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	03/18/2025

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 the Investigation of Complaint IN00455526 and a State Residential Licensure Survey. Complaint IN00455526 - No deficiencies related to the allegations are cited. Survey dates: March 10, 11, 12, 13, 14, 17, and 18, 2025 Facility number: 004831 Provider number: 155751 AIM number: 200809750 Census Bed Type: SNF/NF: 114 SNF: 4 Residential: 46 Total: 164 Census Payor Type: Medicare: 20 Medicaid: 76 Other: 22 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 20, 2025.	F 0000	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 for 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. This facility respectfully requests from the Department a desk review. If anything, further is needed the facility will provide department documentation upon request for paper compliance/desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mac McCallum	Executive Director	04/08/2025

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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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure a self-medication administration assessment was completed for 1 of 1 random observations of medications left at the bedside. (Resident 71) Findings include: On 3/11/25 at 10:30 a.m., a medication cup with 1 large white tablet was observed on the bedside table of Resident 71. Resident 71 indicated it was her stomach medication and the nurses always left it for her to take after she had finished her meal. Resident 71's clinical record was reviewed on 3/11/25 at 11:30 a.m. The diagnosis included, but was not limited to, gastroesophageal reflux disease. The clinical record lacked documentation of a self-medication administration assessment. Current physician orders, dated 3/1/25 through 3/17/25, indicated Resident 71's medications included, but were not limited to, simethicone (for gas) tablet 125 milligrams 4 times a day. During an interview on 3/17/25 at 10:25 a.m., the Director of Nursing Services (DNS) indicated there had not been a self-medication administration assessment completed for Resident 71, however, the medication was just a gas pill and the resident would get sick if she took it before her meal so they let her keep it with her until after she ate. On 3/18/25 at 10:43 a.m., the DNS provided the facility's policy, "Medication Administration-Medication Pass Procedure" with	F 0554	**F 554:** Resident Self-Admin Meds-Clinically Approp 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1 Resident 71's MAR and plan of care were reviewed and updated by the IDT to honor the preference of self-administration by the Resident. All Nurses were educated on medication storage, medication administration and obtaining a physician order for self-administration where applicable. 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 Alert residents will be informed of their right to self-administer medications upon admission. The clinical IDT will review all Resident requests individually and upon request. 3 What measures will be put into place and what systemic	04/14/2025

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	a revised date of 7/2023, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 11. Observed taking medications-not left at bedside ..." 3.1-11(a)		changes will be made to ensure that the deficient practice does not recur. 1 DNS or Designee will complete an audit five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all alert Residents with a preference for self-administration have an updated care plan, physician order and Resident education completed. The plan will be revised, as 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.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data	F 0641	F 641: Accuracy of Assessments 1. What corrective action(s) will be	04/14/2025

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	Set assessment for a resident determined to have a Level II PASARR and a serious mental illness for 1 of 1 resident reviewed for Resident Assessment. (Resident 62) Findings include: Resident 62's clinical record was reviewed on 3/18/25 at 11:00 a.m. The diagnoses included, but were not limited to, anxiety, psychotic disorder with delusions and anorexia nervosa. A Level II PASARR (Preadmission Screening and Resident Review) was completed in January 2023, and indicated the resident had a serious mental illness. The Significant Change Minimum Data Set (MDS) assessment, dated 2/23/25, indicated No to Resident 62 having a Level II PASARR and no to the resident having a serious mental illness. During an interview on 3/18/25 at 10:35 a.m., the Social Services Assistant indicated the Significant Change MDS assessment, dated 2/23/25, for Resident 62 should have been coded Yes to having a Level II PASARR and Yes to the resident having a serious mental illness. On 3/18/25 at 1:20 p.m., the facility provided a copy of the RAI Version 3.0 Manual, page 5, dated October 2023, and indicated it was the policy currently being used by the facility. A review of the RAI manual did not indicate coding of the Level II PASARR. 3.1-31(d)		accomplished for those residents found to have been affected by the deficient practice. 1. Resident 62's PASSR and plan of care were reviewed and updated by the IDT to reflect the status of the Resident. The Director of Social Services/Social Services Assistant were educated on level 1 & 2 completion, along with Intellectual, Mental Disability or related conditions. The IDT has corrected the MDS coding based on the Level 2 recommendations and incorporated it into the president's plan of care. 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. All Residents with a PASSR indicating a Level 2 have been reviewed for accurate coding and appropriate care plans by the IDT. 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 five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all Resident PASSR's are completed accurately and reflect the Residents plan of care. The plan will be revised, as warranted.	

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			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.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation and interview, the facility failed to ensure staff revised the comprehensive care plan for a resident with significant weight loss for 1 of 4 residents reviewed for nutrition. (Resident 47) Findings include: On 3/11/25 from 9:20 a.m. to 9:45 a.m.,. Resident 47 was observed in bed with breakfast on her tray and no food eaten. No staff were present with the resident. On 3/14/25 from 9:25 a.m. to 9:50 a.m., Resident 47 was observed in bed with breakfast on her tray and no food eaten. No staff were present with the resident.	F 0657	**F 657:** Care Plan Timing and Revision 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1 Resident 48's Nutritional plan of care and interventions were reviewed and updated by the IDT to reflect the status of the Resident. All interventions to prevent weight loss have been deemed appropriate by the physician and IDT. 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	04/14/2025

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	On 3/11/25 at 10:10 a.m. Resident 47's clinical record was reviewed. The diagnoses included, but were not limited to, hemiplegia, adult failure to thrive, and unspecified protein-calorie malnutrition. The Quarterly MDS (Minimum Data Set) assessment, dated 3/10/25, indicated the resident had a five percent or more weight loss in the last month or weight loss of ten percent or more in the last 6 months. The Functional Assessment, dated 3/10/25, indicated the resident required supervision or touching assistance for eating. The Follow Up Nutrition Review, dated 3/11/25, indicated the resident had a five percent or more weight loss in the last month or weight loss of ten percent or more in the last six months, was not on a physician prescribed weight loss program, and the care plan had been reviewed and updated. A Nutrition Care Plan, reviewed on 3/11/25, indicated no nutritional care plan interventions since 8/1/23. - On 9/4/24, the resident weighed 154 lbs (pounds) - On 10/3/24, the resident weighed 146 lbs, which was a 5.19 percent weight loss in one month. - On 10/9/24, the resident weighed 152 lbs - On 11/4/24, the resident weighed 144 lbs, which was a 5.26 percent weight loss in one month. - On 3/3/25, the resident weighed 123 lbs, which was a 20.13 percent weight loss in six months. On 3/14/25 at 2:25 p.m., the DON provided the Resident Weight Monitoring policy with a revised date of, 9/2024, and indicated this was the current weight monitoring policy used by the facility. A		affected by this practice.2 All Residents that trigger for an undesired weight loss will be reviewed by the IDT, Registered dietician and physician. Upon review all interventions will be reviewed and updated where applicable within the care plan. All care plans will be review weekly by the IDT team in Nutritional at risk meetings for weight improvement and stability.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 five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all Resident PASSR's are completed accurately and reflect the Residents plan of care. The plan will be revised, as 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.	

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	review of the policy indicated, "...any significant unexplained weight loss is considered a change in condition and must be addressed by the Interdisciplinary Team..." During an interview on 3/17/25 at 10:30 a.m., the DON indicated the resident had significant weight loss and new interventions had not been updated on the nutrition care plan. 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to provide ADL's (Activities of Daily Living) for a dependent resident for 1 of 1 residents reviewed for ADL's. A resident was not shaved. (Resident 48) Findings include: On 3/11/25 at 10:19 a.m., Resident 48 was observed in her room with approximately half inch long whiskers on her chin. On 3/13/25 at 2:50 p.m., Resident 48 was observed in her room with approximately half inch long whiskers on her chin. At that time, Resident 48 wept and indicated having chin whiskers made her sad. She indicated staff used to shave her whiskers and she wished they did this more often, as it made her feel bad to have them on her chin. During an interview on 3/14/25 at 11:40 a.m., RN 1 indicated the resident needed her chin whiskers shaved. On 3/11/25 at 10:10 a.m., Resident 47's clinical	F 0677	F 677: ADL Care Provided for Dependent Residents 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident 48's chin and face were inspected for unnecessary hair. All hair deemed unnecessary was immediately removed. Resident 48's plan of care was reviewed and updated by the IDT to reflect the status for assistance with ADLs specific to facial hair care. 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. All Residents were reviewed for unnecessary facial hair, offered hair care and removal, and had	04/14/2025

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	record was reviewed. The diagnoses included, but were not limited to, hemiplegia, adult failure to thrive, and unspecified protein-calorie malnutrition. The Functional Assessment, dated 3/10/25, indicated the resident required substantial or maximal assistance to maintain personal hygiene, including shaving. A current Activity of Daily Living care plan, with a start date of 7/28/23 indicated the resident was to receive assistance with grooming and hygiene. 3.1-38(a)(3)(D)		care plans updated to reflect the desired statis of the Resident. 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. A daily care companions' program has been implemented for daily rounding and observation. All Residents have been assigned an IDT member. Daily rounding will occur at varied times to ensure ADL care is completed for all Residents. 2. ED or Designee will complete an audit at varied times five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all Resident ADL care plans are accurate and up to date related to Resident hair care preference. The plan will be revised, as 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.	

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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 and the Investigation of Complaint IN00455526. Complaint IN00455526 - No deficiencies related to the allegations are cited Survey dates: March 10, 11, 12, 13, 14, 17, and 18, 2025 Facility number: 004831 Residential Census: 46 Meadow Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 0000	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 for 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. This facility respectfully requests from the Department a desk review. If anything, further is needed the facility will provide department documentation upon request for paper compliance/desk review.	