STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155620	A. BUILDING -- B. WING	08/18/2022

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/18/22 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Emergency Preparedness survey, Zionsville Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 185 certified beds. At the time of the survey, the census was 54. Quality Review completed on 08/22/22	E 0000	Request Desk Review	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/18/22 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Life Safety Code survey, Zionsville Meadows was found not in compliance with	K 0000	Request Desk Review	

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility is a split-level facility with each of the two floors exiting at ground level and was determined to be of Type II (000) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 54 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 08/22/22			
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet clear width requirement exceptions per LSC 19.2.3.4(1) for 1 of 10 corridors. LSC 19.2.3.4(1) requires aisles, corridors, and ramps in adjunct	K 0232	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/09/2022

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	areas not intended for the housing, treatment, or use of inpatients shall not be less than 44 inches in clear and unobstructed width. This deficient practice could affect staff only. Findings include: Based on observations made during a tour of the facility with the Director of Maintenance on 08/18/22 at 12:25 p.m., four semi-trailer pallets full of cardboard boxes of supplies were sitting in the corridor of the Memory Care unit. When measured, the clear width was thirty-eight inches. Based on interview at the time of observation, the Director of Maintenance agreed that the pallets of supplies did indeed obstruct the clear width of the corridor to less than 44 inches and that in the event of an emergency, could make it difficult to evacuate the unit through the corridor. During the exit conference with the facility Executive Director and the Director of Maintenance on 08/18/22 at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**practice:** There was no immediate impact upon residents at the time of the review. The supplies that were sitting in the corridor of the closed unit have been removed and placed into the designated storage rooms located on the closed unit. These designated rooms have self-closing devices with latching hardware. **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 residents have the potential to be affected. The Maintenance Director investigated the corridors in the building and no supplies were found in the corridors. Executive Director provided education to the Maintenance Director, Housekeeping Supervisor, Maintenance Assistant and Supply Clerk to not store supplies in the corridors. All staff also educated to this requirement. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will monitor the corridors 3 times per week for one month; then 2 times per week during the second month; then 1	

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			time per week during the third month. This process will continue for a minimum of 3 months or longer if a pattern of compliance is not established. The Maintenance Director/Designee will bring any identified issues to the morning management interdisciplinary meeting for review and recommendations. 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: The Maintenance Director/Designee will bring the results of the audits to the monthly QAPI Committee for review and recommendations. Any recommendation made by the committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of compliance is not established.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated			

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	from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the Memory Care Unit, a hazardous area, such as a House Keeping/Bio-hazard room, a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff only. Findings include: Based on observations made during a tour of the facility with the Director of Maintenance on 08/18/22 at 12:22 p.m., the Memory Care unit,	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** There was no immediate impact upon residents at the time of the review. The supplies that were sitting in the corridor of the closed unit have been removed and placed into the designated storage rooms located on the closed unit. These designated rooms have self-closing devices with latching hardware.	09/09/2022

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	which was not currently in use for residents, had well over 250 boxes of supplies and PPE stored on the unit. There were even 4 semi-trailer pallets full of cardboard boxes of storage sitting in the corridor. The entry doors to this unit did contain a self-closing device, but the doors had no latching hardware. Based on an interview at the time of the observation, the Director of Maintenance stated that he would have all the boxes being stored in this area moved to an area where the door would self-close and latch into the doorframe as soon as he or his assistants had time to do so. During the exit conference with the facility Executive Director and the Director of Maintenance on 08/18/22 at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**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 residents have the potential to be affected. The designated storage rooms have self-closing devices with latching hardware. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director/Designee will monitor the designated doors 1 time per week for 3 months to ensure that the self-closing device with latching hardware is working properly. This process will continue for a minimum of 3 months or longer if a pattern of compliance is not established. The Maintenance Director/Designee will bring any identified issues to the morning management interdisciplinary meeting for review and recommendations for follow-up. **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:** The Maintenance Director/Designee will bring the results of the audits to the monthly QAPI Committee for review and recommendations.	

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			Any recommendation made by the committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of compliance is not established.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 8 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 24 residents, 4 staff and 1 visitor. Findings include:	K 0372	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There was no immediate impact upon residents at the time of the review. The penetration in the separation wall above the barrier door was filled with fire retardant caulk by the Maintenance Director. **How other residents having the potential to be affected by the**	09/09/2022

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	Based on observations made during a tour of the facility with the Director of Maintenance on 08/18/22 at 12:50 p.m., the barrier doors from the service hall to the lounge area had a 4 inch in diameter hole drilled in the separation wall. This hole had a 2-inch piece of conduit and several data wires passing through it, and there was approximately 4-inches of unsealed annular space around the hole through the barrier wall. Based on an interview at the time of the observation, the Director of Maintenance stated that he was unaware of the penetration in the barrier wall and added that he would fill the unsealed portion of it with approved caulk as soon as he or his assistants could do so. During the exit conference with the facility Executive Director and the Director of Maintenance on 08/18/22 at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. The Maintenance Director inspected all walls above the barrier doors to identify any penetrations. No penetrations were found during the inspection. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will monitor the wall above the barrier doors for any penetration in the barrier wall 1 time per week for one month; then 2 times per month during the second month; then 1 time per month during the third month. This process will continue for a minimum of 3 months or longer if a pattern of compliance is not established. The Maintenance Director/Designee will bring any identified issues to the morning management interdisciplinary meeting for review and recommendations for follow-up. **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:** The Maintenance Director/Designee will bring the results of the audits to the monthly QAPI Committee for	

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			review and recommendations. Any recommendation made by the committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of compliance is not established.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 2 electrical rooms were maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect as many as 12 residents, 3 staff and 2 visitors. Findings include: Based on observations made with the Director of Maintenance on 08/18/22 at 11:47 a.m., the electrical room on the Moving Forward Hall immediately across from resident room #120 had a metal conduit attached to the wall up near the	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** There was no immediate impact upon residents at the time of the review. The exposed wires in the electrical room on the Moving Forward Hall have been covered by an electrical box. The Maintenance Director inspected all electrical rooms to identify any exposed wires. **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:**	09/09/2022

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	ceiling. The box at the end of the conduit had been removed and there were six live electrical wires extending approximately one inch out of the end of the conduit. Based on an interview at the time of the observation, the Director of Maintenance stated that he would address the exposed wires as soon as he or his assistant could to take care of the issue. During the exit conference with the facility Executive Director and the Director of Maintenance on 08/18/22 at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		All residents have the potential to be affected. The exposed wires in the electrical room on the Moving Forward Hall have been covered by an electrical box. The Maintenance Director inspected all electrical rooms to identify any exposed wires. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will monitor the electrical rooms for exposed wires 1 time per week for one month; then 2 times per month during the second month; then 1 time per month during the third month. This process will continue for a minimum of 3 months or longer if a pattern of compliance is not established. The Maintenance Director/Designee will bring any identified issues to the morning management interdisciplinary meeting for review and recommendations for follow-up. **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:** The Maintenance Director/Designee will bring the results of the audits to the monthly QAPI Committee for review and recommendations.	

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			Any recommendation made by the committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of compliance is not established.	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview the facility failed to maintain testing on 1 of 1 elevator firefighter recall in accordance with LSC 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with firefighters' emergency	K 0531	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	09/09/2022

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	operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect as many as 2 residents and 2 staff if using the elevator. Findings include: Based on record review with the Director of Maintenance on 08/18/22 at 10:41 a.m., it was determined that documentation for the monthly firefighter recall testing was not available for review. Based on interview at the time of record review, the Director of Maintenance acknowledged the lack of documentation for monthly firefighter emergency operations recall testing stating that he thought because the second floor was currently not in use for residents that the testing did not need to be conducted. Then during a tour of the facility at 1:07 p.m., it was noted that the elevator did indeed have firefighters' emergency operations capabilities. During the exit conference with the facility Executive Director and the Director of Maintenance on 08/18/22 at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		There was no immediate impact upon residents at the time of the review. The monthly recall and testing and documentation for the elevator will be completed for the month of September and monthly thereafter. **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 residents have the potential to be affected. The monthly recall testing and documentation for the elevator will be completed by the Maintenance Director/Designee for the month of September and then monthly thereafter. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director/Designee will complete the elevator recall testing on a monthly basis. The Maintenance Director/Designee will bring any identified issues to the morning management interdisciplinary meeting for review and recommendations for follow-up. **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:** The Maintenance	

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			Director/Designee will bring any identified issues to the monthly QAPI Committee for review and recommendations. Any recommendation made by the committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of compliance is not established.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation, and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department	K 0711	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** There was no immediate impact upon residents at the time of the review. The Fire Plan was updated to reflect that Certified	09/09/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 01 B. WING	08/18/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff, and visitors Findings include: Based on review of the facilities fire plan entitled "Fire / Explosion Emergency Action Plan" documentation dated 02/20/22 with the Director of Maintenance at 10:52 a.m. on 08/18/22, the written fire safety plan stated in the Fire Essential Tasks section that items on wheels were to be removed from the corridor in the event of a fire. The plan then goes on to assign duties to each of the following staff groups: 1) The Executive Director / Disaster Response Coordinator 2) Nursing staff 3) Certifies Nurses Assistants 4) Director of Nursing 5) Office staff / Medical Records		Nursing Assistants will remove all items on wheels from the corridor. **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 residents have the potential to be affected. The Maintenance Director/Designee will educate the Certified Nursing Assistants regarding the updated Fire Plan pertaining specifically to the removal of all items on wheels from the corridor. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Fire Plan is reviewed on an annual basis by the IDT team. The Maintenance Director/Designee will bring any identified issues to the morning management interdisciplinary meeting for review and recommendations for follow-up. **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:** The Maintenance Director/Designee will bring the identified issues to the monthly QAPI Committee for review and recommendations. Any recommendation made by the	

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	155620	A. BUILDING 01 B. WING	08/18/2022

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	6) Activities Staff 7) Maintenance Personnel 8) Laundry 9) All other staff The fire plan does not assign the task of removing items on wheels in the corridor to any of the aforementioned staff groups. Based on interview at the time of record review, the Director of Maintenance confirmed that although the fire plan mentions the items on wheels and needing to be removed from the corridor, the specific task is not assigned to any staff member or group within the facility and could be easily overlooked in the event of a fire or emergency situation. Based on observations made during a tour of the facility it was noted that wheeled items such as Hoyer lifts, Med carts, and Blood pressure machines that were wheeled were being stored in the corridors of the facility. During the exit conference with the facility Executive Director and the Director of Maintenance on 08/18/22 at 2:25 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		committee will be followed up by the Maintenance Director and the results will be brought to the next scheduled QAPI Committee meeting. This practice will continue for a minimum of 3 months or longer if a pattern of compliance is not established.	