

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

PRINTED: 01/09/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155620		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 11/14/2023	
NAME OF PROVIDER OR SUPPLIER  ZIONSVILLE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 11/14/23</p> <p>Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290</p> <p>At this Emergency Preparedness survey, Zionsville Meadows was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 185 certified beds. At the time of the survey, the census was 60.</p> <p>Quality Review completed on 11/16/23</p>			E 0000	I am respectfully requesting a face to face IDR as I disagree with the scope and severity of E0004, E0013, E0029, E0030, and E0036.		
E 0004 SS=F Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency</p>						

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 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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	<p>preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated</p>			E 0004	1    There is an emergency preparedness plan which has been reviewed and signed by the		11/30/2023

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E 0013 SS=F Bldg. --	<p>at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 11/14/23 between 11:20 p.m. to 11:50 p.m. with the Maintenance Director, documentation for an emergency preparedness plan updated or reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve-month with the last documented date of update being listed as "Nov 17th" with no year listed. Based on interview at the time of record review, the Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its entire emergency preparedness program reviewed by the facility within the most recent twelve-month period.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based</p>				<p>Executive Director.</p> <p>2 All residents have the potential to be affected.</p> <p>3 ED will be educated, to ensure the emergency plan is reviewed and signed annually and as needed.</p> <p>4 Annual review of the Emergency Preparedness Program was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.</p>		

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	<p>on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p>						

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	<p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 11/14/23 between 11:20 p.m. to 11:50 p.m. with the Maintenance Director, documentation of emergency preparedness policies and procedures updated or reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan provided had not been reviewed within the past twelve-month with the last documented date of update being listed as "Nov 17th" with no year listed. Based on interview at the time of record review, the Maintenance Director agreed that according to the documentation provided, the facility could not</p>			E 0013	<p>1 Administrator and Maintenance Director have reviewed and signed the Emergency Preparedness plans policies and procedures.</p> <p>2 All residents have the potential to be affected.</p> <p>3 ED will be educated to ensure the emergency plan including policies and procedures are reviewed and signed annually or as needed.</p> <p>4 Annual review of the Emergency Preparedness Policies and Procedures was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.</p>		11/30/2023

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E 0029 SS=F Bldg. --	<p>show proof of an annual update of its emergency preparedness policies and procedures reviewed by the facility within the most recent twelve-month period.</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 11/14/23 between 11:20 p.m. to 11:50 p.m. with the Maintenance Director, documentation of an emergency preparedness communication plan updated or reviewed by the facility within the most recent twelve-month period was not available for review. The</p>			E 0029	<p>1 Executive Director and Maintenance Director have reviewed and signed the Emergency preparedness communication plan to ensure the communication plan is up to date.</p> <p>2 All residents have the potential to be affected.</p> <p>3 ED will be educated to ensure the emergency communication plan are reviewed and signed annually or as needed.</p> <p>4 Annual review of the Emergency Preparedness Program Communications Plan was added to the TELS checklist</p>		11/30/2023

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E 0030 SS=F Bldg. --	<p>communication plan provided had not been reviewed within the past twelve-month with the last documented date of update being listed as "Nov 17th" with no year listed. Based on interview at the time of record review, the Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its emergency preparedness policies and procedures reviewed by the facility within the most recent twelve-month period.</p> <p>403.748(c)(1), 416.54(c)(1), 418.113(c)(1), 441.184(c)(1), 482.15(c)(1), 483.475(c)(1), 483.73(c)(1), 484.102(c)(1), 485.625(c)(1), 485.68(c)(1), 485.727(c)(1), 485.920(c)(1), 486.360(c)(1), 491.12(c)(1), 494.62(c)(1)</p> <p>Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).</p> <p>[(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]</p> <p>(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].</p>				and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication Plan is completed annually.		

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	<p>(v) Volunteers.</p> <p>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.</p> <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.</p> <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.</p> <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p>				



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	<p>(1) Names and contact information for the following:</p> <p>(i) Hospice employees.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Other hospices.</p> <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Patients' physicians.</p> <p>(iv) Volunteers.</p> <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p> <p>(2) Names and contact information for the following:</p> <p>(i) Staff.</p> <p>(ii) Entities providing services under arrangement.</p> <p>(iii) Volunteers.</p> <p>(iv) Other OPOs.</p> <p>(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).</p> <p>Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)</p> <p>(1). This deficient practice could affect all occupants.</p>			E 0030	<p>1     The executive director has reviewed the communication plan to ensure it includes names and contact information for staff, entities providing services and physicians, other LTC facilities and volunteers.</p> <p>2     All residents have the potential to be affected.</p>		11/30/2023

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E 0036 SS=F Bldg. --	<p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 11/14/23 between 11:20 p.m. to 11:50 p.m. with the Maintenance Director, documentation of an emergency preparedness communication plan updated or reviewed by the facility within the most recent twelve-month period was not available for review. The communication plan provided had not been reviewed within the past twelve-month with the last documented date of update being listed as "Nov 17th" with no year listed. Furthermore, the (1) Names and contact information for: (i) The Administrators name was listed first in the staff contact list. When the Maintenance Director was asked if this person was still the facility Administrator, the Maintenance Director replied "No, she has not been the Administrator for a few years now". Based on interview at the time of record review, the Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its emergency preparedness staff contact information had been reviewed by the facility within the most recent twelve-month period.</p> <p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)</p> <p>EP Training and Testing</p> <p>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p>				<p>3 ED will be educated to ensure the communication plan is complete and includes contact information for staff, entities providing services and physicians, other LTC facilities and volunteers.</p> <p>4 Annual review of the Emergency Preparedness Program Communications Plan was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication Plan is completed annually.</p>		

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	<p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures</p>						

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	<p>at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 11/14/23 between 11:20 p.m. to 11:50 p.m. with the Maintenance Director, documentation of an emergency preparedness training and testing program updated or reviewed by the facility within the most recent twelve-month period was not available for review. The training and testing program provided had not been reviewed within the past twelve-month with the last documented date of update being</p>			E 0036	<p>1 Documentation for an emergency preparedness training and testing program conducted was completed.</p> <p>2 All residents have the potential to be affected.</p> <p>3 ED will be educated to ensure the emergency preparedness training and testing program is completed at least annually.</p> <p>4 Annual review of the training and testing event was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the tabletop is completed annually.</p>		11/30/2023

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E 0039 SS=F Bldg. --	<p>listed as "Nov 17th" with no year listed. Based on interview at the time of record review, the Maintenance Director agreed that according to the documentation provided, the facility could not show proof of an annual update of its emergency preparedness training and testing program reviewed by the facility within the most recent twelve-month period.</p> <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required</p>				

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	<p>community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual</p>				

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	<p>facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based</p>						

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	<p>functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or</p>						



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	<p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is</p>						

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	<p>led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a</p>						

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	<p>set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p>						

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	<p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and</p>						

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	<p>maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[ RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop</p>						

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	<p>exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p>			E 0039	<p>1. Corrective actions for this deficiency include ensuring two emergency exercises are completed annually by facility. A tabletop exercise has been scheduled for 12/15/23 to complete annual requirements.</p> <p>2. All residents have the potential to be affected by this deficiency.</p> <p>3. To ensure that deficiency does not reoccur exercises will be conducted to test the emergency plan at least twice annually. One annual full-scale exercise that is community-based or facility based, and a second approved exercise of choice will be completed.</p> <p>4. Administrator/Designee will be responsible to ensure that exercises are completed timely. QAPI tool will be put in place to monitor completion of exercises and reviewed at monthly QAPI meetings. If 100% compliance is not achieved an action plan will be developed.</p>		12/15/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155620		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 11/14/2023	
NAME OF PROVIDER OR SUPPLIER  ZIONSVILLE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077			
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K 0000  Bldg. 01	<p>Based on review of the facility's Emergency Preparedness Plan on 11/14/23 between 11:20 p.m. to 11:50 p.m. with the Maintenance Director, documentation of an annual full-scale exercise that is community-based was documented as being completed on 06/29/23 but a second full-scale exercise that is community-based or an individual, facility-based functional exercise, or a mock disaster drill, a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan was not available to review. Based on interview at the time of record review, the Maintenance Director agreed that a 2nd exercise of choice had not yet been completed by the facility as of the time of this survey.</p> <p>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).</p> <p>Survey Date: 11/14/23</p> <p>Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290</p> <p>At this Life Safety Code survey, Zionsville Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the</p>			K 0000	I am respectfully requesting a face to face IDR as I disagree with the scope and severity of E0004, E0013, E0029, E0030, and E0036.		

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K 0363 SS=E Bldg. 01	<p>National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>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 60 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review completed on 11/16/23</p> <p>NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p>						



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	<p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing or latching and would resist the passage of smoke. This deficient practice could affect as many as 10 residents, 4 staff, and 2 visitors.</p> <p>Findings include:</p> <p>Based on observations made during a tour of the facility on 11/14/23 at 1:01 p.m. with the Maintenance Director, the corridor door serving as the entrance to the Activities area was propped in the fully open position with a door stop. Based</p>			K 0363	<p>1. The door was immediately closed so that those residents present in the activity room were no longer affected.</p> <p>2. All residents have the potential to be affected by any door being propped open per fire regulations.</p> <p>3. All staff members will be in-serviced on the importance of following fire regulations and specifically not propping open doors.</p> <p>4. Ongoing compliance with this corrective action will be monitored monthly in the QAPI program,</p>		12/08/2023

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K 0753 SS=E Bldg. 01	<p>on an interview at the time of the observation, the Maintenance Director acknowledged the aforementioned corridor door was propped in the fully open position with a wedge placed on the floor and stated that he would talk to the Activities staff about propping open doors to the corridor with door stops.</p> <p>This finding was reviewed with the Administrator at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met:</p> <ul style="list-style-type: none"> <li>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.</li> <li>o Decorations meet NFPA 701.</li> <li>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li> <li>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).</li> <li>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.</li> </ul> <p>19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 main lobby area was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect as many as 16 residents, 8 staff, and 2 visitors.</p>			K 0753	<p>overseen by the executive director. Maintenance Director will complete QAPI tool weekly x 4 weeks and then quarterly thereafter. If 100% compliance is not achieved an action plan will be developed.</p> <p>1.The decorative straw was removed immediately. 2. All residents have the potential to be affected by the deficiency. 3. No decorative straw will be allowed inside the facility, nor any other type of combustible</p>		12/01/2023

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	<p>Findings include:</p> <p>Based on observations made upon entering the facility on 11/14/23 at 9:01 a.m., the following was noted: There were four 24-inch, by 24-inch, by 48-inch bales of hay stacked decoratively in the main entrance lobby of the facility. Based on an interview at the time of the observations, the Maintenance Director was asked what the hay bales were coated with to create an acceptable flame spread rating for the combustible decorations, he stated that they had not coated the hay with anything. He was then asked how long the hay had been placed there and he replied that the hay had only been placed there for the Halloween holidays and had been there approximately three weeks or so adding that they were supposed to be picked up and removed today.</p> <p>This finding was reviewed with the Administrator at the exit conference.</p> <p>3.1-19(b)</p>				<p>decorations.</p> <p>4. Ongoing compliance shall be monitored by the maintenance director/designee who will complete a QAPI tool of inspection of facility for any inappropriate combustible material within the facility. Tool will include weekly inspections of building for compliance x 4 weeks and then quarterly thereafter if compliance is met. If 100% compliance is not achieved then an action plan will be developed.</p>		