

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2011
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 675 S FORD RD ZIONSVILLE, IN 46077		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	INITIAL COMMENTS This State Residential finding is cited in accordance with 410 IAC 16.2-5.	R 000		
R 217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. This RULE is not met as evidenced by: Based on record review and interview, the facility failed to have the Service Plans for 2 of 2 residents living on the Cottage I	R 217		

Indiana State Department of Health

TITLE

(X6) DATE

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

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R 217	<p>Continued From page 1</p> <p>Residential-licensed secured/locked Alzheimer's unit signed by the resident and/or the legally responsible party. This deficiency impacted 2 Residential residents in a sample of 7 reviewed. [Residents #173 and #174]</p> <p>Findings include:</p> <p>The clinical record for Resident #173 was reviewed on 6/29/11 at 10:25 A.M. The clinical record for Resident #174 was reviewed on 6/29/11 at 10:58 A.M.</p> <p>Service Plans were not found for either resident.</p> <p>In an interview on 6/30/11 at 9:50 A.M., the Administrator indicated the "Resident Care/Need Sheet" forms were used on the Cottage I Alzheimer's unit as the Service Plan.</p> <p>A copy of the "Resident Care/Need Sheet" form, dated 6/29/11, was provided for review. Multiple residents were addressed on the front and reverse sides of the form--6 on the front and 8 on the reverse side of Page 1; 4 on the front of Page 2; and 3 on the front of Page 3. The forms listed the care to be provided for showers, A.D.L. [Activity of Daily Living] care, toileting, mobility, activities, equipment and devices, behaviors, and any other special needs. The frequency the care was to be provided was also listed.</p> <p>There was no section or area available on the multi-listing sheet for a resident or legal representative to sign indicating the Service Plan had been reviewed and agreed upon by them.</p> <p>In the interview on 6/30/11 at 9:50 A.M., the Administrator indicated she was aware that Service Plans needed to be signed by the</p>	R 217		

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R 217	Continued From page 2 resident and/or responsible party.	R 217			