STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00176363, IN00176803, and IN00178761. Complaint IN00176363 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00176803 - Substantiated. State Residential deficiency related to the allegation is cited at R242. Complaint IN00178761 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 3, 4, & 5, 2015 Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census bed type: SNF: 15 SNF/NF: 134 Residential: 47 Total: 196 Census payor type: Medicare: 26	F 0000	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 or post survey on or after	

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

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	Medicaid: 92 Other: 31 Total: 149 Sample: 5 Zionsville Meadows was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00176363, IN00176803, and IN00178761.			
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00176803. Complaint IN00176803 - substantiated. State residential deficiency related to the allegation is cited at R242. Residential census: 47 Sample: 3 This state finding is cited in accordance with 410 IAC 16.2-5.	R 0000	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 or post survey on or after	
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of			

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	any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview, the facility failed to monitor and assess bowel elimination patterns for 1 of 3 residents reviewed for efficacy of PRN (as needed) medications resulting in hospitalization for fecal impaction (Resident C). Findings include: The record for Resident C was reviewed on 8/4/15 at 9:55 a.m. His diagnoses included dementia and anemia. The "Evaluation Agreement for Residential Healthcare Services" dated 12/22/14, indicated "Toileting/Incontinence" "0 No assistance needed." The Service Plan, dated 12/22/14, indicated "Toileting/Incontinence" and checked was the response "No assistance needed." A Resident Care Note, dated 2/7/13 at 1:15 p.m., indicated Resident C's granddaughter was concerned about his bowel incontinence and indicated she had a picture of the bathroom commode	R 0242	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident C no longer resides at the facility. Licensed nurses and Qualified Medication aides were reeducated on 8/7/2015 and 8/17/2015 on facility policy for the administration of PRN (as needed) medications, including but not limited to PRN (as needed) medication effectiveness. Licensed nurses and Qualified Medication aides were reeducated by 8/7/2015 and 8/17/2015 on facility policy on Resident Change of Condition, included but not limited to notification of physician and family/responsible party when a signicant change in the resident's condition is noted or unresolved. Licensed nurses and Qualified Medication aides were reeducated by 8/7/2015 and 8/17/2015 on facility policy on 72 Hour Documentation shift monitoring and documentation for residents noted to have acute or change in status situations by the Clinical Director and General Manager. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All	09/01/2015

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	containing loose stool. The note also indicated "..."Stool appeared dark, mucous-like, and was red tinged. Paged on-call MD for [resident's physician name]....Denies pain & denies incontinent loose stool episodes." A physician's order for stool sample was received on 2/7/15 at 1:45 p.m. A 72 Hour Follow Up Charting form was initiated and for the next 72 hours staff were unable to obtain a stool sample to send for testing. A physician's order, dated 2/11/15, indicated the stool sample was to be discontinued and the resident was to receive Imodium (antidiarrhea medication, generic: loperamide) 2 milligrams (mg) 1 tablet 4 times a day PRN for diarrhea. The February, 2015, MAR (Medication Administration Record) indicated Resident C received Imodium on February 12, 13, 18, 20, 21, 22, 23, 24, 25, 26, and 27, 2015. The record did not indicate an assessment for efficacy of medication was completed and the Resident Care Notes did not indicate abdominal assessments were completed or bowel elimination patterns were tracked.		Residents have the potential to be affected. Clinical Director/Designee performed audit of all PRN (as needed) medications, PRN (as needed) medication effectiveness and 72 hour documentation including but not limited residents noted to have constipation, loose stools, or acute change in status situations. Staff were reeducated 8/7/15 and 8/17/2015 on PRN (as needed) medications, 72 hour documentation, and Resident Change of Condition policies What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur? Staff were reeducated 8/7/15 and 8/17/2015 on PRN (as needed) medications, 72 hour documentation, and Resident Change of Condition policies. Clinical Director/Designee will be responsible for daily auditing PRN medication efficacy and documentation to ensure policies are followed. 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? A CQI tool will be completed as a monitoring tool. This tool will be completed weekly x 4, bi-monthly x 2, then on quarterly basis until continued compliance is maintained for 2 consecutive quarters by the Clinical Director/Designee. If a threshold of 95% is not met, the	

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	The March, 2015 MAR indicated he received the Imodium (loperamide) on March 1 and 2, 2015. The record did not indicate an assessment for efficacy of medication was completed and the Resident Care Notes did not indicate abdominal assessments were completed or bowel elimination patterns were tracked Resident Care Notes from 2/11/15-3/2/15 did not indicate concerns were identified and addressed in regard to use of anti-diarrheal medication and did not indicate bowel elimination was tracked or abdominal assessments were completed. A hospital discharge summary, dated 3/5/15, indicated "ADMISSION DIAGNOSIS: Fecal impaction, constipation, mental status changes." DISCHARGE DIAGNOSIS: Fecal impaction resolved...." HOSPITAL COURSE:...He was disimpacted and given enemas along with stool softener and had a large bowel movement on the night of admission...." The Nursing Drug Handbook, 2010, indicated precautions for loperamide administration included give cautiously in elderly patients. Adverse reactions included: constipation, abdominal pain,		results will be reviewed at monthly At-Risk meetings and an action plan will be developed and/or disciplinary action. The CQI tool will be oversee by the Clinical Director and General Manager. By what date the systemic changes will be completed: 9/1/2015.	

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	distention or discomfort. During an interview on 8/4/15 at 1:40 p.m., the Clinical Manager indicated an assessment should have been done first for someone with diarrhea. The assessment should have included checking bowel sounds, assessing the abdomen to see if it was soft or hard and for presence of tenderness, and monitoring frequency and consistency of stools.			