PRINTED: 11/28/2022 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER WILLOW LAKE PLACE WILLOW LAKE PLACE SUMMARY STATEMENT OF DEFICIENCY PRIFFIX TAG REQULATORY OR USE IDENTIFYING INFORMATION ROUDO Bidg. 00 This visit was for the Investigation of Complaint IN00392795 - Substantiated. State deficiencies related to the allegations are cited at R0052. Survey date: October 31, 2022 Facility number: 010234 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 3, 2022. ROUSE Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when the resident was found on the floor, in his room, and feft to lay on the floor for approximately two (2) hours until assistance arrived via 911, to transfer him off the floor, for 1 of 4 residents; or any employees agents, or other LAIRORATORY DIRLICTORS OR PROVIDERS LEPPLIER REPRESENTATIVES SKINATURE STRIET ADDRESS, CITY, STATE, LZIP COD 2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268 INDIANAPOLIS, IN 46268 REQUISITED TAGES AND COMMENTARY AND SAUGHER STATE, COMMENTARY BROUGHT ABOUT AND SAUGHER STATE, COMMENTARY REPRESENT AND RESIDENCE PROVIDERS LEPPLIER REPRESENTATIVES SKINATURE STRIET ADMERS, CITY, STATE, LZIP COD. ACASI PROVIDERS LEPPLIER REPRESENTATIVES SKINATURE STATEMENT ADMERS CITY, STATE, LZIP COD. ACAS CAST COMMENTARY AND SAUGHORY DIVISION OF THE ACCOUNT AND SAUGHORY DIVISION OF THE ACCOUNT O	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/31/2022				
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R 0052 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when the resident was found on the floor, in his room, and left to lay on the floor for approximately two (2) hours until assistance arrived via 911, to transfer him off the floor, for 1 of 4 residents reviewed for neglect. (Resident B) Finding includes: R 0052 Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other	Bldg. 00	IN00392795. Complaint IN0039 deficiencies related R0052. Survey date: Octob Facility number: 0 Residential Census These State Reside accordance with 41	2795 - Substantiated. State It to the allegations are cited at Der 31, 2022 10234 Str. 21 Pential Findings are cited in 10 IAC 16.2-5.	R 00	000					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Residents' Rights (v) Residents hav (1) sexual abuse; (2) physical abus (3) mental abuse (4) corporal punis (5) neglect; and (6) involuntary se Based on observati review, the facility free from neglect v the floor, in his roo for approximately arrived via 911, to of 4 residents revie	e; che right to be free from: e; chment; clusion. con, interview and record failed to ensure a resident was when the resident was found on om, and left to lay on the floor two (2) hours until assistance transfer him off the floor, for 1	R 00	052	Plan of Correction is NOT a le admission that a deficiency ex or, that this Statement of Deficiencies was correctly cite and is also NOT to be constru as an admission against intere by the residence, or any	gal rists ed, ed	11/17/2022		
	LABORATOR	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE		

Jill Smith Administrator 11/16/2022

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 disclodays 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.

State Form Event ID: T2CU11 Facility ID: 010234 If continuation sheet Page 1 of 5

PRINTED: 11/28/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/31/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268 WILLOW LAKE PLACE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE individuals who drafted or may be During an observation, on 10/31/22 at 9:33 a.m., discussed in the response or Plan Resident B was found resting in a low bed, eyes of Correction. In addition, closed. There was a fall mat on the floor next to preparation and submission of this the bed. The resident appeared to be clean and Plan of Correction does NOT dry. A full body mechanical lift was in the room. constitute an admission or agreement of any kind by the During an observation, on 10/31/22 at 10:38 a.m., facility of the truth of any facts Resident B was found resting in a low bed. The alleged or the correctness of any resident responded to his name. He was unable to conclusions set forth in this recall the events related to his fall. allegation by the survey agency. A facility incident report indicated, on 10/15/22, R 052 410 IAC 16.2-5-1.2(v)(1-6) Resident B was found on the floor in his Residents' Rights - Offense apartment. 1. What corrective action(s) will The record for Resident B was reviewed on be accomplished for those residents found to have been 10/31/22 at 11:20 a.m. Diagnosis included, but were not limited to, encephalopathy (any diffuse affected by the deficient disease of the brain which alters brain function or practice: structure), stroke and falls. Resident B was evaluated by A nursing note, dated 10/15/22, no time charted, nursing on 10/19/2022 to ensure indicated the resident placed himself on the floor no injury had occurred. No and no injuries were noted at the time. The abnormal findings identified during resident indicated he was looking for his pants at the assessment. QMA 1 was the time of placement. The resident was placed placed on administrative leave on back into bed with assistance. There were no 10/19/2022 and no longer provides complaints of pain or discomfort and he would be services to the community. monitored. Current staff were re-educated on 10/20/2022 by the Executive During a telephone interview, on 10/31/22 at 12:47 Director (ED) regarding reporting of p.m., QMA 1 indicated when Resident B fell, CNA abuse, fall response, abuse and 2 informed her of fall and she (QMA 1) did check neglect, resident rights, lifting and the resident's vital signs and his body. She asked transferring, and mechanical lift CNA 2 to help get the resident up and was told operation (Attachment 1). no. She asked CNA 3 to assist with the transfer 2. How the facility will identify and was again told no. She then remained with the other residents having the resident until the fire department arrived, but was potential to be affected by the unable to say how long it took for the fire same deficient practice and

State Form Event ID: T2CU11 Facility ID: 010234 If continuation sheet Page 2 of 5

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

PRINTED: 11/28/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
		B. W	B. WING			10/31/2022	
							
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					AKE CIRCLE DR		
WILLOW	LAKE PLACE			INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	department to respon				what corrective action will be	corrective action will be	
					taken:		
	During a telephone	interview, on 10/31/22 at 12:49			On 10/21/2022, Regional Dire	ctor	
	p.m., CNA 5 indica	ated CNA 2 came to the Memory			of Care Services (RDCS) and		
	Care Unit and info	rmed her of the resident's fall			designee conducted a chart audit		
	and she was not ab	le to locate QMA 1. CNA 5			of current residents to ensure	!	
	was not able to leav	ve the unit to assist as the			residents are free from neglect,		
	residents on the uni	it could not be left alone.		with no additional findings noted.			
					By 11/14/2022, ED and designee		
	During a telephone	interview, on 10/31/22 at 4:01			will conduct an interview of		
	p.m., CNA 2 indica	ated she was working with CNA			cognitively intact residents to		
	3 on the unit, but sl	ne was also assisting on the			ensure resident are free from		
	Memory Care Unit. She informed QMA 1 and			neglect. Results will be discussed			
	CNA 3, Resident B was trying to get out of bed.				with RDCS and appropriate		
	At 4:30 p.m., she finished assisting residents to				interventions implemented at time		
	the dining room and went to check on Resident B.				of finding as necessary. By		
	She found the resident on the floor. CNA 2				11/14/2022, residents with		
	indicated she went to find help but was unable to				cognitive deficit will be assess		
	locate QMA 1 or CNA 3. She did find QMA 1				by nursing for signs of potentia	al	
	about 30 minutes la	ater and informed her of			neglect. Results will be discus		
	resident fall. QMA	1 went to the resident's room,			with RDCS and appropriate		
	but would not assist to get the resident off of the				interventions implemented at time		
	floor because she did not want to hurt her back.				of finding as necessary		
	The QMA indicated she was going to call 911 and				3. What measure will be put		
	left the room and closed the door. The QMA did				into place or what systemic		
	return but only to give the resident medicine and				changes the facility will make	е	
	left again. CNA 2 indicated she did call an off duty				to ensure that the deficient		
	nurse, and the nurse informed her QMA 1 had				practice does not reoccur:		
	called her about the fall and she informed the						
	QMA to call 911. CNA 2 indicated there was no			The Regional Executive Director		tor	
	response from 911 (no assistance arrived) at 5:00			(RED) was re-educated on			
	p.m. CNA 2 contacted 911 herself at 5:55 p.m.,			10/20/2022 by the RDCS on			
	after no response and they did respond quickly.			Enlivant's reporting policy and the			
	CNA 2 indicated the resident did have a full body				Indiana state reporting policy		
	mechanical lift in another room but they had not			(Attachment 2). Current staff were			
	been trained on how to use the lift. She indicated				in-serviced regarding resident		
	no one would help her get the resident up off the				rights, abuse, neglect, reportir		
	floor. He was wet, she had to change him on the				policy, fall response, lifting and		
	floor; neither QMA 1 or CNA 3 would help her				transferring and mechanical lit		
change the resident or assist to get him off the					operation on 10/20/2022 by th	е	

State Form Event ID: T2CU11 Facility ID: 010234 If continuation sheet Page 3 of 5

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

PRINTED: 11/28/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
			B. WING			10/31/2022	
		<u> </u>		CTREET (ADDRESS CITY STATE ZIR COR		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD AKE CIRCLE DR		
14/11 1 (0)4/	ALAKE DLAGE						
VVILLOVV	LAKE PLACE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	floor.				ED (Attachment 1). Resident	B's	
					care plan was updated on		
	During an interviev	v, on 10/31/22 at 4:27 p.m., the			10/20/2022 by RDCS to include	de	
	Director of Health	Services indicated staff need to		the appropriate fall interventions			
	be trained and chec	ked off on the full body			and the use of the mechanical lift		
	mechanical use for	each resident related to			in the event of a fall.		
	different types of li	fts and the staff had not been			4. How the corrective action((s)	
	trained/checked off	on Resident B's lift.			will be monitored to ensure t		
					deficient practice will not		
	During a telephone	interview, on 11/1/22 at 9:38			recur, i.e., what quality		
	a.m., CNA 3 indica	ted she was assisting another			assurance program will be p	ut	
	resident at the time	of fall. CNA 2 did locate her			into place:		
	and inform her of R	lesident B's fall. QMA 1 did					
	respond and told th	em not to touch the resident,			The Executive Director is		
	left him on the floo	r and left the room, she		responsible for sustained			
	indicated she was g	oing to call 911. CNA 2 and			compliance. The ED/designee	will	
	CNA 3 took turns s	taying with the resident as			complete audits by interviewin	ıg 3	
	each had to leave th	ne room. CNA 3 indicated she			residents and 3 staff weekly fo	or 4	
	did not believe QMA 1 placed the call to 911				weeks, biweekly for 4 weeks,	then	
	because they did no	ot show up. CNA 3 indicated		monthly for 1 month to ensure			
	they (CNA 2 and CNA 3) contacted 911 at about				residents are free from negled	t.	
	_	ire department responded		The audit willbe discussed at			
	approximately five	(5) minutes later. The resident			monthly QI meetings. The QI		
	had been left on the floor for about 2 hours. CNA				Committee will determine if		
	3 did not observe the QMA check the resident's				continued auditing is necessal	ry	
	vital signs or administer medications when she				based on 3 consecutive month		
	was with the resident. CNA 3 indicated the full				compliance. Monitoring will be	e	
	body mechanical lift was not used to transfer the				on-going		
	resident from the floor because CNA 2 did not				5. By what date will the		
	know how to use the lift and it was a two-person			systemic changes be			
	transfer with the lif	t.			completed?		
					November 17, 2022		
		interview, with 911 Dispatch,					
		a.m., Dispatch 4 indicated one					
	_	October 15, 2022 at 5:57 p.m.,					
	for an assist to the facility for Resident B's						
	apartment.						
	A facility policy, titled "Resident Rights Policy,"						
	dated as effective 0	3/01/22 and provided by the					

State Form Event ID: T2CU11 Facility ID: 010234 If continuation sheet Page 4 of 5

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

PRINTED: 11/28/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/31/2022			
NAME OF PROVIDER OR SUPPLIER WILLOW LAKE PLACE			•	STREET ADDRESS, CITY, STATE, ZIP COD 2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Director of Health Services on 10/31/22 at 10:41 a.m., indicated "Each resident has the right to, at			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE		
	minimumTo receive care, treatment and services which are adequate and appropriateBe free fromneglect" A facility policy, titled "Abuse, Neglect and								
	Exploitation Policy," dated as effective 03/01/22 and provided by the Director of Health Services on 10/31/22 at 10:41 a.m., indicated ""Neglect" meansdepriving the resident of necessary support"								
	Fall Response Poliprovided by the Di 10/31/22 at 3:40 p.	tled "Non-Emergent Resident cy," effective 03/01/22 and rector of Health Services on m., indicated "If unable to s Manager or designee, call "							
	This State Finding IN00392795.	relates to Complaint							

State Form Event ID: T2CU11 Facility ID: 010234 If continuation sheet Page 5 of 5