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	05/07/2025

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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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00458721, IN00449071, and IN00456759. Complaint IN00449071 - State deficiencies related to the allegation(s) are cited at R0052. Complaint IN00458721 - State deficiencies related to the allegation(s) are cited at R0052. Complaint IN00456759 - No deficiencies related to the allegation(s) are cited. Survey Dates: May 5, 6, and 7, 2025 Facility Number: 014910 Facility Census: 111 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 15, 2025.	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 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on observation, interview, and record review, the facility failed to ensure residents were	R 0052	**Tag: R -52 Residents' Rights** 1 What corrective action(s) will	05/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Darlene Adair | Executive Director | 05/23/2025

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	free from abuse for 2 of 4 residents reviewed for abuse (Residents G and L). This deficient practice resulted in Resident G being physically assaulted and fearful of Resident B. Findings include: The clinical record for Resident B was reviewed on 5/6/25 at 12:58 p.m. His diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, depression, insomnia, and anxiety. Resident B's 3/15/25's BIMS (brief interview for mental status) indicated he was severely cognitively impaired. Resident B's 3/15/25 Level of Care assessment indicated "....4. Adaptation to Change: Needs daily support and reassurance when change is discussed, when decisions are being made, and while changes are being implemented. 5. Judgement: Decisions are poor, requiring cueing and supervision in planning, organizing and correcting daily routines. 6. Memory: Dementia Diagnosis and/or significant memory loss combined with behaviors, such as wandering." Resident B's 3/15/25 Wandering Risk Assessment indicated he was forgetful/had a short attention span, was combative/severely agitated, independent with mobility, and was a moderate risk for wandering. Resident B's physician's orders indicated he was on 25 milligrams (mg) of Seroquel (antipsychotic medication) daily at bedtime related to alcohol dependence with alcohol induced persisting dementia, starting 12/19/24.		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 physical altercation, Resident G and Resident B were separated. Resident G was offered medical assistants. Resident B was placed on every 15min checks for 48hours to ensure the safety of other residents in the community. Resident L and Resident B were monitored for 48 hours to ensure safety. Lake Meadows facility will inform residents twice a year during resident council on when, how and to whom to report allegations 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. An investigation was conducted; no other residents were identified as affected by the alleged deficient practice.	

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	Resident B's service plan, revised 8/23/24, indicated a focus of a behavioral problem related to psychiatric/behavior illness. He had behaviors weekly, was aggressive, demanding, and argued with staff. An intervention was to observe and monitor behavioral expression episodes and attempt to determine an underlying cause. Consider time of day, people involved, possible triggers and situations, aggressive, demanding and arguing with staff on duty. A 4/23/25 facility incident report was provided by the ED (Executive Director) on 5/5/25 at 2:28 p.m. It indicated Resident G ran into Resident B with his power chair. Resident B hit Resident G with his forearm. Resident G had a bloody nose, and Resident B had no injuries. The clinical record for Resident G was reviewed on 5/6/25 at 10:51 a.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, and type 2 diabetes mellitus. Resident G's 4/21/25 BIMS indicated he was cognitively intact. An interview was conducted with Resident G on 5/6/25 at 11:23 a.m. He indicated he'd lived in the facility for about two years now. He was "attacked" by Resident B two weeks ago. Almost every day, including that day two weeks ago on 4/23/25, Resident B asked him if he could "get a bump" of alcohol. Resident B was cognitively impaired, so "every day is a new day for him." Resident B's family told Resident G to not give him any alcohol, because it could kill him, so Resident G told Resident B no. Resident B then threatened to kill him, as he did "almost every day, but I like the guy." Resident B physically attacked him, was ranting and raving about Resident G not		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 Elder Abuse with types of abuse noted. All staff will ensure residents' safety and report any type of abuse to the supervisors immediately. 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 Executive Director or designee will interview 5 residents and interview 3 staff members to ensure Lake Meadows Elder Abuse Policy is upheld and residents are free from abuse. The interviews will occur weekly for (4) four weeks, biweekly for (1) one month, then (1) once a month for (2) two months. B By what date the systemic changes will be completed. Compliance Date: May 23, 2025	

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	giving him any alcohol. This occurred in the hallway, right outside of his room. Resident B was a couple of feet away from Resident G's power wheelchair, when Resident G jerked and his wheelchair hit the back of Resident B's heel. Resident B raised his fist to him, and "whams me in the face." Resident B took his forearm and hit Resident G across the nose and mouth. Resident G had blood gushing out of his nose. Then Resident B hit Resident G across the throat and applied pressure with his forearm across his throat. Resident B shoved Resident G so hard, that his power wheelchair, with Resident G in it, flipped completely backwards. Resident J, who lived across the hall, came out of his room and saw the end of it, when Resident G was on the ground with his power wheelchair on top of him, and blood rolling down his face. Resident B was still standing over him, saying 'I'll kill you.' Resident G thought Resident J called 911, because the police, fire department, and paramedics all came to the facility. Resident G informed the police he wanted Resident B arrested, but they didn't arrest him. There were cameras in the hallway, but staff informed him they didn't record. Resident J was the only one who saw any part of it. Resident G indicated he did not hit Resident B "or anything. Just went past him and accidentally clipped his heel. I didn't do it on purpose. I would never intentionally brand anyone." An interview was conducted with Resident J in his room, across the hall from Resident G's room, on 5/6/25 at 12:05 p.m. He indicated some guy flipped over another guy in his wheelchair in the hallway a couple of weeks ago. All Resident J saw was Resident B "with mental issues" standing over Resident G. Resident G had blood on his nose.			

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	The investigative file into the 4/23/25 altercation involving Resident G and Resident B was provided by the ED (Executive Director) on 5/5/25 at 2:28 p.m. The file included the 4/23/25 facility incident report, LPN (Licensed Practical Nurse) 5's written statement, and CNA (Certified Nurse Aide) 3's written statement. CNA 3's written statement indicated, on April 23, 2025, at 10:00 p.m., Resident J pushed his call light a little after 10:00 p.m. Upon approaching Resident J's room, CNA 3 observed Resident G on the ground by the door with his electric chair toppled over. Resident B was sitting on the bench beside Resident G, yelling at and mocking Resident G. Resident G said he accidentally ran into Resident B's leg and that's how the altercation started. Resident B had an open area on his lower left calf/ankle area. Resident B said after Resident G ran into him, he punched Resident G in the face and that's how the resident and his wheelchair got toppled. Resident G was bleeding from his nose and crying. While waiting for the nurse to arrive, Resident B kept laughing at Resident G. After both residents went back to their rooms, Resident B said he was going to keep watch from his doorway, so he could "jump" Resident G again. Upon leaving for the shift, Resident B was sitting back on the same bench he was on earlier. CNA 3 waited and distracted Resident B until the police arrived and stayed in the hallway until the end of her shift. LPN 5's written statement indicated, on 4/23/25 at 9:45 p.m., a CNA called for help on the walkie talkie, saying Resident G was on the floor. LPN 5 went to check on Resident G. When LPN 5 reached Resident G, he was on the floor, and his electric scooter was upside down. Resident G stated Resident B hit him and held his neck with			

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	his forearm and choked him. Resident G was already on the phone with 911. LPN 5 took over the call and explained the situation. They stated police and ambulance were on the way. Resident B was sitting on the chair close to Resident G, and they were arguing with each other in the hallway by another resident's room. Resident B stated he was hit first by Resident G's scooter and had a scratch on his ankle. LPN 5 and other staff separated both residents. The police and EMS (emergency medical services) team came and took both residents' statements. Resident G was bleeding from his nose, and he refused to go to the hospital. Resident G was talking aggressively and wanted Resident B to be arrested. Police took both residents' statements separately, and the EMS team left, since Resident G refused to go to the hospital. Resident G was mad about Resident B not getting arrested. Resident B's 4/24/25 at 10:54 p.m. progress note indicated "Writer was asked to go up and check residents left foot this morning." Resident G stated this morning that he hit Resident B's foot last evening with his scooter. Resident B's left and right foot and ankle areas were checked for signs of discoloration, swelling and pain. None was seen, and no complaints of discomfort or pain were voiced by Resident B. Resident B stated that he did not remember anything about an incident that happened in the hallway last evening. An interview was conducted with the ED on 5/7/25 at 10:46 a.m. She indicated Resident B probably was asking for alcohol. She believed Resident G hit Resident B with his wheelchair, but not intentionally, and Resident B in turn, reacted. During an interview with Resident G on 5/6/25 at 11:23 a.m., he indicated he feared Resident G now,			

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	and "the women are definitely scared of him." Resident B exposed himself to Resident L about four months ago in her room. Resident L turned around, and Resident B's pants were down to his knees. Resident L never told anyone, because she was afraid she'd get in trouble. Resident B was "ranting and raving" in the hallway on Easter, 4/20/25, putting his arm around female residents. Resident G called Resident B's family, on 4/20/25, and they said they would come to the facility, but they never came. Staff intervened and tried to calm him down. The 5/7/25 typed Investigation into Resident L's allegation that Resident B exposed himself to her was provided by the ED on 5/7/25 at 1:30 p.m. It indicated the ED and nurse on duty went to Resident L's room to talk about the incident involving Resident B exposing himself to her. Resident L stated she put her new scooter together, around 11/15/24, and invited Resident G down to her room to look at her scooter, as Resident G had the same scooter. Resident B followed Resident G down to Resident L's room. After Resident G looked at the scooter, he left Resident L's room. Resident B was still in Resident L's room at this time. Resident L went out to the hallway to retrieve her walker. When entering back into her room, Resident B was standing in her doorway with his penis in his hand. Resident B stated, "They have done it before." Resident L told Resident B it was time for him to leave her room, at which time Resident B left Resident L's room without further incident. The ED asked Resident L why she did not report the incident to anyone. Resident L indicated she didn't feel safe to tell anyone at the time. Resident B's 4/25/25 psychiatric note indicated, "[Name of Resident B] is being seen today for a			

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	follow up to mood and behavior. I met the [name of Resident B] today in the hallway. He had resident-to-resident altercation. States that 'I don't remember what to do, what happened but I feel like he is trying to control me and he is the same guy who hurt my leg the other day.' Today, he shared how agitated and irritated he was about that resident who has been trying to control him. He reports that 'my memory is bad and I cannot tell you what has been going on around.' He denies suicidal or homicidal ideations. Collaborated with the patients POA [power of attorney] to discuss the plan of care and she reports that the other resident is following [name of Resident B] all around the facility and tell him what to do and sometimes intentionally bump into him which causes altercation between both of them. We discussed today about moving [name of Resident B] to the memory care unit for resident safety. Patient's POA is looking into an alternative facility with the facility assistance....Moods: aggressive. Thought process: tangential. Affect: anxious and agitated....Insight: poor. Judgement: poor...Assessment: ...Dementia, mild with behavioral disturbances." An interview was conducted with the Interim DON (Director of Nursing) and ED on 5/6/25 at 1:18 p.m. The Interim DON indicated they were trying to find alternative placement for Resident B. The ED indicated they issued a 30-day discharge notice back in the fall of 2024 for financial reasons and because he wandered and was at risk for elopement. Resident B got out of the front door once, but staff followed him and stayed with him to ensure he was safe. Resident B's family came in the evenings almost daily, through the sundown process mainly, and provided him with one on one attention. Resident B received psych services, but his family would not allow his medications to be			

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	adjusted, which was the main reason he was being denied admission by multiple facilities. He currently received Seroquel daily, that started back in December 2024, because he grabbed a staff member and moved her out of the way. Resident B was argumentative, aggressive at times, and came off as aggressive to people. Some residents expressed they feared him, because he came to their door at 5:00 a.m. It kind of made them nervous. Resident M expressed they feared him, as well as Resident N, just that he wandered onto the second floor, and staff have to come get him, and redirect him to his room. The ombudsman was involved as well. They assisted Resident B's family the best they could, but the family was very selective of where he went. "We recommend SNF [skilled nursing facility]", but family wanted assisted living. He'd already been turned down by several assisted living facilities. The ED stated, "I do and don't feel like he's safe." He was not exit seeking at this time, and he hadn't been for a while. As far as other residents fearing him, the facility was their home and environment. She just asked for them to keep their distance. It was hard, because Resident B had dementia. His dementia progressed significantly in the past six months. The courts denied discharge, so the facility just tried to really work with the family. Resident B was observed on 5/7/25 at 1:04 p.m. walking down the hallway, near the dining room, looking into a private dining room. He often sat in a chair near the receptionist desk in the front lobby. The Abuse, Neglect, and Misappropriation Policy and Procedure was provided by the ED on 5/7/25 at 1:30 p.m. It indicated "Each resident has the right to be free from abuse, corporal punishment, mistreatment, and involuntary seclusion.			

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	Residents 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, friends, or other individuals. Policy: Residents have the right to be free from physical, verbal, sexual, mental abuse, misappropriation of property, corporal punishment, and involuntary seclusion. Definitions: Abuse the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish....Physical Abuse-includes 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, residents who have behaviors such as entering other resident's rooms, residents with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff." This Residential Tag relates to Complaints IN00449071 and IN00458721.			