STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155751	A. BUILDING -- B. WING	09/15/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/15/22 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750 At this Emergency Preparedness survey, Meadow Lakes was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 137 certified beds. At the time of the survey, the census was 111. Quality Review completed on 09/19/22	E 0000	/p> /p> /p> /p> ="" p=""> ="" p=""> ="" p=""> ="" p="">	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[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]:			

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

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	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]			

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	(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the			

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	LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the			

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	onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or			

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	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as			

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	needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.	E 0039	=”” p=””> =”” p=””> =”” p=””> =”” p=””> Please find the attached Plan of Corrections for Meadow Lakes Life Safety Survey completed on 9/15/22. The provider respectfully requests the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. =”” p=””> =”” p=””> =”” p=””> The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. /p>	09/30/2022

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	b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the facility's Emergency Preparedness plan entitled "Emergency Preparedness Program" with the facility Maintenance Director and the Maintenance Assistant on 09/15/22 at 12:36 p.m., the facility failed to complete and document any annual full-scale exercise or exercises that were community-based, an annual individual, facility-based functional exercise, an actual natural or man-made emergency that requires activation of the emergency plan, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Based on an interview at the time of record review, the Maintenance Director advised that the facility had been short staffed and extremely busy and had not yet found the time to hold or schedule these exercises. During the exit conference with the facility Maintenance Director and the Maintenance Assistant at 2:45 p.m., no additional		**E – 039 - **Required Drills were completed during the calendar year of 2021 (copies uploaded). The next drills are planned to be completed during the remainder of the calendar year of 2022. Please strike this finding from the 2567**** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Required drills were completed during the calendar year of 2021 (copies have been uploaded). 2022 calendar year required drills will be completed prior to the end of the calendar year of 2022. No residents were identified as having been affected by this potentially deficient practice. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential of being affected if this practice were deficient. The Required drills were	

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	information or evidence could be provided contrary to this deficient finding.		completed during the calendar year of 2021 (copies have been uploaded). 2022 calendar year required drills will be completed prior to the end of the calendar year of 2022. No residents were identified as having been affected by this potentially deficient practice. - **what measures will be put into 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 of the performance of these required drills, and the importance of maintaining these records in an organized manner allowing records 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 quality assurance program will be put into place; and** Emergency Preparedness Drills QAPI Tool will be utilized by Maintenance Supervisor/Designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement	

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			Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** ="" p=""> ="" p=""> ="" p=""> ="" p="">	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/15/22 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750	K 0000	/p> /p> /p> /p> ="" p=""> ="" p=""> ="" p=""> ="" p="">	

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	At this Life Safety Code survey, Meadow Lakes was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 111 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/19/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure the means of egress in 1 of 3 corridors was continuously maintained free of obstructions. This deficient practice could affect as many as 36 residents, 4 staff and 1 visitor.	K 0211	/p> /p> /p> /p>	09/30/2022

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	Findings include: Based on observations made with the Maintenance Assistant on 09/15/22 at 1:16 p.m., the Auguste's Cottage unit, also known as the Memory Care unit, unit had a three-drawer wooden dresser stored in the corridor immediately outside the Activities Closet. Based on an interview with the Maintenance Assistant at the time of the observation, he stated that he has discussed this issue with the Memory Care staff in the past, but they have not respected his wishes when it comes to keeping the corridor clear of unapproved items and agreed that the dresser was not allowed to be kept as storage in the corridor. During the exit conference with the facility Maintenance Director and the Maintenance Assistant at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**K - 211** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The three-drawer wooden dresser stored in the corridor immediately outside the Activities closet has been removed. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential of being affected by this deficient practice. Walking rounds were preformed throughout the facility to identify any other area of egress having any item stored therein. No other such items were identified. - **what measures will be put into 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 and the description of not allowing any items being stored in areas of egress.	

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			- **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Not storing items in areas of egress QAPI Tool will be utilized by Maintenance Supervisor/Designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.**	
K 0222 SS=E	NFPA 101 Egress Doors			

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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 the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with			

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	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 failed to ensure the means of egress through 3 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 50 residents, 12 staff and 6 visitors if needing to exit the facility. Findings include: Based on observations made with the Maintenance Assistant during a tour of the	K 0222	**K - 222** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The three identified exit doors, Main Entrance, Exit nearest social services and Exit nearest therapy now have codes for those keypads posted near the keypad. - **how other residents having the potential to be affected by the same deficient practice will**	09/30/2022

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	facility on 09/15/22 from 12:40 p.m. through 2:15 p.m., the following exit doors were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exit: A. the facility main entrance / exit B. the entrance / exit nearest to the Social Services office C. the entrance / exit nearest to the Therapy Gym Based on an interview at the time of each observation, the Maintenance Assistant agreed that the doors were listed as facility exits and that each door was magnetically locked and would need a four-digit code entered on the nearby keypad to use, and that the code was not posted at the exit listed above. During the exit conference with the facility Maintenance Director and the Maintenance Assistant at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**be identified and what corrective action(s) will be taken.** All residents have the potential of being affected by this deficient practice. Walking rounds were preformed throughout the facility to identify any other Exit Doors that would require posted codes. Codes were added to those that were identified. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Management Team has been inserviced concerning the purpose of having the codes posted near the keypads - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Codes posted near appropriate keypads QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director	

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			If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie 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 failed to ensure 1 of 5 sets of smoke barrier doors	K 0374	/p> /p>	09/30/2022

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	would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 42 residents, 6 staff and 4 visitors. Findings include: Based on observations made with the Maintenance Assistant during a tour of the facility on 09/15/22 at 1:55 p.m., the set of smoke barrier doors between the 600 Hall and the Dining area did not close completely leaving a two-inch gap when tested on three separate occasions. Based on interview at the time of observation, the Maintenance Assistant acknowledged these smoke barrier doors did not close completely leaving a two-inch gap when closed at their fullest. During the exit conference with the facility Maintenance Director and the Maintenance Assistant at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		/p> /p> /p> /p> /p> /p> **K - 374** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Outside contractor has been employed to perform a permanent repair to this single set of double doors that could affect as many as 42 residents. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential of being affected by this deficient practice. Walking rounds were preformed throughout the facility to identify any other issue with smoke barrier doors. No other issues were identified. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.**	

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			Management Staff has been inserviced on the importance of properly functioning smoke barrier doors. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Smoke Barrier Doors QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.**	

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K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are 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. Findings include:	K 0741	/p> /p> /p> /p> **K - 741** - **what corrective action(s)**	09/30/2022

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	Based on review of the facility's "Smoking Policy" written policy with the Maintenance Director and the Maintenance Assistant during record review at 11:50 p.m. on 09/15/22, new resident and staff smoking is not permitted on the premises. Based on interview at the time of record review, the Maintenance Director stated the facility's current policy is resident and staff smoking is not permitted on the premises. Based on observation with the Maintenance Assistant during a tour of the facility at 1:45 p.m. on 09/15/22, over twenty cigarette butts were strewn on the ground outside the facility near the facility 300 kW generator. Ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were not provided where smoking was permitted. Furthermore, two facility employees were seen smoking in the same area, one male and one female. When asked if that location was a designated smoking area, the Maintenance Assistant stated that Meadow Lakes was a non-smoking facility. During the exit conference with the facility Maintenance Director and the Maintenance Assistant at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**will be accomplished for those 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 having the potential to be affected by the same deficient practice will 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 put into 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 of following and enforcing the facility's non-smoking policy including directing their departments to follow the policy as well. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**	

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			Following Non-Smoking Policy QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.**	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA			

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	289. o Decorations, 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 failed to ensure 1 of 1 Aguste's Cottage unit was maintained in accordance with 18.7.5.6. 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.	K 0753	**K - 753** - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All combustible decorations hanging from the ceiling on the Cottage have been removed and discarded. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential of being affected by this deficient practice. Walking rounds were performed throughout the facility to identify any other area where combustible decorations were hanging from the ceiling. No other such items were identified. - **what measures will be put into place and what systemic**	09/30/2022

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	(c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect as many as 40 Residents, 5 staff and 4 visitors. Findings include: Based on observations made with the Maintenance Assistant during a tour of the facility on 09/15/22 at 1:55 p.m., the corridor ceiling on the Aguste's Cottage, also known as the Memory Care unit, had hundreds of decorations hanging from the ceiling within the unit. When asked if the facility could provide flame spread rating documentation for the hanging decorations, it was determined that they could not. Based on interview at the time of the observations, the Maintenance Assistant stated the fire resistance rating of the decorations was not available for review, and that he would have staff locate the flame spread rating for the stated decorations or have them removed as soon as he could do so. During the exit conference with the facility Maintenance Director and the Maintenance Assistant at 2:45 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur.** Management Team has been inserviced on the importance of not allowing any combustible items to be hung from the ceiling as decorations. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Inappropriate Combustible decoration placement and use QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 90% is not achieved, an action plan will be developed to ensure compliance - - **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 01 B. WING	09/15/2022

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

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			as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	