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	10/26/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00416623 and IN00420155. This visit included the State Residential Licensure Survey. Complaint IN00416623 - No deficiencies related to the allegations are cited. Complaint IN00420155 - No deficiencies related to the allegations are cited. Survey dates: October 19, 20, 23, 24, 25, and 26, 2023. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census Bed Type: SNF/NF: 66 Residential: 13 Total: 79 Census Payor Type: Medicare: 2 Medicaid: 54 Other: 10 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 3, 2023.	F 0000		
F 0677 SS=D	483.24(a)(2) ADL Care Provided for Dependent Residents			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Huffman	E.D.	11/24/2023

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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Bldg. 00	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure a resident did not have tangled and matted hair (tangled into a dense mass) for 1 of 4 residents reviewed for activities of daily living (ADL) care (Resident 47). Findings include: On 10/19/23 at 12:10 p.m., Resident 47 was observed in her bed with her hair not brushed. Her hair was severely tangled and standing up on its ends. She was unwilling to show the back of her hair at this time. Her lunch had just arrived, and she was agitated with questioning. On 10/19/23 at 8:45 p.m., a family interview was completed. Her daughter indicated Resident 47's hair had not been brushed in weeks. It was so tangled now that she could not brush it out. The resident's preference was to have her hair brushed into a bun on top of her head with a head band at her hairline. Her hair had been extremely tangled for several weeks. Her daughter indicated she wanted Resident 47 to have clean and detangled hair. On 10/20/23 at 2:35 p.m., Resident 47 indicated the staff didn't brush her hair. Her hair was observed to be severely tangled in its ends, but the top layer of her hair had been lightly smoothed out and a purple decorative comb (used to hold hair back) had been pressed into the tangles. On 10/23/23 at 2:31 p.m., Resident 47 indicated her hair was matted and she could not comb it. Some	F 0677	1. Corrective actions taken for this resident 47include an updated care plan and updated resident preferences. This care plan includes steps to approach the resident regarding combing hair and utilizing detangler when necessary, and reporting requirements when unsuccessful with attempts. The unit manager will check resident 47, three times weekly for the next month to ensure that hair is being managed properly and will report to DNS any issues with process. 2. All residents have the potential to be affected. All care staff will be in serviced on the new care plan regarding approach and reapproach and proper reporting to unit manager of any issues. DNS/designee inspected all other residents to ensure residents' hair was clean, comb and in good condition. 3. To ensure that no other resident has the potential to be affected by the same deficient practice the clinical staff will receive an in-service regarding ADL care, approaches, documentation, and communication to clinical managers of any issues. Shower sheets will be reviewed weekly	12/13/2023

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	of the staff had taken advantage of the fact that sometimes she did not know what was going on. A very large mat of hair was observed on the back of the resident's head encompassing all of the hair on the back of her head. The front and both sides of her hair was further smoothed over the tangles with the purple comb in it. On 10/23/23 at 3:13 p.m., the Director of Nursing Services (DNS) indicated she was not aware of the large mat on the back of Resident 47's head. She indicated the nursing staff should have been aware of this issue since they did weekly skin checks. Her shower sheets were requested at this time, but not received by the end of the survey. On 10/24/23 at 9:51 a.m., Resident 47's record was reviewed. Her diagnoses included, but were not limited to, Alzheimer's disease (brain disorder with memory loss), chronic obstructive pulmonary disease (COPD), and heart failure. A behavioral care plan, dated 9/22/23, indicated she sometimes refused to have ADLs completed such as showers and hair brushing. The interventions were to assess the resident for unmet needs, provided an alternate caregiver, and re-approach at a later time. An ADL care plan, dated 10/13/23, indicated she required assistance with ADLs. The interventions included to assist with bathing as needed per resident preference and assist with dressing, grooming, and hygiene. A cognitive care plan, dated 10/13/23, indicated she exhibited cognitive impairment with a Brief Interview for Mental Status (BIMS) score fluctuations. The interventions were to give resident choices throughout the day regarding		daily by the unit manager to ensure that showers are given, and any skin/hair issues are noted. 4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/designee will complete ADL QAPI tool weekly x4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. . If 100% compliance is not achieved an action plan will be developed.	

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	decisions as able, provide resident with prompts and cues as needed, and provide simple instructions and repeat as needed. On 10/24/23 at 10:34 a.m., the Executive Director (ED) indicated the facility staff were able to get the large mat out of Resident 47's hair last night. They had to use a lot of de-tangler. On 10/24/23 at 12:01 p.m., Registered Nurse (RN) 14 indicated she sometimes worked with Resident 47. She did not refuse care all the time, but sometimes she refused care. If the staff talked with her a lot, it would help with her cooperation. If she refused care, she could call another RN and talk with her about it. She was unaware whether Resident 47 took showers or bed baths. On 10/24/23 at 12:05 p.m., RN 13 indicated she usually worked on Resident 47's hall and the resident sometimes refused ADL care. If she refused, she would talk to her a couple of times and call her daughter to try to get cooperation. Resident 47 would usually get a bed bath but would sometimes scream with it. Her plan was to give the resident a scheduled pain pill (Tylenol or Tramadol) prior to the bed bath to prevent screaming. She was aware of the large mat on the back of her head from lying in bed but did not document it anywhere in her medical chart. It should have been possible to prevent the large mat on the back of her head if the Certified Nursing Aides (CNA) had been brushing her hair. On 10/24/23 at 12:14 p.m., CNA 15 indicated Resident 47 refused everything and started screaming. She refused to wake-up in the morning when sleeping, refused to eat, and refused bed bath and showers. When she got her up, the resident allowed her to wash her face and arm pits.			

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	Then, she said the resident allowed bed baths twice a week but refused her to touch her hair. She was aware of large mat on back of her head and reported to the nurse. She refused care to everyone on staff and was asked to leave her alone. If she called the nurse, the resident still refused. She agreed with changing her disposable brief and washing her face. CNA 15 indicated she did not know how the facility could prevent her hair from matting, but she never tried to use detangler on her hair. On 10/24/23 at 12:24 p.m., Resident 47 was observed in bed with her eyes closed. Her visible hair was pulled back into fabric blue (shower-like) cap. The rest of her hair was unobserved due to her sleeping. CNA 15 indicated Resident 47 usually slept during the day. On 10/25/23 at 11:26 a.m., the DNS indicated Resident 47's care plan indicated she doesn't allow staff to brush her hair. The intervention to re-approach the resident was not always accessible. The facility had a shower cap shampoo available and a silk cap to help prevent issues with her hair. The facility had been trying to brush her hair. On 10/25/23 at 11:26 a.m., the DNS indicated the facility would provide documentation of the resident's preferences for her grooming. This document was not provided. A current document titled, "AM Care," dated 2/2010, was provided by the Regional Nurse Consultant (RNC), on 10/25/23 at 12:23 p.m. A review of the procedure indicated to, " ...comb and style resident's hair per preference ...." 3.1-38(b)(3)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident who admitted to the facility for rehabilitation with a history of falls, received timely fall follow up to prevent falls for 1 of 4 resident reviewed for falls (Resident 38). Findings include: On 10/19/23 at 10:22 a.m., Resident 38 was observed as she laid in bed. A protective medical boot was observed on her right foot. When asked what happened, Resident 38 indicated she had broken her ankle when she fell in her bathroom. It had been her 4th fall in a span of 5 days. She indicated she had just started falling more and more as her legs would get weak and give out, which was what happened that day. She had gone to the bathroom with the assistance of an aide. As she started to back up toward the toilet, she felt her legs get weak, but because her walker was in front of her, and the aide was on the other side of the walker, there was no way the aide could have reached her or assisted her to the floor in a different position. Her legs buckled and the weight of her body collapsing onto her ankle was what caused it to break. Resident 38 indicated she was upset about the fall and her fracture because	F 0689	1. Resident 38 is receiving therapy to assist with preventing additional falls. 4 fall interventions have been implemented care plan has been updated. 2. All residents have the potential to be affected. Staff have been educated on timely follow up of post falls. This includes ensuring nursing to therapy observations are completed when appropriate, ensuring root causes are determined, and immediate interventions are put into place. All new admissions have been reviewed to ensure fall interventions are in place and care plans reflect the fall interventions. 3. All falls will be discussed by the interdisciplinary team at the first clinical meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall event will be reviewed by the team. IDT note will be written. The care plan will be reviewed and	12/06/2023

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	it had caused her to lose all the progress she had made. She was not longer able to get out of bed by herself, she was no longer able to use the bathroom by herself, and all her transfers had to be completed with a Hoyer lift. She felt embarrassed that she could no longer use the bathroom and had to "mess herself" in a brief, and now relied to wait on staff to come clean her up. She was afraid this would lead to bed sores, and she became tearful as she indicated, "now I'm afraid I'll never walk again." On 10/24/23 at 2:28 p.m., Resident 38's medical record was reviewed. She admitted to the facility with diagnoses which included, but were not limited to, idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause cannot be determined and there are often symptoms that affect the feet) lack of coordination, muscle weakness, unsteadiness on feet and abnormalities of gait/mobility. The most recent comprehensive assessment, as an admission Minimum Data Set (MDS) assessment dated 3/6/23. The MDS indicated Resident 38 was cognitively intact and required limited to extensive assistance of at least one staff member for her Activities of Daily Living, (ADLs). Specially, she required extensive assistance to transfer and use the toilet. Resident 38 received physical therapy (PT) rehabilitation services between 2/28/23 to 5/4/23 and her corresponding PT discharge summary indicated the following: a. At the beginning/baseline of therapy on 2/28/23, she required 70% moderate assistance for sit-to-stand from varied surfaces. Upon discharge she had reached her goal and was only required stand by assistance.		updated. Ensure all interventions completed timely. 4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/designee will complete Fall QAPI tool weekly x4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. . If 100% compliance is not achieved an action plan will be developed.	

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	b. She was discharged from therapy and placed on a restorative nursing ambulation program in order to maintain her ability to walk up to 200 feet with her front-wheeled-walker and stand by assistance. A nursing progress note dated 3/31/23 at 6:00 a.m., indicated, Resident 38 was heard screaming for help. Staff entered the room to find her sitting on the floor. She indicated she bent over to pick something up off the floor and lost her balance. She required the use of a Hoyer lift to transfer back into bed. At the time of the fall, was reminded to use her call light for assistance. An Interdisciplinary Team (IDT) progress note dated 3/31/23 indicated a Reacher was provided for Resident 38 to use to pick items up off the floor. A nursing progress note dated 4/11/23 at 9:05 p.m., indicated, Resident 38 sustained a second fall as she ambulated back from the restroom. She called for help, and upon assessment she complained of feeling lightheaded, dizzy and had heart palpation. She was pale, diaphoresis (sweating) and had periods of shortness of breath. The NP was notified and gave a new order for a STAT (immediate) lab to include a BMP and CBC (which were received an unremarkable). The record lacked documentation of an IDT fall follow up, and no root cause intervention was placed. Resident 38's Medicare charting/progress notes from the time of her admission to the time of her discharge on 5/4/23 indicated, she required extensive assistance with her ADLs and transfers. A quarterly MDS assessment, dated 5/30/23,			

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	indicated, her ADL self-performance abilities had improved to only require limited assistance for transfers (even though her Medicare charting indicated extensive assistance). A nursing progress note dated 8/5/23 at 9:26 p.m., indicated, Resident 38 experienced a 3rd unwitnessed fall. She was found in her room sitting on her buttocks with her back on the side of her bed. She indicated she tried to sit down on her recliner, but she fell short and tried to sit on the bed instead to prevent a fall, but was unable to, and fell to the floor. She required the assistance of three staff members and the Hoyer lift to get her back into her recliner. She complained of "bearable" soreness in her left leg. At the time of the fall, she was reminded to ask staff and use her call light for assistance. An Interdisciplinary Team (IDT) progress note, dated 8/7/23 at 3:07 p.m., indicated, Occupational Therapy (OT) was referred to ask for an evaluation for transfers. The record lacked documentation that a therapy referral had been placed. A NP progress note, dated 8/9/23 at 1:41 p.m., indicated, the resident was reviewed for recent labs. The evaluation did not include a review of her 8/7 fall. A nursing progress note dated 9/19/23 at 12:38 a.m., indicated, Resident 38 had an unwitnessed fall, (4th in total) She was found sitting on the floor and indicated she went to the bathroom but lost her balance as she went back to her chair. She indicated she hit the back of her head but had no bumps or pain. She was transferred back to her recliner with a Hoyer lift. The intervention put in			

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	place at the time of her fall was to remind her to call staff for assistance. An IDT progress note, dated 9/19/23 at 10:54 a.m., indicated the root cause analysis of her fall had been weakness during ambulation which resulted in a fall, so the IDT placed a referral to PT for evaluation. A nursing progress note, dated 9/20/23 4:04 p.m., indicated, Resident 38 had an unwitnessed fall, (5th in total). She was found sitting on the floor of her bathroom with both legs stretched out in front of her. She denied hitting her head and did not complain of any pain at that time. It took 5 staff members and a Hoyer lift to get her up and back into her recliner. The interventions put in place at the time of the fall was to remind Resident 38 to ask staff for help. An IDT progress note dated 9/21/23 at 3:29 p.m., indicated, the root cause determination of her fall had been weakness and the follow up intervention was to review her medications and place an OT referral. Although she was seen by the NP that same day and some medication adjustments had been ordered, the record lacked documentation that a PT and/or OT eval could be conducted before she sustained another fall on 9/22/23, (her 6th in total). A PT referral had been placed on 9/19/23, she was not evaluated until 9/28/23 after her return from the hospital on 9/22/23 with a fractured tibia. A nursing progress note dated 9/22/23 at 2:44 a.m., indicated, Resident 38 followed instructions to ask staff for assistance and put her call light on to go to the bathroom. She became "weak in the knees" and was lowered to the floor. When the			

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	nurse arrived, she observed Resident 38 to be on her knees holding onto the grab bar. The mechanical lift was unable to be fitted into the bathroom to assist her up, and 911 was called for assistance to get her up and out of the bathroom. She complained of pain in her ankles and requested the EMTs take her to the hospital. A corresponding hospital discharge summary, dated 9/22/23 indicated, Resident 38 returned from the hospital. She was diagnosed with another UTI and had sustained a right malleolar (ankle) fracture. During an interview on 10/25/23 at 9:58 a.m., the Director of Therapy Services (DTS) indicated, in her review of the Resident 38th therapy referrals, no referral had been placed after the 8/5/23 fall. She also indicated that a PT referral should have been requested instead of an OT referral, but there had been no follow up to clarify and/or complete the referral at that time. During an interview on 10/25/23 at 12:28 p.m., PT Assistant (PTA) 18 indicated, typically a new therapy referral would be followed up by the next business day but was variable due to the case load and/or situation. During an interview on 10/25/23 at 2:06 p.m., the DTS indicated, referral follow up should be completed within 7-10 days after the referral but depended on the situation and case load. The DTS indicated, at the time the referral had been placed she was on persona leave. During an interview on 10/25/23 at 3:15 p.m., the Director of Nursing Services (DNS) indicated, ideally if the nursing department made a referral to therapy, she would expect them to be seen within			

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	1-2 days but would defer to the therapy department depending on their schedules. On 10/25/23 at 12:15 p.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, "Fall Management Policy," revised 8/2022. The policy indicated, "It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls ... Post Fall ... 5. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. 6. All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ...." On 10/25/23 at 12:15 p.m., the RNC provided a copy of current facility policy titled, "Nursing Referrals to Therapy," dated 5/2018 (with no revision date). The policy indicated, "To ensure there is standardized communication to the therapy department when a screen is being requested. When a change in resident functional status is noted a member of the nursing team will open up and complete a "Nursing Referral to Therapy Observation," in Matrix EMR for therapy communication. The Director of Therapy/Designee will run the Matrix Observation Report daily to identify any new referrals from nursing to therapy ...." 3.1-45 3.1-37			
F 0698 SS=D	483.25(l) Dialysis			

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Bldg. 00	§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure a dialysis resident's strict fluid restrictions were followed, STAT labs were completed as ordered, dialysis care plans and assessments were for the correct site, and transportation to dialysis was not missed for 1 of 1 resident reviewed for dialysis (Resident 44). Finding include: On 10/23/23 at 9:00 a.m., Resident 44 was observed with his eyes closed and appeared to be asleep. There was a plastic kitchen cup beside him on the bed which was observed to have water in it. On 10/23/23 at 11:07 a.m., Resident 44 was not in his room, as it was his scheduled Dialysis day. On 10/24/23 at 9:16 a.m., Resident 44 was observed in the activity lounge. He held a plastic cup full of water and drank it as staff walked by. During an interview on 10/24/23 at 9:38 a.m., Resident 44 indicated he was on Dialysis and went every Monday, Wednesday, and Friday. His access site was on his left forearm and he pulled up the sleeve to show that it was active, and no concerns were noted at that time. He indicated he used to have a port for access in his chest, but that had been closed off for a long time. Resident 44 indicated because his kidneys were so bad, he	F 0698	1.Resident 44 has fluid restrictions implemented, resident will be offered fluids as needed, STAT labs are completed as ordered, dialysis care plans are implemented, assessments are completed and documented, and transportation is provided to the dialysis center. 2. All residents who go to dialysis center have the potential to be affected by this deficient practice. A dialysis residents will have care plans reviewed for all dialysis residents to determine if those residents are experiencing the same types of issues. If found, care plans will be updated to include the options to offer/quench thirst and maintain restrictions and no plastic cups left at bedside, along with current access site verified. STAT labs will be verified by on call for the next 30 days and transportation is now handled by in house staff drivers, so dialysis residents do not miss dialysis days. 3. Licensed staff have been educated related to dialysis to include fluid restrictions, stat labs, care plans and transportation. All residents who attend dialysis will	12/06/2023

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	155620	A. BUILDING 00 B. WING	10/26/2023

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	was also on a strict fluid restriction and was only allowed three cups a day. It was hard to manage the fluid restriction because he found himself to always feel thirsty. He also went out a lot to different activities and moved through the facility on his own and that often made him even more thirsty. Staff remind him when he could not have more water, but did not offer any other options like gum, or mints, or suckers, or something else just to satisfy his craving. If he did have too much water or fluid overload, his symptoms made him feel short of breath, and feeling like he couldn't breathe made him anxious. One night her remembered he was going up and down the halls looking for help when he started to feel "off." He could not find anyone, and he was afraid he was going to die, so he called 911 himself and had to go to the hospital. During an interview on 10/24/23 at 11:36 a.m., the Director of Nursing Services, (DNS) indicated Resident 44 was very non-compliant with his fluid restriction, so much so that at one point he was taken off the restriction, but after his last hospitalization he was put back on. When he had too much to drink his symptoms were shortness of breath, that would often make him feel anxious. She indicated he did also have some mental illness and would often refuse to use supplemental oxygen. He was alert and oriented, and able to make his needs know, especially when he's had too much to drink, he could tell by his symptoms. During an interview on 10/24/23 at 12:58 p.m., Qualified Medication Aid (QMA) 19 indicated, sometimes Resident 44 was really good about his fluid restriction and went to dialysis faithfully. Sometimes he would ask for more water or sneak water without letting staff know. QMA 19 indicated he usually asked for more water in the		be reviewed daily by DNS/Designee to ensure residents attended dialysis per order, labs completed per order, residents assessed upon return, and residents received fluids as needed and per order. 4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/designee will complete Dialysis QAPI tool weekly x4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. If 100% compliance is not achieved an action plan will be developed.	

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	evenings when he was alone and board in his room. She indicated sometimes he would keep the cup of water from the morning medication pass and refill it at the water stations throughout the day. Staff would remind him not to, but that was all they could do. During an interview on 10/24/23 at 1:00 p.m., the Activity Director (AD) indicated Resident 44 was very active in the activity program and liked to go on outings and go to group activities. The AD and his staff were aware of his fluid restriction, and they should remind him not to drink too much if he asked, but that was hard to do sometimes since many of the activities included snacks and drinks. During an interview on 10/25/23 at 9:36 a.m., with the DNS and Regional Nurse Consultant (RNC) present, the DNS indicated although Resident 44 was alert and oriented and could make his needs and wants known, he had a mental illness and often was not able to understand that by drinking too much water, it could be harmful. When asked what some other options for someone of a fluid restriction were because just reminding him not to drink too much, the RNS indicated maybe he could have some sugar free mints, because he was also a diabetic. On 10/25/23 at 10:00 a.m., Resident 44's room was observed (he was out to Dialysis at that time). There were three plastic cups thrown away in the trashcan at the foot of his bed. There was an empty plastic kitchen cup beside his recliner on the bed. On 10/25/23 at 10:01 a.m., Resident 44's room was observed with QMA 19. She indicated it could potentially be a problem to throw his medication			

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	water cups away in his room because he could pick them out and use them. She suggested maybe the nursing staff should take the medication water cups out of the room when they passed meds instead of throwing them away in his room. During an interview on 10/25/23 at 10:03 a.m., Certified Nursing Assistant (CAN) 20 indicated sometimes Resident 44 was noncompliant with his fluid restriction but when he had too much to drink he was able to tell them. When asked what staff should do when he was found to be drinking more than he should, she indicated the only thing they could do was just to remind him not to drink too much. During an interview on 10/25/23 at 10:05 a.m., Infection Preventionist (IP) 9 indicated Resident 44 sometimes sneaked cups of water or other beverages when he knew he shouldn't have them. Staff were not supposed to keep water at his bedside, and she was unaware that his medication pass cups were being left in his room. On 10/23/23 at 9:05 a.m., Resident 44's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, end stage renal disease, chronic obstructive pulmonary disease (COPD), schizophrenia, unspecified anxiety, and type II diabetes. He had a physician's order for his Dialysis access site on his left forearm, but he also still had an active order for an access site on his right upper chest. He had a physician's order for a 1500 ml (milliliter) fluid restriction.			

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	A nursing progress note, dated 3/14/23 at 6:58 p.m., indicated, Resident 44 was "very anxious." He was given a nebulizer treatment for shortness of breath, but it had not been effective. Supplemental oxygen was offered, but he did not wear it, and his oxygen saturations ranged between 75%-95%. Although the note indicated, "resident placed on MD list to be assessed in the a.m." the record lacked documentation the physician had been notified of his change of condition at that time. A Dialysis Run Log dated 3/15/23 indicated, Resident 44 complained of Shortness of breath when he laid down and had swelling in his lower legs at 4+ pitting edema. Both his ankles and lower legs were noted to with 4 to 6 millimeters (mm) indent noticeably deep, lasts more than 1 minute, extremity swollen. A Nurse Practitioner (NP) progress note dated 3/15/23 indicated, Resident 44 had been seen that day for follow up for his hypoxia, and " ...resident is being seen today for complaints of increased anxiousness. Per reports of the facility's staff, residents sats ranged between 75-95%..." Upon physical assessment, he was noted to have trace edema to his right lower extremity, and 2+ edema to his left lower extremity. A STAT (immediately or as soon as possible) lab order was placed on 3/15/23 at 11:56 a.m. The record lacked documentation of nursing follow up to obtain the STAT labs. The lab was not collected until 3/16/23 at 1:10 p.m., (approximately 26 hours after the order was placed).			

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	An Event note, dated 3/15/23 at 11:59 a.m., indicated Resident 44 was placed on a 15000 ml fluid restriction, labs were ordered and he was to have a repeat Dialysis session the following day. An NP visit and treatment note, dated 3/15/23, indicated, " ...per the nursing staff, patient was having shortness of breath last night with increase restlessness- saturation maintained after patient was placed on 2 liters of oxygen. Spoke with nephrologist and nursing while he was in the dialysis- patient has fluid overload and needs extra Dialysis- scheduled for dialysis tomorrow morning at 6:00 a.m. ...." An NP visit and treatment note, dated 3/16/23, indicated, " ...he missed dialysis this morning at 6:00 a.m. related to transportation issue- as per the nursing transportation was arranged for 5:30 a.m., but no one showed up to take the patient to dialysis ... Plan: " ...chest x-ray completed that showed moderate CHF [congestive heart failure] with small bilateral pleural effusion- results communicated with nephrologist- 'OK' to monitor patient today since he is doing ok with saturation and will see him in the dialysis tomorrow. Spoke with dialysis nurse and requested longer dialysis tomorrow if possible and check schedule for any chair on Saturday if any chair is available in case patient needs additional days of dialysis ... consider sending patient to the hospital for increase shortness of breath and saturation not maintained at 4-6 liters ...." A nursing progress note, dated 3/16/23 at 10:37 p.m., indicated, Resident 44 removed his oxygen tubing and started yelling and screaming, "nurse! Nurse!" oxygen saturation between 78-88% without oxygen. The nurse replaced his oxygen			

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	nasal cannula and saturation up to 95%, medications and breathing treatments given as ordered and Resident was encouraged to take deep breaths and relax. The note lacked documentation of physician notification. A nursing progress note, dated 3/17/23 at 5:22 p.m., indicated, Resident 44's Dialysis center contacted the facility and informed the nurse he had been transferred to the hospital from dialysis due to fluid overload. The corresponding Hospital admission report dated, 3/17/23 at 7:33 p.m., indicated, " ...presented to the ED [emergency department] yesterday with fluid overload. He started out the week at 15 kg [kilograms] over his DW [dry weight] and despite best efforts by hemodialysis center he remains 5-6 kg over his dry weight. The nursing home is unable to provide him transportation for extra treatments, and yesterday after dialysis he was still requiring 4L of 02 to maintain 02 sats 88-90% It was decided he would probably not make it through the weekend without additional dialysis, so he was brought to the ED for further Eval...." Resident 44 had a comprehensive care plan initiated on 4/4/19 and indicated, he was at risk for fluid imbalance due to: Dialysis, his need for assistance with food/fluid and was on a fluid restriction. "Despite staff education and encouragement for resident to follow potassium restricted diet as well as decrease fluid intake to prevent fluid overload; resident continues to eat foods outside his diet order and drink fluids throughout the day without always consulting with staff ... Interventions for this plan of care included, to record intakes, provide labs as scheduled, document and notify MD of signs and			

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	symptoms of fluid volume deficit ... and to administer medications. On 3/23/23, after he returned from the hospital, a new intervention was added to for his fluid restriction to have no water at bedside. A nursing progress note, dated 6/13/23 at 2:40 p.m., indicated, Resident 44 came to the nurses' station and reported not feeling well. His vital signs were taken and his blood pressure was high. The NP gave a new order to give him hydralazine (a blood pressure medication). A nursing progress note, dated 6/17/23 at 9:59 p.m., indicated, Resident 44 came to the nurses' station around 8 p.m., and was noted to be anxious, was shouting and verbalized "I'm feeling horrible and terrible!" He was given a dose of hydralazine at 8:11 p.m., and encouraged to relax and was offered a snack. Resident came in again and verbalized he felt better but still felt anxious. NP on call spoke with the Resident via phone and ordered a one time dose of Pepto-Bismol and hydroxyzine 25 mg. A nursing progress note, dated 6/18/23 at 3:56 a.m., indicated Resident 44 continued to complain that he did not feel well between 2:00-3:00 a.m. He acted restless, felt hot and was on edge. His blood pressure was 179/90 and his as needed hydralazine was given, but resident after 10 minutes he started to yell out and asked to be sent to hospital. The NP ordered the as needed blood pressure medication and to give him Tylenol for "general comfort." A nursing progress note, dated 6/19/23 at 2:40 a.m., indicated, Resident 44 continued to complain of "feeling that something is wrong." He was anxious, restless and could not settle down. The			

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	Nurse encouraged oxygen, but Resident 44 called 911 and went to the hospital. The corresponding hospital summary, dated 6/19/23, indicated, " ...presented today from his nursing facility with complaints of shortness of breath that began last night. He reports drinking too much fluid this weekend and began to have dyspnea yesterday evening for which he was placed on 3L of oxygen at his facility. He does not typically use oxygen at home. He reports minimal improvement with oxygen and called EMS at 1:30 a.m. Upon arrival to the ER he complaint of continued shortness of breath despite utilization of 3L oxygen and saturation level found to be 88%... Upon interview today patient is laying comfortably in bed and anxiously asks about when he will receive dialysis. He was scheduled to undergo dialysis today as an outpatient at 10:00 a.m. but reports being unable to wait due to continued shortness of breath. Chest x-ray obtained shows findings indicative of volume overload/congestive heart failure with pulmonary edema ... patient also found to have blood pressure 222/101 during interview but denied chest pain, headaches, nausea or vomiting ...." Upon his return from the hospital, an intervention was added to his comprehensive care plan, noted above, on 7/25/23 to "encourage resident to be compliant with fluid restriction." On 10/24/23 at 3:30 p.m., the DON provided a copy of current facility policy titled, "Labs and Diagnostics," dated 11/2017. The policy indicated, "It is the policy of American Senior Communities to provide or obtain laboratory and diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services ... the facility must have			

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	contracts in place if they are utilizing vendors to provide radiology and laboratory services ...." The corresponding vendor contract, Exhibit B, "Statement of Work," was provided by the RNC on 10/25/23 at 2:45 p.m. The contract indicated, " ...C. Vendor provides STAT (life threatening situation) services 24 hours per day, 365 days per year. Laboratory STAT testing will be reported within four (4) hours ... Vendor shall respond to an ASC Location's request for STAT services within 30 minutes ...." On 10/25/23 at 12:15 p.m., the RNC provided a copy of current facility policy titled, "Resident Change of Condition Policy," revised, 11/2018. The policy indicated, "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ... Acute Medical Change: a. any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician ... ..." During an interview on 10/25/23 at 12:15 p.m., the RNC indicated there was not a policy which addressed fluid restrictions, only a policy for hydration management. The policy was provided at this time. It was titled, "Hydration Management," revised 11/2017. The policy indicated, " ...fresh water or other preferred beverages will be passed to all residents, unless medically contraindicated ...." but did not address fluid restriction and/or alternative methods/interventions/approaches for residents who required a fluid restriction. On 10/25/23 at 12:15 p.m., the RNC provided a			

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	copy of current facility policy titled, "IDT Comprehensive Care Plan Policy," revised, 8/2023. The policy indicated, "It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument (RAI) process. The Care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial well-being ...." 3.1-37			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure extended-release medications were not crushed to prevent significant medication errors for 1 of 2 residents reviewed who had gastric tubes (tube inserted in stomach to receive nutrition and medication) in place (Resident 6). Findings include: The record for Resident 6 was reviewed on 10/23/23 at 9:45 a.m., diagnoses included, but were not limited to, dysphagia following cerebral infarction (difficulty swallowing following a stroke), gastrostomy status (tube inserted in stomach to receive nutrition and medication), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (partial paralysis), aphasia (inability to swallow), and	F 0760	1.Resident D is now receiving medication as prescribed. 2.All residents with gastric tubes have the potential to be affected. Nursing personnel to receive in-service on proper medication pass on gastric tube resident by DNS/Designee.. A list of medications “Do not crush,” will be printed and placed at nurses’ station for future reference. 3.Pharmacist Consultant to review all residents with medications administered via gastric tube. Medication reviews by Unit Manager to be completed weekly on this resident to ensure any new medications are being passed appropriately. 4. Ongoing compliance with this	12/06/2023

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	hypertensive (high blood pressure) heart disease with heart failure. Progress note, dated 8/17/2023 at 11:38 a.m., indicated resident now NPO (nothing by mouth) with gastrostomy. Tube feeding and water flushes only for nutrition. Physician order, dated 8/12/23, indicated to administer Metoprolol succinate (beta-blocker that treats high blood pressure) 25 milligram (mg) extended release (ER), one tablet daily through gastric tube. Physician order, dated 8/12/23, indicated staff may crush appropriate medications and administer per G-tube (gastric tube). Special instructions indicated to dissolve each crushed medication in at least 10 milliliter (ml) to 30 ml of water. Physician order, dated 10/23/23, indicated to administer Metoprolol tartrate (beta-blocker that treats high blood pressure) 25 mg tablet, one tablet daily through the gastric tube. The record lacked documentation of new progress notes after 10/20/23. On 10/23/23 at 3:15 p.m., in an interview with the Director of Nursing Services (DNS), she indicated Resident 6 did not take anything by mouth and received everything through his G-tube. On 10/25/23 at 10:32 a.m., Registered Nurse (RN) 13 indicated Resident 6 received all his medications through his g-tube and that all his medications that were pill form were crushed and dissolved before given through the g-tube. The MAR was observed with RN 13 for the medications Resident 6 received that morning.		corrective action will be monitored monthly in the QAPI program overseen by the executive. director. DNS/designee will complete Med Pass QAPI tool weekly x4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the executive director. . If 100% compliance is not achieved an action plan will be developed.	

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	Medications included, but was not limited to, Metoprolol tartrate (treats blood pressure and irregular heartbeats). The medications Resident 6 located inside the medication cart were observed with RN 15, and she read the label as Metoprolol tartrate 25 mg. This was observed to be regular release and scored. She indicated it was ordered on 10/23/23 and that he was not receiving any medications that were not supposed to be crushed. She looked up the order history, prior to the change on 10/23/23, Resident 6 was receiving Metoprolol succinate 25 mg ER. RN 13 indicated that Metoprolol ER was able to be crushed and was not sure why the order was changed. On 10/25/23 at 12:32 p.m., received medication administration record (MAR) for last thirty days from Regional Nurse Consultant (RNC) indicating Metoprolol succinate tablet, extended release 24-hour tablet, was ordered to be administered via gastric tube once daily, started on 8/12/23 and was discontinued on 10/23/23. It had been given every day on the thirty-day report between 9/25/23-10/23/23. The MAR indicated that a new order for Metoprolol tartrate tablet 25 mg, was to be administered via gastric tube, order began 10/23/23. On 10/25/23 at 2:28 p.m., in an interview with the RNC, she indicated the medication Metoprolol succinate 25 mg ER was changed to regular release medication because ER medications were not to be crushed. She indicated they also discontinued the omega 3 (supplement) as well because it was gel capsule and they had to puncture it and squeeze out the contents to administer it. On 10/23/23 at 10:00 a.m., the DNS provided a list from the facility pharmacy titled, "Common Oral			

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	Dosage Forms That Should Not Be Crushed," and deemed it as current. The list of do not crush medications included, "...metoprolol succinate...Reason, extended release ...." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to date eye drops, remove expired eye drops for 2 of 2 residents observed to receive eye drops (Residents 59 and 39), and failed to label and date	F 0761	1. Residents 59 and 39 are receiving eye drops with proper dates. The undated eye drops were discarded. Resident 218 is	12/06/2023

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	the insulin for 1 of 1 resident observed with insulin during medication administration (Resident 218). Findings include: On 10/29/23 at 10:18 a.m., during the medication storage observation, Resident 59 had a bottle of latanoprost (an eye drop used to treat glaucoma). The bottle was opened and lacked a date indicating when it was opened. Resident 59 had a bottle of ofloxacin 0.3% (antibiotic) on the medication cart. The bottle was dated opened on 6/6/23. The manufacturer's directions indicated, " ...You should expect that the eye drops will be stable long enough to finish your treatment. For example, if you're using an antibiotic eye drop like ofloxacin the duration is usually 14 days or less. So, the bottle should be stable for at least 14 days ...." Resident 39 had a bottle of latanoprost 0.05% on the medication cart. It lacked a date the bottle was opened. It was sent from the pharmacy on 9/25/23. Resident 218 had a Lantus insulin pen on the cart. His name was on the pen. The pen lacked directions for use and lacked a date it was opened. A policy titled, "LTC (Long Term Care) Facility's Pharmacy Services and Procedures Manual," indicated, " ...Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulins, irrigation solutions, etc.)...." 3.1-25(j) 3.1-25(m)		receiving insulin with proper dates. Undated insulin was discarded. 2.All residents have the potential to be affected. All eye drops and insulin was reviewed by DNS/designee to ensure these meds were properly labeled and were no expired. 3.All nursing personnel have been in-serviced on proper labeling of Drugs and Biologicals by DNS/Designee 4.Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/Designee will complete Medication QAPI tool weekly x4 weeks and monthly x6 months then quarterly thereafter with results reported to the QAPI committee by the executive director. If 100% compliance is not achieved an action plan will be developed.	

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	3.1-25(n)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure that kitchen equipment was free from disrepair, ensure appropriate low temperature dishwasher chemical sanitization levels, and failed to ensure food was stored at appropriate temperatures for 2 of 2 days of kitchen observation. This issue had the potential to affect 64 of 66 residents who resided in the facility and received dietary services from the kitchen. Findings include:	F 0812	1. Kitchen staff have been educated to check the levels of the chemicals daily and to replace them when the level is too low to obtain proper priming. The hot box was removed immediately. 2. All residents have the potential to be affected. Kitchen staff have been educated to check the levels of the chemicals daily and to replace them when the level is too low to obtain proper priming and to check equipment is in good repair.	11/30/2023

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	1. On 10/19/23 at 10:15 a.m., the Dietary Manager (DM) sent a rack of bowls through the dishwashing machine. One bowl was left right side up to collect water during the cycle. When the cycle was completed, the DM tested for chemical sanitization levels using Hydrion QT 40 chemical test strips. He dipped the test strip into the bowl that had filled during the cycle, read the result to be zero parts per million (ppm). He repeated the chemical sanitization testing process a second time, he read the result was still zero ppm. At 10/19/23 at 10:17 a.m., the DM refilled a jug above the dishwashing machine with a yellow substance labeled Eco-San, he indicated it was the sanitizing solution that went into the dishwashing machine. He indicated it was not empty, he filled it up to be sure that was not the problem. On 10/19/23 at 10:18 a.m., the DM repeated the chemical sanitization testing process for a third time, he read results to be zero ppm and indicated it was supposed to be above 50 ppm and less than 200 ppm. On 10/19/23 at 10:20 a.m., the DM repeated the chemical sanitization testing process for a fourth time, he read result to be zero ppm. He indicated he would try different strips. On 10/19/23 at 10:21 a.m., the DM repeated the chemical sanitization testing process for a fifth time, with new strips, he read the result to be zero ppm. He indicated he was going to drain and refill the dishwashing machine. On 10/19/23 at 10:24 a.m., the DM used the chemical test strips to check the chemical levels in		All equipment in the kitchen was reviewed to ensure proper functioning. 3. Dietary manager/designee will check the sanitation of dishes during each meal to ensure proper sanitation of dishes is occurring and to check equipment to ensure equipment is in good repair. 4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/Designee will complete kitchen sanitation QAPI tool weekly x4 weeks and monthly x5 months then quarterly thereafter with results reported to the QAPI committee by the Executive Director. If 100% is not achieved, an action plan will be developed.	

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	the quaternary (sanitizing solution) buckets that were near dish machine and read the result to be 150 ppm. He indicated the test strips were working. On 10/19/23 at 10:27 a.m., the DM repeated the chemical sanitization testing process for a sixth time after the machine had refilled. He read the results at 10 ppm. On 10/19/23 at 10:29 a.m., the DM repeated the chemical sanitization process for a seventh time. He read the results to be 100 ppm and that it was supposed to be between 50 ppm -100 ppm. He indicated staff tested and recorded the results daily after breakfast. On 10/24/23 at 9:00 a.m., the ED provided a document titled, "Product Specification Document, Eco-San", undated, and indicated this was the user guide currently being used by the facility. The document indicated " ... liquid chlorine sanitizer and destainer specifically formulated for use in low temperature chemical warewashing machines ...tableware sanitizer and destainer for mechanical spray warewashing machines. For sanitizing tableware in low temperature warewashing machines, inject Eco-San into the final rinse water at a concentration of 100 ppm available chlorine. Do not exceed 200 ppm. To ensure that available chlorine concentration does not fall below 50 ppm, periodically test the rinse solution with a suitable test kit and adjust the dispensing rate accordingly ...." 2. On 10/19/23 at 10:09 a.m., hotbox (used to heat up food) observed with DM to be on and in use with cooked mashed potatoes and puree burgers inside. The temperature gauge on the outside was			

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	not functioning, no thermometer was located on the inside. DM indicated a thermometer was normally inside the hotbox, he did not know how long it had been broken. He removed a thermometer from inside another oven and placed it inside the hotbox. On 10/23/23 at 10:26 a.m., second observation of the hotbox with the DM, the hotbox external temperature gauge was not functioning, no internal thermometer located inside. On 10/24/23 at 9:06 a.m., the Executive Director (ED) indicated she had the hotbox removed from the kitchen and she did not know why they used it in the first place. On 10/24/23 at 10:10 a.m., the DM indicated they got rid of the hotbox because the thermometer did not work, there was not a plan to replace it. On 10/25/23 at 12:02 p.m., the ED indicated no one had reported the hotbox as being in disrepair prior to it being removed. On 10/24/23 at 9:00 a.m., the ED provided a policy dated 3/23 of unknown year titled, "Kitchen Safety Guidelines", indicated the policy was the one currently being used by the facility. The policy indicated, " ... 2. All employees will report defective equipment, unsafe conditions, acts, or safety hazards to the supervisor and/or the maintenance department ... 12. The maintenance department is responsible for routine inspections and repair of fans, vents, and equipment ... 3.1-21(i)(3)			
R 0000				

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00416623 and IN00420155. This visit included a Recertification and State Licensure Survey. Complaint IN00416623 - No deficiencies related to the allegations are cited. Complaint IN00420155 - No deficiencies related to the allegations are cited. Survey dates: October 19, 20, 23, 24, 25, and 26, 2023. Facility number: 000538 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 3, 2023.	R 0000		
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure that kitchen equipment was free from disrepair, and failed to ensure food was stored at appropriate temperatures for 2 of 2 observations of the kitchen. This issue had the potential to affect 13 of 13 residents who resided in the facility and	R 0154	1. Kitchen staff have been educated to check the levels of the chemicals daily and to replace them when the level is too low to obtain proper priming. The hot box was removed immediately. 2. All residents have the potential to be affected. Kitchen staff have	11/30/2023

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	received dietary services from the kitchen. Findings include: 1. On 10/19/23 at 10:15 a.m., the Dietary Manager (DM) sent a rack of bowls through the dishwashing machine. One bowl was left right side up to collect water during the cycle. When the cycle was completed, the DM tested for chemical sanitization levels using Hydrion QT 40 chemical test strips. He dipped the test strip into the bowl that had filled during the cycle, read the result to be zero parts per million (ppm). He repeated the chemical sanitization testing process a second time, he read the result was still zero ppm. At 10/19/23 at 10:17 a.m., the DM refilled a jug above the dishwashing machine with a yellow substance labeled Eco-San, he indicated it was the sanitizing solution that went into the dishwashing machine. He indicated it was not empty, he filled it up to be sure that was not the problem. On 10/19/23 at 10:18 a.m., the DM repeated the chemical sanitization testing process for a third time, he read results to be zero ppm and indicated it was supposed to be above 50 ppm and less than 200 ppm. On 10/19/23 at 10:20 a.m., the DM repeated the chemical sanitization testing process for a fourth time, he read result to be zero ppm. He indicated he would try different strips. On 10/19/23 at 10:21 a.m., the DM repeated the chemical sanitization testing process for a fifth time, with new strips, he read the result to be zero ppm. He indicated he was going to drain and refill the dishwashing machine.		been educated to check the levels of the chemicals daily and to replace them when the level is too low to obtain proper priming and to check equipment is in good repair. All equipment in the kitchen was reviewed to ensure proper functioning. 3. Dietary manager/designee will check the sanitation of dishes during each meal to ensure proper sanitation of dishes is occurring and to check equipment to ensure equipment is in good repair. 4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/Designee will complete kitchen sanitation QAPI tool weekly x4 weeks and monthly x5 months then quarterly thereafter with results reported to the QAPI committee by the Executive Director. If 100% is not achieved, an action plan will be developed.	

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	On 10/19/23 at 10:24 a.m., the DM used the chemical test strips to check the chemical levels in the quaternary (sanitizing solution) buckets that were near dish machine and read the result to be 150 ppm. He indicated the test strips were working. On 10/19/23 at 10:27 a.m., the DM repeated the chemical sanitization testing process for a sixth time after the machine had refilled. He read the results at 10 ppm. On 10/19/23 at 10:29 a.m., the DM repeated the chemical sanitization process for a seventh time. He read the results to be 100 ppm and that it was supposed to be between 50 ppm -100 ppm. He indicated staff tested and recorded the results daily after breakfast. On 10/24/23 at 9:00 a.m., the ED provided a document titled, "Product Specification Document, Eco-San", undated, and indicated this was the user guide currently being used by the facility. The document indicated " ... liquid chlorine sanitizer and destainer specifically formulated for use in low temperature chemical warewashing machines ...tableware sanitizer and destainer for mechanical spray warewashing machines. For sanitizing tableware in low temperature warewashing machines, inject Eco-San into the final rinse water at a concentration of 100 ppm available chlorine. Do not exceed 200 ppm. To ensure that available chlorine concentration does not fall below 50 ppm, periodically test the rinse solution with a suitable test kit and adjust the dispensing rate accordingly ...." 2. On 10/19/23 at 10:09 a.m., hotbox (used to heat			

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	up food) observed with DM to be on and in use with cooked mashed potatoes and puree burgers inside. The temperature gauge on the outside was not functioning, no thermometer was located on the inside. DM indicated a thermometer was normally inside the hotbox, he did not know how long it had been broken. He removed a thermometer from inside another oven and placed it inside the hotbox. On 10/23/23 at 10:26 a.m., second observation of the hotbox with the DM, the hotbox external temperature gauge was not functioning, no internal thermometer located inside. On 10/24/23 at 9:06 a.m., the Executive Director (ED) indicated she had the hotbox removed from the kitchen and she did not know why they used it in the first place. On 10/24/23 at 10:10 a.m., the DM indicated they got rid of the hotbox because the thermometer did not work, there was not a plan to replace it. On 10/25/23 at 12:02 p.m., the ED indicated no one had reported the hotbox as being in disrepair prior to it being removed. On 10/24/23 at 9:00 a.m., the ED provided a policy dated 3/23 of unknown year titled, "Kitchen Safety Guidelines", indicated the policy was the one currently being used by the facility. The policy indicated, " ... 2. All employees will report defective equipment, unsafe conditions, acts, or safety hazards to the supervisor and/or the maintenance department ... 12. The maintenance department is responsible for routine inspections and repair of fans, vents, and equipment ...."			

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R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure a nursing assessment was completed and documented prior to the administration of PRN (as needed) medication for 1 of 7 residents (Resident 10). Findings include: On 10/26/23 at 1:00 p.m., Resident 10's record was reviewed. Diagnoses included, but were not limited to, Schwannomatosis (growth of tumors along nerves and in the skull), and gastroesophageal reflux disease (heartburn) with esophagitis (inflammation of the esophagus/throat). Her medication administration record (MAR), dated 7/4/23 at 11:45 a.m., indicated that Resident 10 received one Meclizine 12.5 milligram (mg) tablet (used to treat nausea, vomiting, and dizziness) from Qualified Medication Aide (QMA) 7 after she complained of dizziness. Only the QMA signature was documented after the administration. No nurses signature and no documentation of an assessment completed by a nurse was found. No medication administration progress notes or assessment notes were found	R 0246	1. No corrective actions were taken for this individual resident as they had already been discharged from the facility. 2. All residents have the potential to be affected. All MAR's/ TAR's have been reviewed by DNS/designee to ensure PRN's have been properly documented. 3. To ensure that no other resident has the potential to be affected all nursing personnel have been in-serviced on proper documentation of PRN's/nursing assessments. DNS or designated staff member will audit MAR's weekly for the next 30 days for compliance and monthly thereafter. 4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program overseen by the executive director. DNS/Designee will complete Medication QAPI tool weekly x4 weeks and monthly x6 months then quarterly thereafter with results reported to the QAPI	11/30/2023

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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
	for between 6/28/23 to 7/20/23. In an interview with the Director of Nursing Services (DNS) on 10/26/23 at 1:52 p.m., she indicated a nurse should have completed an assessment and signed after the QMA. It was not completed. No assessment documentation was provided or available. A current policy titled, "PRN Medications," dated 4/14 year unknown, was provided by the Regional Nurse Consultant (RNC) on 10/26/23 at 2:20 p.m. The policy indicated, " ...If QMA is administering the PRN medications: The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse not on the premises for authorization to administer PRN's shall be documented in the nursing notes indicating the time and date of the contact. QMA shall document nurse authorization on back of the MAR ...."		committee by the executive director/general manager. If 100% compliance is not achieved an action plan will be developed.	