STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 00 B. WING	06/05/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 28, 29, 30, 31, June 3, 4, and 5, 2024 Facility number: 004831 Provider number: 155751 AIM number: 200809750 Census Bed Type: SNF/NF: 104 SNF: 15 Residential: 47 Total: 166 Census Payor Type: Medicare: 17 Medicaid: 74 Other: 28 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 7, 2024.	F 0000	The submission of this plan of correction does not indicate an admission by Meadow Lakes Assisted Living that the findings and allegations contained herein are an accurate and true representation of the quality of care and environment provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for residential care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. *This facility respectfully requests from the Department a desk review. If anything further is needed facility will provide department documentation upon request for paper compliance/desk review.	
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or			

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	(E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.			

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	If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure the written notification required for a transfer and discharge was provided to the resident and the resident representative for 4 of 10 residents reviewed for hospitalization. (Resident 20, Resident 90, Resident 93, Resident 74) Findings include: 1. On 6/4/24 at 11:30 a.m., Resident 20's clinical record was reviewed. The diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage and dementia. Resident 20's progress notes indicated the resident was sent to the hospital on 3/13/24. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident representative. 2. On 5/29/24 at 11:50 a.m., Resident 90's clinical record was reviewed. The diagnoses included, but were not limited to,	F 0623	IDR facility requested for scope and severity to B level. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** Res 20, 90, 93, 74 suffered no ill effects from this alleged deficient practice . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All resident discharged to acute hospital setting had the potential to be affected by the alleged deficient practice however none were.	06/21/2024

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	sepsis and vascular dementia. Resident 90's progress notes indicated the resident was sent to the hospital on 5/5/24. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident representative. 3. On 5/29/24 at 2:57 p.m., Resident 93's clinical record was reviewed. The diagnoses included, but were not limited to, congestive heart failure and unspecified dementia. Resident 93's progress notes indicated the resident was sent to the hospital on 4/12/24. The clinical record lacked documentation of written notification of the Notice of Transfer and Discharge forms having been provided to the resident and the resident representative. 4. On 6/4/24 at 11:15 a.m., Resident 74's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and depression. The resident was transferred to the hospital on 3/4/24, 3/28/24, and 3/31/24. The clinical record lacked documentation to indicate the resident and the resident's representative were provided the written notification of the Notice of Transfer and Discharge forms. During an interview on 6/5/24 at 10:42 p.m., the Director of Nursing Services (DNS) indicated there had been no documentation of the Notice of Transfer or Discharge forms having been provided to the resident and the resident representative in writing. She indicated the facility contacted the representative by phone but did not send anything in writing.		. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff education completed to assure all resident being emergently transferred to hospital facility will ensure that the written notification required for transfer and discharge will be provided to resident and the resident representative either in person or via US Mail and documented as such in residents clinical record. . **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The ED/designee will be responsible for completing audit tool to assure every discharged resident and responsible party was given in person or mailed the notice of transfer/discharge. All discharged resident clinical record will be audited to assure documentation of notice was given 1x weekly times 4 weeks, bi-weekly x's 1month, 1x monthly times 2months The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will	

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	On 6/5/24 at 1:20 p.m., DNS provided the facility policy, "Discharge/Transfer", dated 11/2015, and indicated this was the policy currently being used by the facility. A review of the policy indicated, "Procedure: 1. A copy of the discharge or transfer in writing must be included in the resident's clinical record ... and sent to the resident and responsible party, a family member of the resident ..." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(iii)		be developed with results forwarded to QAPI committee. Date of Compliance 06/21/2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure a urinary drainage bag was positioned off the floor to prevent infections for 1 of 2 residents reviewed for urinary catheters. (Resident 81) Findings include: On 5/29/24 at 10:43 a.m., Resident 81 was observed asleep in bed. A urinary drainage bag was observed to be touching the floor. On 5/30/24 at 9:59 a.m., Resident 81 was observed asleep in bed. A urinary drainage bag was observed to be touching the floor. On 5/31/24 at 10:45 a.m., Resident 81 was observed asleep in bed. A urinary drainage bag was observed to be touching the floor. On 6/3/24 at 9:43 a.m., Resident 81 was observed asleep in bed. A urinary drainage bag was observed to be touching the floor. On 6/3/24 at 11:02 a.m., Resident 81 was observed asleep in bed. A urinary drainage bag was observed to be touching the floor. Resident 81's clinical record was reviewed on 6/3/24 at 11:15 a.m. The diagnosis included, but was not limited to, obstructive and reflux uropathy due to neurogenic bladder. Physician orders, dated 5/5/24 through 6/5/24, for Resident 81 indicated "... Cath [catheter] orders:	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident number 81 had catheter tubing and Dignity bag placed up off the floor to prevent further occurrence of dragging floor. . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with a catheter have the potential to be affected, however none were. . **What corrective action(s) will be accomplished for the residents found to be affected by the deficient practice** All residents that have catheters and dignity bag have been reviewed/observed to ensure drainage bags were not touching the floor. No additional resident have been identified as being affected. . **What corrective action(s) will be accomplished for the residents found to be affected by the deficient practice?**	06/21/2024

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	Foley catheter Size: 14, Fr [french] 14 ml [millimeters] bulb ..." A care plan, initiated on 10/23/23, and current through target date 7/4/25, for Resident 81 indicated, "... Problem: Resident requires an indwelling urinary catheter ... Goal: Resident will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection ... Do not allow tubing or any part of the drainage system to touch the floor ..." During an interview on 6/4/24 at 11:06 a.m., Certified Nursing Assistant (CNA) 1 indicated the urinary drainage bag should be positioned off the floor. On 6/5/24 at 1:20 p.m., the Director of Nursing Services provided the facility's policy,"Indwelling Urinary Catheter Care, Emptying Drainage Bag and Catheter Removal" with a review date of 12/2012, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate to keep drainage bag off the floor. 3.1-18(b)(1)		In-Service will be provided to Licensed staff on Infection Control Policy on catheter care and dignity bags which will include no tubing or dignity bags to drag floor. Observations of residents who have a catheter will be monitored during GEMBA to include each shift rounding to ensure Compliance with catheter tubing and dignity bags are positioned off the floor. . **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/designee will be responsible for the completion of the Catheter QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. . Date of Completion 06/21/2024	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 28, 29, 30, 31, June 3, 4, and 5, 2024 Facility number: 004831 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The submission of this plan of correction does not indicate an admission by Meadow Lakes Assisted Living that the findings and allegations contained herein are an accurate and true representation of the quality of care and environment provided to the residents of this facility. This facility recognizes its obligation to provide legally and medically necessary care and service in a safe environment to its residents in an economic and safe manner. The facility herby maintains it is in substantial compliance with the requirements of participation for residential care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state requirements governing the management of this facility. It is thus submitted as a matter of statue only. *This facility respectfully requests from the Department a desk review. If anything further is needed facility will provide department documentation upon request for paper compliance/desk review.	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the			

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	examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, interview, and record review, the facility failed to provide to the resident's a readily accessible location of the survey book for 1 of 1 observations. Findings include: On 6/5/24 at 11:30 a.m., the sign posted in the front entrance indicated the State survey book was located "on Long Term side." The sign did not indicate the Survey results would be posted in a frame on the residential side. On 6/5/24 at 1:35 p.m., the sign posted in the front entrance indicated the State survey book was located "on Long Term side." The sign did not indicate the Survey results would be posted in a frame on the residential side. During an interview on 6/5/24 at 1:41 p.m., the Director of Nursing Services indicated the survey book was located only on the long term side. If a residential resident or visitor wanted to read the survey results, they would need to go through a locked service door or walk around to the long term care side. On 6/5/24 at 2:00 p.m., a policy was requested but not provided.	R 0042	R- 0042 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All resident had the potential to be affected by the alleged deficient practice however none were. . **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Survey results were hung on wall for review at time of survey. The posting that survey binder was located on long-term care side was removed. Education was provided to staff on survey posting and result with binder location. New signage was placed stating " Assisted Living Survey Results are located at reception desk in blue binder at AL entrance"	06/21/2024

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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?** The ED/designee will be responsible for completing audit tool to assure binder is in place with signage 1x weekly times 4 weeks, bi-weekly x's 1month, 1x monthly times 2months The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed with results forwarded to QAPI committee. Date of Compliance 06/21/2024	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with			

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	over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of 1 employee with a First Aid (FA) certification on each shift for 7 of 7 days reviewed. Findings include: On 6/5/24 at 12:30 p.m., the Director of Nursing Services provided the schedule for the week 5/26/24 through 6/1/24 and copies of CPR (Cardiopulmonary Resuscitation) and FA certifications for the employees on the schedule for the week reviewed. At that time, a review of the schedule indicated the following: - On 5/26/24, there were no staff members on night shift that were FA certified. - On 5/27/24, there were no staff members on night shift that were FA certified. - On 5/28/24, there were no staff members on night shift that were FA certified. - On 5/29/24, there were no staff members on nightshift that were FA certified. - On 5/30/24, there were no staff members on night shift that were FA certified. - On 5/31/24, there were no staff members on night shift that were FA certified. - On 6/1/24, there were no staff members on night shift that were FA certified. During an interview on 6/5/24 at 2:20 p.m., the Director of Nursing Services indicated there were	R 0117	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All resident had the potential to be affected by the alleged deficient practice however none were. . **What corrective action(s) will be accomplished for the residents found to be affected by the deficient practice?** **CPR training was completed to ensure that each shift had one wake person with proper training and education on 06/18/2024. Education provided with First Aide Compliance was completed by 06/18/2024.** . **How the corrective action (s)**	06/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155751	A. BUILDING 00 B. WING	06/05/2024

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

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	no staff on night shift with FA certification. On 6/5/24 at 2:20 p.m., the Director of Nursing Services provided the facility's policy, "Staffing Policy," dated 4/2023, and indicated it was the policy being used by the facility. A review of the policy indicated ..."3. A minimum of one (1) awake nursing staff person, with current CPR and first aid certificates, shall be on site at all time..."		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** **A QA audit tool to be completed by General Manager/Clinical Director or designee to ensure compliance for CPR and First Aide training with one properly trained staff member on each shift. The QA tool implemented 06/18/2024 to be completed weekly x4 weeks, bi-weekly x4 weeks, then on a quarterly basis until compliance had been maintained for two consecutive quarters.** The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed with results forwarded to QAPI committee. . Date of completion 6/21/24	