2022
	PROVIDER OR SUPPLIER		200 M	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR RESVILLE, 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
TAG	REGULATORY OF	LISC IDENTIFYING INFORMATION	TAG	- how the corrective action(s) will be monitored to ensure the deficient practic will not recur, i.e., what qua assurance program will be into place; and Not storing items in areas of egress QAPI Tool will be utility by Maintenance Supervisor/Designee weekly weeks, monthly x 6 months, a quarterly thereafter for one you with results reported to the QAssurance and Performance Improvement Committee over by the Executive Director If a threshold of 90% is not achieved, an action plan will developed to ensure complianed by what date the system changes for each deficiency will be completed. After submitting an acceptable Plof Correction, if it is determined that the correctivial not be completed by the date previously submitted, Division needs to be contact as soon as possible. The facility will need to submit a amended plan of correction with the updated plan of	to e lity but zed x 4 and ear uality rseen be nce nic / lan lon e The ted lin
K 0222 SS=F	NFPA 101			correction date.	

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 16 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		A. BUILDING B. WING	01	COM	TE SURVEY MPLETED 15/2022	
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Bldg. 01 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of		200 ME	ADDRESS, CITY, STATE, ZIP COI EADOW LAKE DR ESVILLE, IN 46158)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
Bldg. 01	Doors in a require be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special locking arrows clinical security necession used, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the Clinical or Section are being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system at an attended lock space); and both the systems are arrand upon activation. 18.2.2.2.5.2, 19.2.10 DELAYED-EGRES ARRANGEMENTS Approved, listed detection in the control of the	a latch or a lock that f a tool or key from the s using one of the following angements: S OR SECURITY THREAT king arrangements for the seds of the patient are sking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the 2.2.6, 19.2.2.2.5.1, LOCKING S king arrangements for the e patient are used, all of surity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised or system and the locked I by a complete smoke (or is constantly monitored ation within the locked he sprinkler and detection ged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING				

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet Page 17 of 28

10/05/2022 PRINTED: 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 COMPLETED 01 B. WING 09/15/2022 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 **ELEVATOR LOBBY EXIT ACCESS** LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility K 0222 K - 222 09/30/2022 failed to ensure the means of egress through 3 of 8 exits were readily accessible for residents what corrective action(s) without a clinical diagnosis requiring specialized will be accomplished for those security measures. Doors within a required means residents found to have been of egress shall not be equipped with a latch or affected by the deficient lock that requires the use of a tool or key from the practice? egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be The three identified exit doors, permitted in accordance with 19.2.2.2.5.2. This Main Entrance. Exit nearest social deficient practice could affect over 50 residents, services and Exit nearest therapy 12 staff and 6 visitors if needing to exit the facility. now have codes for those keypads posted near the keypad. Findings include: how other residents having Based on observations made with the the potential to be affected by

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

Maintenance Assistant during a tour of the

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

the same deficient practice will

Page 18 of 28

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155751	B. W	NG		09/15/	2022
				CTD FET	ADDRESS OF A STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
MEADOW	N I AKEO				ADOW LAKE DR		
MEADOV	V LAKES			MOORE	ESVILLE, IN 46158		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility on 09/15/22	from 12:40 p.m. through 2:15		be identified and what			
	-	exit doors were marked as a			corrective action(s) will be		
	facility exit, were magnetically locked and could be opened by entering a four-digit code but the code				taken.		
	was not posted at th				All residents have the potentia	l of	
	A. the facility main				being affected by this deficient		
		it nearest to the Social Services			practice. Walking rounds were		
	office				preformed throughout the facil		
		it nearest to the Therapy Gym			identify any other Exit Doors th	-	
		ew at the time of each			would require posted codes.		
	observation, the Maintenance Assistant agreed				Codes were added to those th	at	
	that the doors were listed as facility exits and that				were identified.		
		netically locked and would					
	_	de entered on the nearby			- what measures will be p	ut	
	•	that the code was not posted			into place and what systemic		
		ove. During the exit conference			changes will be made to		
		intenance Director and the			ensure that the deficient		
		ant at 2:45 p.m., no additional			practice does not recur.		
		ence could be provided			praemes accomentations		
	contrary to this defi	-			Management Team has been		
		5			inserviced concerning the purp	ose	
	3.1-19(b)				of having the codes posted ne		
	()				the keypads		
					,		
					- how the corrective		
					action(s) will be monitored to)	
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p	-	
					into place; and		
					mio piaco, ana		
					Codes posted near appropriat	e	
					keypads QAPI Tool will be util		
					weekly x 4 weeks, monthly x 6		
					months, and quarterly thereaft		
					for one year with results repor		
					to the Quality Assurance and		
					Performance Improvement		
					Committee overseen by the		
					Executive Director		
			1		LASSALIVO BILOGIOI		

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet Page 19 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

		_			· · · · · · ·	
T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU				SURVEY
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETEI B. WING 09/15/202		ETED		
	155751	B. WI	NG		09/15/	/2022
	1		200 ME	ADOW LAKE DR		
Г		1		,eee		T
				PROVIDER'S PLAN OF CORRECTION		(X5)
· ·				CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
				developed to ensure compliants - by what date the system changes for each deficiency will be completed. After submitting an acceptable Plate of Correction, if it is determined that the correction will not be completed by the date previously submitted, T Division needs to be contact as soon as possible. The	nic an on The	
Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that in Nonrated protection are permitted. Do fixed fire window are self-closing or require latching, as in the direction of provides a minimum for swinging or ho 19.3.7.6, 19.3.7.8 Based on observation	arriers are 1-3/4-inch thick d-core doors or of resists fire for 20 minutes. We plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not and are not required to swing egress travel. Door opening um clear width of 32 inches virizontal doors. 1, 19.3.7.9 20 on and interview, the facility	K 0:	374	/p>		09/30/2022
	NFPA 101 Subdivision of Bu Barrie	DENTIFICATION NUMBER 155751 PROVIDER OR SUPPLIER W LAKES SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors	NFPA 101 Subdivision of Building Spaces - Smoke Barrier Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility K 000	NFPA 101 Subdivision of Building Spaces - Smoke Barrier Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Norrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility STREET. 200 ME MOOR STREET. 200 ME MOOR ID PREFIX TAG PREFIX TA	DECVIDER OF CORRECTION IDENTIFICATION NUMBER 155751 ROVIDER OR SUPPLIER N LAKES SUMMARY STATEMENT OF DEFICIENCIE (RACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION If a threshold of 90% is not achieved, an action plan will it developed to ensure compliant - by what date the systen changes for each deficiency will be completed. After submitting an acceptable Pl of Correction, if it is determined that the correction will not be completed by the date previously submitted, In Division needs to be contact as soon as possible. The facility will need to submit a amended plan of correction with the updated plan of correction with the updated plan of correction with the updated plan of correction by the date previously submitted, In amended plan of correction date. NEPA 101 SUBdivision of Building Spaces - Smoke Barrier Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility K (0374)	OF CORRECTION IDENTIFICATION NUMBER 155751 ROVIDER OR SUPPLIER W LAKES SUMMARY STATEMENT OF DEFICIENCIE (BACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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 with the updated plan of correction that resists fire for 20 minutes. NFPA 101 NFPA 101 NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. K 0374 K 0374

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 20 of 28

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155751	B. W	ING		09/15	/2022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	•	
MEADON	A/				ADOW LAKE DR		
MEADOV	V LAKES			MOORE	ESVILLE, IN 46158		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
		novement of smoke for at least			/p>		
		9.3.7.8 requires doors in smoke			/p>		
	-	ly with LSC Section 8.5.4. LSC ors in smoke barrier shall close			/p>		
	-	only the minimum clearance			/p>		
		r operation. This deficient			/p>		
		t as many as 42 residents, 6			K - 374		
	staff and 4 visitors.	,					
					- what corrective action(s)	
	Findings include:				will be accomplished for tho	-	
					residents found to have been	า	
	Based on observations made with the				affected by the deficient		
	Maintenance Assistant during a tour of the				practice?		
	•	at 1:55 p.m., the set of smoke					
		en the 600 Hall and the Dining			Outside contractor has been		
		ompletely leaving a two-inch			employed to perform a permai		
		three separate occasions.			repair to this single set of doul		
		at the time of observation, the			doors that could affect as man	ıy as	
		ant acknowledged these s did not close completely			42 residents.		
		gap when closed at their			- how other residents hav	ina	
	-	exit conference with the facility			the potential to be affected b	_	
		for and the Maintenance			the same deficient practice v	-	
		m., no additional information or			be identified and what		
	-	provided contrary to this			corrective action(s) will be		
	deficient finding.				taken.		
	3.1-19(b)				All residents have the potentia		
					being affected by this deficien		
					practice. Walking rounds were		
					preformed throughout the facil	ity to	
					identify any other issue with smoke barrier doors. No othe	r	
					issues were identified.	ı	
					100000 WOIO INCITUIION.		
					- what measures will be p	ut	
					into place and what systemic		
					changes will be made to		
					ensure that the deficient		
			1		practice does not recur		1

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 21 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	A. BUILDING 01 COMPLET B. WING 09/15/20		(X3) DATE SURVEY COMPLETED 09/15/2022
NAME OF P	ROVIDER OR SUPPLIE V LAKES	R	200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR ESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		of arrier oo e ity out ool eks, terly sults ance nt oe nic an on the ted
				amended plan of correction with the updated plan of	

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

Event ID:

BD6921

Facility ID: 004831

31

correction date.

If continuation sheet Page 22 of 28

CENTERS FOR STATEMEN	T OF HEALTH AND HUR R MEDICARE & MEDIC T OF DEFICIENCIES OF CORRECTION		(X2) MULTIPLE (A. BUILDING	construction 01	FO OM (X3) DATE	NTED: 10/05/2022 ORM APPROVED MB NO. 0938-039 E SURVEY
		155751	B. WING		09/15	5/2022
	PROVIDER OR SUPPLIER	2	200 M	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR RESVILLE, 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 CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustibused or stored an location, and such signs that read No posted with the in smoking.	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable ble gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no				

prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.

(3) Smoking by patients classified as not responsible shall be prohibited.

(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.

(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.

(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.

18.7.4, 19.7.4

Based on record review, observation and interview, the facility failed to enforce its own Smoking Policy. This deficient practice could affect as many as two employees who were observed smoking outside the facility outside near the facility 300 kW generator.

K 0741

K - 741

/p>

/p>

/p>

/p>

If continuation sheet

what corrective action(s)

Page 23 of 28

09/30/2022

Findings include:

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER 155751	A. BUILDING B. WING	01	COMPLETED 09/15/2022
NAME OF P	ROVIDER OR SUPPLIER V LAKES		200 ME	ADDRESS, CITY, STATE, ZIP COD EADOW LAKE DR ESVILLE, 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
TAG	Based on review of written policy with the Maintenance As at 11:50 p.m. on 09/smoking is not perm on interview at the t Maintenance Direct policy is resident an permitted on the pre with the Maintenanc the facility at 1:45 p cigarette butts were the facility near the Ashtrays and metal cover devices into w of noncombustible mot provided where Furthermore, two fasmoking in the same female. When asked designated smoking Assistant stated that non-smoking facility with the facility Ma Maintenance Assistant	the facility's "Smoking Policy" the Maintenance Director and sistant during record review (15/22, new resident and staff nitted on the premises. Based ime of record review, the or stated the facility's current d staff smoking is not emises. Based on observation the Assistant during a tour of the one of the premises of the premises of the premises. The premises of	TAG	will be accomplished for tho residents found to have been affected by the deficient practice? No residents were identified to have been affected by this deficient practice. - how other residents have the potential to be affected by the same deficient practice to be identified and what corrective action(s) will be taken. No residents were identified to have been affected by this deficient practice. - what measures will be printo place and what systemic changes will be made to ensure that the deficient practice does not recur. Management Team has been inserviced on the importance following and enforcing the facility's non-smoking policy including directing their departments to follow the policies well. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be processed.	se n c c c c c c c c c c c c c c c c c c
			İ	into place; and	

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet

Page 24 of 28

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155751		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 09/15/2022			
NAME OF P	ROVIDER OR SUPPLIER V LAKES		200	EET ADDRESS, CITY, STATE, ZIP COD D MEADOW LAKE DR ORESVILLE, IN 46158	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPR	D BE COMPLETION
				Following Non-Smoking P QAPI Tool will be utilized 4 weeks, monthly x 6 mor quarterly thereafter for one with results reported to the Assurance and Performan Improvement Committee of by the Executive Director If a threshold of 90% is not achieved, an action plan of developed to ensure complete of by what date the systemanges for each deficite will be completed. After submitting an acceptable of Correction, if it is determined that the corre will not be completed by date previously submitted Division needs to be con as soon as possible. The facility will need to submanended plan of correct with the updated plan of correction date.	weekly x ths, and e year e Quality nce overseen of vill be oliance stemic ncy e Plan ection the ed, The stacted e it an ion
K 0753 SS=E Bldg. 01	unless one of the operations of the operations of the operations operations of the operations opera	orations rations shall be prohibited			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155751		B. WING 09/15			09/15/2022		
NAME OF F	AN OLUBER OR GURNI IER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				200 ME	EADOW LAKE DR		
MEADOV	V LAKES			MOOR	ESVILLE, IN 46158		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	AG REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG			TAG		DEFICIENCY	DATE	
	289.						
		such as photographs,					
	paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6						
	Based on observation and interview, the facility		K 0	753	K - 753	09/30/2022	
	failed to ensure 1 of 1 Aguste's Cottage unit was		KU	133	K - 700	07/30/2022	
	maintained in accordance with 18.7.5.6. 18.7.5.6				- what corrective action(s)	
	states combustible decorations shall be prohibited				will be accomplished for tho	- I	
		ccupancy, unless one of the			residents found to have been		
	following criteria is met:				affected by the deficient		
	_	retardant or are treated with			practice?		
		lant coating that is listed and					
		ion to the material to which it is			All combustible decorations		
	applied.				hanging from the ceiling on th	e	
	(2) The decorations	meet the requirements of			Cottage have been removed a	and	
	NFPA 701, Standar	d Methods of Fire Tests for			discarded.		
	Flame Propagation	of Textiles and Films.					
	1 1	exhibit a heat release rate not			- how other residents hav	ing e	
	_	when tested in accordance with			the potential to be affected b	y	
		d Method of Fire Test for			the same deficient practice v	vill	
	Individual Fuel Pac	kages, using the 20 kW			be identified and what		
	ignition source.				corrective action(s) will be		
	1 ' '	s, such as photographs,			taken.		
		art, are attached directly to					
	_	nd non-fire-rated doors in			All residents have the potentia		
	accordance with the				being affected by this deficien		
	` ′	non-fire-rated doors do not			practice. Walking rounds wer		
		peration or any required			performed throughout the faci		
	~	and do not exceed the area			identify any other area where		
	limitations of 18.7.				combustible decorations were		
		not exceed 20 percent of the			hanging from the ceiling. No	otner	
		oor areas inside any room or			such items were identified.		
		ompartment that is not				4	
protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.				- what measures will be p			
		1		into place and what systemic	C [

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet Page 26 of 28

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>01</u>		01	COMPLETED		
155751		B. W	B. WING 09/1			2022		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					ADOW LAKE DR			
MEADOW LAKES				MOORESVILLE, IN 46158				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE			1	ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	(c) Decorations do not exceed 30 percent of the				changes will be made to			
		oor areas inside any room or			ensure that the deficient			
	_	ompartment that is protected			practice does not recur.			
	throughout by an approved supervised automatic							
	sprinkler system in accordance with Section 9.7.				Management Team has been			
	(d) Decorations do	not exceed 50 percent of the		inserviced on the importance o				
	wall, ceiling, and door areas inside patient			not allowing any combustible				
	sleeping rooms having a capacity not exceeding				items to be hung from the ceil	ing		
	_	noke compartment that is			as decorations.			
	protected throughout by an approved, supervised							
	automatic sprinkler system in accordance with				- how the corrective			
	Section 9.7.				action(s) will be monitored to			
	This deficient practice could affect as many as 40				ensure the deficient practice			
	Residents, 5 staff ar	nd 4 visitors.			will not recur, i.e., what quali	-		
					assurance program will be p	ut		
	Findings include:				into place; and			
	Based on observation	ons made with the			Inappropriate Combustible			
	Maintenance Assistant during a tour of the				decoration placement and use	,		
	facility on 09/15/22 at 1:55 p.m., the corridor ceiling			QAPI Tool will be utilized weekly x				
	on the Aguste's Cottage, also known as the				4 weeks, monthly x 6 months, and			
	Memory Care unit, had hundreds of decorations				quarterly thereafter for one year			
	hanging from the ceiling within the unit. When				with results reported to the Qu	ıality		
	asked if the facility could provide flame spread				Assurance and Performance			
	rating documentation for the hanging decorations,				Improvement Committee over	seen		
	it was determined that they could not. Based on				by the Executive Director			
	interview at the time of the observations, the				16 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	Maintenance Assistant stated the fire resistance				If a threshold of 90% is not			
	rating of the decorations was not available for				achieved, an action plan will b			
	review, and that he would have staff locate the flame spread rating for the stated decorations or				developed to ensure complian	ice		
					- by what date the system	ic		
	have them removed as soon as he could do so. During the exit conference with the facility				- by what date the system changes for each deficiency			
	Maintenance Director and the Maintenance				will be completed. After			
Assistant at 2:45 p.m., no additional information or				submitting an acceptable Pla	_{an}			
	evidence could be provided contrary to this				of Correction, if it is	411		
	deficient finding.				determined that the correction	on I		
	deficient initing.				will not be completed by the			
	3.1-19(b)				date previously submitted, T	he		
					Division needs to be contact			

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

Event ID:

BD6921

Facility ID: 004831

If continuation sheet Page 27 of 28

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFIC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/15/2022		
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES			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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
				as soon as possible. The facility will need to submit ar amended plan of correction with the updated plan of correction date.	1		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BD6921 Facility ID: 004831 If continuation sheet Page 28 of 28