STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
			B. WI	NG		05/11/	2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	A DOLAYO OF NIOD	A COLOTED I IV/INC			E 126TH STREET		
LAKE ME	ADOWS SENIOR A	ASSISTED LIVING		FISHER	RS, IN 46037		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWDERIC BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG CROSS-REFERENCED TO THE APPROPRIATE		IE.	DATE
R 0000							
Bldg. 00							
			R 00	000	R 000		
	This visit was for a	State Residential Licensure	I K O	000	Disclaimer: The submission of	this	
		ncluded the Investigation of			plan of correction does not	uno	
	-	9914 and IN00407732.			indicate an admission by Lake		
	25mpiamio 1110057	,, 1 . and 11 (00 (01/102)			Meadows Senior Living that th		
	Complaint IN00399	914 - No deficiencies related to			findings and allegations contai		
	the allegations are c				herein are an accurate, true	iicu	
	anogunons are e				representation of the quality of	•	
	Complaint IN00407	732 - State deficiencies related					
	to the allegations are				care provided, and living environment provided to the		
	to the anegations are	e cited at R0167.	· ·		nior		
	Unrelated deficiencies cited residents of Lake Meadows Senior Living. The facility recognizes its						
	Officiated deficiency	ies cited			Living. The facility recognizes		
	Survey dates: May 9	0 10 and 11 2022			obligation to provide legally an	u	
	Survey dates. May	9, 10, and 11, 2023			medically necessary care and services to its residents in an		
	Facility number: 01	4010				_	
	racinty number. 01	4910			economic and efficient manne		
	Residential Census:	116			The facility hereby maintains it		
	Residential Celisus.	110			in substantial compliance with		
	Thosa Stata Dagidan	tial Eindings one sited in			requirements of participation for		
		atial Findings are cited in			Assisted Living Facilities. To the		
	accordance with 410	J IAC 10.2-3.			end, the plan of correction sha		
	O1'	-1-4-1 M 10, 2022			serve as the credible allegation	1 01	
	Quality review com	pleted on May 19, 2023			compliance with all state and		
					federal requirements governing		
					management of this facility. It is	S	
					thus submitted as a matter of		
					statue only. The facility		
					respectfully requests from the		
					department a desk review for		
					substantial compliance.		
D 0000		- 0.44 - 2					
R 0092	410 IAC 16.2-5-1.3						
	Administration and	d Management -					
Bldg. 00	Noncompliance						
	• •	t maintain a written fire and					
		ness plan to assure					
	continuity of care	of residents in cases of					
			<u> </u>				

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

(X6) DATE

Darlene Adair **Executive Director** 06/08/2023

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.

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 1 of 18

TITLE

PRINTED: 06/14/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	transmission of a fisimulation of emerexcept that the more residents to safe at the building is not conducted quarter familiarize all faciliand emergency acconditions. At least held every year. Whetween 9 p.m. ar announcement manufactor and emergency of the same of the personnel person	in facilities shall include the fire alarm signal and gency fire conditions, ovement of nonambulatory areas or to the exterior of required. Drills shall be ly on each shift to ty personnel with signals of the drills are conducted at twelve (12) drills shall be ly hen drills are conducted at 6 a.m., a coded at be used instead of lists (6) months, a facility old the fire and disaster drill at the local fire department. In hing and drills shall be the names and signatures resent. In and record review, the facility drills were conducted to a feet 116 do in the facility. In the facility. In the local fire department to affect 116 do in the facility. In the facility drills. A fire the fall/early winter of the see drywall dust caused the The fire department showed also conducted an in-service in	R 0092	Tag R 092/ Administration at Management What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; It is the practice of this facility hold fire drills at unexpected the All residents have the potentiable affected, however there was actual harm to any residents. How the facility will identify other residents having the potential to be affected by the same deficient practice awhat corrective action will be taken; The deficient practice had the	to imes all to as no

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 2 of 18

PRINTED: 06/14/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 05/11	
	PROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
	indicated the subject signatures.	n-In Sheet", dated 3/1/23, t was fire drills with staff		potential to affect all residing in the community above for corrective action. What measures will be polace or what systemic changes the facility will at to ensure that the deficie practice does not recur; The Fire Drill policy and procedures was reviewed. Director of Maintenance of 6, 2023. The Director of Maintenance created a so calendar as to which drills conducted. This calendar shared with ED and/or dewho will monitor monthly that drills occur per the so and in accordance with the regulations. How the corrective action will be monitored to ensure deficient practice will no recur, i.e., what quality assurance program will into place; The Director of Maintenar schedule and facilitate fire while the Executive Direct Designee will monitor that drills occur in accordance regulations. The Director of Maintenance will be responsible to the completing the drills, a process will be reviewed in for compliance by the Executive. By what date the system changes will be	see in. intinto make int by the in June heduled will be signee in ent o ensure hedule int int int int int int int in	

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	COMPLETED	
			B. WI	NG		05/11/2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 11570 E 126TH STREET FISHERS, IN 46037			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S DLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					completed.	
					Changes will be completed by 06/09/2023.	r:
R 0116	410 IAC 16.2-5-1.	, ,				
	Personnel - Nonco	•				
Bldg. 00	(a) Each facility sh	•				
	l •	and implemented for the				
		pective employees.				
		ies shall be made for byees. The facility shall have				
	a personnel policy that considers references					
	and any convictions in accordance with IC					
	16-28-13-3.					
				116	Tag R-116/ Personnel	06/09/2023
	Based on interview	and record review, the facility			· What corrective action	n(s)
		eening for newly hired			will be accomplished for tho	se
		onducting reference checks			residents found to have been	n
		files reviewed. ((Qualified			affected by the deficient	
		(MA) 2, QMA 3, and			practice;	
	Housekeeping Staff	(5))			·No residents were directly	4:
	Findings include:				impacted by the deficient prac Immediate corrective action for	
	Tindings include.				QMA #2: employee reference	
	The employee files	were reviewed on 5/11/23 at			checks have been completed	and
		QMA 3, and Housekeeping			added to the employee's	
	Staff 5 did not have	reference checks within their			personnel file. Immediate	
	files.				corrective action for QMA #3:	
					employee reference checks ha	ave
		cted with the Executive			been completed and added to	the
	` ''	/11/23 at 2:55 p.m., indicated			employee's personnel file.	
		ember new to the role of			Immediate corrective action fo	or
		vee files. There was no further			Housekeeping #5: employee	
	information in the employee files.				reference checks have been	
	A policy titled "Der	sonnel Files", undated, was			completed and added to the employee's personnel file.	
		N on 5/11/23 at 1:55 p.m. The			Administrative Assistant or	
	1 *	employee personnel file may			designee will audit employee	files
		n, two reference checks.			to ensure reference checks ha	
1	,				1	i

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2023
	ROVIDER OR SUPPLIER	ASSISTED LIVING	11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
				been completed on all emplor. How the facility will identify other residents have the potential to be affected the same deficient practice what corrective action will taken; All residents have the possible to be impacted by the deficient practice. What measures will be put into place or what systematice.	ving by and be collity ent
				changes the facility will ma to ensure that the deficient practice does not recur; Immediately corrected revie personnel files. Correct exist personnel files by auditing (** personnel files monthly for (6 months to ensure 100 perce compliance. This process wi	ewed ting 10) ten 6)
				continue monthly with all new hires for (6) months to ensur percent compliance. All new hired staff will have complete reference checks when onbowith the facility. How the corrective	e 100 vly ed parding
				action(s) will be monitored ensure the deficient practic will not recur, i.e., what qua assurance program will be into place; and Audit tool will be used to cor existing personnel files by at (10) ten personnel files moniensure 100 percent compliant All newly hired staff will have completed reference checks	ce Ality put rect uditing thly to nce.

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 5 of 18

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	COMPLETED 05/11/2023	
	PROVIDER OR SUPPLIER	ASSISTED LIVING	11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				onboarding with the facility. By what date the systemic changes will be completed. 06/09/2023	
R 0119		4(d)(1)(A-E)(2)(A-D)(3-			
Bldg. 00	Personnel - Nonco (d) Prior to working employee shall be facility by the supe designee) of the de employee will work employees shall in (1) Instructions on specialized popula (A) aged; (B) developmental (C) mentally ill; (D) dementia; or (E) children; served in the facilit (2) A review of the applicable procedu (A) organization of (B) personnel polic (C) appearance ar employees; and (D) residents' right (3) Instruction in fil procedures, and fil procedures, incl procedures. (4) Review of ethic confidentiality in re-	empliance g independently, each given an orientation to the given an orientation of her epartment in which the c. Orientation of all clude the following: the needs of the tions: ly disabled; dy. facility's policy manual and ures, including: hart; cies; had grooming policies for s. est aid, emergency re and disaster			
	each resident to w providing care.	in, the particular needs of hom the employee will be of the orientation in the			

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 6 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. W	ING		05/11/	/2023
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
		ASSISTED LIVING	11570 E 126TH STREET FISHERS, IN 46037				
LAKE ME	EADOWS SENIOR	ASSISTED FIVING		FISHER	33, IN 4003/		
(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	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	employee's persor	nnel record by the person					
	supervising the or						
			$\int \mathbf{R} 0$	119	Tag R-119/ Personnel		06/09/2023
	Based on interview	and record review, the facility			· What corrective action	(s)	
		cord of orientation was kept in			will be accomplished for tho		
		of newly hired employees for 3			residents found to have been		
	-	reviewed. ((Qualified			affected by the deficient		
		QMA) 2, QMA 3, and			practice;		
	Housekeeping Staff				No residents were directly		
		**			impacted by the deficient pract	tice.	
	Findings include:				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		
	J				Immediate corrective action for	r	
	The employee files were reviewed on 5/11/23 at				QMA #2: record of orientation		
		QMA 3, and Housekeeping			been completed and added to		
	_	a record of orientation within			employee's personnel file.		
	their files.				Immediate corrective action for	r	
					QMA #3: record of orientation		
	An interview condu	acted with the Executive			been completed and added to		
		/11/23 at 2:55 p.m., indicated			employee's personnel file.		
		ember new to the role of			Immediate corrective action for	r	
		vee files. There was no further			Housekeeping #5: record of		
	information in the e				orientation have been complete	ted	
					and added to the employee's		
	A policy titled "Per	sonnel Files", undated, was			personnel file. Administrative		
	provided by the DO	N on 5/11/23 at 1:55 p.m. The			Assistant or designee will aud	it	
		employee personnel file may			employee files to ensure reco		
	include record of or	rientation and continuing			orientation have been comple		
	education.	-			on all employees.		
]		
					· How the facility will		
					identify other residents havi	ng	
					the potential to be affected b	_	
					the same deficient practice a	-	
					what corrective action will be		
					taken;		
					All residents have the possibil	ity	
					to be impacted by the deficien	-	
					practice.		
					· What measures will be		
			1				i

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 7 of 18

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	OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				put into place or what system changes the facility will make to ensure that the deficient practice does not recur; Immediately corrected reviewed personnel files. Correct existing personnel files by auditing ten personnel files monthly for six months to ensure 100 percent compliance. This process will continue monthly with all new hires for six (6) months to ensure 100 percent completed orientation when onboarding with the facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place; and Audit tool will be used to correct existing personnel files by auditen (10) personnel files month ensure 100 percent compliance. All newly hired staff will have a completed record of orientation when onboarding with the facility. By what date the systemic changes will be completed. 06/09/2023	ed ed eg (10) (6) ty ut ect litting ly to ee. ea n
R 0120	410 IAC 16.2-5-1.4 Personnel - Nonco				
Bldg. 00	(e) There shall be education and train	an organized inservice ning program planned in rsonnel in all departments			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2023		
	PROVIDER OR SUPPLIE	R ASSISTED LIVING	11570	E 126TH STREET ERS, IN 46037	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	is not limited to, r and control of info safety, accident p specialized popu administration, an appropriate, as fo (1) The frequency education and tra accordance with the facility persor this shall include inservice per cale of inservice per	y and content of inservice ining programs shall be in the skills and knowledge of inel. For nursing personnel, at least eight (8) hours of endar year and four (4) hours alendar year for nonnursing the above required inservice have contact with residents mum of six (6) hours of a training within six (6) a (3) hours annually the needs or preferences, vely impaired residents gain understanding of the sof care for residents with			
	shall indicate the (A) The time, dat (B) The name of (C) The title of th (D) The names o (E) The program	e, and location. the instructor. e instructor. f the participants. content of inservice. Il acknowledge attendance			
	failed to ensure residementia training upon hire and cont	and record review, the facility ident rights, abuse, and was documented as provided inued thereafter for annual employee files reviewed.	R 0120	Tag R-120 / Personnel What corrective actio will be accomplished for the residents found to have bee affected by the deficient practice;	ose

State Form Event ID: Z2O811 Facility ID: 014910 If continuation sheet Page 9 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPL	ETED
			B. WING 05/			05/11/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF F	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
1 A125 NAS	A DOWN OF NIOD	ACCIOTED I IVINO			E 126TH STREET		
LAKE ME	EADOWS SENIOR	ASSISTED LIVING		FISHER	RS, IN 46037		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	((Qualified Medica	tion Aide (QMA) 2, QMA 3,			No residents were directly		
	QMA 4, Dementia	Care Coordinator, and			impacted by the deficient prac	tice.	
	Housekeeping Staft	f 5))			Immediate corrective action fo	r	
					QMA #2: resident rights, abus	e, or	
	Findings include:				dementia training have been		
					completed and added to the		
	The employee files	were reviewed on 5/11/23 at			employee's personnel file.		
	12:00 p.m. The foll	owing was noted:			Immediate corrective action fo	r	
					QMA #3: resident rights, abus	e, or	
	QMA 2 did not hav	re resident rights, abuse, or			dementia training have been		
	dementia training u	pon hire,			completed and added to the		
					employee's personnel file.		
	QMA 3 did not hav	re resident rights, abuse, or			Immediate corrective action fo	r	
	dementia training upon hire,			QMA #4 Dementia Care			
					Coordinator: resident rights,		
		re resident rights, abuse, or			abuse, or dementia training ha	ive	
	dementia training o	n an annual basis,			been completed and added to	the	
					employee's personnel file.		
		ordinator did not have resident			Immediate corrective action for	or	
	rights or abuse trair	ning on an annual basis, and			Housekeeping #5: resident rig	hts,	
					abuse, or dementia training ha		
		f 5 did not have resident rights,			been completed and added to	the	
	abuse, or dementia	training upon hire.			employee's personnel file.		
					Administrative Assistant or		
		acted with the Executive			designee will audit employee f		
		5/11/23 at 2:55 p.m., indicated			to ensure resident rights, abus		
		ember new to the role of			and dementia training have be		
		yee files. There was no further			completed on all employees. A		
	information in the e	employee files.			newly hired staff will have resid	dent	
					rights, abuse, and dementia		
		sonnel Files", undated, was			training completed when		
		ON on 5/11/23 at 1:55 p.m. The			onboarding with the facility.		
		e employee personnel file may			How the facility will		
		rientation and continuing			identify other residents havin	_	
	education.				the potential to be affected b		
					the same deficient practice a		
					what corrective action will be	•	
					taken;	£.	
					All residents have the possibili	-	
					to be impacted by the deficien	I	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2023
	ROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				practice.	
				what measures will be put into place or what syste changes the facility will make to ensure that the deficient practice does not recur; Immediately corrected review personnel files. Correct existing personnel files by auditing tempersonnel files monthly for six months to ensure 100 percent compliance. This process will continue monthly with all new hires for six (6) months to ensure 100 percent compliance. All newly hired staff will have restrights, abuse, and dementia training completed when onboarding with the facility. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be printo place; and Audit tool will be used to correction of the process of the process of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place; and audit tool will be used to correction of the place of the pla	mic see red ing in (10) ix (6) it sure sident the
				(10) ten personnel files month ensure 100 percent complian This process will continue mo	nly to ce.
				with all new hires for six (6) months to ensure 100 percen compliance. All newly hired swill have completed resident rights, abuse, or dementia tra	ining
				when onboarding with the factories. By what date the systemic changes will be	ility.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/11/2023
	PROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				completed. 06/09/2023	
R 0123	410 IAC 16.2-5-1. Personnel - Nonce				
Bldg. 00	(h) The facility shat accurate personned recincled the followi (1) The name and (2) Social Security (3) Date of beginn (4) Past employmeducation, if application, if application of completion, if a (6) Position in the (7) Documentation facility, including respecific job skills. (8) Signed acknown residents' rights. (9) Performance exith facility policy.	all maintain current and bel records for all employees. Cords for all employees shall ang: address of the employee. In number. Ing employment. Ing employment. Ing employment. Ing employment or registration assistant certificate or letter applicable. In facility and job description. In of orientation to the esidents' rights, and to the avelagement of orientation to			
	Based on interview failed to ensure emplicensure and/or cer at the facility. ((Qua 6)) Findings include: The employee files	and record review, the facility bloyee files contained a tification for 1 of 53 employees alified Medication Aide (QMA) were reviewed on 5/11/23 at	R 0123	Tag R-123 / Personnel What corrective action will be accomplished for thor residents found to have been affected by the deficient practice; No residents were directly impacted by the deficient pract Immediate corrective action for QMA #6: QMA was terminated	se n tice.
	12:00 p.m. QMA 6 certification/licensu 11/5/2021.	did not have a re. QMA 6's hire date was		All newly hired staff will have resident rights, abuse, and dementia training completed v	vhen

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023				
NAME OF PROVIDER OR SUPPLIER LAKE MEADOWS SENIOR ASSISTED LIVING			11570	STREET ADDRESS, CITY, STATE, ZIP COD 11570 E 126TH STREET FISHERS, IN 46037				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	An interview condu Nursing (DON), on QMA 6 has a licens in the process of scl Indiana license/cert A policy titled "Per- provided by the DO policy indicated the	cted with the Director of 5/11/23 at 1:30 p.m., indicated e in another state. QMA 6 was neduling to take a test for the iffication for a QMA. sonnel Files", undated, was an on 5/11/23 at 1:55 p.m. The employee personnel file may not or certificates, if	TAG	onboarding with the facility How the facility will identify other residents hav the potential to be affected the same deficient practice what corrective action will be taken; All residents have the possibit to be impacted by the deficient practice. What measures will be put into place or what syste changes the facility will malt to ensure that the deficient practice does not recur; Immediately corrected review personnel files. Correct existit personnel files by auditing telepersonnel files monthly for six months to ensure 100 percer compliance. This process will continue monthly with all new hires for six (6) months to ensure 100 percent compliance. All reflicted staff will have license/certification complete when onboarding. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quall assurance program will be printo place; and Audit tool will be used to corrective action (10) personnel files month ensure 100 percent compliant. This process will continue month in the process will be process will be process.	ing by and be dility int e mic ke red ng n (10) k (6) bt l r sure newly d d to e litty but ect diting nly to ce.			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2023
	ROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
R 0187 Bldg. 00	410 IAC 16.2-5-1. Physical Plant Sta (k) Hot water temphand washing faci an automatic cont temperature at pomaintained betweed degrees Fahrenhee (120) degrees Fahrenhee (120) degrees Fahrenhee (120) degrees Fahrenhee (120) degrees and 120 degrees and 121 degrees in 1230 p.m. The followed: Resident 4's room and 122.1 degrees in Room 119 (vacant resident, 125 degrees in Room 119 degrees in Room 119 (vacant resident, 125 degrees in Room 119 d	of (k) Indards - Deficiency Derature for all bathing and lities shall be controlled by rol valve. Water Sint of use must be een one hundred (100) Selt and one hundred twenty Derenheit. On, interview, and record failed to ensure water Derensal to the facility. Derensult of the facility of the facility. Derensult of the facility of the facility. Derensult of the facility of the	R 0187	with all new hires for six (6) months to ensure 100 percer compliance. All newly hired swill have completed license/certification when onboarding with the facility. By what date the systemic changes will be completed. 06/09/2023 Tag R-187 / Physical Plant Standards What corrective actio will be accomplished for the residents found to have bee affected by the deficient practice; No residents were directly impacted by the deficient pra An immediate site visit from a contracted vendor for an on-sinspection of our hot water he system was performed. The facilities contracted vendor inspected the hot water system and temperature. The contracted vendor found the Water Pum vendor found the Water Pum	of total and tot
		- 127 degrees in the kitchen, n - 126.6 degrees in the kitchen,		malfunctioning/stopped worki and therefore needed to be replaced and was not mainta	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 B. WING		COMPLETED 05/11/2023				
NAME OF PROVIDER OR SUPPLIER LAKE MEADOWS SENIOR ASSISTED LIVING			11570	STREET ADDRESS, CITY, STATE, ZIP COD 11570 E 126TH STREET FISHERS, IN 46037				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	An interview condu Director, on 5/11/23 water heater was set it's been on that sett as the Maintenance adjusted the valve s wasn't making a dif- temperatures. So, he and the valve was th	cted with the Maintenance 3 at 11:54 a.m., indicated the t on 128 degrees. He believed ing since he's been employed Director for over a year. He etting to 120 degrees and that ference in the water te turned down the water heater nen reading at 119 degrees. es to complaint IN00407732.		the correct temperature in the resident's apartments. The howater pump was replaced, the temperature was set and controlled. How the facility will identify other residents havithe potential to be affected by the same deficient practice awhat corrective action will be taken; All residents have the possibil to be impacted by the deficient practice. The facility will perform an audithe resident apartments in variants of the building. What measures will be put into place or what system changes the facility will make to ensure that the deficient practice does not recur; Audit tool Hot Water Heater Temperature Log will be used ensure deficient practice does recur. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be proposed in the proposed in the facilities resided apartments to ensure hot water temperature daily for five (5) or designee, will audit ten (10) percent of the facilities resided apartments to ensure hot water temperature daily for five (5) or designee, will audit for five (5) or designee, will addit for five (5) or designee, will audit for five (5) or designee.	ng py and e ity it dit of rious e to s not o e ity ut			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2023	
	ROVIDER OR SUPPLIER		11570	ADDRESS, CITY, STATE, ZIP COD E 126TH STREET RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				then one (1) time weekly for the following four (4) weeks, and (1) time monthly to ensure the water temperature stays at an acceptable temperature per IS guidelines. By what date the systemic changes will be completed. 06/09/2023	one hot
R 0273	(f) All food prepara (excluding areas in maintained in acco local sanitation an standards, includin Based on observation review, the facility of storage related to probatining food temperature. This had the residents that reside Findings include: 1. A kitchen tour wa a.m. The main refrightat contained the for top rack consisting second rack consisting second rack consisting found beef with pa with a red substance fourth rack consisting	anal Services - Deficiency attion and serving areas in residents ' units) are ordance with state and d safe food handling ing 410 IAC 7-24. In the interview, and record failed to ensure adequate food oper thawing of food and operatures prior to serving potential to affect all 116 in the facility. In the facility. In the facility is as conducted on 5/9/23 at 10:45 gerator was noted with a rack following: In the facility is got a large package of the per underneath that was wet as underneath, sing of a large, packaged	R 0273	Tag R-273 / Food and Nutritional Services What corrective action will be accomplished for tho residents found to have beer affected by the deficient practice; No residents were directly impacted by the deficient pract In-Service completed by Exect Director with new Culinary Manager and all other kitchen staff. In service topics will incl proper food thawing, and food temping. All new hires in the culinary department will be trained on these topics upon onboarding How the facility will identify other residents havi	se n extice. eutive uded
		nderneath that was wet with a		the potential to be affected by	-

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STATEMENT OF DEFICIENCIES 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. WING			05/11/2023	
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
1 A 1/E NA		A COLOTED LIVING			E 126TH STREET		
LAKE ME	EADOWS SENIOR	ASSISTED LIVING		FISHER	RS, IN 46037		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	red substance, &				the same deficient practice a	nd	
	- fifth rack consisting	ng of a large, packaged turkey			what corrective action will be)	
	with paper underne	ath that was wet with a red		taken;			
	substance.				All residents have the possibili	ty	
					to be impacted by the deficient		
	The paper on all 5 s	shelves indicated the food was			practice.		
	pulled from the free	ezer on 5/4/23.					
					· What measures will be		
	An interview condu	acted with the Dietary		put into place or what syst		nic	
	Manager, on 5/9/23	at 10:55 a.m., indicated all food			changes the facility will make	e	
	_	e freezer on 5/4/23. The turkey			to ensure that the deficient		
		or the following day, 5/10/23,			practice does not recur;		
	and the food can be stored up to a week after				Audit tool Food Temperature L	_og	
	pulled from the freezer.				will be used to ensure deficien	t	
					practice does not recur.		
	A policy titled "thawing food", undated, was						
	provided by the Executive Director (ED) on				· How the corrective		
	5/10/23 at 10:42 a.m. The policy indicated the				action(s) will be monitored to		
	following, "Food that is frozen should be				ensure the deficient practice		
		anner as to prevent the			will not recur, i.e., what quality		
	temperature of the food from rising above 41 degrees Fahrenheit1. Under refrigerationa.				assurance program will be p	ut	
					into place; and		
		will be placed in the					
	_	o, or three days before it is			The Culinary Manager, or		
		o be thawed at 41 degrees or			designee, will audit thawing fo	od.	
	^	f timeb. Meats to be thawed			The Culinary Manager, or		
	_	he lowest shelf in the			designee, will audit Food		
		ent contamination of other			Temperature Log two (2) times		
	foods with meat jui	ces"			day for one (1) week, then one		
	2 4 4 1 1 1 1				times a day for one (1) week, t		
	2. Another kitchen observation was conducted on			two (2) times per week for two (2)			
	5/9/23 at 11:50 a.m. The temperature log was			months to ensure 100 percent			
	reviewed for food temperatures and the following date(s)/meals did not have documentation of food temperatures being obtained prior to meal service:				compliance.		
					Distributed data disa		
					By what date the		
	5/2/22 for dinns:				systemic changes will be		
	5/3/23 for dinner, 5/5/23 for breakfast	and lunch			completed.		
		· · · · · · · · · · · · · · · · · · ·			06/09/2023		
	5/6/23 for breakfast and dinner,						
5/7/23 for breakfast,							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2023		
NAME OF PROVIDER OR SUPPLIER LAKE MEADOWS SENIOR ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP COD 11570 E 126TH STREET FISHERS, IN 46037				
(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 APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	5/8/23 for breakfast, & 5/9/23 for breakfast. A policy titled "FOOD TEMPERATURES", revised 3/19/2020, was provided by the ED on 5/10/23 at 10:42 a.m. The policy indicated the following, "PolicyFoods should be served at proper temperatures to insure food safety and palatability6. If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution10. Maintain food temperature records from survey to survey (1 year) or in accordance to state regulations"						

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