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	06/27/2024

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: 06/27/24 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750 At this Emergency Preparedness survey, Meadow Lakes was found 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 118. Quality Review completed on 06/28/24	E 0000		
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: 06/27/24 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750 At this Life Safety Code survey, Meadow Lakes was found not in compliance with Requirements	K 0000	The submission of this plan of correction does not indicate an admission by Meadow Lakes 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annette Starnes	Executive Director	07/10/2024

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.

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	06/27/2024

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
	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 118 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 06/28/24		manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled 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.**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 2 of over 10 exit signs in the facility were marked with directional indicators to identify the direction of travel to the public way. LSC 7.10.1.2 requires exits, other than main exterior exit doors that obviously and clearly are	K 0293	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by the	07/09/2024

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	06/27/2024

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
	identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. This deficient practice could affect at least 20 residents, staff and visitors in the entrance hall and 300 hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Maintenance Assistant on 06/27/23 from 12:50 p.m. to 2:28 p.m., the following was noted: a) the exit sign at the corridor door set by resident room 301 near the nurse station had both directional arrows visible. To the left is an enclosed interior courtyard and to the right is the dining/activities area in Auguste Cottage. b) the exit sign in the main lobby entrance hall by 200 hall had both directional arrows visible. To the right is an interior enclosed courtyard. To the left is the main entrance/exit to outside. Based on interview at the time of observations, the Maintenance Director confirmed that the exit signs in 300 hall and main lobby entrance hall did not accurately identify the direction of travel to the public way. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		alleged deficient practice however none were. . **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 residing on skilled unit 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?** Staff education completed with department to assure understanding of requirements of K-0293 and that signage accurately identifies the direction of travel to the public way. Signage was changed and corrected to accurately show the direction of travel for public way. . **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 signage is appropriately placed 1x weekly times 4 weeks, bi-weekly x's	

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	06/27/2024

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
			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 07/09/2024	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 100 Hall in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space	K 0351	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	07/09/2024

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	06/27/2024

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
	around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and at least 13 residents in the 100 Hall smoke compartment. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant on 06/27/24 at 1:25 p.m., the sprinkler nearest to the window in resident room 127 had a missing escutcheon. Based on interview at the time of observation, the Maintenance Assistant confirmed the escutcheon was missing, and would have it replaced. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		Residents in room 127 had the potential to be affected by the alleged deficient practice however they were not. . **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 residing on skilled unit 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?** Staff education completed with department to assure understanding of requirements of K-0351 and **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were affected by the alleged deficient practice however none were. . **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 residing on skilled unit had the potential to be affected by the alleged deficient	

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	06/27/2024

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
			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?** Staff education completed with department to assure understanding of requirements of K-0351. Escutcheon was placed around sprinkler head in room 127. Audit was completed with tool to assure no other missing escutcheon. . **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 escutcheon is appropriately placed around sprinkler heads on skilled units 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 07/09/2024	

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	06/27/2024

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