STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET FISHERS, IN 46037

(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
R 0000 Bldg. 00	This visit was for the Investigations of Complaints IN00417358, IN00419137, IN00417524, IN00421537, IN00427851 and IN00427292. Complaint IN00417358 - State deficiencies related to the allegations are cited at R117. Complaint IN00419137 - No deficiencies related to the allegations are cited. Complaint IN00417524 - State deficiencies related to the allegations are cited at R117. Complaint IN00421537 - No deficiencies related to the allegations are cited. Complaint IN00427851 - No deficiencies related to the allegations are cited. Complaint IN00427292 - State deficiencies related to the allegations are cited at R052. Unrelated deficiencies are cited. Survey date: May 15, 16, and 2024 Facility number: 014910 Residential Census: 114 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 21, 2024	R 0000	R 000 Disclaimer: The submission of this plan of correction does not indicate an admission by Lake Meadows Senior Living that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Lake Meadows Senior Living. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for Assisted Living Facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0052	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darlene Adair	Executive Director	05/31/2024

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.

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Bldg. 00	(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 interview and record review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 5 of 7 reviewed for abuse (Resident C, M, N, P, and R). Findings include: 1a. The clinical record for Resident M was reviewed on 5/15/24 at 2:45 p.m. The Resident's diagnosis included, but were not limited to, dementia and psychotic disorder with hallucinations. 1b. The clinical record for Resident N was reviewed on 5/16/24 at 4:30 p.m. The Resident's diagnosis included, but were not limited to, anxiety and depression. A service plan, initiated 2/16/222, indicated Behaviors. The goal was that staff would be able to identify factors that would help to prevent inappropriate behaviors. The interventions, initiated 2/16/22, was to exhibit normal, functional behavior patterns daily. Resident N's clinical record contained an incident note, dated 3/31/2024 at 1:37 p.m., which read "...Notified by the staff, Resident (l)) [sic] was coming down the hallway for lunch, Resident (D) [sic] was sitting on the chair. Resident (l) [sic] started yelling at resident (l) [sic] that she was ugly, go back to your room. Resident (L) [sic]	R 0052	**Tag: R -52 Residents' Rights** 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A All residents are at risk of being affected by this citing. It is the intent of Lake Meadows to ensure all residents are free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect, and involuntary seclusion. Upon notification of alleged resident abuse 15 minute checks will be in placed to ensure all residents safety from any risk of any type of abuse. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A All residents had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice.	05/28/2024

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	stayed clam stated stop talking to me like this. When resident (L) [sic] got closer to resident (D) [sic], resident stood up and walked over her with a fist. Resident (L) [sic] don't hit me. Resident (d) [sic] than punched resident in the face. Resident (L) [sic] tried to hit her back, but resident turned her back and moved forward. resident sat separately afterwards. No incidents noted afterwards. both residents remained clamed afterwards had lunch. DON/ADON/NP made aware. Both parties' families made aware by this writer..." On 5/16/24 at 4:27 p.m., the DON (Director of Nursing) provided a copy of an Incident Report which was submitted to the IDOH (Indiana Department of Health) on 3/31/24 at 1:37 p.m., which indicated Resident N was going to the dining room and Resident M was sitting in a chair in the hallway. Resident M yelled out at Resident N that Resident N was ugly and to go back to her room. Resident N said not to talk to her like that to Resident M. Resident M stood up and "punched" Resident N in the face. Resident N tried to hit Resident M back, but Resident M had turned her back and moved forward. There were no injuries noted. The immediate action taken was to immediately ensure the residents were safe. The staff intervened by separating Resident M and Resident N. The Nurse Practitioner and Power of Attorneys were notified. The preventative measures taken were kept residents separated to ensure safety and monitored residents for 24 hours. The Psychiatric Nurse Practitioner was contacted for medication review. The investigation of the incident report between Resident N and Resident M included a statement from CNA (Certified Nursing Assistant) 40, dated 3/31/24, which indicated that Resident N was		3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A All-staff will be in-serviced on Resident Rights and Elder Abuse with types of abuse noted. B All Nursing staff will be In-serviced on 15-minute check process to ensure all resident safety 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; and A The Director of Nursing or designee: Will perform a resident safety audit by reviewing the 15 minute check documentation. (1) Once weekly for the first month then (2) Two times a monthly for (3) months to ensure Resident Rights and Safety. Audits shall be conducted monthly and reported to the QAPI Committee. 5 By what date the systemic changes will be completed. Compliance Date: May 28, 2024	

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	coming down the hallway for lunch. Resident M was sitting on the chairs, and started yelling at Resident N that she was ugly and to go back to her room. Resident N told Resident M to stop talking to her. When Resident N got closer, Resident M stood up and walked toward Resident N, Resident M had her fist raised. Resident N said, "don't you dare hit me" and then Resident M "punched Resident N in the face. Resident N tried to hit Resident M back, but Resident M had backed up too far. 1c. The clinical record for Resident P was reviewed on 5/16/24 at 4:30 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease. Resident P's clinical record contained a Behavior Note, dated 4/2/24 at 11:50 a.m., which read "...CNA [sic] reported this resident [Resident P] twisted another resident's arm [Resident M]. Then both residents started "slapping" at each other. CNA [sic]separated residents and monitoring both residents..." On 5/16/24 at 4:27 p.m., the DON provided a copy of an Incident Report, submitted to the IDOH on 4/2/24 at 11:50 a.m., which indicated Resident P had twisted Resident M's arm in the dining room. Resident M reacted by slapping Resident P's hands and arms. There were no injuries noted. The immediate action taken was to ensure resident safety. Staff intervened by separating Resident P and Resident M. The Residents were assessed for injuries and the Nurse Practitioner and Power of Attorneys were notified. The preventative measures were to keep Resident M and Resident R separated to ensure safety. Monitor Residents for 24 hours. The Psych Nurse Practitioner was contacted for medication review.			

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	1d. The clinical record for Resident C was reviewed on 5/15/24 at 11:45 a.m. The Resident's diagnosis included, but were not limited to, dementia and anxiety. Resident M's clinical record contained a Behavior Note, dated 4/3/2024 2:52 p.m., which read "...CNA [sic] reported that this resident [Resident M] walked over to another resident [Resident C], sitting on couch sleeping, and slapped the resident [Resident C] in the face. CNA intervened and this resident [Resident M] stated "it was and [sic] accident", but denied slapping the other resident..." On 5/16/24 at 4:27 p.m., the DON provided a copy of an Incident Report, submitted to the IDOH on 4/3/24 at 2:52 p.m., which indicated Resident M walked over to Resident C and "slapped" Resident C in the face while she was sitting on the couch. Resident M denied slapping Resident C. There were no injuries noted. The immediate action taken was to ensure resident safety and the staff intervened by separating residents. The preventative measures taken were to keep Resident M and Resident C separated to ensure safety. The follow-up, added 4/9/24, was that Resident M was referred to an inpatient psychiatric hospital on 4/4/24. Resident M's clinical record contained a Nurse Practitioner Note, dated 4/4/24 at 12:08 p.m., which read "...Reason for visit: Psychotropic medication review and Follow-up to mood and behaviors. Changes since the last visit: 1/6/24: resident grabbed another resident's arm and other resident was screaming. 1/7/24: This res got into a verbal altercation with another res.			

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	1/25/24: Resident refused taking her med tonight. 4/1/24: Resident is sitting in LR watching TV. No s/s of distress notice at this time 4/2/24: CNA reported another resident twisted this resident's arm. Then both residents started "slapping" at each other. 4/3/24: CNA reported that this resident walked over to another resident, sitting on couch sleeping, and slapped the resident in the face. CNA intervened and this resident stated 'it was and[sic] accident', but denied slapping the other resident. Clinical Narrative: [Resident M] being seen today for follow-up on mood and behaviors. I met with the patient in the milieu. She is anxious and tearful. She reports that she is irritated by everyone in the facility, sharing 'I just hate this place and I feel extremely irritated by everyone.' When asked why she feels irritated, she shared 'I don ' t know, I just get very upset, I feel like I don ' t want to see anyone here any longer and I ' m sick of all of them.' She is anxious. She was provided with redirection. Facility staff reported that for the past 3 days she has been nice, happy and laughing one moment and when no one is looking she will walk to the resident and tries to hit them unprovoked..." Resident M was discharged to an inpatient psychiatric hospital on 4/5/24 and returned to the facility on 4/16/24. A service plan, initiated 4/16/24, indicated Resident M had the potential to be physically aggressive related to her dementia. The goal was for her to be receptive to team member interventions and validations of their feelings and redirect when agitation occurs and that she would not harm herself or others. The intervention was to observe, and document observed behavior and			

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	attempted interventions in the behavior log, revised 4/29/24. A service plan, initiated 4/16/24, indicated that staff would conduct every 2-hour wellness checks for Resident M. The goal was for staff to conduct every 2-hour wellness checks. The intervention would not be resistant of assistance. 1e. The clinical record for Resident R was reviewed on 5/16/24 at 4:30 p.m. The Resident's diagnosis included, but were not limited to, Alzheimer's disease. Resident R's clinical record contained a Behavior Note, dated 4/24/24 at 11:10 a.m., which read "... Resident [Resident R] was hugging resident is LR [living room] and another resident [Resident M] tried to break them apart, Both resident [Resident R and Resident M] fighting with each other, pulled each other resident hair. Resident scratched other resident on her neck. Immediately ensured resident safety Staff intervened by separating residents. Assessed residents for injuries. NP notified. Left a voice massage [sic] to POA..." On 5/16/24 at 4:27 p.m., the DON provided a copy of an Incident Report, submitted to the IDOH on 4/24/24 at 11:10 a.m., which indicated Resident M had tried to break apart Resident R and Resident N while they were hugging in the living room. Resident M and Resident R bean to fight with each other and pulled each other's hair. There were no injuries noted. The immediate action taken was that staff separated residents and assessed both residents for injuries. The Nurse Practitioner and the Power of Attorneys were notified. The preventative measures were to assess both residents for any adverse outcomes.			

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	No distress was noted. Both residents were monitored for 24 hours. The Psych Nurse Practitioner was contacted for a medication review. Resident R's clinical record contained a Psych Nurse Practitioner note, dated 04/25/2024 at 10:37 a.m., which read "... [Resident R] ...is being seen today for a follow up to mood and behavior. She denies complaint of pain or discomfort. When asked how she was doing, reported she feels fine. She has been sleeping and eating well. She denies worsening anxiety or depression. She denies suicidal or homicidal ideations. When asked about her mood, she reported her mood has been 'so_so, some days are better than other.' She reported that she was involved into a fight with another resident recently and she shared that the resident was the instigator because she complained of her staring at her and so they got into a fight. She shared that the fight did not affect her..." Resident M's clinical record contained a Psych Nurse Practitioner progress note, dated 4/25/24 at 10:27 a.m., which read "...[Resident M]...is being seen today for follow-up on mood and behaviors. I met with the patient in the milieu. She is anxious with interaction today. She reported that she got into a fight with two other residents, stating they just got upset with me because 'I tried to tell them not to stare at me.' When asked what they were doing, she reported that she feels as if everyone is staring at her and she points to another resident 'look at that one right there, right now she is staring at me, makes me feel as I need to go and smack her in the face for doing that.' She reported that she feels as if everyone is very observing of her. They are constantly staring at her which makes her to feel very agitated.... Collaborated with nursing staff. They reported that... [Resident			

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	M] has had ongoing behavioral problem. She has been the instigator in the fight that she had with other residents on the unit and she has been difficult to redirect...." During an interview on 5/15/24 at 2:13 p.m., FM (Family Member) 22 indicated that while Resident C was sleeping on the couch in the common area. Resident M had come up and hit Resident C in the face. Resident M had also hit other residents. Resident M continued to walk around the unit after hitting others and was not monitored so that she would not do it again. On 5/16/24 at 4:40 p.m., the ED (Executive Director), DON and ADON (Assistant Director of Nursing) were interviewed. The ED indicated that after the incident on 3/31/24, Resident M was put on 2-hour checks. All the residents on the EPC (Enhanced Personal Care) unit received every 2-hour checks. Resident M was not placed on every 15-minute checks or one-on-one monitoring. 15-minute checks may have been appropriate. Resident M was seen weekly by the Psych Nurse Practitioner. The DON indicated that staff on the unit would attempted to keep Resident M engaged in activities to keep her busy. Resident M did not have a service plan addressing her behaviors until 4/16/24. On 5/16/24 at 8:50 a.m., the ED provided the current Abuse, Neglect, and Misappropriation Policy and Procedure which read "...Each resident has the right to be free from abuse, corporal punishment, mistreatment, and involuntary seclusion. Resident must not be subjected to abuse by anyone including, but not limited to: facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians,			

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	friends, or other individuals...Definitions...Physical Abuse- including hitting, slapping, pinching, and kicking...Prevention...The community identifies, corrects, and intervenes in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. This includes...The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors..." This state finding relates to complaint IN00427292.			
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 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			

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	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 staff were available to provide services for insulin administration for 1 of 3 residents reviewed for change of condition. (Resident F) Findings include: The clinical record for Resident F was reviewed on 5/15/24 at 2:00 p.m. The diagnosis included, but was not limited to, Type 1 diabetes mellitus. A service plan for Resident F revision date of 1/25/24 indicated "staff is administering a schedule meds..." A level of care dated 3/16/24 indicated insulin injections would be administered by staff. A physician order dated 2/27/24 indicated resident was to receive 5 milligrams of glipizide extended release twice a day. A physician order dated 3/14/24 indicated Resident F was to receive a sliding scale of Novolog insulin three times a day. The sliding scale was the following: 150-200 blood sugar readings = 2 units of insulin, 201-250 blood sugar readings = 4 units insulin, 251-300 blood sugar readings = 6 units of insulin, 301-350 blood sugar readings = 8 units of insulin, 351-400 blood sugar readings = 10 units of insulin The March 2024 Medication Administration Record indicated on 3/23/24, the resident refused her 5:00 p.m., scheduled Novolog sliding scale insulin. The resident's blood sugar reading was	R 0117	R Tag 117 Personnel 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A It is Lake Meadows Senior Living's intention to ensure that trained staff in First aid, CPR and Insulin Certified are on duty and are within the guidelines of 1 staff member to every 50 residents. Those employees identified as missing First aid, CPR and Insulin Certification were scheduled for such training. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A All residents had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice. B Administrative staff audited all current employees records for documentation of First aid, CPR and Insulin certification and training will be scheduled and/or completed no later than 5/28/2024.	05/28/2024

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	213. A progress note dated 3/23/24 at 11:18 p.m., indicated Resident F's blood sugar reading was 335. "Resident stated she felt funny and checked." A progress note written by Qualified Medication Aide (QMA) 3 dated 3/24/24 at 12:35 p.m., indicated "Writer was informed of resident blood sugar 335 at 11:05 p.m. ADON [Assisted Director of Nursing] was informed, ADON Informed DON [Director of Nursing]. ADON gave instructions to encourage resident to take 8 Unit of her insulin by herself since writer was not yet insulin certified. Resident refused, explaining it was new to her. ADON gave further instruction to call the EMS [emergency medical services] to come assist. EMS came in and explained that giving insulin was outside of their scope, they rather take the resident to the hospital. Resident refused going to the hospital. Insulin process was further explained to the resident and she administered the insulin herself." An interview was conducted with ED [Executive Director], ADON and DON on 5/16/24 at 11:14 a.m. The DON indicated the staff administer medications to Resident F. The ADON indicated late night of 3/23/24, QMA 3 notified her by phone, Resident F was requesting for insulin administration due to her blood sugar being 335. She had told QMA 3, the resident could self administer 8 units of Novolog insulin utilizing the Novolog sliding scale order. She was over an hour away from the facility, so the resident would have to self administer the insulin due to QMA 3 was not certified to administer insulin. The resident refused to administer the insulin herself, but agreed to contacting the EMS to come and		3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A Training is provided to all staff to obtain proper certifications. Personnel files will be updated with a copy of First aid, CPR and Insulin certification once obtained. CPR and First Aid training classes are being offered for all interested staff; nursing staff are required to participate in the class and obtain needed certifications. 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; and A In addition, the Nursing Manager will identify on the daily schedule the staff that are. All new employees will be scheduled for First aid, CPR and Insulin Certified in the following quarterly class schedule. Compliance will be monitored by use of an Audit Process and Tracking Form. 5 By what date the systemic changes will be completed. Compliance Date: May 28, 2024	

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		A. BUILDING 00 B. WING	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET FISHERS, IN 46037

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	administer the insulin to her. After EMS arrived, they indicated it was out of their scope of practice to administer insulin, but they could take the resident to the hospital to receive insulin administration. The resident refused to be taken to the hospital to receive her insulin, so EMS instructed the resident how to give the insulin to herself. The ED indicated the ADON or DON should have come to the facility to administer the insulin. An interview was conducted with QMA 3 on 5/16/24 at 3:10 p.m. She indicated on the night of 3/23/24, Resident F's blood sugar was checked, and it was "pretty high." She was not certified to administer insulin, so she notified the ADON. The ADON instructed the resident to self administer 8 units of Novolog insulin. The resident was not comfortable with administering the insulin. The ADON then instructed QMA 3 to contact the fire department to come and administer the insulin to Resident F. After they arrived, they also were unable to administer the insulin, but they offered to take her to the hospital to receive insulin. The resident refused to go to the hospital. At that time, the fire department staff "guided" the resident to administer the insulin to herself. This state finding relates to Complaints IN00417358 and IN00417524.			
R 0157 Bldg. 00	410 IAC 16.2-5-1.5(n) Sanitation and Safety Standards - Deficiency n) The facility shall develop, adopt, and implement written policies and procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area. Based on interview and record review, the facility failed to implement a written policy and/or	R 0157	R Tag 157- Sanitation and Safety Standards	05/17/2024

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		A. BUILDING 00 B. WING	05/16/2024

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LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET FISHERS, IN 46037

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	procedure to ensure the cleaning, disinfecting, and sterilization of equipment used by more than one person in a common area by not accurately documenting the cleaning of the ice machine and soda nozzle dispensers within the facility. This had the potential to affect 114 of 114 residents residing in the facility. (Facility) Findings include: An interview with Resident J was conducted on 5/15/24 at 3:05 p.m. Resident J indicated, they had a concern that the facility had not cleaned, disinfected, or sanitized the ice machine or the soda machine nozzles for over a year. They indicated, in the past when the ice machine was about to be cleaned, the residents within the community were notified of the cleaning because ice would not available while the cleaning/disinfecting/sanitation was being done. An interview with the Culinary Manager (CM) conducted on 5/16/24 at 12:21 p.m. indicated, he did not have a cleaning log/schedule for the ice machine nor the soda nozzles. He stated, he had just cleaned the ice machine and removed the "black gunk" but was unable to provide evidence of when it was cleaned/disinfected/sanitized prior to that. CM indicated, the cleaning of the soda machine nozzles was part of the server closing check list. A blank sample of the Server Closing Checklist was provided by CM on 5/16/24 at 1:54 p.m. The checklist had a place to put the date, initials of the person who performed each duty, space for a signature and date, and a space for the cook's signature and date. The duties to perform at closing included, but not limited to, "pull nozzles from both juice and Coke machines and soak in		1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A Lake Meadows in serviced staff on Sanitation and Safety Standards policy for cleaning, disinfecting, and sterilizing equipment which includes Soda Nozzles, Ice Machine used by more than one (1) person in a common area. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; A All residents had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice. 3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A Sanitation log will be in place on cleaning, disinfecting, and sterilizing equipment. 4 How the corrective action(s) will be monitored to ensure the	

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	hot water" and "pull nozzles from both coke and juice machines soak in sani water." A Cleaning and Sanitizing the Ice Machine policy/procedure was provided by Executive Director (ED) on 5/16/24 at 1:54 p.m. It indicated: On a daily basis to: "1. Wash exterior of machine with hot water and detergent. Rinse with clean water and cloth. Use sanitizing solution and clean cloth to sanitize. 2. Remove drainage grate and tray and sent through dishmachine. 3. Allow to air dry... 6. Document cleaning on the Cleaning Schedule." On a weekly basis to: "1. Unplug the ice machine. Remove ice. 2. Wash inside of machine with approved detergent and hot water. Rinse with clean water. Then use sanitizing solution an clean cloth to sanitize... 6. Document cleaning of ice machine on Cleaning Schedule..." Twice yearly to: "1. The cleaning and sanitizing of internal components of the ice machine should follow EPA[sic, Environmental Protection Agency] registered label use instructions and is usually done by the maintenance department or by a contracted ice machine maintenance company. 2. Food and Nutrition Services staff cannot do the actual cleaning of the internal components but are responsible to see that it is completed per manufacture guidelines which will specify the appropriate cleaner and sanitizer. 3. Per Food Code the internal components must be cleaned and sanitized per manufacturer guidelines, county or state regulations and not less than 2x[sic, times] per year. 4. Food and Nutrition Services is to note on the cleaning schedule when this cleaning occurs."		deficient practice will not recur, i.e., what quality assurance program will be put into place; and A The Culinary Manager, or designee, will audit Dispenser Sanitizing Log (2) two times a day for (1) one week, then (1) one times a day for (1) one week, then (2) two times per week for (2) two months to ensure 100 percent compliance. 5 By what date the systemic changes will be completed. Compliance Date: May 17, 2024	

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		A. BUILDING 00 B. WING	05/16/2024

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R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to notify a physician to receive orders to address a resident with elevated blood sugars, and instructed the resident to administer insulin without assessing if the resident was able to safely self administer insulin for 1 of 3 residents reviewed for change of condition. (Resident F) Findings include: The clinical record for Resident F was reviewed on 5/15/24 at 2:00 p.m. The diagnosis included, but was not limited to, Type 1 diabetes mellitus. A service plan for Resident F revision date of 1/25/24 indicated "staff is administering a schedule meds..." A level of care dated 3/16/24 indicated insulin injections would be administered by staff. A physician order dated 2/27/24 indicated resident was to receive 5 milligrams of glipizide extended release twice a day. A physician order dated 3/14/24 indicated Resident F was to receive a sliding scale of Novolog insulin three times a day. The sliding scale was the following: 150-200 blood sugar readings = 2 units of insulin, 201-250 blood sugar readings = 4 units insulin, 251-300 blood sugar readings = 6 units of insulin, 301-350 blood sugar readings = 8 units of insulin, 351-400 blood sugar readings = 10 units of insulin	R 0240	Tag: R -240 Health Services - 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A Upon the discovery of this allegation of deficiency, Lake Meadows immediately began an investigation. Upon investigation it was discovered that all Nursing staff that handle medications should be re-educated on the resident medication administration and PRN doctors orders. The Director of Nursing will complete an audit of those residents who self-administer, conduct an assessment to see if they can safely administer insulin themselves and update the service plan if needed. 2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: A All residents had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice.	05/28/2024

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	The March 2024 Medication Administration Record indicated on 3/23/24, the resident refused her 5:00 p.m., scheduled Novolog sliding scale insulin. The resident's blood sugar reading was 213. A progress note dated 3/23/24 at 11:18 p.m., indicated Resident F's blood sugar reading was 335. "Resident stated she felt funny and checked." A progress note written by Qualified Medication Aide (QMA) 3 dated 3/24/24 at 12:35 p.m., indicated "Writer was informed of resident blood sugar 335 at 11:05 p.m. ADON [Assisted Director of Nursing] was informed, ADON Informed DON [Director of Nursing]. ADON gave instructions to encourage resident to take 8 Unit of her insulin by herself since writer was not yet insulin certified. Resident refused, explaining it was new to her. ADON gave further instruction to call the EMS [Emergency Medical Services] to come assist. EMS came in and explained that giving insulin was outside of their scope, they rather take the resident to the hospital. Resident refused going to the hospital. Insulin process was further explained to the resident and she administered the insulin herself." A progress note written by QMA 3 on 3/24/24 at 2:07 a.m., indicated "...Resident called to inform writer that her blood sugar was 82..., Resident checked blood sugar again and it was 77... at about 1:39 a.m. A cup of orange juice was given to the resident." An interview was conducted with ADON and DON on 5/16/24 at 11:14 a.m. DON indicated Resident F did not have an as needed (PRN) insulin order. Resident F's medications are stored		3 What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A To ensure deficiency does not reoccur, going forth, all Nursing staff that handle medication will have education to include that proper medication administration, medication policy and procedures, including doctors PRN orders for insulin administration. 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; and A The Director of Nursing/designee will audit 10% resident records for compliance with medication administration guidelines as follows: 3 times weekly for one month; 2 times weekly for two months and weekly thereafter. Any deficiencies found in the audits will be corrected at the time discovered and retraining provided, as appropriate. Findings will be reported to the QAPI Committee. 5 By what date the systemic changes will be completed. Compliance Date: May 28, 2024	

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	in her room, but the staff administer her medications. The resident will at times refuse for staff to administer her medications and will administer her mediations to herself. The ADON indicated it was late night of 3/23/24, QMA 3 notified her by phone, Resident F was requesting for insulin administration due to her blood sugar being 335. She had told QMA 3, the resident could self administer 8 units of Novolog insulin utilizing the Novolog sliding scale order. She was over an hour away from the facility, so the resident would have to self administer the insulin due to QMA 3 was not certified to administer insulin. The resident refused to administer the insulin herself, but agreed to contacting the EMS to come and administer the insulin to her. After EMS arrived, they indicated it was out of their scope of practice to administer insulin, but they could take the resident to the hospital to receive insulin administration. The resident refused to be taken to the hospital to receive her insulin, so EMS instructed the resident how to give the insulin to herself. The resident does not utilize the facility's medical provider. The ADON indicated she did not call the resident's medical provider nor the facility's medical provider to receive orders on how to address the resident's blood sugar of 335. An interview was conducted with QMA 3 on 5/16/24 at 3:10 p.m. She indicated on the night of 3/23/24, Resident F's blood sugar was checked, and it was "pretty high." She was not certified to administer insulin, so she notified the ADON. The resident refused to administer the insulin herself. The resident was not comfortable with administering the insulin. The ADON then instructed QMA 3 to contact the fire department to come and administer the insulin to Resident F. After they arrived, they also were unable to administer the insulin, but they offered to take her			

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	to the hospital to receive insulin. The resident refused to go to the hospital. At that time, the fire department staff "guided" the resident to administer the insulin to herself.			