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	05/11/2023

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 a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00399914 and IN00407732. Complaint IN00399914 - No deficiencies related to the allegations are cited. Complaint IN00407732 - State deficiencies related to the allegations are cited at R0187. Unrelated deficiencies cited Survey dates: May 9, 10, and 11, 2023 Facility number: 014910 Residential Census: 116 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 19, 2023	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 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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	emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were conducted monthly. This had the potential to affect 116 residents that resided in the facility. Findings include: An interview conducted with the Maintenance Director, on 5/10/23 at 2:07 p.m., indicated he wasn't sure on how to conduct fire drills. A fire alarm went off in late fall/early winter of the previous year because drywall dust caused the fire alarm to go off. The fire department showed up at that time. He also conducted an in-service in March of 2023 regarding fire drills. There was no documentation about the fire department coming out to the facility in late	R 0092	**Tag R 092/ Administration and Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** It is the practice of this facility to hold fire drills at unexpected times All residents have the potential to be affected, however there was no actual harm to any residents. **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;** The deficient practice had the	06/09/2023

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	fall/early winter of 2022. An "In-Service Sign-In Sheet", dated 3/1/23, indicated the subject was fire drills with staff signatures. There was no further documentation to reflect fire drills being conducted.		potential to affect all residents residing in the community. See above for corrective action. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Fire Drill policy and procedures was reviewed by the Director of Maintenance on June 6, 2023. The Director of Maintenance created a scheduled calendar as to which drills will be conducted. This calendar will be shared with ED and/or designee who will monitor monthly to ensure that drills occur per the schedule and in accordance with the regulations. **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;** The Director of Maintenance will schedule and facilitate fire drills while the Executive Director or Designee will monitor that fire drills occur in accordance with the regulations. The Director of Maintenance will be responsible for completing the drills, and the process will be reviewed monthly for compliance by the Executive Director. **By what date the systemic changes will be**	

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			completed. Changes will be completed by: 06/09/2023.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on interview and record review, the facility failed to ensure screening for newly hired employees by not conducting reference checks for 3 of 5 employee files reviewed. ((Qualified Medication Aide (QMA) 2, QMA 3, and Housekeeping Staff 5)) Findings include: The employee files were reviewed on 5/11/23 at 12:00 p.m. QMA 2, QMA 3, and Housekeeping Staff 5 did not have reference checks within their files. An interview conducted with the Executive Director (ED), on 5/11/23 at 2:55 p.m., indicated there was a staff member new to the role of maintaining employee files. There was no further information in the employee files. A policy titled "Personnel Files", undated, was provided by the DON on 5/11/23 at 1:55 p.m. The policy indicated the employee personnel file may include, at minimum, two reference checks.	R 0116	**Tag R-116/ Personnel** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** ·No residents were directly impacted by the deficient practice. Immediate corrective action for QMA #2: employee reference checks have been completed and added to the employee's personnel file. Immediate corrective action for QMA #3: employee reference checks have been completed and added to the employee's personnel file. Immediate corrective action for Housekeeping #5: employee reference checks have been completed and added to the employee's personnel file. Administrative Assistant or designee will audit employee files to ensure reference checks have	06/09/2023

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			been completed on all employees. · **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;** All residents have the possibility to be impacted by the deficient practice. · **What measures will be put into place or what systemic 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 (10) ten personnel files monthly for (6) months to ensure 100 percent compliance. This process will continue monthly with all new hires for (6) months to ensure 100 percent compliance. All newly hired staff will have completed reference checks 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 put into place; and** Audit tool will be used to correct existing personnel files by auditing (10) ten personnel files monthly to ensure 100 percent compliance. All newly hired staff will have completed reference checks when	

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			onboarding with the facility. · **By what date the systemic changes will be completed.** 06/09/2023	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the			

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	employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to ensure a record of orientation was kept in the personnel files of newly hired employees for 3 of 5 employee files reviewed. ((Qualified Medication Aide (QMA) 2, QMA 3, and Housekeeping Staff 5)) Findings include: The employee files were reviewed on 5/11/23 at 12:00 p.m. QMA 2, QMA 3, and Housekeeping Staff 5 did not have a record of orientation within their files. An interview conducted with the Executive Director (ED), on 5/11/23 at 2:55 p.m., indicated there was a staff member new to the role of maintaining employee files. There was no further information in the employee files. A policy titled "Personnel Files", undated, was provided by the DON on 5/11/23 at 1:55 p.m. The policy indicated the employee personnel file may include record of orientation and continuing education.	R 0119	**Tag R-119/ Personnel** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were directly impacted by the deficient practice. Immediate corrective action for QMA #2: record of orientation have been completed and added to the employee's personnel file. Immediate corrective action for QMA #3: record of orientation have been completed and added to the employee's personnel file. Immediate corrective action for Housekeeping #5: record of orientation have been completed and added to the employee's personnel file. Administrative Assistant or designee will audit employee files to ensure record of orientation have been completed on all employees. · **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;** All residents have the possibility to be impacted by the deficient practice. · **What measures will be**	06/09/2023

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			put into place or what systemic 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 (10) personnel files monthly for six (6) 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 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 put into place; and** Audit tool will be used to correct existing personnel files by auditing ten (10) personnel files monthly to 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	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments			

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	at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure resident rights, abuse, and dementia training was documented as provided upon hire and continued thereafter for annual training for 5 of 5 employee files reviewed.	R 0120	**Tag R-120 / Personnel** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**;	06/09/2023

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	((Qualified Medication Aide (QMA) 2, QMA 3, QMA 4, Dementia Care Coordinator, and Housekeeping Staff 5)) Findings include: The employee files were reviewed on 5/11/23 at 12:00 p.m. The following was noted: QMA 2 did not have resident rights, abuse, or dementia training upon hire, QMA 3 did not have resident rights, abuse, or dementia training upon hire, QMA 4 did not have resident rights, abuse, or dementia training on an annual basis, Dementia Care Coordinator did not have resident rights or abuse training on an annual basis, and Housekeeping Staff 5 did not have resident rights, abuse, or dementia training upon hire. An interview conducted with the Executive Director (ED), on 5/11/23 at 2:55 p.m., indicated there was a staff member new to the role of maintaining employee files. There was no further information in the employee files. A policy titled "Personnel Files", undated, was provided by the DON on 5/11/23 at 1:55 p.m. The policy indicated the employee personnel file may include record of orientation and continuing education.		No residents were directly impacted by the deficient practice. Immediate corrective action for QMA #2: resident rights, abuse, or dementia training have been completed and added to the employee's personnel file. Immediate corrective action for QMA #3: resident rights, abuse, or dementia training have been completed and added to the employee's personnel file. Immediate corrective action for QMA #4 Dementia Care Coordinator: resident rights, abuse, or dementia training have been completed and added to the employee's personnel file. Immediate corrective action for Housekeeping #5: resident rights, abuse, or dementia training have been completed and added to the employee's personnel file. Administrative Assistant or designee will audit employee files to ensure resident rights, abuse, and dementia training have been completed on all employees. All newly hired staff will have resident rights, abuse, and dementia training completed when onboarding with the facility. · **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;** All residents have the possibility to be impacted by the deficient	

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			practice. · **What measures will be put into place or what systemic 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 (10) personnel files monthly for six (6) 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 resident rights, abuse, and dementia training completed 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 put into place; and** Audit tool will be used to correct existing personnel files by auditing (10) ten personnel files monthly 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 completed resident rights, abuse, or dementia training when onboarding with the facility. · **By what date the systemic changes will be**	

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			completed. 06/09/2023	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on interview and record review, the facility failed to ensure employee files contained a licensure and/or certification for 1 of 53 employees at the facility. ((Qualified Medication Aide (QMA) 6)) Findings include: The employee files were reviewed on 5/11/23 at 12:00 p.m. QMA 6 did not have a certification/licensure. QMA 6's hire date was 11/5/2021.	R 0123	**Tag R-123 / Personnel** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were directly impacted by the deficient practice. Immediate corrective action for QMA #6: QMA was terminated. All newly hired staff will have resident rights, abuse, and dementia training completed when	06/09/2023

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	An interview conducted with the Director of Nursing (DON), on 5/11/23 at 1:30 p.m., indicated QMA 6 has a license in another state. QMA 6 was in the process of scheduling to take a test for the Indiana license/certification for a QMA. A policy titled "Personnel Files", undated, was provided by the DON on 5/11/23 at 1:55 p.m. The policy indicated the employee personnel file may include copy of license or certificates, if applicable.		onboarding with the facility · **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;** All residents have the possibility to be impacted by the deficient practice. · **What measures will be put into place or what systemic 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 (10) personnel files monthly for six (6) 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 license/certification completed when onboarding. · **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** Audit tool will be used to correct existing personnel files by auditing ten (10) personnel files monthly to ensure 100 percent compliance. This process will continue monthly	

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			with all new hires for six (6) months to ensure 100 percent compliance. All newly hired staff will have completed license/certification when onboarding with the facility. · **By what date the systemic changes will be completed**. 06/09/2023	
R 0187 Bldg. 00	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. Based on observation, interview, and record review, the facility failed to ensure water temperatures were maintained between 100 degrees and 120 degrees. This had the potential to affect all 116 residents that reside in the facility. Findings include: An environmental tour was conducted on 5/10/23 at 2:30 p.m. The following temperatures were noted: Resident 4's room - 121.4 degrees in the kitchen and 122.1 degrees in the bathroom, Room 119 (vacant room) - 124.5 degrees in the kitchen, Resident 39's room - 127 degrees in the kitchen, Resident 108's room - 126.6 degrees in the kitchen, &	R 0187	**Tag R-187 / Physical Plant Standards** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were directly impacted by the deficient practice. An immediate site visit from our contracted vendor for an on-site inspection of our hot water heater system was performed. The facilities contracted vendor inspected the hot water system and temperature. The contracted vendor found the Water Pump was malfunctioning/stopped working and therefore needed to be replaced and was not maintaining	06/09/2023

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		A. BUILDING 00 B. WING	05/11/2023

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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	Room 266 (vacant room) - 128 degrees in the kitchen. An interview conducted with the Maintenance Director, on 5/11/23 at 11:54 a.m., indicated the water heater was set on 128 degrees. He believed it's been on that setting since he's been employed as the Maintenance Director for over a year. He adjusted the valve setting to 120 degrees and that wasn't making a difference in the water temperatures. So, he turned down the water heater and the valve was then reading at 119 degrees. This State Tag relates to complaint IN00407732.		the correct temperature in the resident's apartments. The hot water pump was replaced, the temperature was set and controlled. · **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;** All residents have the possibility to be impacted by the deficient practice. The facility will perform an audit of the resident apartments in various parts of the building. · **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Audit tool Hot Water Heater Temperature Log will be used to ensure deficient practice does not 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 put into place; and** The Maintenance Director, or designee, will audit ten (10) percent of the facilities resident apartments to ensure hot water temperature daily for five (5) days,	

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			then one (1) time weekly for the following four (4) weeks, and one (1) time monthly to ensure the hot water temperature stays at an acceptable temperature per ISDH guidelines. · **By what date the systemic changes will be completed.** 06/09/2023	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure adequate food storage related to proper thawing of food and obtaining food temperatures prior to serving meals. This had the potential to affect all 116 residents that reside in the facility. Findings include: 1. A kitchen tour was conducted on 5/9/23 at 10:45 a.m. The main refrigerator was noted with a rack that contained the following: - top rack consisting of a large package of beef, - second rack consisting of a large package of beef, - third rack consisting of a large package of ground beef with paper underneath that was wet with a red substance underneath, - fourth rack consisting of a large, packaged turkey with paper underneath that was wet with a	R 0273	**Tag R-273 / Food and Nutritional Services** · **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were directly impacted by the deficient practice. In-Service completed by Executive Director with new Culinary Manager and all other kitchen staff. In service topics will included 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 having the potential to be affected by**	06/09/2023

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	red substance, & - fifth rack consisting of a large, packaged turkey with paper underneath that was wet with a red substance. The paper on all 5 shelves indicated the food was pulled from the freezer on 5/4/23. An interview conducted with the Dietary Manager, on 5/9/23 at 10:55 a.m., indicated all food was pulled from the freezer on 5/4/23. The turkey was for the menu for the following day, 5/10/23, and the food can be stored up to a week after pulled from the freezer. A policy titled "thawing food", undated, was provided by the Executive Director (ED) on 5/10/23 at 10:42 a.m. The policy indicated the following, "...Food that is frozen should be thawed in such a manner as to prevent the temperature of the food from rising above 41 degrees Fahrenheit...1. Under refrigeration...a. Food to be thawed will be placed in the refrigerator one, two, or three days before it is needed to allow it to be thawed at 41 degrees or less over a period of time...b. Meats to be thawed must be placed on the lowest shelf in the refrigerator to prevent contamination of other foods with meat juices...." 2. Another kitchen observation was conducted on 5/9/23 at 11:50 a.m. The temperature log was reviewed for food temperatures and the following date(s)/meals did not have documentation of food temperatures being obtained prior to meal service: 5/3/23 for dinner, 5/5/23 for breakfast and lunch, 5/6/23 for breakfast and dinner, 5/7/23 for breakfast,		**the same deficient practice and what corrective action will be taken;** All residents have the possibility to be impacted by the deficient practice. · **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Audit tool Food Temperature Log will be used to ensure deficient practice does not 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 put into place; and** The Culinary Manager, or designee, will audit thawing food. The Culinary Manager, or designee, will audit Food Temperature Log two (2) times a day for one (1) week, then one (1) times a day for one (1) week, then two (2) times per week for two (2) months to ensure 100 percent compliance. · **By what date the systemic changes will be completed**. 06/09/2023	

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	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, "...Policy...Foods should be served at proper temperatures to insure food safety and palatability...6. If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution...10. Maintain food temperature records from survey to survey (1 year) or in accordance to state regulations...."			