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	12/09/2024

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 IN00441015, IN00444032, IN00444498, IN00446334. This visit included a State Residential Licensure Survey. Complaint IN00441015- No deficiencies related to the allegations are cited. Complaint IN00444032 - Federal/state deficiencies related to the allegations are cited at F804. Complaint IN00444498 - No deficiencies related to the allegations are cited. Complaint IN00446334 - No deficiencies related to the allegations are cited. Survey dates: December 2, 3, 4, 5, 6, and 9, 2024 Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 4 Medicaid: 54 Other: 24 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	I am requesting paper compliance for our survey here at Zionsville Meadows. May we have paper compliance? Thank you, Dana Huffman, E.D.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana Huffman	E.D.	01/02/2025

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	Quality review completed on December 19, 2024.			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response Based on observations, interviews, and record review, the facility failed to ensure repeated grievances brought to the attention of the facility by the resident council were responded to for 7 of 12 months of resident council reviewed. Findings include: On 12/3/24 at 1:10 p.m., the Activity Director (AD) provided the Resident Council Minutes for review. On 12/3/24 at 1:15 p.m., the Resident Council Minutes were reviewed. Repeated concerns for the previous 12 months included, but were not limited to: food temperatures, availability and/or access to adequate amounts of linens, staff attitude and/or body language, and staff use of cell phones and ear buds. 1. Cold Food: a. Concerns related to cold food were discussed during the months of: January, February, June, July, September, October (two meetings), and November. b. Responses to concerns related to food temperatures were not found for the months of: February, June, July or September. 2. Quantity/quality and/or access to/availability of linens: a. Concerns related to linens were discussed during the months of: January, June, August (times two meetings), September, and October	F 0565	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **1.a.** Grievances received during the council meeting were appropriately followed up by the applicable staff member. Corrective actions taken include re-education of dietary staff that includes the proper delivery of all food trays. This includes that delivery of food trays will only be made in enclosed carts only. Corrective action has been taken to remove two blue carts that are currently in operation without doors. These carts will be replaced by two new stainless-steel carts with doors. Corrective action has been taken to add steam table operation in the main dining room for all three meals. Staff encourage residents to go to the dining room for meals. Corrective action has been taken to re-educate clinical staff on the timeliness of meal tray delivery	01/09/2025

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	(two meetings). b. Responses to concerns related to linens were not found for the months of: August (for 8/26/24 meeting) or October (for the 10/14/24 meeting). 3. Staff attitude/body language and use of cell phones/ear buds: a. Concerns related to staff attitude and/or the use of phones were discussed during the months of: January, February, March, July, August, September, and October (two meetings). b. Responses to concerns related to staff attitude and/or the use of phones were not found for the months of: February, March, July, and August. On 12/4/24 at 12:08 p.m., a Resident Council meeting was conducted with 6 residents who regularly participated in Resident Councill. The residents indicated there were still ongoing concerns and complaints related to cold food, access to and the amount of linens available, and staff attitude. When responses were provided from previous meetings, they were often the same answers and over time if the issue was fixed for a couple of weeks, it would come back around again. Overall concerns were not resolved, and residents were often told, "we'll look into it." The residents indicated they still had complaints about food, it was, "cold, cold, cold." The residents indicated they still had complaints about access to linens but felt that it had been better the previous month. The residents indicated they still had concerns regarding staff attitudes and body language that made them feel, "devalued." During an interview on 12/4/24 at 12:49 p.m., the AD indicated, it was sometimes a struggle to get resident council responses back from each department, and that sometimes the responses had not been accepted by Resident Council,		and all who are responsible for this task. **2.a.** Corrective action has been taken by creating a new par level of linens for use. Large order of linen completed. Hsk/Lau Supervisor will be responsible for inventory and ensure par level is met. Additional laundry hours have been added to ensure processing meets demand. **3.a.** Corrective action has been taken with staff members participating in in-service training regarding professional attitude and body language. Both Relias module and face-to-face training will be used to accomplish this. Staff to be re-educated on the use of earbuds and cell phones while in the workplace. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected. The corrective actions mentioned	

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	especially if the concerns were repeated. Common or repeated issues were always related to food being too cold, staff use of their personal cell phone or ear buds, and trying to get enough linens. The AD indicated he had seen some staff on their phone or ear buds and had to stop them and remind them to remove the earbuds because the residents deserved undivided attention. The issues related to staff attitude and body language were often discussed as a cultural and language barrier between some residents and some staff who have immigrated from Africa, but the AD did not know if that had been addressed with the nursing staff. On 12/4/24 at 1:22 p.m., an unidentified Dietary Aide was observed as she left the main dining room with a 4-wheeled rolling cart. The cart had two shelves and was not enclosed and uninsulated. There were 7 lunch trays stacked on the cart. On 12/4/24 at 1:24 p.m., a blue, insulated room tray cart was observed on the back hall. The cart did not have a door. An unidentified Certified Nursing Assistant (CNA) who assisted with meal delivery indicated, the cart had not had a door for a long time and maybe that was why residents complained about cold food. On 12/5/24 at 9:26 a.m., the blue insulated room tray cart was observed on the back hall as breakfast trays were delivered. The cart remained in disrepair as the door was missing. During an interview on 12/5/24 at 9:13 a.m., the Housekeeping (HK) Supervisor indicated linen supply was a constant complaint, and the HK department spent on average $1,000.00 a month on a linen budget. HK staff were to empty soiled		above are corrective actions for all residents. All resident council minutes were reviewed for the last 12 months to ensure all concerns had appropriate follow up by the ED/Designee. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** ED will review the resident council minutes to ensure all resident concerns have appropriate follow up from each meeting Measures put in place to ensure that cold food isn't served to residents include the corrective actions above along with oversight by all department leaders who will be on a rotation for supervision of delivery of meals. Dietary manager will also ensure that food is properly tempted before being served. Dietary manager will also complete random temperatures of trays after the cart is sent to the hallways. Measures put in place to ensure that linen is available for all residents include a new par level that will be maintained and additional hours of operation in the	

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	laundry rooms and restock linen supply closets every 2 hours. On 12/5/24 at 9:15 a.m., the linen supply closet for the skilled long-term care halls was observed with the Housekeeping Supervisor (HKS). The shelves were not empty, but the linens were not stocked to the fullest (designated by brightly colored tape on the wall). There was only one stack of washcloths on the labeled shelf, with empty space for two additional stacks. The HKS indicated there was an ample supply at that time, and HK would come around soon to restock. On 12/5/24 at 9:20 a.m., the linen supply closet for the secured memory care unit was observed with the HKS. The shelves were not empty, but the linens were not stocked to the fullest. There were only 5 towels. The HKS opened two towels, which were thin, worn, and not larger than an average bathmat rug. The HKS indicated that HK staff would stock the closet again. The HKS indicated missing linen may have been misplaced, or nursing staff used many wash clothes to clean residents and probably threw them away. During an interview on 12/5/24 at 2:00 p.m., with the Dietary Manager (DM) and Clinical Regional Dietician (CRD) present, the DM indicated she was aware of continued resident complaints about cold food, and it had been an ongoing issue as long as she had worked at the facility. The CRD indicated a new "heat on demand" system had replaced an outdated "pellet" warmer, and staff were educated on how to use the system. On 12/6/24 at 12:45 p.m., the Regional Nurse Consultant (RNC) provided a copy of the current facility policy titled, "Resident Council," revised 2/2020. The policy indicated, "The facility will		laundry. Measures put in place to ensure that staff are maintaining a professional attitude and presenting themselves in a positive manner, along with proper use of earbuds and cellphones in the workplace. All staff will receive Relias module training and will be further educated at all staff meetings in person. Department heads will be responsible to make walking rounds to ensure that staff are adhering to standards. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** ED/designee will complete Resident council QAPI tool weekly x4 weeks and monthly x6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the ED. If 100% compliance is not achieved an action plan will be developed Dietary Manager/designee will complete hallway tray tempting QAPI tool weekly x 4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee overseen by the executive director.	

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	promote and support the residents' right to participate and organize resident council. The Council will be used to communicate concerns, give suggestions for future programming and events, and otherwise participate in and guide facility life ... concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive Director will review all minutes and concern to ensure thorough resolution of concerns ... the facility responses to concerns/grievances will be reviewed by the Resident Council President and the resident council on their next meeting ...." On 12/6/24 at 12:45 p.m., the RNC provided a copy of the current facility policy titled, "Resident Concerns and Grievances," revised 9/2024. The policy indicated, " ...the Executive Director/Grievance Official shall review all complaints and agree with the actions taken towards resolution. Responses to resident, representative and/or family shall be made as soon as possible and preferably immediately. Actions taken to resolve the complaint shall be made within 72 hours from the time the concern/Grievance form was received unless there is a compelling reason for delay. Actions taken include contacting the resident, representative and/or family with an explanation of the steps the facility will take to resolve the complaint and to ensure their satisfaction ... all concerns/grievances will be trended monthly by the Grievance Official or designee and reported in summary form to the QAPI committee ...." 3.1-3(l) 3.1-3(m)		If 100% compliance is not achieved an action plan will be developed. Hsk/Lau Supervisor/designee will complete par level QAPI tool weekly x 4 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. DNS/designee will complete Workplace Professionalism QAPI tool weekly x 4 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.	
F 0623 SS=E	483.15(c)(3)-(6)(8) Notice Requirements Before			

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Bldg. 00	Transfer/Discharge Based on interview and record review, the facility failed to ensure the Ombudsman received end-of-the month hospital discharges information for 4 of 4 hospitalization discharges (Resident 14) and the Ombudsman did not receive hospitalization discharges from October 26, 2023, until October 24, 2024, for 21 of 34 residents. The deficient practice was corrected on October 24, 2024, prior to the start of the survey, and was therefore past noncompliance. Findings include: On 12/6/24 at 9:53 a.m., Resident 14's record was reviewed. He was admitted on 9/25/23. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (lung disease with constriction of airways and difficulty breathing), emphysema (chronic lung disease that damages the air sacs in the lungs), and dysphagia (difficulty swallowing). He had four recent hospitalizations: from 1/30 to 2/6/24 because his nephrostomy tube (a thin tube that drains urine from the kidney to a bag outside of the body) was pulled out, from 2/29 to 3/8/24 because his nephrostomy tube was pulled out, from 3/27 to 3/29/24 due to abdomen pain and tenderness, and from 8/27 to 9/3/24 due to low sodium levels. During an interview, on 12/5/24 at 2:52 p.m., the Regional Director of Clinicals (RDC) indicated she was unable to provide Resident 14's Ombudsman hospital discharge notifications because the facility did not send the end-of-the-month hospital discharge information to the Ombudsman. The facility found this deficiency in	F 0623	Past noncompliance: no plan of correction required.	01/09/2025

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	August 2024 and started the action plan in October 2024. During an interview, on 12/6/24 at 11:36 a.m., the Social Services Director (SSD) indicated the facility conducted an internal survey in September 2024 and did not find any Ombudsman notifications of hospital discharges. On October 24, 2024, all previously unsent hospital discharge notifications were sent to the Ombudsman. On 12/6/24 at 11:53 a.m., the SSD provided documentation of all total discharge and hospital discharges since October 26, 2023. The SSD indicated since October 26, 2023, there had been a total of 34 residents discharged from the facility with 21 residents having a hospital discharge. He indicated the Ombudsman had not notified of the hospital discharges at the end-of-the-month of their discharges. A current policy, titled, "Emergency Transfer Notifications," dated 4/18, was provided by the Regional Director of Clinicals (RDC), on 12/6/24 at 10:50 a.m. A review of the policy indicated, " ...Purpose of Policy: Provide guidance regarding notification requirements to the ombudsman when an emergency transfer occurs to an acute care setting ...The Census Activity Report will be faxed or mailed to the state Ombudsman each month ...." The deficient practice was corrected by October 24, 2024, after the facility implemented a systemic plan that included the following actions: auditing all discharges of residents, education of staff, notification of the ombudsman, and a system to monitor compliance. 3.1-1(r)(6)(A)(iv)			

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to ensure a resident received requested and desired nail trimming and shaving for 1 of 9 residents reviewed for nail trimming and shaving (Resident 135). Findings include: On 12/6/24 at 9:46 a.m., Resident 135's record was reviewed. His diagnoses included, but were not limited to, mild cognitive impairment (difficulties with thinking, learning, remembering, and making decisions), glaucoma (eye disease causes blindness), and a history of myocardial infarction (heart attack). His care plan, dated 11/25/24, indicated he required assistance and/or monitoring for morning (AM) and afternoon (PM) care, nutrition, hydration, and elimination. The goal indicated he would have his activities of daily living (ADLs) needs met. An Approach indicated his PM care included bathing, dressing, hair combing, and oral care. His care plan, dated 12/5/24, indicated he required assistance with activities of daily living (ADL)s due to history of TIA (stroke), left sided weakness, glaucoma (eye disease that causes blindness), obesity, and impaired mobility. A nursing care approach indicated to assist with bathing as needed per resident preference. Another approach was to assist with dressing, grooming, and hygiene as needed. During an interview, on 12/3/24 at 9:47 a.m., Resident 135 indicated he only had two showers	F 0677	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Corrective action for resident 135 included both fingernails and toenails were trimmed and face shaven. The Unit Manager/designee will check resident 135 3 x weekly for the next month to ensure that all personal care is completed. Unit Manager/designee will report any issues to DNS. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected. All care staff will be in-serviced on completing all tasks of personal care during scheduled showers or resident request. DNS/designee inspected all residents to ensure that nails were trimmed, showers done, and shaving completed. **what measures will be**	01/09/2025

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	since he arrived at the facility, one last week and one this week. He indicated he had asked staff to cut his fingernails and toenails, he really needed his toenails cut, especially on his right foot. His right foot toenails were observed to be discolored and long to the end of his toes and just past his toes. During an interview, on 12/6/24 at 9:24 a.m., the Regional Nursing Consultant (RNC) indicated nail care was part of the resident receiving a shower. During an interview, on 12/6/24 at 10:02 a.m., Resident 135 indicated he wanted to be shaved and have his fingernails and toenails cut. He told Certified Nursing Aide (CNA) 25 during his shower and she did not do it. He was observed with fingernails to the ends of his fingers and had noticeably visible facial hair. During an interview, on 12/6/24 at 10:06 a.m., CNA 25 indicated she did not provide nail cutting when providing a shower, but she should have shaved him. During an interview, on 12/6/24 at 10:38 a.m., Registered Nurse (RN) 26 indicated during resident's showers the CNAs should look for any skin issues, bathe, shampoo, and trim their nails. Sometimes the nurses cut the residents' toenails. The CNAs did shave the residents during the shower. If there was a delay and they could not shave the resident during the shower, they should not wait until the next shower, but should do it the same day as the shower. If residents wanted to go to activities, ADL care should be done after that activity. On 12/6/24 at 10:56 a.m., the RDC provided Resident 135's shower sheets, dated 11/26, 11/29,		**put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** To ensure that no other residents have 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, daily by the unit manager to ensure that showers are given and any skin/hair issues are noted. DNS/designee will round daily to observe dependent resident nails, hair, shaven faces to ensure resident receive ADL care. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** 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 x 4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI	

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	and 12/3/24. The showers sheets dated 11/26 and 12/3/24 indicated Resident 135 was not shaved. The shower sheets for 11/26 and 11/29/24 indicated no nail care was provided. A current policy, titled, "Resident Rights," dated 10/23, was provided by the RDC, on 12/2/24, after the entrance conference. A review of the policy indicated, " ...Respect and Dignity ...The resident has the right to ...reside and receive services in the facility with reasonable accommodation of resident needs and preferences ...Self-Determination ...A resident has the right to: ...Make choices about aspects of his or her life in the facility that are significant such as schedules, including but not limited to sleeping, waking, eating, and bathing ...." 3.1-38(a)(3)(d) 3.1-38(a)(3)(e)		committee overseen by the executive director. If 100% compliance is not achieved an action plan will be developed.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observations, interviews and record review, the facility failed to prevent the potential for accidents by ensuring bed rail/mobility devices were appropriately monitored/adjusted to reduce the risk of entrapment for 2 of 5 residents reviewed for accidents (Residents 67 and 32), and failed to ensure fall interventions were in place for 1 of 5 residents reviewed for accidents, (Resident 27). Findings include: 1. On 12/2/24 at 10:26 a.m., Resident 67 was observed in her room on the secured memory care unit. She was seated in a regular wheelchair; her bed was neatly made. Bilateral side rails observed	F 0689	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Corrective action for resident 67 and resident 32 included maintenance director correcting the type of bedrail attached to their beds. Corrective action for resident 27 included the mattress being replaced with a scoop mattress. A “Call Before You Fall” sign was	01/09/2025

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ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

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	installed to the frame of her bed. There was a large gap between the edge of the mattress and the side rail. On 12/2/24 at 3:35 p.m., Resident 67's bed frame and side rails were observed with the Maintenance Director. He measured the gap between the edge of the mattress to the rail. The Maintenance Director indicated without measuring, he could tell the gap was too large and failed visual inspection. After measuring, he indicated the gap was 5 inches wide and needed to be adjusted to meet the bed zone requirements. The Maintenance Director indicated it was important to ensure there was not too large of a gap to prevent the potential for entrapment. On 12/2/24 at 3:45 p.m., the Maintenance Director provided a copy of the current procedure for bed rail safety checks. The Maintenance Director indicated the problem area on Resident 67's bed was "zone 3, between rail and mattress" which should not measure greater than 4 and 3/4 inches. On 12/3/24 at 11:51 a.m., Resident 67's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, dementia (a degenerative brain disease which affects memory and cognitive function), glaucoma (a progressive eye disease which causes vision loss), muscle weakness, and anxiety. She had a current physician's order, dated 9/11/23, for two half side rails to enhance her bed mobility. A care plan, dated 9/12/23, indicated Resident 67 required assistance with activities of daily living (ADLs) which included bed mobility and an		also placed in the room. The room was audited for appropriate fall interventions. Fall Care plan/Profile to include educating the staff to maintain the proper distance of the oxygen tank from the bed. To assist blue colored tape will mark the floor where tank should be kept. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by inappropriate gap measures. The Maintenance Director completed an audit of all bedrails to ensure gap distance was correct. All residents have the potential to be affected by lack of appropriate fall interventions. DNS/designee completed fall safety sweep to ensure fall interventions in place. **what measures will be put into place and what**	

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	intervention for this plan of care included, but was not limited to, bilateral half side rails. The care plan lacked implementation and/or revision to include routine ongoing assessments and/or monitoring of the side rails for safety and appropriateness. A "Bed Rail Notification," observation was created on 8/7/24 at 7:32 p.m. The notification was not signed by the resident and/or their representative to acknowledge the potential hazards of the use of side rails as stated on the notification; "I have been informed and understand the potential hazards that may occur with the use of bed rail (s) as follows: Potential hazards may include: decreased independence with getting in and out of bed, potential for bruising, potential for skin tears, potential for entrapment causing serious injury or death, and increased distance of falling if resident climbs over bed rails with possibility of greater injury." The record lacked any ongoing assessments and/or monitoring of the side rails for safety. 2. On 12/4/24 at 9:26 a.m., Resident 32 was observed. He was reclined in his bed and a large gap was observed from the edge of his mattress to the bilateral mobility bars. On 12/4/24 at 2: 47 p.m., Resident 32 remained in bed. He indicated the mobility bars were too far away for him to reach by himself, but he used them to hold on to when he was turned in bed to get cleaned up or for bed baths. On 12/5/24 at 9:25 a.m., Resident 32's bed frame was observed with the Maintenance Director who measured the gap. The Administrator (ADM) was also present at that time.		**systemic changes will be made to ensure that the deficient practice does not recur;** Systemic changes include, clinical staff will be educated on fall interventions per care plan, to ensure fall interventions are in place. Systemic changes include Maintenance and Clinical staff will be in-serviced to ensure bedrails are appropriately monitored and adjusted to prevent entrapment. The maintenance Director is responsible for conducting sweeps of beds to ensure correct gap measurement on all beds with bedrails. DNS/Designee to conduct rounds on shifts to ensure fall interventions are in place per plan of care **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** The Maintenance Director/designee will complete bedrail QAPI tool weekly x 4 weeks and monthly x 6 months, then quarterly thereafter with	

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	The Maintenance Director indicated the gap on the right side of the bed was 5 and a half inches, and the gap on the left side was 4 and one quarter inches. The Maintenance Director indicated he was aware Resident 32 had the mobility bars installed on his bed, but it appeared that nursing had switched his mattress and not notified the Maintenance Director to come and inspect them and/or adjust to the appropriate measurement. The Maintenance Director indicated the gap on the right side was too wide, and he would adjust the bars immediately. On 12/5/24 at 1:52 p.m., Resident 32' medical record was reviewed. He was a long-term care resident with a diagnosis which included but was not limited to Parkinson's disease (a chronic, progressive brain disorder that affects the nervous system and causes movement problems). His record lacked documentation of the mobility bars initial and/or ongoing assessments for safety and appropriateness. On 12/3/24 at 9:30 a.m., the Regional Nurse Consultant, (RNC) provided a copy of current facility policy titled, "Restraints: Bed Rail Safety Check," updated 8/2021. The policy indicated, "Purpose: to ensure bed rails utilized in the facility are safely and appropriately secured to the bed. A bed rail safety check will be completed on all beds that have any type of rail. The bed rail safety check will be completed upon initiation or change of any bed rail, mattress and or bed frame, and at least annually thereafter. The bed rail safety check form will be completed with each safety check and will be maintained at the facility for 10 years ...."3. On 12/2/24 at 10:00 a.m., Resident 27 was observed sitting on the side of the bed. The Resident's face was bruised from underneath both		results reported to the QAPI committee overseen by the executive director. If 100% compliance is not achieved an action plan will be developed. The DNS/designee will complete fall management QAPI tool weekly x 4 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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	eyes to her hairline and on her bilateral knees and shins. Her bed was in a low position with a regular mattress on the frame, her oxygen concentrator was by the bedside approximately 1 foot from the Resident. A "call before you fall" sign was not observed in her room. The resident indicated she had recently become very off balance and that she had fallen out of bed twice and hit her face on the oxygen concentrator next to her bed causing the bruising to her face. On 12/3/24 at 11:02 a.m., Resident 27 was observed sitting on the side of her bed, with her oxygen concentrator pushed up against the right side of the bedframe. There was a normal mattress on the bed frame. A "call before you fall" sign was not observed in the room. On 12/4/24 at 1:50 p.m., The Director of Nursing Services (DNS) and the Assistant Director of Nursing services (ADNS) were observed talking to Resident 27 in her room. After the DNS and ADNS left the room, the Resident was observed sitting on the side of the bed with her call light and glasses on the floor partially under the bed. There was a normal mattress on the bed frame, the bed was approximately 1 to 2 feet away from the wall. and there was no A "call before you fall" sign was not observed in the room. On 12/05/24 2:15 p.m., Resident 27 was observed lying in bed with her eyes closed. The resident was lying on the edge of the right side of the bed, her oxygen concentrator was approximately 6 inches from the right side of the bed and her call light was on the floor. Qualified Medication Aide (QMA) 6 was asked to check on Resident 27. QMA 6 was observed pulling Resident 27 over to the middle of the bed, QMA 6 asked the Resident if she needed anything else and then left the			

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	room. The Residents call light remained on the floor and her oxygen concentrator was not moved away from the side of the bed. On 12/04/24 at 10:10 a.m., Resident 27s medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, end stage renal disease, dependance on renal dialysis, generalized muscle weakness, and unsteadiness on her feet. A nursing progress note, dated 10/27/24 at 4:13 a.m., indicated an unknown CNA found Resident 27 lying on the floor next to her bed, and the Resident indicated that she had hit her head on the oxygen concentrator. An IDT progress note, dated 10/27/24 at 4:20 a.m., indicated that the cause of the fall was poor bed boundaries, weakness, unsteady gait, and unaware of physical limitations. The note also indicated that the intervention put in place was a "call before you fall" sign in the resident's room. A nursing progress note, dated 11/21/24 at 6:54 a.m., indicated that Resident 27 was found lying beside the bed and that the Resident indicated that she fell asleep sitting on the side of the bed. An IDT progress note, dated 11/21/24 at 6:26 a.m., indicated that the cause of the fall was poor bed boundaries and weakness. The note also indicated that the interventions put in place were nonskid strips next to the bed and a scoop mattress. A physician order, dated 11/21/24, indicated for a scoop mattress to be placed on her bed. A care plan, initiated on 7/17/24, indicated that			

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	she was at risk for falls. Interventions for this plan of care included but were not limited to: scoop mattress to the Residents bed and "call before you fall" sign in the Residents room. During an interview on 12/05/24 at 2:50 p.m., The DNS and ADNS indicated that resident call lights should always be placed within reach of the resident. They indicated that in order to change out mattresses, the nurse who received the order for a new mattress should contact maintenance and then they would change the beds out. They indicated that they did not know why her mattress wasn't changed but agreed that Resident 27 should have a scoop mattress on her bed. They indicated that oxygen concentrators should be placed far enough away from the bed so that resident could not fall onto them. 3.1-45(a)(1)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure food was hot when served to a resident for 1 of 1 test tray temperature checked and for 7 of 12 months of resident council minutes reviewed. Findings include: On 12/3/24 at 1:15 p.m., the Resident Council Minutes were reviewed. Repeated concerns for the previous 12 months included but were not limited to: cold food temperatures for hot foods. Concerns related to cold food were discussed during the months of: January, February, June, July, September, October (two meetings) and	F 0804	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** 1.a. Corrective actions taken include re-education of dietary staff that includes the proper delivery of all food trays. This includes that delivery of food trays will only be made in enclosed carts only. Corrective action has been taken to remove two blue carts that are currently in operation without doors. These carts will be	01/09/2025

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	November. Responses to the concerns related to cold food temperatures were not found for the months of: February, June, July or September. Facility responses and interventions included repeated staff in-services, repeated assurance that plate warmers were being used, and assurance that test trays would be sampled by staff members. On 12/4/24 at 12:08 p.m., a Resident Council meeting was conducted with 6 residents who regularly participated in Resident Council. The residents agreed there was still ongoing concerns and complaints related to cold food. When responses were provided from previous meetings, they were often the same answers and over time if the issue was fixed for a couple of weeks, it would come back around again. The residents agreed, overall concerns were not resolved, and residents were often told, "we'll look into it." The residents indicated they still had complaints about food, and it was, "cold, cold, cold." During an interview, on 12/4/24 at 12:49 p.m., the Activity Director (AD) indicated, it was sometimes a struggle to get Resident Council responses back from each department. On 12/4/24 from 1:04 to 1:33 p.m., the 200 hall meal cart was observed to be left open while lunch trays were being delivered on the 200 hall. On 12/4/24 at 1:33 p.m., the Certified Dietary Manager (CDM) was present on the 200 hall to check the temperature of the last tray removed from the 200 hall meal cart for Resident 16. She indicated the tuna casserole was 123 degrees Fahrenheit (F), the green beans were 113 degrees F, and the applesauce should have been 34 - 35 degrees F, but the applesauce temperature was 57 degrees F. She indicated the hot foods should		replaced by two new stainless-steel carts with doors. Corrective action has been taken to add steam table operation to the main dining room for all three meals. Staff encourage residents to go to the dining room for meals. Corrective action has been taken to re-educate clinical staff on the timeliness of meal tray delivery and all who are responsible for this task. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected. The corrective actions mentioned above are corrective actions for all residents. Corrective action has been taken to re-educate clinical staff on the timeliness of meal tray delivery and all who are responsible for this task. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Measures put in place to ensure that cold food isn't served	

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	have been above 140 degrees F. On 12/4/24 at 1:38 p.m., the CDM indicated she needed to provide Resident 16 another lunch from the kitchen. During an interview on 12/5/24 at 2:00 p.m., with the Dietary Manager (DM) and Clinical Regional Dietician (CRD) present, the DM indicated she was aware of continued resident complaints about cold food, and it had been an ongoing issue as long as she had worked at the facility. The CRD indicated a new "heat on demand" system had replaced an outdated "pellet" warmer, and staff were educated on how to use the system. During a Quality Assurance Performance Improvement (QAPI) interview, the Executive Director (ED) indicated the QAPI team met every other month and consisted of many department heads, but not the dietary manager because she was new to the facility. A review of the employee records indicated the CDM started on 9/13/24. Regarding the cold food complaints from the residents, some of it was repetitive from certain residents. The ED indicated the kitchen got new carts to help with the food temperatures. The facility used "Dynex" hot plate bases that were heated to help with temperatures. The ED indicated she wanted to get residents out of their rooms and coming back to the dining room. She wanted to work with the Certified Nursing Aides (CNA) and the Social Services Director (SSD) to encourage residents to get out of their rooms. A current policy, titled, "Food Temperatures," dated 6/23, was provided by the RNC, on 12/6/24 at 10:50 a.m. A review of the policy indicated, " ...All hot and cold food items will be served to the resident at a temperature that is considered		to residents include the corrective actions above along with oversight by all department leaders who will be on a rotation for supervision of delivery of meals. The dietary manager/designee will also ensure that food is properly tempted before being served by logging the temps of meals each meal. The dietary manager will also complete the temperatures of trays after the cart is sent to the hallways. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed. Ongoing compliance with the above corrective actions will be monitored monthly in the QAPI program overseen by the executive director. Dietary Manager/designee will complete hallway tray tempting QAPI tool weekly x 4 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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	palatable at the time the resident receives the food ...Hot food will be held at or above 135 degrees F. If minimum temperature requirements are not maintained, food will need to be reheated to a minimum of 165 degrees F for 15 seconds before serving ...Cold food will be held at or below 41 degrees F. If cold food temperature is not maintained, food item will need to be chilled to less than or equal to 41 degrees F before serving ...." This citation relates to Complaint IN00444032. 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure drinks were covered while providing lunch trays on the 200 hall for 4 of 10 resident reviewed (Resident 6, 34, 40, and 135). Findings include: On 12/2/24 at 1:01 p.m., Certified Nursing Aide (CNA) 7 was observed carrying a lunch tray to Resident 40's room, the coffee cup was uncovered. On 12/4/24 at 1:06 p.m., CNA 7 was observed carrying a lunch tray to Resident 6's room, her coffee and orange drink were uncovered. On 12/4/24 at 1:06 p.m., the Activity Director was observed carrying a lunch tray to Resident 34's room, his orange drink was uncovered. The lunch tray was carried to the Assisted Dining room.	F 0812	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Corrective actions will be accomplished for residents 6,34,40, and 135 to ensure a lid is secured to the cups of all drinks. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected. The corrective actions mentioned above are corrective actions for all	01/09/2025

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	On 12/4/24 at 1:06 p.m., CNA 7 was observed carrying a lunch tray to Resident 135's room, his orange drink was uncovered. A current policy, titled, "Meal Service and Distribution," dated 4/24, was provided by the Regional Nursing Consultant (RNC), on 12/3/24 at 9:15 a.m. A review of the policy indicated, " ...Prepared food will be transported to other areas either covered or in covered container/enclosed carts. Food and beverage items should be covered when being taken a distance such as down a hall or to another unit ...." 3.1-21(i)(2)		residents. All staff are in-serviced on proper lid use. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Audits to be conducted by the Dietary Manager/designee to ensure that lids are placed on carts for use by all staff delivering drinks. Charge Nurse/designee to ensure that staff delivering drinks utilize lids. All staff are in-serviced on proper lid use. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** Dietary Manager/designee will complete audit QAPI tool weekly x 4 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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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control A. Based on observation, interview, and record review, the facility failed to ensure staff wore personal protective equipment (PPE) appropriately for 11 of 11 observations of PPE, and failed to ensure the facility had a thorough process for contact tracing of infections for 2 of 2 months of infection tracking reviewed. B. Based on observations, interview and record review, the facility failed to ensure appropriate infection prevention procedures for laundry/linen services were followed to prevent the potential for the spread of germs and infection for 1 of 1 observation of the laundry room. This deficient practice had the potential to affect 82 of 82 residents who received laundry services from the facility. C. Based on observation, interview, and record review, the facility failed to ensure staff cleaned a blood glucose glucometer properly for 1 of 1 observation of glucometer cleaning. Findings include: A1. On 12/2/24 at 10:24 a.m., a sign was noted on Resident 4's door indicating he was on enhanced barrier precautions (EBP). The sign indicated staff were to wear gowns and gloves when providing activities of daily living (ADL) care and specified personal protective equipment (PPE) was to be worn during care that involved changing briefs, dressing, transferring, and bathing/showering.	F 0880	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A. Corrective actions for resident 4, 25, 33, 22, 81, 12, 136, 54, 57, 238, 136 includes education of all staff regarding donning and doffing of all PPE. A Corrective actions for contact tracing of infections include review of policy and procedures of contact tracing by facility IP. B Corrective action for the potential to affect all residents, include in-service training through both Relias modules and hands on training with regional director of housekeeping and laundry to ensure laundry is handled properly per infection control procedures. C Corrective action includes in-service on proper blood glucose machine cleaning for all licensed nurses. Corrective action for resident 4 includes in-service all staff to be able to readily identify any/all residents on EBP.	01/09/2025

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	During an interview, on 12/2/24 at 10:25 a.m., Certified Nursing Aide (CNA) 7 indicated she helped Resident 4 get up for the day which included assisting with dressing him. She indicated she did not wear a gown or gloves or PPE while assisting him because the resident had been there a long time and was not the resident under enhanced barrier precautions. The resident in isolation was his roommate, a new admission. During an interview, on 12/2/24 at 11:54 a.m., the Infection Preventionist (IP) indicated Resident 4 was on EBP and the staff should have worn gown and gloves when providing direct care because he had a feeding tube. A2. On 12/3/24 at 9:33 a.m., Housekeeper 23 was observed not wearing a mask while cleaning floor near the 200 hall where there were COVID-19 positive residents. On 12/3/24 at 11:11 a.m., Qualified Medication Aide (QMA) 6 was observed wearing a surgical mask. Before she entered Resident 25's COVID-19 positive room, she placed on N95 on top of her surgical mask. She exited wearing the same surgical mask. She subsequently went into Resident 33's COVID-19 positive room, still wearing her surgical mask and placed an N95 mask on top of it. During an interview on 12/3/24 at 11:30 a.m., the IP indicated the facility had a COVID-19 outbreak. Staff members who tested COVID-19 positive on 12/2/24 were the Executive Director (ED), Payroll Director (PD), Guest Relations (GR), and the facility Bus Driver (BD). She indicated she talked with the staff to figure out who they were around and would test those residents. All staff should		**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** A All residents have the potential to be affected. Corrective actions include those above and completion of PPE observation tool by IP. B All residents have the potential to be affected. Corrective actions include those above. The completion of audits by the hsk/lau supervisor/designee of correct on the job procedures. C All residents who receive blood glucose monitoring have the potential to be affected. Corrective actions include those above. DNS/designee will observe skills checkoff for blood glucose cleaning procedures with licensed nurses. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** A Measures put in place include the above. Systemic changes will include IP nurse/designee conducting rounds each shift ot ensure staff are properly donning	

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	be wearing surgical masks in the facility. For source control, she indicated the surgical mask must be removed before using an N95. During an interview, on 12/3/24 at 11:30 a.m., the Director of Nursing Services (DNS) indicated the facility's COVID-19 outbreak included 4 cases, two residents and two staff would be reported to the Health Department. Their source control was N95 masks, and they were available. On 12/3/24 at 11:35 a.m., Housekeeper 24 was observed not wearing a mask while cleaning the 200 hall shower room. On 12/3/24 at 11:50 a.m., Resident 22 was reported to be positive for COVID-19. On 12/3/24 at 12:00 p.m., Housekeeper 24 was observed in the hallway, near the Sunshine lunchroom, with a visible hole in his surgical mask. On 12/3/24 01:17 p.m., QMA 22 was observed with a beard. He put an N95 mask on top of a surgical mask before entering Resident 136's COVID-19 positive room to provide his lunch tray. QMA 22 indicated he did not know if it was acceptable to wear an N95 mask on top of a surgical mask, but he would ask the DNS. A Covid in-service was completed on 12/3/24 at 3:30 p.m. by the DNS. It included handwashing, PPE, double masking, COVID-19, alcohol-based hand rub, and donning and doffing of PPE. The in-service signature sheet showed 18 attendees, and included QMA 6 and QMA 22. The LTC (Long Term Care) Respiratory Surveillance Line List, dated 12/2024, was provided by the Executive Director (ED), on		and doffing PPE per protocol. B Measures put in place include the above. Systemic changes will include the completion of audits by the hsk/lau supervisor/designee of correct on the job procedures. Laundry Supervisor/designee will conduct rounds to ensure proper handling of linen. C. Measures put in place include the above. Systemic changes will include DNS/designee will randomly audit licensed nurses 3 x weekly x 4 weeks. If 100%compliance audits will cease. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** IP Nurse/designee will complete Infection Control QAPI tool weekly x 4 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 Hsk/Lau/designee will complete QAPI tool weekly x 4 weeks and monthly x 6 months, then quarterly thereafter with results reported to the QAPI committee	

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	12/4/24 at 1:59 p.m. A review indicated: a. Resident 81 was symptomatic on 11/26/24 and was tested on the same day. The testing result was COVID-19 positive. b. The ED was symptomatic on 11/27/24 and was tested on 11/29/24. The testing result was COVID-19 positive. She returned to work on 12/2/24. c. Resident 57 was symptomatic on 11/29/24 and was tested on the same day. The testing result was COVID-19 positive. d. The Bus Driver (BD) was symptomatic on 12/2/24 and was tested on the same day. The testing result was COVID-19 positive. e. The Payroll Director (PD) was symptomatic on 12/2/24 and was tested on the same day. The testing result was COVID-19 positive. f. Receptionist 27 was symptomatic on 12/2/24 and was tested on the same day. The testing result was COVID-19 positive. g. Resident 238 was symptomatic on 12/2/24 and was tested on the same day. The testing result was COVID-19 positive. h. Resident 136 was symptomatic on 12/2/24 and was tested on the same day. The testing result was COVID-19 positive. i. Resident 54 was symptomatic on 12/2/24 and was tested on the same day. The testing result was COVID-19 positive. j. Resident 33 was symptomatic on 12/3/24 and was tested on the same day. The testing result was COVID-19 positive. k. Resident 12 was symptomatic on 12/3/24 and was tested on the same day. The testing result was COVID-19 positive. l. Resident 25 was symptomatic on 12/3/24 and was tested on the same day. The testing result was COVID-19 positive. m. CNA 28 was symptomatic on 12/4/24 and was tested on the same day. The testing result was		overseen by the executive director. If 100% compliance is not achieved an action plan will be developed DNS/designee will complete QAPI tool weekly x 4 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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	COVID-19 positive. n. CNA 29 was symptomatic on 12/4/24 and was tested on the same day. The testing result was COVID-19 positive. On 12/4/24 at 10:30 a.m., the IP indicated Resident 45 and Resident 65's COVID-19 tests result were positive. On 12/4/24 at 1:04 p.m., Resident 22's door was observed with an isolation sign, it indicated to keep the door closed, to perform hand hygiene, wear a gown, N95 mask, eye protection, and disposable gloves before entering the room. QMA 22 put on a gown, face shield, and disposable gloves. He was observed already wearing a surgical mask. He did not wear an N95 mask. He entered Resident 22's COVID-19 positive room. He left the residents door open and after delivering his lunch tray, came out without his surgical mask. He gelled his hands and put on a new surgical mask. Her door hanger was observed with both N95 and surgical masks. On 12/4/24 at 1:09 p.m., Resident 12's door was observed with an isolation sign. QMA 22 was already wearing a surgical mask, he put on a gown, face shield, and disposable gloves. He did not wear an N95 mask. He left the resident door open and after delivering her lunch tray, came out without his surgical mask. He gelled his hands and put on a new surgical mask. Her door hanger was observed with both N95 and surgical masks. On 12/4/24 at 1:14 p.m., Resident 136's door was observed with an isolation sign. QMA 22 was already wearing a surgical mask, he put on a gown, face shield, and disposable gloves. He did not wear an N95 mask. He left the resident door open and after delivering his lunch tray, came out			

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	without his surgical mask. He gelled his hands and put on a new surgical mask. Her door hanger was observed with both N95 and surgical masks. On 12/4/24 at 1:19 p.m., Resident 54's door was observed with an isolation sign. QMA 22 was already wearing a surgical mask, he put on a gown, face shield, and disposable gloves. He did not wear an N95 mask. He left the resident door open and after delivering his lunch tray, came out without his surgical mask. He gelled his hands and put on a new surgical mask. His door hanger was observed with both N95 and surgical masks. On 12/4/24 at 1:25 p.m., Resident 81's door was observed with an isolation sign. QMA 22 was already wearing a surgical mask, he put on a gown, face shield, and disposable gloves. He did not wear an N95 mask. He left the resident door open and after delivering her lunch tray, came out without his surgical mask. He gelled his hands and put on an N95 mask. Her door hanger was observed with both N95 and surgical masks. During an interview, on 12/4/24 at 1:30 p.m., QMA indicated he did not know which mask to wear in a COVID-19 positive room, but he just put on an N95 mask because he needed to go into Resident 16's room to assist him with eating and his roommate, Resident 22, was COVID-19 positive During an interview, on 12/5/24 at 10:50 a.m., the IP indicated QMA 22 would have needed a good seal with his N95 mask for it to work properly and he would be unable to accomplish it with a beard. He should not have entered the COVID-19 positive room without a seal on his N95 mask. During an interview, on 12/4/24 at 2:53 p.m., the Regional Nurse Consultant (RNC) indicated QMA			

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	22 would be tested for COVID-19. During an interview, on 12/5/24 at 10:30 a.m., the IP indicated she became IP certified on 2/24/24 and became the facility's IP person at that time. She had been using the facility's transmission-based precautions and the COVID-19 outbreak policy as resources to guide her through the current outbreak. During an interview, on 12/5/24 at 10:44 a.m., the IP indicated Resident 59 and Resident 64 were COVID-19 positive. Also, the Charge Nurse 30 from the 100 hall was Covid positive. She indicated she was aware of the breaks in the COVID-19 policy and procedure and had been rounding more. During an interview, on 12/5/24 at 10:56 a.m., the IP indicated since the COVID-19 outbreak started she was doing contact tracing and would provide documentation. She indicated she documented where she observed the COVID-19 residents. During the contact tracing interview, on 12/6/24 at 11:30 a.m., the IP provided the, "Covid-19 Outbreak Investigation Contact Tracing Form," for COVID-19 positive residents. Four Covid positive residents were reviewed: a. Resident 81 tested positive on 11/26/24. The resident indicated a friend visited, no date or contact information was provided. No information if the friend was contacted. The section, Identify Close Contacts, and the Outbreak Testing Plan were observed blank. b. Resident 57 tested positive on 11/29/24. The section for the Outbreak Testing Plan was observed blank. c. Resident 238 tested positive on 12/2/24. The resident was in the therapy gym, but IP did not			

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	add other residents or staff who were also in the therapy gym to complete contact tracing. The section, Identify Close Contacts, and the Outbreak Testing Plan were observed blank. d. Resident 136 tested positive on 12/2/24. The resident was in the therapy gym and visited with family, but IP did not add other residents or staff who were also in the therapy gym or contact the family to complete contact tracing. The section, Identify Close Contacts, and the Outbreak Testing Plan were observed blank. During an interview, on 12/5/24 at 3:12 p.m., the IP indicated COVID-19 began in the facility at the end of November with Resident 81 as the first case and on 11/26/24 and Resident 57 on 11/29/24. She indicated there were signs on the doors, use of PPE, and we were trying to use dedicated staff for the 100 hall. The ED was symptomatic on 11/27/24 and tested positive on 11/29/24. During a review of the IP's tracking and trending, on 12/5/24 at 3:22 p.m., she indicated the COVID-19 positive cases were not tracked on the November color coded map. There was a cluster of urinary tract infections (UTI) noted on her November map. She did not follow-up with staff education regarding the UTIs or was aware of any further cluster of UTI near those resident rooms. She indicated she would compile the December infection information later. The analysis of infection was determined by looking at the color-coded map. During an interview, on 12/5/24 at 3:22 p.m., the Float IP indicated the facility did not graph infections to gather more information. The pharmacy provided an antibiotics analysis. A job description, titled, "Infection Preventionist			

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	Position Description", dated 7/2020, was provided by the DNS, on 12/6/24 at 1:54 p.m. A review of the IP job description indicated, " ...The Infection Preventionist is responsible for assessing and educational needs of staff, coordinating programs based upon identified needs, and ensuring compliance with all State and Federal guidelines for infection prevention and control, in-service education ...." A current procedure, titled, "Personal Protective Equipment (PPE) Donning and Doffing," dated 7/2023, was provided by the Director of Nursing Services (DNS), on 12/3/24 at 3:30 p.m. A review of the policy indicated, " ...fit the mask to the face so it [sic] snug to face and below chin, if N-95 respirator ...." A current policy, titled, "Covid-19 Policy," dated 7/2023, was provided by the IP, on 12/3/24 at 11:46 a.m. A review of the policy indicated, " ...Routine Infection Prevention and Control Practice ...residents and visitors will be offered education about the importance of receiving the Covid-19 vaccine ...Staff to follow appropriate PPE use according to the Standard and Transmission Based Precautions policy ...Source control option for HCP [health care providers] include: ...A well-fitting facemask ...When evaluating the need for source control, the Infection Preventionist will use multiple sources to make an informed decision when recommending source control including, but not limited to, respiratory virus transmission in the local community, respiratory virus transmission in the facility including staff date, local SARS-CoV-2 hospital admission data form the CDC COVID Data Tracker, and risk of current population served ...." A current policy, titled, "Standard and			

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	Transmission-Based Precautions (Isolation) Policy," dated 4/24/24, was provided by the RNC, on 12/2/24 at 4:01 p.m. A review of the policy indicated, " ...Personal Protective Equipment (PPE) refers to protective items or garments worn to minimize exposure to hazards that cause injuries and illnesses ...Respirator includes a fit-tested NIOSH-approved N95 or higher-level respirator for healthcare personnel when indicated ...Covid-19, which includes the use of N-95 respiratory ...residents suspected or confirmed with Covid-19 should remain in their current location ...Use of Personal Protective Equipment HCP should wear an N95 or higher-level respirator, eye protection (i.e. goggles or a face shield that cover the front and sides of the face), gloves, and gown when care for these resident ...."B. On 12/5/24 at 9:30 a.m., the facility's laundry service and processing rooms were observed with the Housekeeping Supervisor (HKS) present. Upon initial observation on 12/5/24 at 9:30 a.m., the laundry room was dimly lit, paint was peeled/chipped away from the walls in various areas, the overhead vents had clumps of dark debris and dust stuck to the grates. There was an empty unidentified plastic bottle on the floor behind the washing machines. The remainder of the floors behind the washing machines were littered with dust, lint and other unidentified debris. The tubes which carried detergent/sanitizer and other laundry chemicals from their containers to the machines, were observed to have a film of and clumps of the chemicals that had spilled down. The metal wire-baskets in which the chemicals were stored were rusted and the paint had chipped/peeled off. The soiled linen closet was observed. There were 9 large plastic trash can barrels lined with clear			

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	plastic bags. Two lids had been secured in place, three lids were on top of the can, but not secured closed, and four barrels were open to air as the clear plastic bags were not tied shit, and there were no lids on top of the barrels. There was a door between the soiled linen closet, and the main washing/drying areas which remained open. There were no hand sanitizers/hand hygiene stations for entrance/exit of the laundry area or within the laundry area. During an interview on 12/5/24 at 9:33 a.m., with the HKS, HK/laundry Aides (HKA) 30 and 31 present, HKS 30 and 31 indicated, they knew there was a COVID-19 outbreak in the facility at that time. There was no special way they were supposed to collect and sanitize COVID-19 positive soiled linens from regular, everything was treated the same. HKA 31 indicated, when COVID-19 was first around, the facility had utilized a color-coded trash bag system, so that staff would know which clothes or linen came from the COVID-19 positive rooms, so it could be stored and washed separately. HKA 30 and 31 did not know what temperatures were required to sterilize the linen, they did not know if linen was sterilized with chemicals, heat, or a combination of both. On 12/5/24 at 9:38 a.m., HKA 31 was observed as she demonstrated the wash cycle procedure. Without performing hand hygiene or donning personal protective equipment (PPE) she put on a pair of translucent surgical gloves and entered the soiled side. She retrieved a barrel and rolled it to a washing machine. On top of the pile of clothes in the barrel was a soiled pair of green flannel pants. There was a large smeared and crusted blotchy stain. HKA 31 indicated it was poop that the			

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	CNAs were supposed to rinse off in the "Hoppers" which were located in the soiled utilities room. HKS 31 grabbed an armful of soiled clothes, which included the soiled flannel pants smeared with poop, and dumped the items into the washing machine. As she continued to grab armfuls of laundry, the items brushed against the bare skin of her forearms, as she wore a short-sleeved shirt. As the barrel became empty, HKA 31 needed to bend over, into the barrel to retrieve the rest of the items. Without PPE in place, the edge and side of the soiled barrel came into direct contact with the front of her scrub shirt. When all the items were in the machine, HKA 31 did not remove her gloves before she pressed a series of buttons to begin the wash cycle. When the machine started, HKA 31 removed her gloves, without performing hand hygiene, she went to the clean laundry area and resumed folding clean clothes. During an interview on 12/5/24 at 9:45 a.m., the HKS indicated, HKA 31 should have worn a yellow gown which was reusable and hung on the back of the laundry room door. The purpose of the gown was to protect the staff member from potential contamination while in contact with soiled items and help prevent the spread of infection. On 12/5/24 at 9:47 a.m., the soiled linen closet on Pine Hall (where the majority of COVID-19 positive residents resided) was observed with the HKS present. There was a large industrial plastic bin. The lid of the bin was left open and leaned backwards against the wall. Inside the bin there were several clear plastic bags of soiled laundry. Two of the bags were observed untied and open to the air. The HKS indicated the soiled linen in plastic bags should be tied and sealed up and the			

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	lid on the bin should remain closed. On 12/5/24 at 9:57 a.m., the Float Infection Preventionist, (F-IP) indicated, it was the policy of the facility that all soiled linen and laundry should be considered contaminated and standard Infection Prevention procedures should be in effect. During an interview on 12/5/24 at 10:29 a.m., with the Facility's Infection Preventionist (IP) and F-IP present. The F-IP indicated staff should wear a PPE gown and gloves when they handled soiled linens to prevent contaminated items from coming in contact with their person. After handling soiled items, staff were expected to perform hand hygiene. Soiled closets should be kept tidy, and the bins lids should be closed. During an interview on 12/6/24 at 12:02 p.m., the Corporate HK Consultant indicated all staff who assisted with laundry should follow standard precautions. Contaminated laundry should be securely contained from the source. Staff would then execute procedures to handle contaminated items in a manner that protected the employee and precluded the contamination of clean linen. On 12/5/24 at 10:10 a.m. the F-IP provided a copy of the current facility policy titled, "Laundry/Linen," revised 12/2021. The policy indicated, " ...Purpose of the policy" to ensure the proper care and handling of linen and laundry to prevent the spread of infection ... all linen in use is contaminated. All linen, including that from a resident with a diagnosed infection is treated the same way except a resident who is under transmission-based precautions for C-Diff ... soiled linen, carry away from body to prevent soiling uniform ... containers in soiled linen room			

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

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	should be labeled, lined with will-fitted lids ... keep soiled linen covered in container until ready to load in machine ... before removing or touching clean laundry, perform hand hygiene ...." C. On 12/4/24 at 12:52 p.m., RN 20 was observed cleaning a blood glucometer meter. She wiped the meter with a Chlorox Bleach Germicidal wipe and sat it on a paper towel to dry. She did not allow the meter to remain wet with contact from the wipe for at least 3 minutes. On 12/9/24 at 1:22 p.m., the Assistant Director of Nursing (ADNS) was interviewed. She indicated the glucometer needed to remain wet for 3 minutes. A skills competency procedure was provided by the Regional Nurse Consultant (RCS) on 12/4/24 at 1:10 p.m. It indicated, " ...Wipe entire external surface of the blood glucometer meter wipe (Clorox Bleach Germicidal Wipes) and allow the surface of the meter to remain wet for 3 minutes. When using Clorox Bleach Germicidal wipes in the individual packet, it is best to squeeze out excess solution into a trash container or plastic cup to be disposed of ...." 3.1-18(b)(1)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00441015, IN00444032, IN00444498, IN00446334. This visit included a Recertification and State Licensure Survey. Complaint IN00441015- No deficiencies related to the allegations are cited.	R 0000	I am requesting paper compliance for our survey here at Zionsville Meadows. May we have paper compliance? Thank you, Dana Huffman, E.D.	

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	Complaint IN00444032 - Federal/state deficiencies related to the allegations are cited at F804. Complaint IN00444498 - No deficiencies related to the allegations are cited. Complaint IN00446334 - No deficiencies related to the allegations are cited. Survey dates: December 2, 3, 4, 5, 6, and 9, 2024 Facility number: 000538 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 19, 2024.			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure narcotic medications were signed out in the Medication Administration Record (MAR) at the time of administration for 1 of 3 residents reviewed for narcotic administration (Resident 2) and did not sign out narcotics at the time of administration in the narcotic binder for 3 of 3 residents reviewed (Resident 2, 5, and 12). Findings include: On 12/9/24 at 1:45 p.m., the narcotic count was compared to the narcotic binder for accuracy. 1 At 1:49 p.m., Resident 5's narcotic was checked	R 0243	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Corrective actions for residents 2, 5, and 12 include all narcotics being signed out per policy. **how other residents having the potential to be affected by the same deficient practice will be identified and**	01/09/2025

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	in the narcotic drawer of the Assisted Living (AL) Medication Cart. Her Tramadol 50 mg count was 47. Licensed Practical Nurse (LPN) 5 was observed opening the narcotic binder and signing out 1 Tramadol to make the narcotic count correct. A limited Medication Administration Record (MAR) review, on 12/9/24 at 2:30 p.m. indicated Resident 5's Tramadol 50 mg was administered between 7:00 a.m. to 11:00 a.m. 2. At 1:53 p.m., Resident 12's narcotic was checked in the narcotic drawer of the AL Med Cart. Her Lyrica 100 mg count was 44. LPN 5 was observed opening the narcotic binder and signing out 1 Lyrica to make the narcotic count correct. A limited MAR review, on 12/9/24 at 2:35 p.m. indicated Resident 12's Lyrica 100 mg was administered between 7:00 a.m. to 11:00 a.m. 3. At 1:57 p.m., Resident 2's narcotic was checked in the narcotic drawer of the AL Med Cart. His Hydrocodone-acetaminophen 5-325 mg count was 15. LPN 5 was observed opening the narcotic binder and signing out 2 Hydrocodone-acetaminophen 5-325 to make the narcotic count correct. A limited MAR review, on 12/9/24 at 2:40 p.m. indicated Resident 2's Hydrocodone-acetaminophen order was to administer two 5-325 mg tablet for a total amount of 10-650 mg as needed every 4 hours. This order started on 11/23/24 and was open ended. His 7:00 to 11:00 a.m. administration was not charted in his MAR. During an interview, on 12/9/24 at 2:02 p.m., LPN 5 indicated she should have signed out the		**what corrective action(s) will be taken.** All residents receiving controlled substances have the potential to be affected. Corrective action includes narcotic book reviewed by DNS to ensure that all narcotics have been properly documented. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Measures put in place include nurses and qma's have been in-serviced on Controlled Substances: Storage, Documentation, Inventory and Destruction. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed.** DNS/designee will complete QAPI tool weekly x 4 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	

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	narcotics when she gave them at 8:00 a.m. During an interview, on 12/9/24 at 2:10 p.m., the Assistant Director of Nursing Services (ADNS) indicated the staff only needed to sign out narcotics before the end of their shift. Any time was fine. A current policy, titled, "Controlled Substances: Storage, Documentation, Inventory and Destruction (Includes Fentanyl Patch Removal and Destructions), dated 2/1/2018, was provided by the ADNS, on 12/9/24 at 2:37 p.m. A review of the policy indicated, " ...When a controlled substance is administered to a resident, it must be recorded in the resident's Medication Administration Record (MAR) as well as in the resident's Controlled Substances Inventory Record at the time of administration ...."		achieved an action plan will be developed.	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance Based on observation, interview, and record review, the facility failed to ensure insulin pens were primed before insulin administration to ensure the correct dosage for provided for 2 of 4 residents who required insulin (Resident 9 and 11). Findings include: On 12/9/24 at 11:48 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident 9's insulin sensor was 181 and per his insulin sliding scale he would get 2 units of Novolog insulin per his physician's order. She was observed removing his Novolog insulin pen from the Assisted Living (AL) Medication Cart. She did not prime the insulin	R 0296	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Corrective actions for residents 9 and 11, include notifying NP and obtaining one time orders to administer missed insulin. Corrective actions include nurse on duty who administered this insulin was re-educated on proper insulin pen administration procedures.	01/09/2025

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	needle before turning the dial to 2 units and administered it. She indicated the open date was 12/1/24 and the insulin would last until the manufacturer expiration date of 12/31/26. On 12/9/24 at 12:00 p.m., LPN 5 indicated Resident 11's insulin sensor was 283 and per her insulin sliding scale she would get 8 units of Lispro per her physician's order. She went to the EDK since the the insulin was missing from the AL Med Cart. She did not prime the insulin needle before turning the dial to 8 units and administered it. She was observed to write the open date on the Lispro pen. During an interview, on 12/9/24 at 12:31 p.m., LPN 5 indicated she was not aware of the need to prime insulin needle pens before administering insulin. During an interview, on 12/9/24 at 12:40 p.m., the Director of Nursing Services (DNS) indicated when using an insulin pen, the nurses should wipe off end with an alcohol wipe, then prime the pen with 1 or 2 units of insulin to make sure the pen was functioning. The nurses write the open date on the insulin pen and insulin only lasted 28 days after it was opened. She would reach out to the provider to let them know what happened regarding the insulin pen needles not being primed. A current procedure, titled, "Insulin Pen Administration," dated 6/2018, was provided by the Assistant Director of Nursing Services (ADNS), on 12/9/24 at 1:05 p.m. A review of the procedure indicated, " ...Attach pen needle by twisting the needle onto end of insulin pen. Pull off and remove outer pen needle protective cap and cover. Prime the pen by dialing 2 units. Push the end of the pen to push out the 2 units. A small		**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents who receive insulin via pen have the potential to be affected. Corrective actions include those above. DNS/designee will observe skills checkoff for pen administration procedures with licensed nurses. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Systemic changes include to re-educate all assisted living licensed nurses on proper insulin pen administration procedures. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DNS/designee will complete QAPI tool weekly x 4 weeks and monthly x 6 months, then quarterly thereafter with results	

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	drop of insulin should be visible. If insulin does not appear, repeat. Dial desired insulin dosage to be administrated [sic] to resident ...."		reported to the QAPI committee overseen by the executive director. If 100% compliance is not achieved an action plan will be developed	