STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	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) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00137487. Complaint IN00137487-Substantiated. Federal/State deficiencies related to the allegation(s) are cited at F314 and F441. Survey date(s): October 9, 10, and 11, 2013. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Survey team: Jeanna King, RN-TC Lora Brettnacher, RN Census bed type: SNF: 15 SNF/NF: 151 Residential: 68 Total: 234 Census payor type: Medicare: 18 Medicaid: 123 Other: 93 Total: 234 Sample: 10	F000000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered as the letter of credible allegation and request a desk review on or after November 5, 2013.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	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) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on 10/18/2013 by Brenda Marshall Nunan, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, record review, and interview, the facility failed to ensure a pressure redistribution cushion was placed in a resident's chair to prevent further skin breakdown and to help with healing of pressure ulcers for 1 of 3 residents reviewed with pressure ulcers (Resident C). Findings include: Resident C's record was reviewed on 10/10/2013 at 12:15 A.M. Resident C had diagnosis which included but were not limited to, incontinence, Alzheimer's disease, congestive heart failure, chronic pain, severe lower bilateral contractures, dysphasia, adult failure to thrive, and stage four pressure ulcers to her left ischial and coccyx.	F000314	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A pressure redistribution cushion was added to Resident C's chair. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with pressure areas or interventions in place to prevent pressure ulcers have the potential to be affected by the alleged deficient practice. An audit of all residents was completed to ensure that all pressure ulcer interventions were accurate and in place and all care plans and assignment sheets were updated accordingly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All nursing staff will be reeducated on the facility's Skin Management Program by	11/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	During an observation on 10/10/2013 at 1:10 P.M., Certified Nursing Assistant(s) (CNA) #4 and #5 were observed transferring Resident C to a broda chair. The chair did not have a cushion in it. During an observation on 10/11/2013 at 8:30 A.M., Resident C was observed seated in the dining room in her chair. A cushion was not observed in Resident C's chair. During an interview on 10/11/2013 at 8:34 A.M., Licensed Practical Nurse (LPN) #5 indicated there was not a cushion in Resident C's chair at that time. During an interview on 10/11/2013 at 8:35 A.M., Resident C's Nurse (Registered Nurse) RN #7 indicated she was not sure if Resident C required a cushion in her chair. During an interview on 10/11/2013 at 8:44 A.M., the Director of Nursing (DON) indicated Resident C should of had a pressure redistribution cushion in her chair. Resident C's current care plan dated 9/27/2013, indicated Resident C had impaired skin integrity with stage 4 pressure areas to her left ischial and		the Clinical Education Coordinator by November 5, 2013. Unit Managers or designee will observe all residents with pressure areas daily on all three shifts to ensure appropriate interventions are in place. These observations will be recorded and will continue until compliance is achieved. Should any non compliance be noted, corrective action will be completed immediately. IDT team will also observe all residents with pressure ulcers weekly during weekly wound rounds to ensure all treatments and interventions are in place. These rounds will be conducted with a wound care physician or nurse practitioner in order to ensure that all treatments and interventions are appropriate. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Once compliance is achieved the Skin Management CQI tool will be completed by the Unit Manager for all residents with pressure ulcers weekly x 4 weeks, monthly x 2 months and quarterly thereafter, to ensure facility skin management program is being followed and that all appropriate interventions are in place. Through the audits, if any non compliance is noted, corrective action will be completed immediately. The audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	coccyx. This care plan indicated Resident C was a hospice patient and her family had declined aggressive treatment for the wounds. A Goal listed for Resident C indicated her wounds would be free from signs of complications. Interventions listed to meet that goal included Resident C would be out of bed for meals only and when she was out of bed a pressure reducing/redistribution cushion would be placed in her chair. A policy titled "Skin Management Program, dated 9/13/2013, and identified as current by the Director of Nursing (DON) on 10/11/2013 at 12:06 P.M., indicated, "...It is the policy of American Senior Communities to assess each resident to determine the risk of potential skin integrity impairment.... Pressure reduction devices are to be put in place immediately.... Direct care givers will be notified of skin alterations and specific care needs...." This Federal tag relates to Complaint IN00137487. 3.1-40(a)(2)		reviewed by the CQI committee and action plans will be developed, as needed, to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
F000441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and policy review, the facility failed to	F000441	What corrective action(s) will be accomplished for those residents	11/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	ensure staff washed/sanitized their hands between patient care and/or handled and transported linens in a manner which prevented the spread of infection. This deficient practiced had the potential to affect 6 of 8 residents observed during care for facility infection control prevention practices (Resident K, L, M, P, T, and Z). Findings include: 1. During constant observations of care on 10/9/2013, from 6:45 P.M. -7:15 P.M., (Certified Nursing Assistant) CNA #1 was observed to provide care. The following observations were made: CNA (Certified Nursing Assistant) #1 walked out of the dining room and entered Resident K's room. CNA #1 did not wash or sanitize her hands prior to entering Resident K's room. CNA #1 applied gloves and removed Resident K's brief. CNA #1 cleaned feces off of Resident K's buttocks, touched his arm and clean gown, applied a clean brief, gathered dirty linens and placed them in a clear bag, adjusted his pillow case, covered him with a clean sheet, pulled the privacy curtain back, cranked his bed down, pushed his wheel chair into the		found to have been affected by the deficient practice? CNA #1, CNA #2 and Nurse Manager were all immediately reeducated on proper hand washing procedures and glove utilization. All nursing staff on duty the night of October 9th was reeducated by the Clinical Education Coordinator and Director of Nursing Services on hand washing procedures, glove utilization, and skill validations were completed that same night. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by the alleged deficient practice. All staff will be reeducated on proper infection control procedures, including hand washing technique and glove utilization by the Clinical Education Coordinator or designee by November 5, 2013. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff will be reeducated on proper infection control procedures, including hand washing technique and glove utilization by the Clinical Education Coordinator or designee by November 5, 2013. Skills validations will be completed on all staff. How will the corrective action(s) be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	restroom. CNA #1 failed to remove the soiled gloves and or wash/sanitize her hands after she cleaned the feces from Resident K's buttocks and prior to providing care to Resident K. While in the restroom, CNA #1 removed her dirty gloves, turned on the bathroom sink faucet, applied soap, rubbed her hands together, turned the faucet off with her bare hands, and dried her hands with a paper towel. The entire hand washing/drying procedure lasted four seconds. With bare hands, CNA #1 picked up the contaminated dirty linen bags, carried them to the dirty soiled storage room, entered the soiled linen room, lifted the lid on the dirty linen barrel, placed the bags in the barrel, and closed the lid. CNA #1 failed to wash/or sanitize her hands at this time. CNA #1 walked to the dining room. While in the dining room she touched a resident's hand. CNA #1 failed to wash/sanitize her after handling dirty linens, prior to direct contact with the resident in the dining room, or after direct contact with the resident in the dining room. CNA #1 entered Resident L and Resident Ms' room. CNA #1 reached into the closet and removed clean		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Clinical Education Coordinator or designee will observe a minimum of five employees per shift daily to ensure proper hand washing and glove usage is being utilized. Through these observations, if any non compliance is noted, corrective action will be completed immediately. Once compliance is achieved an Infection Control CQI tool will be completed by Clinical Education Coordinator or designee for 10 employees weekly x 4 weeks, monthly x 2 and quarterly x 3, to ensure proper hand washing and glove utilization is maintained. Through the audits, if any non compliance is noted, corrective action will be completed immediately. The audits will be reviewed by the CQI committee and action plans will be developed, as needed, to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	wash clothes and handed them to Resident M. CNA #1 failed to wash/sanitize her hands prior to handling clean linens. CNA #1 applied gloves, picked up dirty clothes off of Resident L's bed, put them in the clear trash bag and sat them in the resident's closet. Without removing the contaminated gloves, CNA #1 closed the closet door, gathered dirty bed linen, placed them into another clear trash bag and then picked up a clean wash cloth and towel, touched Resident L's bed, touched the privacy curtain, reached into Resident L's bedside table, removed a clear bag which contained a tooth brush and handed it to Resident L. CNA #1 failed to wash/sanitize her hands and/or change gloves during the above care or handling of clean linens. CNA #1 removed the contaminated gloves. CNA #1 failed to wash/sanitize her hands at this time. With her bare hands she gathered trash from the trash can, tied the linen bag, handed Resident L a remote control and the call light, opened the door, walked to the soiled linen room, removed the key which hung on a hook outside the soiled utility room, unlocked the door, removed the lid from the soiled linen barrel, put the bag into the barrel, closed the barrel lid, closed the door,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	and returned the key to the hook. CNA #1 failed to wash/sanitize her hands before, after, or during the above care. 2. During constant observations of care on 10/9/2013, from 6:18 P.M. -7:30 P.M., (Certified Nursing Assistant) CNA #2 was observed to provide care. The following observations were made: CNA #2 reached into the clean linen storage and removed clean linen. She walked down the hall holding the clean linens against her scrub top. CNA #2 entered Resident T's room, covered Resident T with a sheet and a blanket, handed her a call light, turned off her light, pushed a wheel chair out of the room into the hallway, picked up a clear trash bag which contained dirty linens, carried the bag of dirty linens up against her scrub top, entered Resident Z's room, dropped the dirty bag of linens on the floor, turned a light on for Resident Z, picked up the dirty bag of linens, carried them to the soiled linen room, lifted the lid of the dirty linen barrel, placed the bag into the barrel, shut the door to the dirty linen storage room. CNA #2 failed to wash/sanitize her hands before, during, or after the above care and/or properly handle			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013
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) COMPLETION DATE
	soiled linen. CNA #2 entered Resident T's room, applied gloves, removed Resident T's pillows from her bed and placed them on the dresser, walked out of the room wearing the contaminated gloves, touched Resident P on her shoulder, walked down the hall to the clean linen storage cart, pulled the cart back to Resident T's room, reached into the clean linens, touched several items of clean linen, removed clean linens, entered Resident T's room, then removed her gloves. and applied clean gloves. CNA #2 failed to wash/sanitize her hands before, after, or during the above care and handling of clean linen. 3. During an observation on 10/9/13 at 7:25 P.M., the Nurse Manager entered Resident T's room and asked CNA #2 if she needed help. The Nurse Manger entered the restroom, turned on the water at the sink, put soap on her hands, rubbed her hands together, rinsed her hands, and dried her hands with a paper towel. The total time for the handwashing procedure was five seconds. During an interview at this time, the Nurse Manager was queried regarding her expectations of how long staff were to wash their hands. The Nurse Manager stated, "20 seconds."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	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) COMPLETION DATE
	A facility policy titled "Infection Control and Prevention Program" dated 10/11, identified as current by the Executive Director on 10/10/2013 at 9:30 A.M., indicated, ".... Hand Hygiene... procedure steps... Apply soap, rub hand together, between fingers to create a lather... Lather all surfaces of fingers and hands including wrists... Use friction for at least 20 seconds.... Note: 5 Moment of required hand hygiene: -Before patient -Before an aseptic task -After body fluid exposure risk -After patient contact -After contact with patient surroundings..." A facility policy titled "Laundry/Linen" dated 2/12, identified as current by the Director of Nursing (DON) on 10/11/13 at 12:06 P.M., indicated, "...All linen is contaminated.... Staff shall follow standard precautions, using gloves and/or aprons if direct contact with body fluids is likely.... Soiled linen: Carry away from body to prevent soiling uniform.... Clean linen must be protected from soiling or contamination. Clean linen should be carried away from body to prevent contamination...." This Federal tag relates to Complaint IN00137487.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	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) COMPLETION DATE
	3.1-18(a) 3.1-18(j)			