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	08/21/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00440485 Complaint IN00440485 - State deficiencies related to the allegations are cited at R0028 and R0185. Survey dates: August 19, 20, and 21, 2024 Facility number: 014910 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 28, 2024.	R 0000	R 000 Disclaimer: The submission of this plan of correction does not indicate an admission by Lake Meadows Senior Living that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Lake Meadows Senior Living. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for Assisted Living Facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0028 Bldg. 00	410 IAC 16.2-5-1.2(c) Residents' Rights - Deficiency Based on interview and record review, the facility failed to ensure residents were treated with	R 0028	**R- Tag 28 Residents' Rights** 1.What corrective action(s) will be accomplished for those residents	09/03/2024

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

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	dignity and respect and to ensure residents were able to exercise their resident rights without fear of coercion or threats of reprisal for 11 of 11 residents reviewed for dignity (Resident B, Resident S, Confidential Interview 10, 11, 12, 13, 14, 15, 16, 17, and 18). Findings include: Confidential interviews were conducted during the survey. 1a. During Confidential Interview 12, they indicated the Administrator (ADM) often spoke to them disrespectfully. They had been prevented from having an advocate of their choice at a meeting. They felt they always needed a witness when speaking with the ADM because of the risk of what they said would be wrongly interpreted. They had planned on moving from the facility due to the constant harassment and felt as though she had been through "psychological warfare" with the facility. 1b. During Confidential Interview 13, they indicated during a meeting when she first arrived, they had asked to see the binder of rules for the facility. The AD (Activity Director) had told them that if they did not like the rules of the facility they could move. This had made them feel intimidated and embarrassed. They felt it was intimidation and done in front of a crowd so that "everyone would get the point". They had experienced sleeplessness and fear of retaliation for being berated in public. 1c. During Confidential Interview 14, they indicated they had witnessed the incident that Confidential Interview 13 had referenced and was surprised by the AD's reaction and comments.		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.** 2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **A All residents had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **All residents have the right to be treated with dignity and respect and to ensure residents are able to exercise their resident rights without fear of coercion or threats of reprisal.** A **All-staff will be in-serviced on Resident Rights. An audit**	

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	They were scared to complain or voice concerns about anything for fear of being discharged from the facility. They had trouble sleeping and had anxiety at times due to the fear of retaliation. 1d. During Confidential Interview 10, they indicated the staff were rude and not respectful. They were propelling themself in a wheelchair with one free hand down the hall when a resident approached and assisted with pushing their wheelchair. The Memory Care Director had observed them and walked up to them in the hallway. She then "berated" them, because the resident was assisting with pushing the wheelchair. The Memory Care Director continued to rudely lecture them in the hallway, that the resident should not have assisted with pushing the wheelchair. They felt like they were treated like a "child." The staff do not knock on residents' doors and ask for permission prior to entering the apartments. During a shower, a male staff person had entered the apartment. They had yelled out for the male staff person not to come in due to being unclothed and in the shower. He did not listen and came into the apartment anyway. The male staff person indicated he had to hang a sign on the apartment door, and he was "just doing his job." 1e. During Confidential Interview 11, they indicated the staff are disrespectful. They do not complain, because they don't want to be kicked out. "The residents' here are treated like numbers not like people." They had assisted with pushing a resident down the hallway when the Memory Care Director walked up to them and "ripped us a new one." Apparently, she did not like them assisting another resident down the hall. The Memory Care Director stated rudely, "you should know better." The situation could have been addressed much differently, but the Memory Care		**tool will be used to ensure Residents Rights** 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 perform an audit by reviewing . (1) Once weekly for the first month then (2) Two times a monthly for (3) months to ensure Resident Rights Audits shall be conducted monthly and reported to the QAPI Committee.** 5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	

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	Director's personality and demeanor was "very demanding." They stay in the apartment due to the facility being very "clicky." The Activities Director (AD) was the leader of the "clicks." If she doesn't want you to go on an outing, she will do whatever she can, so you don't get to go. 1f. During Confidential Interview 15, they indicated the nursing staff are disrespectful at times to the residents. The staff speak in a rude tone toward the residents. They had not witnessed staff being verbally abusive, but disrespectful. 1g. During Confidential Interview 16, they indicated nurses and certified nursing assistants (CNAs) speak rudely at times to the residents. 1h. During Confidential Interview 17, they indicated the Memory Care Director does use a firm tone when speaking to others. 1i. During Confidential Interview 18, they indicated the management staff, which includes Executive Director and the Memory Care Director, do not speak to residents or staff respectfully. They do have their favorite residents, so not all residents are treated the same. 2. The clinical record for Resident B was reviewed on 8/19/24 at 3:00 p.m. The diagnoses included, but were not limited to, hypertension and depression. A BIMS (Brief Interview for Mental Status) assessment, dated 8/9/24, indicated Resident B was cognitively intact. During an interview, on 8/20/24 at 1:30 p.m., Resident B indicated he felt he had been harassed			

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	since day one at the facility. He had voiced a concern about the food having too much sodium for him to eat due to his health concerns and had asked for chicken breasts. His food concern was not addressed at the facility level, so he had called the corporation to express the request. The day after he called the corporate office, four staff members came to his room first thing in the morning to talk with him, telling him that it was not possible for him to receive the chicken breast. He felt they were attempting to intimidate and retaliate against him since he called the corporate office with a concern. The facility held several meetings with him about concerns they had with him about one thing or another. They threatened to "kick him out". The facility did not have an acceptable reason to give him a 30-day notice of discharge, so they are trying to make his life hard so he will leave. He was wanting to move soon. 3. The clinical record for Resident S was reviewed on 8/21/24 at 10:45 a.m. The diagnoses included, but were not limited to, chronic kidney disease. A service plan, dated 9/28/23, indicated, "I enjoy having my special friends as overnight guest at times...Resident directed goal: I will be able to invite...the Activity Director to be an overnight guest in my home. Interventions: Encourage participation in activities of interest: Enjoy the company of overnight guest. Family/Resident is ok to call res [resident] grandma. My family is supportive of my overnight company..." During Confidential Interview 12, Confidential Interview 13, and Confidential Interview 14, they indicated the AD has a "weird" relationship with Resident S. The AD refers to Resident S as her grandmother. Resident S indicated to them, the AD stays the night in her apartment at times, so			

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	she will take her places. The AD and Resident S did go on a "Brown County" trip and stayed overnight in a cabin. Resident S and the AD shared a bed on that trip. An interview was conducted with Resident S's Representative on 8/20/24 at 3:40 p.m. She indicated she was aware the AD spends the night with Resident S at times. If Resident S and the AD are going somewhere early in the morning or returning late then the AD will stay the night in the resident's apartment. She was hesitant agreeing to the arrangement, but as long as Resident S was happy with the arrangement; she was fine with it. An interview was conducted with the AD on 8/20/24 at 4:00 p.m. She indicated she has stayed the night in Resident S's apartment. She had stayed the night in the apartment once. A carnival activity had taken place at the facility, and it had ended around 7:00 p.m., which was late. So, the resident offered the AD to stay the night in her apartment. She slept in the resident's bed, and the resident slept on the couch per the resident's preference. Resident S's Representative was aware and was fine with her staying the night with Resident S at times. The resident's service plan did indicate she was able to stay the night in the resident's apartment. She had not stayed the night with any other resident. The AD and Resident S had taken a trip to the Covered Bridge Festival, and it was an overnight trip. There were no other residents that wanted to go on that trip. The facility had paid for a two-bedroom cabin. They did not share a bed. An interview was conducted with Resident S on 8/21/24 at 8:53 a.m. She indicated she does have a friendship with the AD. She was perfectly fine			

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	with the AD staying overnight. If the AD needs to stay over, she can sleep in her apartment. "When someone is nice to her; she is nice to them in return." She had not shared a bed with the AD. An interview was conducted with the Director of Nursing (DON) on 8/21/24 at 2:00 p.m. The facility did not have a policy for staff members staying overnight with residents in their apartments. During an interview with the DON, the Regional Director of Clinical Services (RDCS), and the Regional Director of Operations (RDO), on 8/21/24 at 5:45 p.m., the RDO and the DON indicated Resident S was alert and oriented. It was her right to choose her overnight guest in her home. During an interview, on 8/20/24 at 4:42 p.m., the DON indicated the staff were here for the residents to make them feel like it was there home. During an interview, on 8/21/24 at 3:31 p.m., the RDCS indicated Residents being treated with dignity and respect is a part of the resident rights. On 8/21/24 at 2:00 p.m., the DON provided the Resident Rights policy which indicated, "...Purpose: To ensure that resident rights are respected and protected. To inform residents of their rights and provide an environment in which they can be exercised...Resident's rights and responsibilities shall include, but not be limited to the following...Every resident, resident's representative and resident's legal representative, in any, shall have the right to present grievances on behalf of himself or herself or others, to the residences' staff, administrator or assisted living operator, to governmental officials, to long term care ombudsmen or to any other person without fear of reprisal, and to join with other residents or			

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	individuals within or outside of the residence to work for improvements in resident care... This citation is related to Complaint IN00440485.			
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense Based on interview and record review, the facility failed to ensure a resident remained free from neglect related to a delay in initiation of Cardiopulmonary Resuscitation (CPR) in accordance with the physician's order for 1 of 1 resident reviewed for death (Resident 10). This deficient practice resulted in Resident 10 sustaining an anoxic (deprivation of oxygen) brain injury and death. Findings include: The clinical record for Resident 10 was reviewed on 8/19/24 at 11:32 a.m. The diagnoses included, but were not limited to, hypertension and diabetes. A physician's order, dated 10/26/21, read "...Advanced Directive: CPR..." A service plan, dated 8/8/24, indicated Resident 10 had a history of falls and was at risk to experience further falls, but did not include documentation to determine the resident's advanced directives. A Neurological Checklist, dated 8/10/24 at 5:50 p.m., indicated Resident 10 was unresponsive and non-arousable. Her pupils were not equal, round, and reactive to light. She could not follow finger with her eyes. She was unable to respond to simple commands and unable to verbalize	R 0052	**POC** **Tag: R -52 Residents' Rights** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A All residents are at risk of being affected by this citing. It is the intent of Lake Meadows to ensure all residents are free from sexual abuse, physical abuse, mental abuse, corporal punishment, neglect, and involuntary seclusion.** 2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **A All residents had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into place or what systemic changes	09/03/2024

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	appropriately. Her pain level was unable to be determined. There was no movement of limbs and sensation was not intact in her left arm, right leg, and left leg. She was nonresponsive and emergency medical services had been called. An Orders - General Note written by Qualified Medication Aide (QMA) 3, dated 8/10/24 at 7:52 p.m., read "...Unwitness [sic] fall, Resident was found on the floor, Not vevaly [sic] responding and eyes small [sic] open and blinking. After the other Qma [sic] have called [sic] to come check the resident she was already lying on the floor. while taking vitals. temp [Temperature] 91 [degrees], O2 [oxygen saturation] 89, B/P [blood pressure] 123/66 P [pulse] 56. Staff stay [sic] with resident in the mean [sic] time I called ADON [Assistant Director of Nursing], I called 911 who came help take the resident to the hospital This writer print resident information and [sic] it to EMS [Emergency Medical Services] during that time they already transport the resident to the emergency ambilance [sic]. ADON already call POA [Power of Attorney] and notify them..." The note did not include information on where the fall had occurred, or vital signs included respirations being obtained. An incident note, dated 8/10/24 at 8:22 p.m., indicated, "...This nurse notified by QMA that a resident reported this resident laying in the hallway. QMA took VS [vital signs], instructed to call EMS. This nurse notified ED [Executive Director], DON [Director of Nursing], NP [Nurse Practitioner], and POA [Power of Attorney]. QMA called this nurse back to update that EMS gave CPR and O2 [oxygen] and now transporting..." The incident note did not include sufficient documentation to determine facility staff immediately initiated CPR.		the facility will make to ensure that the deficient practice does not recur; **All Nursing staff are required to have CPR and First Aide Training upon hire.** **A All Nursing staff will be in serviced/ reeducated on the process of when to start CPR and how to identify signs of a person needing CPR. The In-service/ reeducation process will be on going and include role-play with each nursing staff member to ensure how to identify signs of a person needing CPR and when to start CPR.** 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **A The Director of Nursing or designee: Will perform an audit by conducting live drills with staff on different shifts. (1) Once weekly for the first month then (2) Two times a monthly for (3) months to ensure Resident Rights and CPR Process. Audits shall be conducted monthly and reported to the QAPI Committee.**	

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	A communication with family note, dated 8/10/24 at 8:39 p.m., indicated, "...POA notified this nurse that physician stated 'resident is brain dead and is being taken off of machinery and blood pressure medications'..." A communication with family note, dated 8/10/24 at 11:12 p.m., indicated, "...POA notified this nurse resident passed away..." The hospital Emergency Department Physician Progress Note, dated 8/11/24 at 5:59 a.m., indicated Resident 10 fell at the facility and CPR was not immediately initiated by facility staff. The fire department had initiated chest compressions upon arrival to the facility. The note indicated the resident sustained a brain injury from disrupted oxygen supply. On 8/19/24 at 2:36 p.m., the Administrator (ADM) provided the schedule as worked for 8/10/24. There were three QMAs and three Certified Nurse Aides (CNAs) listed as working the evening shift on 8/10/24. The staff consisted of QMA 2, QMA 3, QMA 4, CNA 12, CNA 13, and CNA 14. There was no licensed nurse listed on duty for 8/10/24 on the evening shift. During an interview, on 8/19/24 at 11:32 a.m., FM (Family Member) 20 indicated, on 8/10/24 at approximately 5:45 p.m., they had received a call from the facility that Resident 10 had been found lying on the floor near the front desk. The Assistant Director of Nursing (ADON) called to inform him Resident 10 had fell and was going to the ER for an evaluation. Resident 10 required CPR and was "brain dead" while in the emergency room. FM 20 indicated he was upset because he did not believe there was a nurse on duty at the		5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	

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	time and did not feel the facility staff knew what to do for Resident 10 when she was found on the floor. On 8/20/24 at 2:50 p.m., the DON provided the American Red Cross CPR certification, dated 9/29/2023, for QMA 2. The document indicated the certification was valid for two years. On 8/20/24 at 2:50 p.m., the DON provided the American Health Care Academy online training CPR certification, dated 6/6/2024, for QMA 3. The document indicated the certification was valid for two years, but did not include documentation to indicate the online training component included hands-on practice and in-person skills assessment to demonstrate competence. An education in-service attendance form and literature, dated 6/20/24, was provided by the Director of Nursing (DON) on 8/20/24 at 2:50 p.m. The form indicated education was provided to 20 nursing staff members. The document indicated QMA 3 attended the training, but QMA 2 did not. The literature indicated if an unconscious resident is found on the floor, staff should call for assistance, clear the area, start taking vitals, call 911, and start CPR. On 8/19/24 at 4:38 p.m., the ADM provided the investigation file of the incident involving Resident 10 on 8/10/24. The investigation included, but were not limited to, the following: An undated written statement of the ADON indicated, on Saturday, 8/10/24, the ADON had received a call from QMA 3 that Resident 10 was on the floor and not responding. The ADON instructed QMA 3 to call EMS. The ADON called the POA and informed him that she would call the			

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	facility back to let the facility know which hospital she should be transferred to. The ADON had called the facility back and was informed by QMA 3 that EMS had arrived, applied oxygen, and started CPR. QMA 3 had called the ADON back and told her "They had gotten her back and transported to the ER [Emergency Room]". The statement did not include information to determine facility staff initiated CPR after activating 911. During an interview, on 8/20/24 at 9:47 a.m., QMA 2 indicated she had found Resident 10 on 8/10/24. She was behind the receptionist desk, in the office, faxing paperwork and heard Resident J calling for help. QMA 2 responded to the call for help and found Resident 10 lying on the floor outside of the receptionist desk. QMA 2 called QMA 3 to assist Resident 10. Resident 10's eyes had been slightly open and blinking. QMA 3 had taken vital signs and called the ADON (Assistant Director on Nursing) and 911. QMA 2 had stayed with Resident 10 while QMA 3 went to the nursing station to get paperwork to send with Resident 10 to the hospital. QMA 2 did not obtain any vital signs after QMA 3 left the area. QMA 2 was certified in CPR, but did not start CPR. The emergency medical services arrived while QMA 3 was gone and took over the care and started CPR when they arrived. QMA 2 believed there was an AED (Automatic External Defibrillator) (which is used to provide electrical shocks to people, if needed, during CPR) by the door of the receptionist area, she had not thought of using it. During an interview, on 8/20/24 at 11:00 a.m., the EMS Supervisor indicated that the firemen were the first to arrive at the facility after 911 was called on 8/10/24. The fire department arrived on the scene first and initiated CPR after finding her with no pulse or respirations. The facility staff had not			

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	started CPR prior to the fire departments arrival. The EMS team arrived on the scene after the fire department and continued CPR efforts. During an interview, on 8/20/24 at 2:15 p.m., Resident J indicated that she had found Resident 10 on the floor by the receptionist desk on 8/10/24 at approximately 5:45 p.m. Resident 10 had not been moving when Resident J found her. Resident J yelled out for help. She had yelled for help three times and then Resident 10 had looked up at her and her head had "clasped" back. Someone had come from behind the receptionist desk to assist Resident 10, so Resident J had left the area and gone to her room. Resident J returned to the receptionist desk area approximately five minutes later and Resident 10 was still laying on the floor in the same position as when Resident J had left her. There were two staff members attempting to get her vital signs. Resident J thought that Resident 10 looked like she was not breathing. The staff were not performing CPR. 911 had showed up around five minutes later and said that Resident 10 had no pulse. During an interview, on 8/21/24 at 1:50 p.m., the DON indicated the code status list at the receptionist desk was for the receptionist use. The nursing staff had not known about the code status list kept at the receptionist desk, but if they had known, it may have improved the response time for Resident 10. During an interview, on 8/21/24 at 1:50 p.m., Concierge (CON) 4 indicated there was a list of resident code status at the receptionist desk. It was the second page of the forms kept in the plastic sleeve on top of the file cabinet. It has been located there since she had started in			

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	October of 2023. The list was updated routinely by the DON. During an interview, on 8/21/24 at 2:03 p.m., QMA 3 indicated she had been assigned to two different areas the evening of 8/10/24, the second-floor enhanced care unit and part of the first-floor assisted living unit. She had been assigned to provide medications for Resident 10, who lived on the first floor. QMA 3 had been finishing her medication pass on the second-floor enhanced care unit, when QMA 2 called her to come to the receptionist desk because Resident 10 was on the floor. QMA 3 quickly finished what she was doing on the enhanced care unit and went to the first-floor reception desk. When QMA 3 arrived at the reception desk area, she saw Resident 10 lying on the floor with her eyes slightly open and blinking. QMA 2 had informed her that Resident 10 had been found lying on the floor and no vital signs had been taken. QMA 3 then ran back to the medication cart on the second floor to get the supplies to obtain Resident 10's vital signs, hurried back downstairs to the reception desk area, and took Resident 10's vital signs. There was not a nursing station on the first floor. After obtaining the vital signs, QMA 3 called the ADON and then 911. QMA 3 did not initiate CPR after calling 911. QMA 3 took the vital sign equipment with her and quickly ran back upstairs to the facilities only nurses' station, located on the enhanced care unit. She started to print out paperwork to send with Resident 10 to the hospital and check Resident 10's code status, while QMA 2 stayed with Resident 10 on the first floor by the reception desk. When QMA 3 came back downstairs to the reception desk area with the paperwork and code status, 911 had arrived and were putting oxygen on Resident 10. QMA 3 was not aware that the resident's code status was			

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	available at the reception desk. QMA 3 did not know how long it took her to get the paperwork and code status information ready, the nurses' station was a long way from the reception desk area. QMA 3 had not seen Resident 10 prior to being called to the receptionist desk that evening. She never conducted anything like that before and was still upset and tearful about what happened. There had not been a nurse on duty the evening of 8/10/24. There was sometimes a nurse on duty on the weekends, but not that day. On 8/20/24 at 2:50 p.m., the DON provided the Emergency Care policy which indicated, "...To assure adequate response to resident emergencies...Staff will be trained in first aid and CPR for early management of problems. When in doubt, the emergency medical services system will be activated..." On 8/21/24 at 2:00 p.m., the DON provided the Abuse, neglect, and Misappropriation Policy and Procedure which indicated, "...Residents have the right to be free from physical, verbal, sexual, mental abuse, misappropriation of property, corporal punishment, and involuntary seclusion. Definitions...Neglect- failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect means recklessly failing to provide a resident with any treatment, care or services necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident..." The article, "What Is an Automated External Defibrillator?" dated 4/23, was retrieved on 8/22/24 from the American Heart Association website at https://cpr.heart.org/en/cpr-courses-and-kits/heartsaver/heartsaver-cpr-aed-training.html. The			

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	article read "...Why are AEDs important? AED's save lived they are an important part of responding to a cardiac arrest. A person's chance of surviving drops by 7% to 10% every minute a normal heartbeat isn't restored. So immediate CPR and AED use can double or triple the person's chance of survival..." The article "CPR- adult and child after onset of puberty" dated 1/2/2023, was retrieved from the Medline Plus website at //medlineplus.gov/ency/article/000013.htm on 8/23/23. The article indicated, "...CPR stands for cardiopulmonary resuscitation. It is a lifesaving procedure that is done when someone's breathing or heartbeat has stopped.... Permanent brain damage or death can occur within 4 minutes if a person's blood flow stops. Therefore, you must continue CPR until the person's heartbeat and breathing return, or trained medical help arrives...Time is very important when an unconscious person is not breathing. Permanent brain damage begins after 4 minutes without oxygen and death can occur as soon as 5 to 6 minutes later...Symptoms CPR should be done if a person has any of the following symptoms: No breathing or difficulty breathing [gasping] No pulse Unconsciousness First Aid 1. Check for responsiveness. Shake or tap the person gently. See if the person moves or makes a noise. Shout, 'Are you OK?' 2. Call 911 or the local emergency number if there is no response. Shout for help and send someone to call 911 or the local emergency number. If you are alone, call 911 or the local emergency number and retrieve an AED (if available), even if you have to leave the person. 3. Carefully place the person on their back... 4. Perform chest compressions... 5. Open the airway. 6. Look, listen, and feel for breathing..."			

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R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance Based on observation, interview, and record review, the facility failed to ensure the designated director for an Alzheimer's and dementia special care unit had a minimum of twelve hours of dementia-specific training within three months of initial employment as the director of the Alzheimer's and dementia care unit for 1 of 5 employee files reviewed. (Dementia Care Director) Findings include: An employee records form received on 8/19/24 at 2:50 p.m., indicated the facility had a Dementia Care Director (DCD). The DCD's date of hire was 9/22/23. The employee personnel files received, on 8/20/24, indicated the DCD completed four computer-based dementia-specific training on 10/10/23, 10/11/23, and 10/13/23 for a total of 4 hours of dementia-specific training. The DCD's employee file contained a note regarding dementia training provided by the facility's Director of Memory Care and Engagement (DMCE) which indicated three topics were reviewed for two hours of dementia-specific training. An interview conducted with the Administrator (ADM), on 8/20/24 at 1:36 p.m., indicated she would clarify with the DMCE the total number of hours for dementia-specific training he provided to the DCD within the past year. An email from the DMCE to the ADM, received on 8/20/24 at 2:17 p.m., and dated 8/20/24 at 2:03 p.m., indicated the DCD had attended the	R 0095	**R Tag-95 Administration and Management** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A All Memory Care residents (17) had the potential of being affected by this citing. It is the intent of Lake Meadows to ensure the Memory Care Director receives the required 12 hours dementia training and continuous monthly training.** 2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; **A All Memory Care residents (17) had the potential to be affected by the alleged deficient practice. No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;	09/03/2024

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	dementia specific-trainings last week for a total of six hours however, the instructions were the team members that had attended the trainings were to print a training sign-up sheet, sign it, and email him a copy. It indicated the DCD had not returned her sign-up sheet nor did he receive any training sign-up sheets from the DCD when she started. The DMCE indicated he reached out multiple times to the DCD to complete the training. The DCD did not have 12 hours of dementia-specific training within the first three months of hire. The facility's website, located at HTTPS://lakemeadowsseniorliving.com, last accessed on 8/20/24, indicated on the enhanced personal care (EPC) unit "Residents will enjoy a structured daily plan that focuses on wellness and supporting independence, all while ensuring dignity and respect. This environment allows those with memory impairments to maintain functional abilities for as long as possible while remaining comfortable along their journey. Staff with specific dementia-centered training and experience support our residents with memory loss, including accommodations such as dietary oversight, assistance with medication, and general hygiene." The facility's EPC unit was a locked unit accessed by the use of a key fob which staff kept on their person.		**A The Memory Care Director was in serviced on ISDH regulation which includes 12 hour Dementia training that is required for the Memory Care Director.** **B The Memory Care Director will complete on going dementia training to meet the needs or preferences, or both, of cognitively impaired residents.** 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 **Executive Director or designee will perform an audit to ensure compliance with required Memory Care Dementia Training. (1) Once weekly for the first month then (2) Two times a monthly for (3) months to ensure Resident Rights. Observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee** 5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	

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R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on interview and record review, the facility failed to ensure a staff member's personnel record was accurate by employing a person whose nursing license did not match their government issued identification information at time of hire for 1 of 5 employee files reviewed. (Licensed Practical Nurse 11) Findings included: An employee records form was received, on 8/19/24 at 2:50 p.m., from the Administrator (ADM). Five employee records were requested for further review and were received on 8/20/24. The personnel file for Licensed Practical Nurse 11 (LPN 11) was reviewed on 8/21/24 at 10:56 a.m. The personnel file contained a nursing license verification from the Indiana Professional Agency with a different last name from the employee records list. On 8/21/24 at 11:42 a.m., the Director of Nursing (DON) provided a copy of LPN 11's Indiana Driver's license which indicated LPN's last name did not match the last name listed on the nursing license. When asked about why the names do not match, DON indicated the staff member may have gotten married and/or changed her last name. When asked if the facility had evidence to support LPN 11's name change, DON indicated she did not have any such evidence at the time of hire nor did the facility have evidence of a name change since the time of hire. On 8/21/24 at 11:42 a.m., LPN 11's timecards from	R 0123	**R Tag- 123 Personnel** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A No residents were directly impacted by the deficient practice.** 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 have the possibility to be impacted by the deficient practice.** 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **A Inservice Administrative Assistant that all newly hired staff will have the correct name on license/certification when onboarding with the facility.** 4.How the corrective action(s) will be monitored to ensure the	09/03/2024

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	1/5/24 to 8/21/24 were received from DON. The timecards indicated she had worked at the facility on 15 occasions during the time frame.		deficient practice will not recur, i.e., what quality assurance program will be put into place; and A **Executive Director, or designee: Audit tool will be used to correct existing personnel files by auditing 10 personnel files (1) time a week for (1) Month then (1) time a month for (3) months to ensure 100 percent compliance. All newly hired staff will have the correct name on license/certification when onboarding with the facility**. 5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	
R 0185 Bldg. 00	410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance Based on observation, interview, and record review, the facility failed to ensure residents had a working and timely method to summon a staff person. This had a potential to affect 110 of 110 residents that reside in the facility. Findings include: During Confidential Interview 10, they indicated they had to wait long times for staff to come when they needed staff assistance. They had to wait an hour and a half for a staff person to come to the apartment after pushing the pendant.	R 0185	**R Tag- 185 Physical Plant Standards** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A All residents (110) had the potential of being affected by this citing. It is the intent of Lake Meadows to ensure residents have a working and timely method to summon a staff person.**	09/03/2024

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	During Confidential Interview 11, they indicated they had to wait as long as 30 to 45 minutes for a staff person to come and assist them in the apartment after pushing the pendant. An environmental tour was conducted with the Director of Maintenance (DOM) on 8/21/24 at 1:34 p.m. During a call system check, Resident V's call light cord in the resident's bathroom was pulled. The call light did not light up. The DOM indicated the call light button on the wall mount should light up. He was unaware the call light in the resident's bathroom was not working. During the tour, Resident T was observed in his room. The resident's call light cord in his bathroom was pulled at 1:46 p.m. The resident indicated he has had to wait on the toilet as long as 45 minutes for a staff person to come to the apartment to assist with toileting. At 2:13 p.m., a staff person was observed walking down the hallway and had walked past Resident T's room. An interview was conducted with the DOM on 8/21/24 at 2:20 p.m. He indicated staff utilize pagers, walkie talkies, and a computer monitor that was located on the Enhanced Care Unit for staff at the nurse's station to monitor. The monitor on the unit was not audible. There were broken walkie talkies and pagers returned to him, for repair, on a regular basis. An interview was conducted with Certified Nursing Assistant (CNA) 5 on 8/21/24 at 2:49 p.m. She indicated she did have a pager, but it was given to the Memory Care Director. The pager was in need of repair. At the time of the interview, CNA 11 did have a pager, and staff would send text messages to her utilizing her cell phone. An interview was conducted with Director of		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 No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **A Lake Meadows will audit all residents' pendants and emergency bathroom call cords linked to staffing pagers to ensure they are in working order and response time is efficient.** **B In service Maintenance Director and Housekeeping supervisor on company policy I-150 for 24 hour emergency response.** **C In Service Nursing staff on Emergency Call Light response time.** 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 facility will audit 10%**	

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	Nursing (DON) on 8/21/24 at 4:01 p.m. She indicated staff are issued pagers. She was unaware CNA 5's pager had broken. An Emergency Care policy was provided by the Administration Assistant on 8/21/24 at 5:02 p.m. It indicated, "...To assure adequate response to resident emergencies. Residents will appropriate emergency care and will have an emergency call system in their dwelling unit....Prompt response to an activated call system will be provided 24-hours a day..." This citation is related to Complaint IN00440485.		**of resident's pendants and bathroom call cords(1) times weekly for 1 month, then (1) times monthly for 3 months to ensure they are properly functioning in working order.** 5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	
R 0192 Bldg. 00	410 IAC 16.2-5-1.6(p) Physical Plant Standards - Nonconformance Based on observation, interview, and record review, the facility failed to ensure the safety of residents who reside on an enhanced care unit (ECU) by having cleaning chemicals stored in an unlocked cabinet in the unit's kitchen area. This had the potential to affect 15 of 15 residents who reside on the locked enhanced care unit. Findings include: An observation of the locked enhanced care unit (ECU) was conducted on 8/21/24 at 2:32 p.m. During the observation, residents were walking about the unit randomly. The kitchen area on the unit contained cabinets and drawers and most of the cabinets or drawers had cabinet latches which limited the ability of the cabinet/drawer to open fully. One cabinet, below the microwave, did not have a cabinet latch and contained several cleaners. The cleaning agents located in the cabinet included, but were not limited to, a	R 0192	**R Tag- 192 Physical Plant Standards** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A All residents had the potential to be affected by the alleged deficient practice.** 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 No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into	09/03/2024

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	container of disinfecting wipes, clinging toilet bowl cleaner, a can of "Steri-Fab", an unlabeled spray bottle containing a yellow liquid, and a cleaning solution. An interview with Certified Nursing Assistant (CNA) 8 was conducted at the same time as the observation. CNA 8 indicated she was unaware of the cleaning solutions stored in the cabinet. She indicated the cleaning supplies probably should not be left in an unlocked cabinet where residents with known cognitive decline could come in contact with them. On 8/21/23 at 2:48 p.m., an interview with the Director of Nursing (DON) was conducted. The DON indicated cleaning chemicals should be stored in the locked closet next to the nursing station and kept out of the residents' reach. The Material Data Safety Sheets (MSDS) for the identified cleaning supplies were provided by HSK 32 (Housekeeping Supervisor 32) on 8/21/24 at 3:35 p.m. They indicated the following cleaners were hazardous: - Lysol Clean & Fresh Multi Surface Cleaner (spray bottle with yellow liquid) has a "serious eye damage" hazardous identification. - Clinging Toilet Bowl Cleaner "causes severe burns and serious eye damage. May be corrosive to metals...Causes burns/serious damage to mouth, throat and stomach." - Steri-Fab is a disinfectant/insecticide which has a flammable liquid and vapor. Vapors have a narcotic effect. Precautionary statement indicated it was a hazard to humans and domestic animals.		place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **A All staff including staff on EPC unit will be in serviced on cleaning supplies and storage of cleaning supplies.** 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 Maintenance Director or designee: Will perform an audit by conducting inspections on cleaning supplies and proper storage location. (1) Once weekly for the first month then (2) Two times a monthly for (3) months. Audits shall be reported monthly to the QAPI Committee.** 5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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		A. BUILDING 00 B. WING	08/21/2024

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	Based on interview and record review, the facility failed to ensure residents and/or representatives were involved and signed their service plans for 3 of 5 resident's reviewed for service plans. (Resident F, Resident S and Resident 111) Findings include: 1. The clinical record for Resident F was reviewed on 8/19/24 at 1:25 p.m. The diagnoses included, but were not limited to, respiratory failure. The resident was admitted to the facility on 5/6/24. An interview was conducted with Resident F on 8/19/24 at 2:42 p.m. She indicated she had not been invited to any service plan meetings. A service plan for the resident, review date 5/13/24, was provided by the Director of Nursing (DON) on 8/20/24 at 10:45 a.m. The service plan did not include the resident and/or representative signature. A service plan for Resident F, review date of 8/9/24, did not include the resident and/or representative signature. 2. The clinical record for Resident 111 was reviewed on 8/19/24 at 11:45 a.m. The diagnoses included, but were not limited to, dementia. The resident was admitted to the facility on 12/30/21. A service plan for Resident 111, review date of 8/12/24, was provided by the DON on 8/19/24 at 4:33 p.m. The service plan did not include the resident and/or representative signature. 3. The clinical record for Resident S was reviewed on 8/21/24 at 10:45 a.m. The diagnoses included,	R 0217	**R – Tag: 217 Evaluations-Service Plans** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A The corrective actions that will be accomplished for those residents found to have been affected by the alleged deficient practice; Visits were scheduled for residents 111, F, and S, at which the service plans were reviewed and signed.** 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 Lake Meadows residents have the potential to be affected by the alleged deficient practice. All service plans without signatures of resident and/or family, will be updated and a visit scheduled to review and sign the service plan.** 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;	09/03/2024

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	but were not limited to, chronic kidney disease. The resident had been admitted to the facility on 10/5/21. An interview was conducted with Resident S's Representative on 8/20/24 at 3:40 p.m. She indicated she was unaware of service plan meetings. She had not been invited to one. The service plan for Resident S, review date of 6/13/24, was provided by the DON on 8/21/24 at 10:45 a.m. It did not include a resident's and/or representative's signature to indicate the service plan had been reviewed. An interview was conducted with the DON on 8/21/24 at 11:26 a.m. She indicated she was unable to provide service plans that had been signed by the resident nor representative for Resident 111, Resident S and Resident F. A service plan policy was provided by the DON on 8/20/24 at 10:28 a.m. It indicated the following, "Coordination/Individualization of Services. To assure continuity of services to each resident. To assure individualization of services to each resident, thus decreasing the feeling of an institutional environment....Following the residency assessment and move-in, an individualized assistance/service plan will be developed prior to move-in. The plan will be established by the Resident Services Coordinator and the Manager with input from the resident and family/responsible person..."		**A The DON was In serviced on the facility policy and ISDH regulations for evaluations and service plans. An audit will be completed for all residents to determine any service plans not signed by family and/or resident and visits will be scheduled for those residents and the service plan will be reviewed and signed. DON or designee will be responsible for ensuring service plans are updated and signed by resident/family.** 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 **B A tracking tool will be utilized by the DON or designee, who will audit service plans weekly x 4 weeks, then monthly x 3 months to ensure that updates are completed timely. Visits with residents and family will be scheduled to review the updated service plans. Audits will be reported monthly to the QAPI Committee.** 5.By what date the systemic changes will be completed. **Compliance Date:**	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to maintain proper food storage in the refrigerator and freezer with the potential to affect 110 of 110 residents who reside at the facility. Findings include: On 8/19/24 at 10:15 a.m., the facility kitchen was observed with the CM (Culinary Manager). The facility refrigerator was observed to have two uncovered slices of pie. A food storage container was observed to have no label indicating what was in the container or the date the container was placed in the refrigerator. The facility freezer contained an undated package of fried chicken which had ice crystals on the inside of the package and a package of fish squares was open to air. There were multiple boxes of food sitting on the floor at the entrance of the freezer. During an interview, on 8/19/24 at 10:15 a.m., the CM indicated the slices of pie in the refrigerator should have been covered and dated. The sealed container contained pork chops and should have been labeled and dated prior to being placed in the refrigerator. The package of fried chicken should have been labeled and dated. The package of fish squares should not have been open to air. The boxes of food located on the floor had been recently delivered and should not have been stored on the floor of the freezer. On 8/19/24 at 2:37 p.m., the Administrator	R 0273	**September 3, 2024** **R- Tag 273 Food and Nutritional Services** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A All residents had the potential to be affected by the alleged deficient practice.** 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 No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **A All Dietary staff including staff working in the EPC unit will be in serviced on Food Storage and Expired Foods.**	09/03/2024

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	provided the Storage of Refrigerated and Dry Foods procedure that indicated, "...Food being returned to storage after cooking or preparation must be covered. All containers must be labeled with the contents and date food items was placed in storage..."		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 Culinary Director or designee: Will perform an audit by conducting inspections on Food Storage and Expired Foods. (1) Once weekly for the first month then (2) Two times a monthly for (3) months. Audits shall be reported monthly to the QAPI Committee.** 5.By what date the systemic changes will be completed. **Compliance Date: September 3, 2024**	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 by having a trash can from a COVID-19 positive resident's room, which contained used personal protective equipment (PPE), positioned outside of the resident's room (Resident 82) during a random observation. Findings include: An initial tour of the facility with the Director of Nursing (DON) was conducted on 8/19/24 at 10:23 a.m.	R 0407	**R- Tag 407: Infection Control** 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **A All residents had the potential to be affected by the alleged deficient practice.** 2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	09/03/2024

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	During the initial tour it was observed, Resident 82's room door had a sign on it which indicated to not enter the resident's room and to see nursing. When asked about the reason for the sign, the DON indicated Resident 82 was in isolation due to having a positive COVID-19 test. When asked if the trash can, which contained used articles of PPE, should be located outside of the resident's room instead of inside the room, DON indicated all used PPE articles should be disposed of in a proper receptacle prior to exiting the isolation room. A line list of residents who have tested positive for COVID-19 since the initial outbreak started, on 7/23/24, was provided by DON on 8/19/24 at 3:00 p.m. The line list indicated Resident 82 tested positive for COVID-19 on 8/16/24. The facility for the duration of the survey, from 8/19/24 until 8/21/24, did not require the use of masks for staff or visitors while in an outbreak of COVID-19. No signage was present to indicate the facility was in a COVID-19 outbreak nor the need to wear a mask. A "COVID-19 clinical updates 8/29/23, 9-15-23" procedure/policy, received on 8/19/24 at 3:00 p.m., indicated the following, "Outbreak: This is one staff or resident positive case in the community...Ensure signage is posted to let visitors know we have outbreak in the facility and also that they need to wear masks...PPE...We need to keep masks...available at entrances; Mask use if in outbreak. This can be the surgical mask, unless going into room for COVID positive resident...PPE must be discarded before exiting the room..."		will be taken; **A No other residents were identified as affected by the alleged deficient practice.** 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; **A All staff educated on infection control policies and procedures, including but not limited to: properly prevent and/or contain COVID-19 by not having a trash can from a COVID-19 positive resident's room outside.** 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **A The Director of Nursing or designee: will monitor all infection control policies and procedures by use of an audit tool (1) Once weekly for the first month then (2) Two times a monthly for (3) months. Audits will be reported monthly to the QAPI Committee.** 5.By what date the systemic	

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			changes will be completed. **Compliance Date:** **September 3, 2024**	