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 11/22/2013

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 a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00139236. Complaint IN00139236-Substantiated. No deficiencies related to the allegation(s) are cited. Survey dates: November 18, 19, 20, 21, and 22, 2013. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Survey Team: Lora Brettnacher, RN-TC Jeanna King, RN Karen Hartman, RN Laura Brashear, RN (November 20 & 21, 2013) Mary Weyls, RN (November 20 & 21, 2013) Teresa Buske, RN (November 20 & 21, 2013) Census bed type: SNF: 15 SNF/NF: 146 Residential: 72	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 December 19, 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.

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	Total: 233 Census payor type: Medicare: 19 Medicaid: 113 Other: 101 Total: 233 Residential Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 11/27/2013 by Brenda Marshall Nunan, R.N.			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure recommended bed position and toileting program were implemented according to the plan of care for 1 of 37 residents reviewed for plans of care (Resident #147). Findings include: Resident #147's record was reviewed on 11/21/2013 at 10:32 A.M. Resident #147 had diagnoses which included, but were not limited to, dementia, chronic pain, abnormal gait, lack of coordination, abnormal posture, and Parkinson's disease. A quarterly minimum data assessment tool (MDS) dated 7/6/2013, indicated Resident #147 was cognitively impaired, BIMS (brief interview mental status) could not be completed, required extensive assistance from staff for toileting, was on a toileting program, and was frequently incontinent of bowel and bladder. During constant observation on 11/21/2013 from 9:20 A.M. through	F000282	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 147 was assisted to the restroom and his bed was placed back in the lowest position per plan of care.	12/19/2013

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	11:55 A.M., Resident #147 was not taken to the bathroom. During an observation on 11/21/2013 at 2:05 P.M., Resident #147 was observed in his bed. The bed was observed not in its lowest position. RN #1 entered the room and was observed to lower Resident #147's bed. She indicated the bed was to be in the lowest position. She indicated she lowered it at least a foot and a half. A care plan dated 4/17/2013, indicated Resident #147 was at risk for falls due to poor safety awareness, dementia, memory impairment, a history of falls, gait disturbance, weakness related to Parkinson's disease. Interventions included ensuring his bed was in the lowest position and staff were to take him to the toilet every hour while he was awake. Review of Resident #147's CNA assignment sheet titled "American Senior Communities Resident Care/Need Sheet" identified by RN #1 as current on 11/21/2013, indicated Resident #147 required the assistance of two staff for toileting needs, was to be toileted hourly, and his bed should be positioned in the		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 have the potential to be effected by the deficient practice. DNS and nurse managers conducted an audit of all residents' fall and toileting care	

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	lowest position at all times. During an interview on 11/19/2013 at 10:38 A.M., RN #1 indicated Resident #147 had fallen within the last 30 days. During a telephone interview on 11/19/2013 at 12:21 P.M., Resident #147's wife indicated Resident #147 was not provided the assistance with toileting that he needed. She stated, "He can go to the bathroom and use it but they just leave a brief on him." She indicated she visits daily from 4:30 P.M. to 7:30 P.M. and while she was there staff does not take him to the toilet. During an interview on 11/21/2013 at 2:33 P.M., RN #1 indicated the CNAs knew the bed should have been in the lowest position because it was on their assignment sheet. During an interview on 11/22/13 at 9:00 A.M., Registered Nurse (RN) #1 indicated Resident #147 would use the toilet if he had not already done so in his brief. She stated, "...Sometimes he will tell you but not always. With him some days are better than others. He is a heavy wetter. That's why we went to every hour instead of every two hours. He		plans for accuracy and effectiveness of interventions. CNA assignment sheets were updated with all appropriate interventions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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	was overly wet at two hours." 3.1-35(g)(2)		All nursing staff will be re-educated by the Clinical Education Coordinator regarding the importance of following plans of care and ensuring interventions are in place. Re-education will be completed by December 19, 2013. DNS/designee will conduct rounds daily on each shift to ensure bed positioning and toileting are done per the residents' plan of care. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality	

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			assurance program will be put into place? To ensure compliance, the DNS/Designee is responsible for the completion of the Fall Management CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F000311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview, and record review, the facility failed ensure a resident was taken to the toilet to maintain abilities with continence of bladder. This deficient practice affected 1 of 37 residents reviewed for provision of necessary assistance. (Resident #147). Findings include: Resident #147's record was reviewed on 11/21/2013 at 10:32 A.M. Resident #147 had diagnoses which included, but were not limited to, insomnia, psychosis, dementia, chronic pain, abnormal gait, lack of coordination, abnormal posture, and Parkinson's disease. During constant observation on 11/21/2013 from 9:20 A.M. through 11:55 A.M., Resident #147 was not taken to the bathroom. A quarterly minimum data assessment tool (MDS) dated 7/6/2013, indicated Resident #147 was cognitively impaired, BIMS (brief	F000311	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #147 was assisted to the restroom every hour per plan of care. DNS/Nurse Management reviewed resident #147's care plan and toileting schedule for accuracy and appropriateness. Resident #147's CNA assignment sheet states the resident is to be assisted with toileting every hour.	12/19/2013

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	interview mental status) could not be completed, required extensive assistance from staff for toileting, was on a toileting program, and was frequently incontinent of bowel and bladder. A quarterly MDS dated 10/1/2013, indicated Resident #147 was cognitively impaired, required extensive assistance of two staff for toileting, was not on a toileting schedule, and had declined from frequently incontinent to always incontinent of bowel and bladder. A care plan dated 4/17/2013, indicated Resident #147 was dependent upon staff for all activities of daily living and he did not initiate, sequence, or implement tasks without staff assistance or guidance due to his diagnoses of Parkinson's disease, dementia, chronic pain, weakness, gait disturbance, and debility. Goals listed included Resident #147's needs would be met. Interventions to meet this goal included staff were to assist Resident #147 with tasks as needed. Review of Resident #147's CNA assignment sheet titled "American Senior Communities Resident Care/Need Sheet" identified by RN #1 as current on 11/21/2013, indicated Resident #147 required the assistance of two staff for toileting		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 have the potential to be affected by this deficient practice. The DNS/Nurse Managers completed an audit of all ADL care plans to ensure accuracy and appropriateness of interventions. Care plans and CNA assignment sheets were updated as appropriate.	

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	needs and was to be toileted hourly. During a telephone interview on 11/19/2013 at 12:21 P.M., Resident #147's wife indicated Resident #147 was not provided the assistance with toileting that he needed. She stated, "He can go to the bathroom and use it but they just leave a brief on him." She indicated she visits daily from 4:30 P.M. to 7:30 P.M. and while she was there staff does not take him to the toilet. During an interview on 11/22/13 at 9:00 A.M., Registered Nurse (RN) #1 indicated Resident #147 would use the toilet if he had not already done so in his brief. She stated, "...Sometimes he will tell you but not always. With him some days are better than others. He is a heavy wetter. That's why we went to every hour instead of every two hours. He was overly wet at two hours." 3.1-38(2)(C)		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 re-educated by the Clinical Education Coordinator regarding the importance of following plans of care, ensuring appropriate ADL assistance is provided. Re-education will be completed by December 19, 2013. DNS/designee will do daily rounds on all shifts to ensure resident's toileting schedule is followed per plan of care	

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			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? To ensure compliance, the Unit Managers/Designee is responsible for the completion of the Accommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee	

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			overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F000323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure exposed electrical wiring was out of a resident's reach and failed to ensure fall prevention interventions were implemented. This deficient practice affected 2 of 4 residents reviewed for accident/hazards (Resident #120 and Resident #147). Findings include: 1. Resident #120's record was reviewed on 11/21/2013 at 10:32 P.M. Resident #147 had diagnoses which included, but were not limited to, depression, heart failure, and hypertension. An annual minimum data set assessment tool (MDS) dated 10/3/13, indicated Resident #120 was severely cognitively impaired. During an observation on 11/18/2013 at 1:00 P.M., Resident #147 was observed in her bed. The bed was positioned with the right side of the bed against the wall. An electrical	F000323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The wiring in Resident #120's room was rerouted and new wiring moulding was added. All wires were secured behind the new wire moulding.	12/19/2013

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	phone jack junction box was located at the bed's mattress level towards the middle of the bed. The junction box was not secured to the wall. From behind the phone jack junction box a loose cable jacket leading up the wall into a call light junction box that was pulled loose from the wall. The cable jacket had been pulled down exposing coated wire. During an interview on 11/18/2013 at 1:01 P.M., Certified Nursing Assistant #2 (CNA), stated, "She grabs and yanks at the wires. She pulled it out again. They just fixed it..." CNA #2 indicated Resident #120 would become aggravated when positioned on her right side during care and would grab a hold of the wire and pull on it. During an interview on 11/18/2013 at 1:18 P.M., with the Executive Director (ED), the Assistant Administrator, and the Maintenance Supervisor present, the Maintenance Supervisor stated, "Whole lot worse than it was Friday." He indicated he was made aware of the wiring on Friday 11/15/13, but did not fix it because the nurse did not want the resident moved due to her condition. He stated, "... We have been battling this for a long time. It is hard wired into the wall... It is 24		Resident #120's bed was rearranged so that she could no longer reach the wiring and moulding. Resident 147's bed was immediately placed back into its lowest position. How will you identify other residents having the potential to be affected by the same deficient practice and what	

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	volt...." During an interview on 11/19/2013 at 9:50 A.M., the Maintenance Supervisor indicated indicated the wiring ran down through the ceiling to the phone jack and then up a foot and a half to the call light junction box. He indicated approximately three inches of the wire insulation was exposed. When queried if Resident #120 could have hurt herself if she came in contact with the wiring he replied, "She would have felt it." 2. Resident #147's record was reviewed on 11/21/2013 at 10:32 A.M. Resident #147 had diagnoses which included, but were not limited to, insomnia, psychosis, dementia, chronic pain, abnormal gait, lack of coordination, abnormal posture, and Parkinson's disease. During an observation on 11/21/2013 at 2:05 P.M., Resident #147 was observed in his bed. The bed was not in the lowest position. At this time RN #1 entered the room. RN #1 lowered Resident #147's bed to the lowest position. She indicated it was not in the lowest position and she had lowered it at least a foot and a half.. A care plan dated 4/17/2013,		corrective action will be taken? All residents have the potential to be affected by the deficient practice All resident rooms were audited to ensure wiring and mouldings were intact. Any noted concerns were immediately corrected. Customer Care Representatives completed an audit of all their assigned rooms to ensure that identified fall interventions, including environmental adaptations, were in place. Any noted concerns were immediately corrected.	

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	indicated Resident #147 was at risk for falls due to poor safety awareness, dementia, memory impairment, a history of falls, gait disturbance, weakness related to Parkinson's disease. A goal indicated Resident will be free from fall related injuries. Interventions to meet this goal included ensuring his bed was in the lowest position. Review of Resident #147's CNA assignment sheet titled "American Senior Communities Resident Care/Need Sheet" identified by RN #1 as current on 11/21/2013, indicated Resident #147 required the assistance of two staff for toileting needs, was to be toileted hourly, and his bed should be positioned in the lowest position at all times. During an interview on 11/19/2013 at 10:38 A.M., RN #1 indicated Resident #147 had fallen within the last 30 days. During an interview on 11/21/2013 at 2:33 P.M., RN #1 indicated the CNAs knew the bed should have been in the lowest position because it was on their assignment sheet. 3.1-45(a)(1) 3.1-45(a)(2)		DNS/designee will conduct daily rounds on all shifts to ensure bed positioning is correct per residents' plan of care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All Department Managers were re-educated on the Customer Care Rounds process. They	

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			were also educated on the proper way to complete the QIS environmental observations. Education was conducted by the Executive Director and Customer Care Coordinator on December 6, 2013. Customer Care Representatives will complete the QIS environmental observations for their assigned rooms weekly. All findings from the observations will have a Maintenance Work Request form completed.	

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			Maintenance Supervisor and Executive Director will review all work request forms from the previous day to ensure that noted concerns are corrected. 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? Nursing Call systems and room wiring has been added to the weekly Preventative Maintenance Program and will be audited by the Maintenance Department weekly.	

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			To ensure compliance, the Customer Care Coordinator/Designee is responsible for the completion of the Customer Care CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to ensure therapeutic dietary interventions ordered to prevent weight loss were implemented for 1 of 7 residents reviewed for weight loss (Resident #96). Findings include: 1. Resident #96's record was reviewed on 11/21/2013 at 9:00 A.M. Resident #96 had diagnoses which included, but were not limited to, weight loss and dementia. A quarterly minimum data set assessment tool (MDS) dated 5/7/2013 indicated Resident #96, was severely cognitively impaired, required extensive assistance of one person for eating, was 63 inches tall and weighed 127 pounds.	F000325	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #96 is receiving meals per diet order and as stated on tray card. Resident #96's weight and diet orders were reviewed by the IDT team including the Registered Dietician. Resident #96 was observed by Registered	12/19/2013

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	A quarterly MDS dated 8/7/2013, indicated Resident #96 weighed 122 pounds. An IDT AR (Interdisciplinary Team Nutrition Assessment Review) note dated 9/13/2013 at 3:04 P.M., indicated, "...Resident is receiving a Regular diet w(with)/fortified foods (implemented 8/20/2013) and per meal consumption records generally consumes 25-100 percent at breakfast, 25-100 percent at lunch, and 25-50 percent at dinner. Intakes remain varied. Estimated energy needs should be met with diet and intakes greater than 75%...Remains at risk for further weight decline d/t (due to) varied po (oral) intakes and dx (diagnosis) of Dementia...." A quarterly MDS dated 9/24/2013, indicated Resident #96 weighed 118 pounds, was not on a physician's prescribed weight loss diet, required one person physical assist for eating, and had lost more than 5% in the last month or had a loss of 10% in the last 6 months. Physician's recapitulation orders for October 2013, indicated Resident #96 had orders for a regular diet with fortified food at all meals, fortified milk, ice cream and peanut butter		Dietician receiving her diet per order. Resident #96's weight has remained stable since last MDS was completed. 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 weight loss have a potential to be affected by the deficient practice. Registered Dietician and Dietary Manager completed an audit of all resident's diet orders to ensure appropriate diets were ordered and that tray cards reflect the appropriate diet.	

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	sandwich with every meal. A current care plan dated 10/2/2013, indicated Resident #96 had experienced a weight loss over the last 180 days. A goal listed for Resident #96 indicated she would be without a significant weight decline. Interventions included: provide a regular diet with fortified foods, offer ice cream and peanut butter and jelly with meals, monitor food/fluid intake at meals, offer her a substitute if less than 50 percent of any meal was consumed. A Registered Dietician (RD) note dated 10/11/2013 at 1:54 P.M., indicated, "....shows a significant weight loss in 180 days. St (speech therapy) screen notes resident's attention span has decreased and requires cueing to consume meals...now walking increasing intake need. Per meal records res consumes 50-100 % of Reg (regular) Fortified Food diet with Fortified Milk at meals, ice cream and peanut butter sandwich for added kcals (kilocalories). Will clarify diet to read Regular Fortified Food, ice cream and peanut butter sandwich each meal. Res will consume 100% of peanut butter and ice cream most meals. Nutrition supplemented with House		All nursing staff will be re-educated on the facility's Food and Fluid Documentation Procedure and the use of fortified foods and supplements. Re-education will be completed by the Clinical Education Coordinator and the Registered Dietician by December 19, 2013. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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	Supplement (two-cal) 120 cc bid (twice a day) consumes 50 % or greater usually. Res (Resident) continues remeron as an appetite stimulate and Calcium and Vit (vitamin) D for Dx (diagnoses) osteoporosis...Continue with POC (plan of care) and monitor pending Phys (physician) approval for diet clarification." A RD note dated 10/16/2013 at 1:13 P.M., indicated, "....Resident has had a 7.2% (9#) WT (weight) loss over 90 days and 11.5 % (15#) WT loss over 180 days. Past WT loss likely d/t Hx (history) of decreased intakes and increased activity, which may have increased nutritional needs. Diet order is regular. She takes her meals in the dining room and feeds herself after setup...." Consumption records were reviewed from 9/21/2013 through 11/21/2013. The record lacked documentation Resident #96 was offered and/or consumed the peanut butter and jelly sandwiches and/or ice cream. The record lacked documentation Resident #96 was offered a substitute when less than 50 percent of a meal was consumed on 9/23/2013, 9/25/2013, 9/26/2013, 9/29/2013, 10/2/2013, 10/3/2013, 10/4/2013,		All residents with triggered significant weight loss will be reviewed weekly by IDT team during Nutritional At Risk Meeting. IDT team will review weights, diet orders, and interventions to ensure all are appropriate and effective. Changes will be made as deemed appropriate to ensure nutritional status is maintained. The Dining Room Monitor/designee will complete the NAR Meal Time Check List for all residents identified by the IDT team as nutritionally at risk daily times four weeks, then weekly thereafter. This check list will be completed to ensure	

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	10/11/13, 10/12/13, 10/13/13, 10/31/2013, 11/5/2013, 11/12/13, 11/14/2013,11/16/2013 (breakfast), 11/16/2013 (lunch), and 11/20/13. On 11/22/2013 at 9:30 A.M., The ED (Executive Director) provided an undated and untitled document which indicated Resident #96's weights from May 2013 through 11/18/2013. This document indicated on May 7, 2013, Resident #96 weighted 127 pounds and on November 18, 2013, she weighed 116 pounds. During an interview on 11/19/2013 at 10:30 A.M., RN (Registered Nurse) #1 indicated Resident #96 received fortified foods due to weight loss. RN #1 indicated consumption of dietary interventions such as high caloric foods implemented for weight loss and provided with meals were not documented separately from meal consumption. During an interview on 11/22/2013 at 1:00 P.M., with the Executive Director, the DON (Director of Nursing), and the Memory Care Facilitator (MCF) present, the ED indicated indicated consumption of dietary interventions such as high caloric foods implemented for weight loss and provided with meals were		that residents are receiving interventions per tray card/physician order and interventions were accepted. 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? To ensure compliance, the Dietary Manager is responsible for the completion of the Meal Observation CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive	

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	not documented separately from meal consumption. When queried how the interventions were evaluated for effectiveness if consumption was not monitored, the DON indicated he did not know. The ED indicated the facility would change how they monitored the consumption of dietary interventions implemented for residents with weight loss. 3.1-46(a)(1) 3.1-46(a)(2)		quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure a system for monitoring behaviors after resolution of a medical condition and failed to implement non -pharmacological interventions prior to introduction of an antipsychotic medication for 1 of 10 residents reviewed for unnecessary medications (Resident #23). Findings include:	F000329	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	12/19/2013

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	Resident #23's record was reviewed on 11/21/2013 at 9:30 A.M. Resident #23 had diagnoses which included, but were not limited to, dementia, chronic pain, benign prostatic hyperpiesia (BPH), and depression. A change in status minimum data set assessment tool (MDS) dated 7/23/2013, indicated Resident #23 had a brief interview mental status score (BIMS) 6 out of 15, exhibited no signs or symptoms of delirium, behaviors, or rejected care, required extensive assistance of 1 or 2 staff for all activities of daily living (ADLs), could not ambulate, exhibited symptoms of depression, and had indicated it was very important to him to participate in religious services and to make choices about his daily activities. An untimed geriatric psychiatric consult note dated 10/21/2013, indicated, "...Chart reviewed...Consult requested due due dementia with behaviors. Staff report pt (patient) is constantly praying over staff and peers. Calls others "the devil." Talks and prays loudly all noc. (night). 10/16/2013 altercation with roommate. Wants to room with his wife who is on Cottage 3, but that is not an option due to safety		Resident # 23 will be provided non-pharmacological interventions prior to the administration of anti-psychotic medication when warranted. Resident #23 was seen by a Geriatric Psychiatrist. Current course of treatment was deemed appropriate. 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 receiving	

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	concerns...." This note indicated Resident #23 had depression and dementia. A progress note dated 10/30/2013 at 10:00 A.M., indicated: Resident #23 had a new/worsening behavior and was started on an antibiotic on 10/24/2013 to treat a urinary tract infection (UTI). The antibiotic was not effective so he was started on a different antibiotic on 10/28/2013. An interdisciplinary team (IDT) note dated 10/31/2013 at 6:36 P.M., indicated the root cause of his behaviors was due to a urinary tract infection. A progress note on 11/15/2013 at 9:37 P.M., indicated staff spoke with the psychiatrist's nurse practitioner regarding Resident #23's increased delusions. The nurse practitioner ordered Risperdal (anti-psychotic) medication. During an interview on 11/22/13 at 1:50 P.M., with the Director of Nursing (DON) and the Memory Care Facilitator (MCF) present, the MCF indicated Resident #23 had finished his antibiotic regimen for the UTI on 11/6/2013 but his behaviors continued. Care plans which included		anti-psychotic medications have the potential to be affected. DNS/Social Services will complete a review of all residents receiving anti-psychotic medications to ensure appropriate diagnosis and documentation warranting the use of medications is present. Gradual dose reductions were also reviewed to ensure that timely attempts at reductions were completed. Adjusted medication orders, updated care plans, and updated documentation was completed when appropriate. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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	non pharmacological interventions implemented prior to administering the anti-psychotic medication and documentation of Resident #23's behaviors after treatment completed for a urinary tract infection were requested. During an interview on 11/22/13 at 3:30 P.M., with the DON and the MCF present, the MCF indicated, the record lacked documentation of behaviors other than when Resident #23 complained of pain, threatened to pull out his catheter, and prayed to Jesus to remove the catheter, at which time he was administered his PRN anti-anxiety medication along with pain medication which was effective; when he kicked the medication cart because he was hungry and when provided food he calmed down; and when he expressed fear of being kidnapped when staff attempted to put him in a van with a stranger to be transported to a doctor's appointment. The MCF further indicated documentation was not available which indicated Resident #23's behaviors were tracked or the implementation and efficacy of non pharmacological interventions prior to introducing an anti-psychotic medication.		All nursing staff will be re-educated on the facility's Behavior Management Program, which includes the use of non-pharmacological interventions and proper documentation. Re-education will be conducted by Social Services and completed by December 19, 2013. Nurse Management/designee will be contacted prior to the requesting any changes with anti-psychotic medication to ensure non-pharmacological interventions were attempted and monitored for effectiveness. How will the corrective action(s) be	

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	During the exit conference on 11/22/2013 at 4:17 P.M., the DON indicated he did not have any further information or documentation regarding the implementation of an anti-psychotic medication to Resident #23's medication regimen. 3.1-48(a)(3) 3.1-48(a)(4)		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, DNS/designee will be responsible for the completion of the Unnecessary Medication CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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R000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00139236. Complaint IN00139236-Substantiated. No deficiencies related to the allegation(s) are cited. Survey dates: November 18, 19, 20, 21, and 22, 2013. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Survey Team: Lora Brettnacher, RN-TC Jeanna King, RN Karen Hartman, RN Laura Brashear, RN (November 20 & 21, 2013) Mary Weyls, RN (November 20 & 21, 2013) Teresa Buske, RN (November 20 & 21, 2013) Census bed type: SNF: 15 SNF/NF: 146 Residential: 72	R000000	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 December 19, 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 11/22/2013
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
	Total: 233 Census payor type: Medicare: 19 Medicaid: 113 Other: 101 Total: 233 Residential Sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on 11/27/2013 by Brenda Marshall Nunan, R.N.			