

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

PRINTED: 12/27/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155751		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/12/2024	
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES				STREET ADDRESS, CITY, STATE, ZIP COD 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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00448807, IN00448656, and IN00448649.</p> <p>Complaint IN00448807 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00448656 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00448649 - Federal/State deficiencies related to the allegations are cited at F689.</p> <p>Survey dates: December 11 and 12, 2024</p> <p>Facility number: 004831 Provider number: 155751 AIM number: 200809750</p> <p>Census Bed Type: SNF: 16 SNF/NF: 108 Residential: 44 Total: 168</p> <p>Census Payor Type: Medicare: 22 Medicaid: 75 Other: 27 Total: 124</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed December 13, 2024.</p>			F 0000	<p>The submission of this plan of correction does not indicate an admission by Meadow Lakes Nursing Facility 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 Nursing 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.</p>		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident						

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

TITLE

(X6) DATE

Mac McCallum

Executive Director

12/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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Bldg. 00	<p>Hazards/Supervision/Devices</p> <p>Based on interview and record review, the facility failed to ensure a resident received adequate assistance to prevent a fall for 1 of 3 residents reviewed for accidents. (CNA in Training 1, Resident C)</p> <p>Finding includes:</p> <p>During an interview on 12/11/24 at 11:30 a.m., Resident E indicated on 11/28/24 at approximately 10:30 a.m., she observed a new CNA in Training (CNA in Training 1) attempting to transfer her roommate, Resident C, from her wheelchair to her bed. Resident E told CNA in Training 1 Resident C required 2 staff to transfer her. CNA in Training 1 told her she could transfer Resident C by herself. CNA in Training 1 attempted to move Resident C from Resident C's wheelchair but was unable to support her, and they both slid to the floor. CNA in Training 1 left the room and brought other staff to the room to help lift Resident C to her bed. She had not seen CNA in Training 1 since the incident.</p> <p>On 12/11/24 at 11:55 a.m., Resident E's clinical record was reviewed. The Admission Minimum Data Set (MDS) assessment, dated 10/13/24, indicated the Resident E had no cognitive impairment.</p> <p>During an interview on 12/12/24 at 9:45 a.m., Resident C indicated on 11/28/24 at approximately 10:30 a.m., CNA in Training 1 attempted to transfer her from her wheelchair to her bed with no other staff helping. CNA in Training 1 could not support Resident C and they both slid to the floor. Resident C indicated she was supposed be assisted by two staff members due to having little to no use of her left side extremities. Resident C</p>			F 0689	<p>F 689: Free of Accidents and Hazards</p> <p>1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1 Resident(s) C's plan of care and transfer status were reviewed by the IDT and deemed appropriate for care level and function. All CNA's and NAIT were educated on transfer status and safe patient handling based on Resident Care Profile.2 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.1 All Residents have the potential to be affected by this practice.2 A campus wide review was completed to ensure all Residents that require two-person assistance have an active care plan and are transferred appropriately per plan.3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1 DNS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all two person transfers are completed as designated. The plan will be revised, as</p>		12/27/2024

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	<p>indicated she was not injured during the incident. She had not seen CNA in training 1 since the incident.</p> <p>On 12/12/24 at 10:05 a.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction and hemiparesis.</p> <p>The Quarterly MDS assessment, dated 11/18/24, indicated Resident C had no cognitive impairment, had impaired upper and lower extremities on one side, and required extensive assistance of two people for support and transfers from one surface to another.</p> <p>A Fall Event Record, dated 11/28/24 at 10:38 a.m., indicated prior to the fall the resident was in her wheelchair, and following the fall the resident was on the floor by the bed.</p> <p>A Fall Care Plan intervention, with a start date of 11/5/21, indicated the resident required two staff for transfers.</p> <p>During an interview on 12/12/24 at 10:45 a.m., LPN 1 indicated on 11/28/24 at approximately 10:30 a.m., CNA in Training 1 reported to LPN 1 that Resident C had been lowered to the floor after CNA in Training 1 attempted to transfer her from her wheelchair to her bed. Resident C was only to be transferred with assistance of two staff due to impairment to her left extremities as well as a contracture of the left arm.</p> <p>This citation relates to Complaint IN00448649.</p> <p>3.1-45(a)(2)</p>				<p>warranted.⁴ 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.¹ For quality assurance, the DNS or designee will review any findings daily, with subsequent corrective action and education for identified staff.² Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.</p>		