STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620		X2) MULTIPLE CONSTRUCTION A. BUILDING O B. WING  X3) DATE SURVEY COMPLETED 08/05/2015					
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE  675 S FORD RD  ZIONSVILLE, IN 46077					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0000  Bldg. 00  This visit was for the Complaints IN0017 and IN00178761.  Complaint IN00170 No deficiencies related are cited.  Complaint IN00170 State Residential deallegation is cited at Complaint IN00178	he Investigation of 76363, IN00176803,  6363 - Substantiated. ated to the allegations  6803 - Substantiated. eficiency related to the at R242.  8761 - Substantiated. ated to the allegations  2015  000538 155620 100267290	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 regulation. This provider respectfully requests that the 2567 Plan of Correction be considered as the Letter of Credible Allegation and request desk review or post survey on after	of t s n of			

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

TITLE

(X6) DATE

Any defiency statement 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.

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JETIPLE CO ILDING	00	(X3) DATE COMPL		
		155620	B. WI			08/05/		
NAME OF PROVIDER OR SUPPLIER  ZIONSVILLE MEADOWS		1	STREET ADDRESS, CITY, STATE, ZIP CODE  675 S FORD RD  ZIONSVILLE, IN 46077					
		TATEMENT OF DEFICIENCIES		ID	,		(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	:	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Other: Total:	92 31 49						
	compliance with Subpart B and 41	5  ows was found to be in  42 CFR Part 483,  10 IAC 16.2-3.1 in estigation of Complaints  00176803, and						
R 0000								
Bldg. 00	This visit was for Complaint IN00	r the Investigation of 176803.	R 00	000	The creation and submission of this plan of correction does no constitute an admission by this provider of any conclusion set	t S		
	•	176803 - substantiated. deficiency related to the d at R242.			forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be			
	Residential censu				considered as the Letter of Credible Allegation and reques desk review or post survey on			
	Sample: This state finding with 410 IAC 16	g is cited in accordance .2-5.			after			
R 0242	410 IAC 16.2-5-4(							
Bldg. 00		onense  nall be observed for  ons. Documentation of						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETED	
		155620	B. W	B. WING		08/05/2015	
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .			FORD RD		
	LLE MEADOWS		_	ZIONS	VILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG				TAG	BLI ICILIACT)		DATE
TAG	any undesirable e the clinical record notified immediate occur, and such n documented in the Based on record the facility failed bowel elimination residents review (as needed) med hospitalization for (Resident C).  Findings included  The record for R on 8/4/15 at 9:55 included dement  The "Evaluation Residential Heal 12/22/14, indicat "Toileting/Incom needed."  The Service Plat indicated "Toilet	ffects shall be contained in an arrival of the physician shall be sely if undesirable effects of the physician shall be selved in the contained in an arrival of the physician shall be selved in the contained in the physician shall be selved in the contained in the physician shall be selved in the contained in the physician in t	RO	TAG	What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? Residen 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 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 8/17/2015 on facility policy on Resident Change of Condition included but not limited to notification of physician and family/responsible party when signicant change in the reside 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 Hour Documentation shift monitoring and documentation residents noted to have acute	oe nts y nt C /. I the g ss s and , a nt's ed. I 72 of for or	09/01/2015
	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				change in status situations by Clinical Director and General Manager. How other residents having the potential to be affect by the same deficient practice be identified and what correcting action(s) will be taken. All	s cted will	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			COMPLETED		
155620		B. W	ING		08/05/	2015	
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
ZIONSVILLE MEADOWS				ORD RD			
ZIONSVI	LLE MEADOWS			ZIONS	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	containing loose	stool. The note also			Residents have the potential to	0	
	indicated ""Sto	ool appeared dark,			be affected. Clinical		
		d was red tinged. Paged			Director/Designee performed		
	-	• •			audit of all PRN (as needed)		
	· ·	resident's physician			medications, PRN (as needed		
	name]Denies	•			medication effectiveness and		
	incontinent loos	e stool episodes."			hour documentation including not limited residents noted to	but	
					have constipation, loose stools	s or	
	A physician's or	der for stool sample was			acute change in status situation		
	received on 2/7/	-			Staff were reeducated 8/7/15 a		
	Teccived on 2/7/	13 ut 1. 13 p.m.			8/17/2015 on PRN (as needed		
	A 70 II F 11				medications, 72 hour	,	
	A 72 Hour Follow Up Charting form was				documentation, and Resident		
	initiated and for the next 72 hours staff				Change of Condition policies		
	were unable to obtain a stool sample to				What measures will be put into		
	send for testing.				place or what systematic chan	-	
					will be made to ensure that the		
	A physician's order deted 2/11/15				deficient practice does not occ		
	A physician's order, dated 2/11/15, indicated the stool sample was to be				Staff were reeducated 8/7/15 8/17/2015 on PRN (as needed		
		_			medications, 72 hour	1)	
		d the resident was to			documentation, and Resident		
	receive Imodiun	n (antidiarrhea			Change of Condition policies.		
	medication, gene	eric: loperamide) 2			Clinical Director/Designee will	be	
	milligrams (mg)	1 tablet 4 times a day			responsible for daily auditing F		
	PRN for diarrhe	•			medication efficacy and		
					documentation to ensure polic		
	The February 20	015 MAD (Madiantian			are followed. How the correct	ive	
	1	015, MAR (Medication			action(s) will be monitored to		
		Record) indicated			ensure the deficient practice w	/ill	
	Resident C received Imodium on				not recur, i.e., what quality		
	February 12, 13, 18, 20, 21, 22, 23, 24,				assurance program will be put		
	25, 26, and 27, 2015. The record did not				into place? A CQI tool will be completed as a monitoring too	ı.	
	indicate an assessment for efficacy of				This tool will be completed we		
		·			x 4, bi-monthly x 2, then on		
	medication was completed and the				quarterly basis until continued		
		otes did not indicate			compliance is maintained for 2		
		sments were completed			consecutive quarters by the		
	or bowel elimina	ation patterns were			Clinical Director/Designee. If a		
	tracked.				threshold of 95% is not met, th	ne	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155620		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE S COMPLI	ETED		
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE  675 S FORD RD  ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE PPROPRIATE	(X5) COMPLETION DATE	
	The March, 201 received the Imo March 1 and 2, 2 indicate an assess medication was Resident Care N abdominal assess or bowel eliminatracked  Resident Care N did not indicate and addressed in anti-diarrheal meindicate bowel eliminate indicate bowel eliminate.	5 MAR indicated he odium (loperamide) on 2015. The record did not ssment for efficacy of completed and the otes did not indicate sments were completed ation patterns were detected at the otes from 2/11/15-3/2/15 concerns were identified a regard to use of edication and did not limination was tracked or sments were completed.		results will be reviewed monthly At-Risk meetin action plan will be deve and/or disciplinary actic CQI tool will be oversed Clinical Director and Go Manager. By what date systemic changes will be completed: 9/1/2015.	gs and an eloped on. The e by the eneral e the		
	A hospital disch 3/5/15, indicated DIAGNOSIS: F constipation, me DISCHARGE Dimpaction resolv COURSE:He given enemas all and had a large l night of admissi  The Nursing Druindicated precau administration in elderly patien	arge summary, dated I "ADMISSION ecal impaction, ental status changes." DIAGNOSIS: Fecal red" HOSPITAL was disimpacted and ong with stool softener bowel movement on the					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	l í	JILDING	ONSTRUCTION  00	(X3) DATE COMPI 08/05	LETED	
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)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	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.							

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