STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00425622, IN00424692, IN00406737, and IN00406679. This visit was in conjunction with the Investigation of Complaints IN00427360 and IN00427339. Complaint IN00425622 - Federal/State deficiencies related to the allegations are cited at F584. Complaint IN00406737 - Federal/State deficiencies related to the allegations are cited at F584 and F880. Complaint IN00406679 - Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00424692 - No deficiencies related to the allegations are cited. Complaint IN00427360 - Federal/state deficiencies related to the allegations are cited at F677 and F689. Complaint IN00427339 - Federal/state deficiencies related to the allegations are cited at F584, F677, F686, and F880. Survey dates: January 24, 25, 26, 29, and 30, 2024 Facility number: 012466 Provider number: 155786 AIM number: 201014060 Census Bed Type:	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keith Davis	Executive Director	02/16/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	SNF/NF: 109 SNF: 23 Total: 132 Census Payor Type: Medicare: 10 Medicaid: 81 Other: 41 Total: 132 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2024			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure a clean, comfortable, and homelike environment for Residents F and G, and the potential to affect all 37 residents that reside on the memory care unit (MCU). Findings include: 1. An observation conducted on the MCU, on 1/25/24 at 10:39 a.m., of 2 residents sitting in dining room chairs in the hallway outside of the dining room. There were no couches, benches, or other lounge chairs located within the hallways on the MCU. Another observation conducted on the MCU, on 1/26/24 at 1:42 p.m., of 3 residents sitting in the hallway in dining room chairs. There was a total of 5 chairs located within the hallway outside of the dining room.	F 0584	**F 584** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - dining room chairs have been removed from the memory care hallway. New benches ordered to provide additional appropriate seating for residents on the memory care unit. - the brown streak on the wall adjacent to the beds of Resident F and resident G has been cleaned How other residents having the	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Another observation conducted on the MCU, on 1/26/24 at 3:29 p.m., of 3 residents sitting in the hallway in dining room chairs. There was a total of 5 chairs located in the hallway outside of the dining room. An interview conducted with the Regional Director of Clinical Care, on 1/26/24 at 3:28 p.m., indicated they believe the MCU is too tight within the common areas. It potentially funnels the residents and the residents become too close to one another. There have been discussions about tearing down that partial wall on the MCU. It appeared that the dining room was not big enough to accommodate all the residents on the MCU. An observation conducted on the MCU, on 1/29/24 at 10:14 a.m., of 4 dining room chairs located in the hallway outside of the dining room with one resident sitting in such chair. An interview conducted with Social Services Director Float, on 1/29/24 at 2:21 p.m., indicated she floats to different facilities, specifically ones that contain a MCU. She mentioned that she submits a report to the corporation in regard to items that she had noticed. She indicated that she had noticed a lack of color, lack of pictures/decorations on the walls, and she was then going to mention the dining room chairs. The residents on the MCU will take the dining room chairs and place them back in the hallway after the facility staff places them back in the dining room. The Social Services Director Float indicated she even put a dining room chair towards the end of the hallway to allow for residents to sit down further down the hallway. This would also give the residents an opportunity to sit down on other		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 this alleged deficient practice - dining room chairs have been removed from the memory care hallway. New benches ordered to provide additional appropriate seating for residents on the memory care unit -Education provided to all staff by the Executive Director by 2/22/24 on providing a clean, comfortable and homelike environment to all residents - the brown streak on the wall adjacent to the beds of resident f and resident g has been cleaned. - an audit has been performed on all resident rooms by customer care representatives to ensure room cleanliness and a homelike environment are being provided What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	parts of the MCU along with staff to redirect them away from other residents, if needed. 2. An observation conducted on 1/25/24 at 11:13 a.m., of a brown streak running down the wall adjacent to the beds of Resident F and Resident G. An observation conducted on 1/26/24 at 1:40 p.m., of a brown streak running down the wall adjacent to the beds of Resident F and Resident G. An observation conducted on 1/29/24 at 10:14 a.m., of a brown streak running down the wall adjacent to the beds of Resident F and Resident G. An interview conducted with Family Member 30, on 1/29/24 at 2:25 p.m., indicated they hanged fly strips on the walls adjacent to Resident F and Resident G's bed. It was possibly the adhesive from the fly strips that caused the brown streaks along the walls. The fly strips were removed approximately a month ago because "they were so disgusting". An interview conducted with Interim Director of Nursing Services, on 1/29/24 at 1:40 p.m., indicated there was no policy regarding environment. The expectations are to follow the regulations for a safe, comfortable, and homelike environment. This citation relates to Complaints IN00427339, IN00425622 and IN00406737. 3.1-19(f)(5)		- Education provided to all staff by the Executive Director by 2/22/24 on providing a clean, comfortable and homelike environment to all residents - dining room chairs removed from the memory care hallway and new benches ordered to provide additional appropriate seating - brown streak on the wall has been removed and cleaned - Memory Care Support Specialist/designee will inspect the halls daily to ensure that dining room chairs are not in the hallway - audits to be conducted daily by customer care representatives to ensure room cleanliness and an homelike environment are being provided How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as F-584 will be completed weekly x 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; 2/22/24 Completion date: 2/22/24	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to report resident to resident altercations that resulting in pain and bruising for 2 of 37 residents on the memory care unit. (Residents 89 and 92) Findings include: 1. The clinical record for Resident 92 was reviewed on 1/24/24 at 1:30 p.m. Her diagnoses included, but were not limited to, dementia and anxiety. The clinical record for Resident 58 was reviewed on 1/26/24 at 2:00 p.m. Her diagnoses included, but were not limited to: dementia, anxiety, bipolar disorder, major depressive disorder, and insomnia. Resident 92's 1/13/24, 3:06 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 9, indicated she had a witnessed fall today. She wandered into another resident's room (Resident 58,) and Resident 58 got upset. Resident 58 pushed the door on Resident 92 resulting in in Resident 92 falling to the floor. Resident 92 had a hematoma to the right side of her forehead. Staff attempted to complete a head to toe assessment and she became agitated and would not let staff complete a full assessment. Resident 92's 1/13/24 fall event, created by LPN 9 on 1/13/24 and completed by the RDCC (Regional Director of Clinical Care on 1/16/24, indicated Resident 92 had an unwitnessed fall in another resident's room. Prior to the fall, Resident 92 was	F 0609	**F 609** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 92, 89 have communicated no further complaints of pain and their respective bruising has healed. Residents 92, 89 have been followed by Social Service Director/Memory Care Support Specialist with no psychosocial distress noted and participating in activities per baseline. Alleged incidents in question have been reported to the ISDH Gateway and reviewed by surveyors during annual survey. (See incidents #627, #628 , #629 in gateway) 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 the alleged deficient practice. RVPO to in-service ED/DNS/RDCC on abuse policy by 2/22/24 related to timely and appropriate reporting.	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wandering into another resident's room. It read, "Another res [resident] was trying to remove this res out of her room by pushing the door on this res w/hand [with hand] as well resulting in a fall." Resident 92 hit her head, was experiencing pain, and kept holding her head where a hematoma had accrued. The 1/15/24 IDT (Interdisciplinary Team) note for Resident 92 indicated prior to Resident 92's 1/13/24 fall, she was walking in the hallway. "Resident was attempting to go into another residents room, other resident was attempting to keep resident out of her room by closing the door. This caused resident to lose her balance and fall. Resident was fully clothed with shoes on. Injuries sustained: Bruising to right side of forehead....Determined root cause of fall: Resident attempted to enter another residents room, door was pushed closed and caused resident to lose her balance and fall." 2. The clinical record for Resident 89 was reviewed on 1/29/24 at 9:30 a.m. The diagnosis for Resident 89 included, but was not limited to, dementia with behavioral disturbances and schizoaffective disorder. Resident 89's 1/15/24, 11:25 a.m. nurse's note, written by RN (Registered Nurse) 4, read, "Res had unwitnessed fall in other res room. Res believe [sic] that other res took her clothes and went to other res room to get back her clothes. Both res flighted [sic] with each other and other res hit her and then res fell. Checked vitals WNL [within normal limits,] but res has pain in both arms, Left shoulder and back pain. Gave her Tylenol for pain and res resting in her bed. Will continue to monitor."		What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; RVPO to in-service ED/DNS/RDCC on abuse policy by 2/22/24 related to timely and appropriate reporting. Executive Director/Regional Social Services Director to review all resident to resident incidents to determine whether criteria is met for reporting to the ISDH Gateway. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as abuse 609 will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 89's 1/15/24, 11:56 a.m. nurse's note, written by LPN (Licensed Practical Nurse) 7, read, "This writer called back to the 200 hall by QMA [Qualified Medication Aide.] this writer was asked to assess resident at this time. Resident displaying s/s [signs/symptoms] of pain when AROM/PROM [active range of motion/passive range of motion] performed to left shoulder. This writer then palpated left shoulder and resident grimaced as if in pain. NP [Nurse Practitioner] notified at this time and this writer given verbal order for STAT [immediately] XR [x-ray] of left shoulder." The 1/15/24, 10:59 a.m. fall event indicated Resident 89 had an unwitnessed fall in another resident's room (Resident 92.) It read, "Res was in her bedroom and other res took some clothes from her bedside drawer and took in in room. That time res was going to other res room to get back her clothes and other res hit her [sic] she fell by hitting." Resident 89's 1/16/24 IDT note for Resident 89, written by the SSDF (Social Services Director Float,) read, "Description of behavior: Peer believed resident had peer's clothing and peer entered room and this resident pushed peer. Immediate interventions: Peer was assisted out of the room immediately. Assessment of potential correlation to root cause: Cognitive level (dementia staging, BIMS [brief interview for mental status] assessment), Environment (over/under stimulation, approach, positioning, other resident behavior.) Potential correlation(s) to root cause: Peer entering resident's room caused behavior. Root cause of behavioral expression: Peer entered this resident's room accusing [sic] her of having peer's clothing. Describe preventative intervention relating to		2/22/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	above root cause: Ensure resident's name is on her door. Allow resident to express frustration and provide space Care plan updated and current interventions revised as applicable: Yes" The 1/16/24 IDT note, written by the Interim DON (Director of Nursing), read, "Prior to fall resident was in her room. Resident wandered into another residents room. Resident waas found lying on her back in another residents room. Injuries sustained: No visible injury. Had both arms/shoulders and back pain...X-rays obtained: Yes. X-Ray results: No acute findings." The 1/5/24 fall event for Resident 89, created by LPN 12, indicated she had an unwitnessed fall in her bedroom. She was found sitting on her buttock in her room with her roommate. "Resident stated that she and her roommate were tugging over the same shirt then lost her balance and fell backwards." She had pain in her lower lumbar/spine and sacrum/coccyx. She also had pain with range of motion. The 1/5/24, 10:20 a.m. nurse's note for Resident 89, written by LPN 12 indicated staff heard loud screaming coming from Resident 89's room. Staff went to the room and found both Resident 89 and her roommate, Resident 29, on the floor sitting on their buttock areas. Resident 89 had a shirt that belonged to her roommate in her hand. The 1/5/24, 10:39 a.m. behavior note for Resident 89, written by LPN 12, indicated Resident 89 attempted to grab another resident's shirt from her thinking that it belonged to her. Resident 89 was accusing the other resident of stealing her things. Writer notified psych due to Resident 89's increased hallucinations and delusions. Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	89 just returned back from psyche stay for increased hallucinations, delusions, and suicidal ideation. The 1/8/24 IDT (Interdisciplinary Team) note read, "Resident observed on the floor on her buttocks. Resident stated she and her roommate had a disagreement over an item of clothing and were both pulling on said item at which time she fell to her buttocks, Resident assessed by staff and neuro checks initiated. Resident reported pain to her lower lumbar spin, sacrum and coccyx areas. Injuries sustained: Pain to lower lumbar spine, sacrum and coccyx areas....X-rays obtained: Yes. X-Ray results: Modest osteoarthritis of the lumbar spine. No fracture seen. Old right hip fixation...Determined root cause of fall: Resident and roommate had a disagreement over an item of clothing. Intervention put in place to address root cause of fall: Resident's roommate moved to a new room." An interview was conducted with the RDCC and the Interim ED (Executive Director) on 1/26 at 12:08 p.m. The ED indicated they did not report the 1/13/24 incident when Resident 92 obtained bruising to the right side of her face from being hit with the door by Resident 58, because Resident 92 was wandering and Resident 58 shut the door. They did not report the "tussling" over the clothing, because the residents did not recall the incidents and there was no injury. The RDCC indicated the nursing note referenced Resident 92 being hit by the door due to Resident 58 pushing the door. An interview was conducted with The RDCC and ED on 1/29/24 at 4:25 p.m. The Interim ED indicated they didn't feel the incidents fit the criteria for reporting at the time, as they were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unaware of the reporting requirement for resulting in pain. The Abuse Prohibition, Reporting, and Investigation policy was provided by the Interim DON (Director of Nursing) on 1/24/24 at 10:47 a.m. It read, "Physical Abuse - A willful act against a resident by another resident, staff member, or other individual(s). Examples may include but not be limited to hitting, slapping, punching, and choking....Reporting/Response: 1. All abuse allegations must be reported to the Executive Director immediately. Failure to report will result in disciplinary action, up to and including immediate termination. 2. The Executive Director will ensure that if the alleged violation involves abuse or results in serious bodily injury, it must be reported immediately but no later than 2 hours to the Long-Term Care Division of the Indiana State Department of Health via the Gateway Portal. 3. Resident to resident altercation with no injury, either resident was not mentally injured or physically harmed, there was no psychosocial distress, the altercation does not need to be reported to IDOH." 3.1-28(c)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary assistance needed for showering at least twice weekly as preference	F 0677	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by a resident for 1 of 4 residents reviewed for ADLs. (Resident Q) Findings include: The clinical record for Resident Q was reviewed on 1/29/24 at 12:10 p.m. Resident Q's diagnoses included, but not limited to, chronic kidney disease, Rheumatoid arthritis, congestive heart failure, generalized muscle weakness, and low back pain. An interview conducted with Resident Q on 1/25/24 at 10:18 a.m. indicated, they weren't receiving showers at least twice weekly. They also indicated, they preferred having a shower over a complete bed bath. A significant change MDS (Minimum Data Set) completed on 5/28/23 indicated, when asked "how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?", they answered "Very important". A Quarterly MDS dated 12/12/23 indicated, Resident Q required substantial/maximal assistance with showers and ability to bathe self. Resident Q's care plan dated 2/7/23 indicated, the resident required assistance with ADLs. Interventions included, but not limited to, assist with bathing, as needed, per residents preference and to offer a shower two times per week and a partial bath in between. Resident Q's electronic health record, under point of care services indicated, for December 2023 and January 2024, they received a shower on the following dates: 12/7/23		of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. F-677 ADL Care Provided for Dependent Residents **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident Q) Resident shower preferences were reviewed, and residents are receiving shower per resident preference. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. All residents to be interviewed for shower/bathing preferences by IDT, bathing preferences will be updated in the profile and plan of care. All residents plans of care to be reviewed and reflective of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/11/23 12/21/23 1/1/24 1/8/24 Resident Q's shower sheets provided by RDCC (Regional Director of Clinical Care) on 1/29/24 at 2:33 p.m. indicated, for December 2023 and January 2024, they received a shower on the following dates: 12/11/23 12/21/23 12/25/23 1/8/23 An interview with RDCC conducted on 1/29/24 at 2:49 p.m. indicated, residents should get showers and/or bed baths per their preference. A "Preferences for Customary Routine and Activities" observation was to be completed on admission and each resident should have a care plan for preferences. The facility was unable to provide an ADL policy per RDCC on 1/29/24 at 3:42 p.m. This tag relates to complaint IN00427339 and IN00427360. 3.1-38(b)(1)		preferences regarding bathing. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff to be educated regarding shower schedules and resident specific preferences. Nursing management to review shower sheets daily to ensure bathing preferences are being met. **1.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?** Nursing management to review shower sheets daily to ensure bathing preferences are met and showers given per preference. Bathing/Showers QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to: monitor and assess a resident's bruising, per policy, for 1 of 7 residents reviewed for dementia care (Resident 92); accurately monitor fluid consumptions for a resident that was ordered to be on a 1,500 milliliter (ml) fluid restriction for 1 of 5 residents reviewed for unnecessary medications and monitor a resident's output every shift per the plan of care for 1 of 1 residents reviewed for hospitalization (Resident 35 and Resident 127); and administer insulin and to obtain daily weights as ordered by the physician for 1 of 5 residents reviewed for	F 0684	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unnecessary medications and 1 of 1 resident reviewed for skin condition (Resident P and 33). Findings include: 1. The clinical record for Resident 92 was reviewed on 1/24/24 at 1:30 p.m. Her diagnoses included, but were not limited to, dementia and anxiety. Resident 92's 1/13/24, 3:06 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 9, indicated she had a witnessed fall today. She wandered into another resident's room (Resident 58,) and Resident 58 got upset. Resident 58 pushed the door on Resident 92 resulting in in Resident 92 falling to the floor. Resident 92 had a hematoma to the right side of her forehead. Staff attempted to complete a head to toe assessment and she became agitated and would not let staff complete a full assessment. Resident 92's 1/13/24 fall event, created by LPN 9 on 1/13/24 and completed by the RDCC (Regional Director of Clinical Care on 1/16/24, indicated Resident 92 had an unwitnessed fall in another resident's room. Prior to the fall, Resident 92 was wandering into another resident's room. It read, "Another res [resident] was trying to remove this res out of her room by pushing the door on this res w/hand [with hand] as well resulting in a fall." Resident 92 hit her head, was experiencing pain, and kept holding her head where a hematoma had accrued. The 1/15/24 IDT (Interdisciplinary Team) note for Resident 92 indicated prior to Resident 92's 1/13/24 fall, she was walking in the hallway. "Resident was attempting to go into another residents room, other resident was attempting to		F 684 Quality of Care. Facility failed to monitor and assess a resident's bruising per policy (Res 92), accurately monitor fluid consumptions for a resident that was ordered to be on a 1,500mL fluid restriction (Res 35), monitor a resident's output every shift per the plan of care (Res 127), administer insulin and to obtain daily weights as ordered by physician (Resident P and 33). **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident 92 bruising has since resolved. IDT review was completed. Resident 35 fluid restriction has been clarified to include supplements and physician has seen resident and changed the fluid restriction order. Resident 127 was discharged from facility prior to survey. Resident 33 weight order changed to 2x/week and being completed as ordered. Resident P unknown due to complaint so no identifier given. All residents with orders for insulins reviewed with provider. **1.How will you identify other residents having the potential to be affected by the same**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	keep resident out of her room by closing the door. This caused resident to lose her balance and fall. Resident was fully clothed with shoes on. Injuries sustained: Bruising to right side of forehead....Determined root cause of fall: Resident attempted to enter another residents room, door was pushed closed and caused resident to lose her balance and fall." An observation of Resident 92 was made on 1/24/24 at 1:44 p.m. Her right eye had a dark, blackish yellow bruise underneath it. The Events section of Resident 92's clinical record did not include an event for the bruising to Resident 92's right side of her face. The Wound Management section of Resident 92's clinical record did not include assessment of the bruising to the right side of her face. The 1/15/24 weekly skin assessment did not reference bruising to the right side of Resident 92's face. The 1/22/24 weekly skin assessment referenced bruising to her right side of her forehead. It did not include a detailed description of the bruising such as measurement, color, or healing status of the area. An interview was conducted with RN 4 on 1/26/24 at 11:36 a.m. She indicated she'd worked at the facility for 6 months and they do weekly assessments of skin conditions. She reviewed Resident 92's clinical record and indicated there was no weekly assessment of Resident 92's bruising to the right side of her face, and she was unsure as to why.		**deficient practice and what corrective action will be taken?** All residents have the potential to be affected by applicable alleged deficient practices. Wound Nurse/designee to review documentation daily for new skin impairment and complete appropriate events and reviews. DNS/Designee to review fluid restrictions for affected residents daily to totaling and compliance and notify provider as needed. POC compliance to be reviewed each shift for compliance with documentation and education to be provided for missed documentation. DNS/Designee to review daily weights daily to ensure completion and notify provider as needed for all residents affected. All residents who receive sliding scale insulin /hold orders were reviewed to ensure physicians orders were followed. Insulin orders reviewed with provider, those with hold orders to be reviewed daily by DNS/designee to ensure physician orders were followed. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Wound Nurse/designee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An interview was conducted with the RDCC (Regional Director of Clinical Services) on 1/30/24 at 10:14 a.m. She indicated upon recognition of Resident 92's bruising to the right side of her face, a new skin event should have been initiated in the clinical record, which would have triggered wound management to begin. After 72 hours, if the area was healing appropriately, it could be taken out of wound management, however this process was not followed. The Skin Management Program policy was provided by the RDCC on 1/26/24 at 3:12 p.m. It read, "PROCEDURE FOR ALTERATIONS IN SKIN INTEGRITY - PRESSURE AND NON-PRESSURE...4. All newly identified areas after admission will be documented on the New Skin Event. 5. The wound nurse/designee will be notified of alterations in skin integrity. a) The wound nurse/designee is responsible for communicating to IDT [Interdisciplinary Team] on a weekly basis for pressure and non-pressure wounds. b) The wound nurse/designee will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day. The observed date indicated on thee Wound Management document is the date the wound was assessed, including but not limited to measurements, staging, condition of tissue, and drainage...Wound management entries will be completed for non-ulcers (bruises, skin tear, abrasion, rashes). If no signs of complications or worsening in condition of skin alteration and doesn't meet the guidelines for IDT Weekly Wound Review the wound management entry can be closed after 72 hours."2. The clinical record for Resident 35 was reviewed on 1/24/24 at 10:00 a.m. The diagnoses for Resident 35 included, but were not limited to, liver cancer, kidney disease, and		review documentation daily and ensure appropriate events are opened related to skin impairment. Fluid restrictions to be reviewed by DNS/Designee daily to ensure accurate totaling and notification of non-compliance to provider. POC documentation to be reviewed by DNS/Designee daily to check for missing documentation related to urinary output and education to be provided to staff as needed. Daily weights to be reviewed by DNS/designee to ensure completion and notification completed as ordered. Insulin orders reviewed with provider, those with hold orders to be reviewed daily by DNS/designee to ensure physician orders were followed. All nursing staff to be educated on fluid restrictions and documentation of restriction, documentation of urinary output and obtaining daily weights. Licensed nurses to be educated on policy regarding new skin impairment, fluid restriction, POC compliance reports, daily weight orders and notifications and insulin administration as it related to call orders and hold orders. **1.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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	congested heart failure. A nutrition care plan dated 12/13/23 indicated "...Resident is on a fluid consumption..." The approach indicated the resident was to receive 1,500 ml of fluids a day. The resident did not have a care plan in place to address the resident's noncompliance with fluid restriction as ordered. A physician order dated 12/7/23 indicated the staff was to document all fluids taken with medications every shift. A physician order dated 12/12/23 indicated the resident was to be on a fluid restriction of a total daily fluid intake of 1500 ml. The resident was to receive the following fluids: 360 ml with meals, and in between meals 180 ml on day shift and 120 ml in the evening and 120 ml at night. A physician order dated 1/15/24 indicated the resident was to receive 1 packet of juven in a cup of fluid twice a day. A physician order dated 1/17/24 indicated the Resident was to receive 17 grams of mirlax mixed in 6-8 ounces of fluid (237 ml) once a day. A physician order dated 1/17/24 indicated the staff was to total the resident's fluid intake amount for 24 hours. The resident was to be on a fluid restriction of 1,500 ml a day. The December 2023 Medication/Treatment Administration Record (MAR)(TAR) indicated the following total of all 3 shifts of fluid consumptions during medication administrations were recorded:		**into place?** Bruises QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. Fluid Restrictions QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. Daily weights QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. POC Compliance QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. Insulin Administration QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/13/23 - 360 ml of fluid consumption, 12/16/23 - 360 ml of fluid consumption, 12/19/23 - 340 ml of fluid consumption, 12/27/23 - 480 ml of fluid consumption, 12/30/23 - 600 ml of fluid consumption, and 12/31/23 - 720 ml of fluid consumption The following were recorded fluid consumptions per shift, and the resident's total fluid consumption in the 24 hour day: 12/13/23 - 6:00 a.m. - 2:00 p.m. = 240 ml consumption, 2:00 p.m. - 10:00 p.m. = 360 ml consumption, 10:00 p.m. - 6:00 a.m. = 360 ml consumption, the total amount of fluid consumption that day was documented as 360 ml. 12/16/23 - 6:00 a.m. - 2:00 p.m. = 360 ml consumption, 2:00 p.m. - 10:00 p.m. = 240 ml consumption, 10:00 p.m. - 6:00 a.m. = 1,800 ml consumption, the total amount of fluid consumption that day was documented as 1,800 ml. 12/19/23 - 6:00 a.m. - 2:00 p.m. = 480 ml consumption, 2:00 p.m. - 10:00 p.m. = 240 ml consumption, 10:00 p.m. - 6:00 a.m. = 360 ml consumption, the total amount of fluid consumption that day was documented as 360 ml. 12/27/23 - 6:00 a.m. - 2:00 p.m. = 360 ml consumption, 2:00 p.m. - 10:00 p.m. = 360 ml consumption, 10:00 p.m. - 6:00 a.m. = 240 ml consumption, the total amount of fluid consumption that day was documented as 240 ml. 12/30/23 - 6:00 a.m. - 2:00 p.m. = 900 ml consumption, 2:00 p.m. - 10:00 p.m. = 240 ml consumption, 10:00 p.m. - 6:00 a.m. = 120 ml consumption, the total amount of fluid		re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	consumption that day was documented as 1,140 ml. 12/31/23 - 6:00 a.m. - 2:00 p.m. = 120 ml consumption, 2:00 p.m. - 10:00 p.m. = 480 ml consumption, 10:00 p.m. - 6:00 a.m. = 240 ml consumption, the total amount of fluid consumption that day was documented as 1,500 ml. The January 2024 Medication/Treatment Administration Record (MAR)(TAR) indicated the resident received the 17 grams of mirlax in fluid and juvan packet in 6-8 ounces fluid as ordered. The total of all 3 shifts fluid consumptions during medication administrations were the following recorded: 1/1/24 - 480 ml of fluid consumption, 1/7/24 - 2,360 ml of fluid consumption, 1/8/24 - 2,360 ml of fluid consumption, 1/15/24 - 600 ml of fluid consumption, and 1/17/24 - 600 ml of fluid consumption The following fluid consumptions were recorded per shift, and the resident's total fluid consumption in the 24 hour day: 1/1/24 - 7:00 a.m. - 3:00 p.m. = 480 ml consumption, 3:00 p.m. - 11:00 p.m. = 480 ml consumption, 11:00 p.m. - 7:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 1,080 ml. 1/7/24 - 7:00 a.m. - 3:00 p.m. = 240 ml consumption, 3:00 p.m. - 11:00 p.m. = 480 ml consumption, 11:00 p.m. - 7:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 1,500 ml.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/8/24 - 7:00 a.m. - 3:00 p.m. = 480 ml consumption, 3:00 p.m. - 11:00 p.m. = 240 ml consumption, 11:00 p.m. - 7:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 1,500 ml. 1/15/24 - 7:00 a.m. - 3:00 p.m. = 300 ml consumption, 3:00 p.m. - 11:00 p.m. = 360 ml consumption, 11:00 p.m. - 7:00 a.m. = 240 ml consumption, the total amount of fluid consumption that day was documented as 0 ml. 1/17/24 - 7:00 a.m. - 3:00 p.m. = 480 ml consumption, 3:00 p.m. - 11:00 p.m. = 520 ml consumption, 11:00 p.m. - 7:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 1,500 ml. An observation was made of Resident 35 in his room on 1/24/24 at 2:45 p.m. The bedside table contained a 16 ounce bottle of water. During an interview with Resident 35 on 1/24/24 at 2:50 p.m., he indicated the staff bring him plenty of water to drink ,and he also drinks glucerna supplements through out the day. An observation was made of Resident 35 in the hallway on 1/29/24 at 9:18 a.m. The resident was observed with a 16 ounce bottle of water and an 8 ounce bottle of glucerna. An interview was conducted with the Regional Director of Clinical Care (RDCC) 1/29/24 at 11:53 a.m. She indicated the staff had not been recording accurately the resident's fluid consumptions. Resident 35's family does bring him in drinks. He was not compliant with his fluid			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restriction. She notified the medical provider to review the fluid restriction to see if it needs to continue. A "Hydration Management" policy was provided by the RDCC on 1/29/24 at 12:15 p.m. It indicated "...Procedure:...13. 24-hour fluid totals will only be calculated for those residents on a fluid restriction or as ordered by physician." 3. The clinical record for Resident 127 was reviewed on 1/26/24 at 10:32 a.m. The diagnosis for Resident 127 included, but was not limited to, kidney disease. A care plan dated 12/1/23 indicated "Resident (127) has inflammatory bowel disease:...Approach:...Report signs of dehydration (dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry cracked lips, dry mucus membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance)...." A care plan dated 11/22/23 indicated Resident 127 "Requires assistance and/or monitoring AM/PM [a.m., p.m.,) care, nutrition, hydration, and elimination..." An approach indicated the staff was to document every shift urine outputs. The resident's December 2023 urine outputs for Resident 127 was provided by the Regional Director of Clinical Care (RDCC) 1/29/24 at 8:57 a.m. It indicated the following days and shifts urine output amounts were recorded: 12/2/23 - night shift , 3:18 a.m. - urine = large amount, 12/2/23 - day shift, 10:51 a.m. - urine = small amount,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/2/23 - no other recorded urine amounts, 12/3/23 - night shift, 12:49 a.m. - urine = medium amount, 12/3/23 - day shift, 6:51 a.m. - urine = medium amount, 12/3/23 - no other recorded urine amounts, 12/4/23 - night shift, 1:54 a.m. - urine = large amount, 12/4/23 - day shift, 8:03 p.m. - urine = large amount, 12/4/23 - no other recorded urine amounts, 12/5/23 - no recorded night shift urine amount, and 12/5/23 - day shift, 9:22 a.m. - urine = medium amount An interview was conducted with the RDCC on 1/29/24 at 2:06 p.m. She indicated she was unable to provide additional urine outputs for Resident 127. 4. The clinical record for Resident P was reviewed on 1/24/24 at 2:22 p.m. The Resident's diagnosis included, but were not limited to, diabetes and dementia. A Quarterly MDS (Minimum Data Set) Assessment, completed 12/18/23, indicated Resident P was severely cognitively impaired and that he received insulin daily. A care plan, last reviewed 12/22/23, indicated he was at risk for adverse effects of hyperglycemia (high blood sugar), or hypoglycemia (low blood sugar) related to his use of insulin and diagnosis of diabetes. The goal was for him to not experience symptoms of hyperglycemia or hypoglycemia. The interventions included, but were not limited to, document abnormal findings and notify MD, initiated 10/15/23, observe for symptoms of hypoglycemia: such as sweating, tremor, tachycardia (high pulse), pallor,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nervousness, confusion, slurred speech, lack of coordination, staggering gait, initiated 10/15/2023, observe for symptoms of hyperglycemia: increase thirst/appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, acetone (fruity) breath, stupor, initiated 10/15/2023, monitor blood sugars as ordered, initiated 10/15/2023, and administer medications as ordered, initiated 10/15/2023. A physician's order with a start date of 12/6/23, indicated he was to receive Humalog (quick acting) insulin 5 units three times a day with meals. The December 2023 MAR (Medication Administration Record) did not contain documentation that the Humalog 5 units was administered on the following days and times: 12/9 at 5 p.m., 12/10 at 5 p.m., 12/11 at 7 a.m., 12/12 at 5 p.m., 12/16 at 8 a.m., and 12/18 at 8 a.m. On 12/20/23 the order was discontinued. A physician's order with a start date of 12/20/23, indicated he was to receive Humalog insulin 8 units twice daily and to hold the insulin if his blood sugar was less than 120. The December 2023 and January 2024 MAR did not contain documentation that the Humalog 8 units was administered, as ordered, on the following days and times: 12/21 at 12 p.m., 12/23 at 12 p.m., 12/30 at 5 p.m., 1/1 at 12 p.m., 1/18 at 5 p.m., 1/21 at 5 p.m., and 1/25 at 12 p.m. During an interview on 1/29/23 at 10:15 a.m., The DON (Director of Nursing) indicated the Resident P's Humalog should have been administered as ordered by the physician. 5. The clinical record for Resident 33 was reviewed on 1/24/23 at 2:57 p.m. The Resident's diagnosis			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, but were not limited to, chronic heart failure and diabetes. A care plan, initiated 8/1/23, indicated that Resident 33 was at nutritional risk related to his diagnosis of diabetes and chronic heart failure. Weight changes were expected due to fluid shifts with CHF (Chronic Heart Failure) and diuresis. The goal was for him to be free of significant weight changes. The interventions included, but were not limited to, monitor weight, initiated 8/15/23, and to notify family and physician of significant weight change, initiated 8/15/23, A physician's order, dated 12/20/23, indicated he was to have his weight done daily and the physician was to be notified of weight gains of 3 pounds in one day or 5 pounds in one week. A Significant Change in Status MDS Assessment, dated 12/21/23, indicated he was cognitively intact. A nurse practitioner follow up note, dated 12/26/23, indicated Resident 33 had chronic congestive heart failure, which was stable. He was to continue his current medications and daily weights were to be done and reported if weight gain of greater than 2 pounds in one day or 5 pounds in one week. On 1/24/24 at 2:57 p.m., Resident 33 was observed laying in bed. He had edema in both of his feet. He indicated the swelling in his feet went up and down. There were no weights recorded in the clinical record on the following days from December 20,2023 through 1/26/24: 12/21, 12/22, 12/23, 12/24, 12/27, 12/28, 12/30, 1/2, 1/3, 1/5, 1/8, 1/9, 1/10, 1/11,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/12, and 1/13/24. During an interview on 1/26/24 at 3:12 p.m., the Float Director of Nursing indicated that there were some missing daily weight and that the weights should have been documented. On 1/29/24 at 9:28 a.m., the Regional Director of Clinical Care provided the Resident Weight Monitoring Policy, last updated 7/2023, which read "...The physician/ health care practitioner will be notified of unplanned significant weight loss/ gains..." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care, consistent with professional standards of practice, to prevent a stage III pressure ulcer from developing on a resident with a moderate risk for developing a pressure ulcer for 1 of 1 residents	F 0686	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed for pressure ulcers. (Resident R) Findings include: The clinical record for Resident R was reviewed on 1/26/24 at 10:42 a.m. Resident R's diagnoses included, but not limited to, hemiplegia (inability to move a side of body) of left dominant side; diabetes type II, generalized muscle weakness, and lack of coordination. The most current Braden Scale for Predicting Pressure Sore Risk assessment was a quarterly assessment completed by 12/28/23- 01/03/24 indicated, Resident R scored a 14 indicating, a moderate risk for the development of a pressure ulcer. Resident R's current physician orders for January 2024 as well as December 2023 physician's orders included, but not limited to, an order to have pressure reducing boots to bilateral lower extremities at all times with the exception for bathing and skin assessments and for skin assessments to be completed weekly. A care plan for Resident R initiated on 11/1/23 and last reviewed/revised on 1/17/24 indicated, Resident R was "at risk for further skin breakdown due to: Muscle weakness, Impaired mobility, Difficulty in walking, Admitted with Pressure ulcers to sacrum, incontinence of bowel and bladder, Left sided weakness due to TIA[sic, Trans-ischemic attack], AMS[sic, altered mental status]". An intervention dated 11/1/23 included, but not limited to, " Pressure reducing boot to BLE[sic, bilateral lower extremities] at all time[sic]. May [sic] removed for skin assessment and bathing.		This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. F686 Treatment/Services to Prevent/Heal Pressure Ulcers **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident R) All residents with skin care interventions were reviewed to ensure interventions were in place per the plan of care. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. Facility-wide audit will be completed to ensure all wound care interventions in place per order and Resident Profile. Corrective action will be taken as needed. CEN/Designee will educate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An observation of Resident R conducted on 1/25/24 at 10:02 a.m. found the resident in bed without any pressure reducing boots on to either lower extremity. An observation conducted on 1/26/24 at 2:10 p.m. found Resident R lying in bed without their pressure reducing boots on their feet. The pressure reducing boots were located in Resident R's wheelchair across the room. An observation conducted on 1/29/24 at 10:38 a.m. found Resident R sitting in their wheelchair without any pressure reducing boots on their feet and legs in a dependent position. Resident R's skin assessment completed on 12/25/23 did not indicate any new skin issues. A New Skin Event dated 1/3/24 indicated, Resident R had an open area to the left lateral ankle which was draining serosanginous (thin, watery, bloody) fluid. It was described as a stage III pressure ulcer (a full thickness ulcer that might involve the subcutaneous fat) which was not present on admission and measured 2.6 cm(centimeters) in length and 2.3 cm in width. A wound assessment completed on 1/4/2024 at 9:25 a.m. indicated, the Stage III pressure ulcer on the left lateral ankle of Resident R was 2.5 cm in length and 2.3 cm in width with a depth of 0.1 cm. It indicated, the exudate was a light amount of serous fluid "(clear, amber, thin and watery)". The base of the wound was covered with 50% slough (dead tissue, usually cream or yellow in color which can harbor pathogenic organisms). A wound assessment completed on 1/9/2024 at 11:22 a.m. indicated, the stage III pressure ulcer on		all nursing staff on ensuring all wound care interventions are in place per order and Resident Profile. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** CEN/Designee will educate all nursing staff on ensuring all wound interventions are in place per order and Resident Profile each shift. CARE Companions/Dept Heads/Designee will round daily to ensure wound care interventions are in place. **1.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?** Skin Interventions QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the left lateral ankle of Resident R was 2 cm in length and 2 cm wide. The wound did not have any exudate and described the tissue type as necrotic (death of living cells in tissue) and the wound was 100% covered by eschar (dry, thick, leathery tissue that is often tan, brown, or black). A wound assessment completed on 1/16/2024 at 12:52 p.m. indicated, Resident R's left lateral ankle wound was 2 cm in length and 2 cm in width. Exudate was a light amount of serosanginous "(pale red to pink, thin and watery)" fluid. The tissue type was described as slough and covered 100% of the wound. The comments included that measurements were unchanged but the tissue type changed from 100% eschar to 100% slough. A care plan initiated on 1/4/24 (after the identification of the new wound) and last updated on 1/27/24 indicated, Resident R "has a pressure ulcer to the left lateral ankle. Resident is at risk for further skin breakdown due to: Muscle weakness, Impaired mobility, Difficulty in walking, Admitted with Pressure ulcers to sacrum, incontinence of bowel and bladder, Left sided weakness due to TIA, AMS. Interventions in place prior to wound development include: Pressure reducing boots to BLE, turn/reposition Q 2 hours, weekly skin checks, routine bathing". This tag related to complaint IN00427339. 3.1-40 3.1-40(a)(2)		the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place for 2 of 5 residents reviewed for accidents. (Resident L and P) Findings include: 1. The clinical record for Resident L was reviewed on 1/26/24 at 11:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, dementia, major depressive disorder, anxiety disorder, muscle weakness, and history of falling. A fall care plan, revised 1/11/24, indicated Resident L was at risk for falls and had a history of falls. She required assistance with mobility, transfers, and ambulation along with poor safety awareness. The approaches included, but were not limited to, the following: Wheelchair to be kept in a locked position at bedside when resident is in bed dated 12/26/23, Leave wheelchair at dining room entrance/exit dated 8/9/23, & Wheelchair to have anti tippers dated 6/12/23. An observation of Resident L, on 1/26/24 at 10:33 a.m., of them lying in bed with appearance of sleep. There was no wheelchair in her room. An observation of Resident L, on 1/26/24 at 1:43	F 0689	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. F689- Free of Accident Hazards/Supervision/Devices **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. All residents with fall interventions were reviewed to ensure fall interventions were in place per plan of care. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what**	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., of them up in a wheelchair in the hallway of the unit. There were no anti tippers to such wheelchair. An observation of Resident L, on 1/26/24 at 3:29 p.m., of them up in a wheelchair in the dining room during an activity. There were no anti tippers to such wheelchair. An observation of Resident L, on 1/29/24 at 10:12 a.m., of them up in a wheelchair in the dining room. There were no anti tippers to such wheelchair. An interview conducted with the Regional Director of Clinical Care on 1/29/24 at 4:35 p.m., indicated the residents on the Memory Care Unit (MCU) will move the chairs around, including the wheelchairs. The facility staff were unsure about putting residents' names in their wheelchairs for identification purposes. A policy titled "Fall Management Policy", revised 8/2022, was provided by the Interim Director of Nursing Services on 1/29/24 at 11:22 a.m. The policy indicated the following, " ...3. A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. Care plan including interventions and fall risks will be reviewed at least quarterly ...Post fall ...6. All falls will be discussed by the interdisciplinary team [IDT] at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ...." 2. The clinical record for Resident P was reviewed on 1/24/24 at 2:22 p.m. The Resident's diagnosis included, but were not limited to, diabetes and dementia. A care plan, initiated 10/4/23, indicated Resident P		**corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents fall care plans to be reviewed for listed interventions. All interventions to be audited to ensure they are in place as ordered/care planned. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff and IDT members to be educated on fall plan of cares and interventions. Checks for fall interventions to be completed by IDT members/designee each shift. **1.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?** Fall Intervention QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was at risk for falls due to a history of falls, insomnia, anxiety and depression conditions and medications that increase fall risk. The goal was for his fall risk factors would be reduced in an attempt to avoid significant fall related injury. The interventions included, but were not limited to, dycem (tacky plastic) underneath wheelchair cushion, initiated 10/23/23, anti-rollbacks (brakes to prevent rolling) to wheelchair, initiated 12/4/23, dump (lower the back of the seat) wheelchair, initiated 12/4/23, nonskid footwear, initiated 10/4/23, and offer and encourage him to in the dining room and common area after getting ready for the day, initiated 10/6/23. The clinical record included Fall Events with the following dates: 12/01/23, 12/4/23, 12/9/23, 12/20/23, 1/3/24, and 1/23/24. A Fall Risk Assessment Tool, dated 12/18/23, indicated he was at high risk for falls. A Quarterly MDS (Minimum Data Set) Assessment, completed 12/18/23, indicated Resident P was severely cognitively impaired, was dependent on staff for putting on and taking off footwear, needed maximum assist with transfers, and had fallen 2 or more times without injury since his last MDS assessment. On 1/24/24 at 2:22 p.m., Resident P was observed sitting in his wheelchair in his room. There were no anti-roll back brakes present on the wheelchair and the wheelchair seat was not dumped (the seat was not slanted to the back of the seat). On 1/25/24 at 9:45 a.m., Resident P was observed sitting in his wheelchair in the doorway of his room. He was wearing regular black socks and no shoes. His wheelchair did not have anti-roll back		achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	brakes and the wheelchair seat was not dumped. On 1/26/24 at 9:13 a.m., Resident P was observed sitting in the dining room. His wheelchair did not have anti-roll back brakes, there was no dycem or cushion in his wheelchair and the seat of the wheelchair was not dumped. On 1/26/24 at 10:50 a.m., Resident P's wheelchair was observed with the Float DON (Director of Nursing), who indicated that there were no anti-roll back brakes on the wheelchair, however the Float DON believed that the wheelchair Resident P had been sitting in was not wheelchair. During an interview on 1/26/24 at 11:01 a.m., the Rehab Coordinator indicated that Resident P was not in the wheelchair that he should have been in. Staff would sometimes switch out resident's wheelchairs accidentally, especially if the resident went out for an appointment. Resident P had gone to an appointment on 1/25/24. On 1/26/24 at 1:51 p.m.., the Regional Director of Clinical Care provided the Fall Management Policy, last revised 8/2022, which read "... It is the policy of ... to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related falls...Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls...Residents who are categorized as moderate to high risk should have fall interventions implemented based on resident specific risk 3.1-45(a)(2)			
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to provide thickened liquids at bedside, as ordered by the physician, for 1 of 1 resident reviewed for hydration (Resident F) Findings include: The clinical record of Resident F was reviewed on 1/25/24 at 11:14 a.m. The Resident's diagnosis included, but were not limited to, dysphagia (difficulty swallowing) and hypertension. A Quarterly MDS (Minimum Data Set) Assessment, completed 11/6/23, indicated he was moderately cognitively impaired and received a mechanically altered diet.	F 0692	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. F-692 Nutrition/Hydration Status Maintenance. Facility failed to provide thickened liquids at bedside, as ordered by the	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician's order, dated 1/8/24, indicated he was to receive a regular diet with nectar thick (mildly thick) liquid, no straw. A care plan, last reviewed 1/21/24, indicated Resident F was at risk for altered nutritional status related to a diagnosis of dysphagia and hypertension. He received thickened liquids related to diagnosis of dysphagia. The goal was for him to maintain his current weight or have a slow weight gain. The interventions included, but were not limited to, regular diet, nectar thick/ mildly thick liquids, no chocolate milk, no straw, and magic cup with lunch and dinner, initiated 1/15/24, and monitor food and fluid intakes, initiated 6/8/22. On 1/25/24 at 11:11 a.m., Resident F was observed to have a white Styrofoam cup with a straw in it sitting on his bedside table. On 1/26/24 at 9:10 a.m., Resident F was observed to have a white Styrofoam cup with a straw in it sitting on his bedside table. During an interview on 1/26/24 at 9:18 a.m., LPN (Licensed Practical Nurse) 2 indicated the white Styrofoam cup on Resident F's bedside table was filled with ice water. The water in the cup was not thickened. LPN 2 was unsure Resident F was to receive thickened liquids but would check. On 1/26/24 at 11:08 a.m., the Regional Director of Clinical Care provided the Altered Fluid Consistency Policy, last revised 1/2023, which read "...Residents requiring altered fluid consistency will have appropriate fluids available to safely maintain hydration..."		physician. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident F) All residents are receiving thickened liquids at bedside per physician order. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with orders for thickened liquids have the potential to affected by the alleged deficient practice. All nursing staff and IDT members to be educated regarding thickened liquids and need for thickened liquids at bedside as ordered. All staff to be educated on identifiers and what they mean for the resident. All residents with orders for thickened liquids were monitored by DNS/Designee to ensure thickened liquids were available at bedside. **1.What measures will be put into place or what systemic**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-46(a)(2)		**changes will you make to ensure that deficient practice does not recur?** ·All nursing staff and IDT members to be educated regarding thickened liquids and need for thickened liquids at bedside as ordered. ·Identifier to be placed in resident room for altered fluid consistency. ·All staff to be educated on identifiers and what they mean for the resident. ·All profiles update to ensure residents to receive thickened liquids at bedside. ·DNS/Designee to conduct rounds each shift to ensure residents with order to receive thickened liquids have thickened liquids at bedside. **1.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?** Altered Fluid Consistency QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant/Regional Dietary Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review, the facility failed to provide adequate monitoring and supervision and implement behavior care plan interventions for 8 of 37 cognitively impaired residents on the memory care unit. (Residents 4, 29, 58, 63, 64, 89, 92, and 100) Findings include: 1. The clinical record for Resident 92 was reviewed on 1/24/24 at 1:30 p.m. Her diagnoses included, but were not limited to, dementia and	F 0744	**F 744** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Residents 4, 29, 58, 63, 64, 89, 92 and 100 have been reviewed in behavior management meeting with plans of care updated to meet	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	anxiety. The 4/21/23 behavioral symptoms care plan for Resident 92, last reviewed/revised 1/16/24, indicated she would intrusively wander into other resident's rooms. The goal was for her to not be in distress or danger with her intrusive wandering. Approaches were to redirect her back to her room, starting 4/21/23; to redirect her to meal time, starting 4/21/23; to encourage her to participate in preferred activity or task, starting 6/6/23; to call her daughter to talk with her or visit with her, starting 6/6/23; to assess her for unmet needs such as hunger, thirst, or pain, starting 1/12/24; to use visual identifiers for her room location-name on door, starting 1/15/24; and to use communication tools or visual cueing to assess if she is looking for her room or bathroom, starting 1/15/24. 2. The clinical record for Resident 58 was reviewed on 1/26/24 at 2:00 p.m. Her diagnoses included, but were not limited to: dementia, anxiety, bipolar disorder, major depressive disorder, and insomnia. The 8/18/23 behavioral symptoms care plan for Resident 58, last reviewed/revised 1/24/24, indicated she had episodes of anxiety. She may experience feeling nervous, restless or tense, having a sense of impending danger, panic or doom, having an increased heart rate, breathing rapidly, episodes of verbal/physical agitation. The goal was for her to be free from anxiety. An approach was to intervene immediately and keep agitating peers separated, as able, starting 8/18/23. The 8/18/23 behavior care plan for Resident 58, last revised 1/24/24, indicated she preferred to keep the door to her room closed, at times. She		individualized needs. Meeting attendees included Psyche NP, DNS, SSD, MCSS. 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 this alleged deficient practice - all staff educated by 2/22/24 by the Regional Social Services Director/designee on behavior management program/intrusive wandering - all resident behavior care plans for residents who reside on the cottage were reviewed by IDT/designee to ensure behavioral care plans and interventions were person centered and met residents needs. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - staff supervision increased throughout the day to provide adequate monitoring utilizing members of the IDT team. (see attachment A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could become agitated verbally/physical when preference was not honored. The goal was for her preference to be honored. Approaches were to honor her preference to keep door closed, starting 8/18/23; to assist in preventing peers from opening the door, as able, starting 8/18/23; and for a stop sign to be placed on her doorway to deter peers, starting 1/15/24. The 1/16/24 behavioral symptoms care plan for Resident 58, last reviewed/revised 1/24/24, indicated she had a history of physical aggression when peers enter her room. The goal was for her to not have altercations with peers and to notify staff when needing assistance with another resident. Approaches were to have a stop sign banner in her doorway, starting 1/16/24 and when observing another resident wandering towards her room, to redirect the other resident away from rooms, starting 1/16/24. Resident 92's 1/11/24 nurse's note indicated she had a behavioral expression on 1/11/24 at 7:00 p.m. She was throwing her walker, irritable, yelling, and intrusively wandering. Staff attempted interventions of a drink, snack, and change in environment which were not effective. Resident 92's daughter came in and she calmed down. Resident 92's 1/13/24, 3:06 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 9, indicated she had a witnessed fall today. She wandered into another resident's room (Resident 58,) and Resident 58 got upset. Resident 58 pushed the door on Resident 92 resulting in in Resident 92 falling to the floor. Resident 92 had a hematoma to the right side of her forehead. Staff attempted to complete a head to toe assessment and she became agitated and would not let staff complete a full assessment.		) - all staff educated by the Regional Social Services Director/designee on behavior management/intrusive wandering - DNS/designee to review facility activity report daily to ensure that social wellness needs are addressed - All residents on the memory care unit will have plans of care reviewed quarterly - IDT/designee will monitor to ensure interventions are implemented per resident plan of care when residents exhibit behaviors How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as F-744 will be completed weekly x 4 weeks, monthly times 6 months,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 92's 1/13/24 fall event, created by LPN 9 on 1/13/24 and completed by the RDCC (Regional Director of Clinical Care on 1/16/24, indicated Resident 92 had an unwitnessed fall in another resident's room. Prior to the fall, Resident 92 was wandering into another resident's room. It read, "Another res [resident] was trying to remove this res out of her room by pushing the door on this res w/hand [with hand] as well resulting in a fall." Resident 92 hit her head, was experiencing pain, and kept holding her head where a hematoma had accrued. The 1/15/24 IDT (Interdisciplinary Team) note for Resident 92 indicated prior to Resident 92's 1/13/24 fall, she was walking in the hallway. "Resident was attempting to go into another residents room, other resident was attempting to keep resident out of her room by closing the door. This caused resident to lose her balance and fall. Resident was fully clothed with shoes on. Injuries sustained: Bruising to right side of forehead....Determined root cause of fall: Resident attempted to enter another residents room, door was pushed closed and caused resident to lose her balance and fall." An observation of Resident 92 was made on 1/24/24 at 1:44 p.m. Her right eye had a dark, blackish yellow bruise underneath it. An observation of Resident 92 was made on 1/24/24 at 1:38 p.m. She walked into and came out of Resident 109's room. There was a stop sign hanging from the doorway, but the stop sign was not up. No staff addressed Resident 92 going into the room. An observation was made on 1/29/24 at 2:00 p.m.		and quarterly thereafter until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be completed; Completion date: 2/22/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the hallway. There was a stop sign across Resident 58's room and the door to Resident 58's room was closed. Resident 92 opened the door to the room, went underneath the stop sign, entered the room and said hello. After leaving Resident 58's room, she opened the door to Resident 63's and 180's room and said hello. There was no stop sign on this door. No staff redirected her from entering Resident 58's room or after opening the door to Resident 63's and 180's room. An observation of Resident 92 was made on 1/29/24 at 2:40 p.m. in the hallway. She was walking down the hallway and opened the door to another resident's room, Resident 63's and Resident 180's room, looked inside, stood there for a moment, and eventually shut the door and continued down hallway. No staff were observed to redirect her after opening the door to Resident 63's and Resident 180's room. 3. The clinical record for Resident 89 was reviewed on 1/29/24 at 9:30 a.m. The diagnosis for Resident 89 included, but was not limited to, dementia with behavioral disturbances and schizoaffective disorder. A Quarterly MDS (Minimum Data Set) assessment dated 11/29/23 indicated Resident 89 resident was severely cognitively impaired. Resident 89's care plan dated 12/18/23 indicated "Resident was having delusional thinking that there was man in her room. Resident crying, yelling out in her language and packing up her belongings. Concerns that roommate has key to closet and taking items." Resident 89's care plan dated 12/26/23 indicated Resident 89 "will have episodes of agitation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	including verbal/physical aggression i.e. raising voice, attempting to take other's mobility device. Resident 89's care plan dated 1/8/24 indicated Resident 89 "believes peers are wearing her clothes...does not recall she resides in a semi private room and believes all items are hers. She has had an episode of attempting to take belongings from roommate and others which increases risk of altercations." An approach indicated placement of a name sign identifier on her side of the room. An approach indicated staff to re-direct. Resident 89's care plan dated 1/16/24 indicated Resident 89 intrusively wanders. Resident 89's 1/15/24, 11:25 a.m. nurse's note, written by RN (Registered Nurse) 4, read, "Res had unwitnessed fall in other res room. Res believe [sic] that other res took her clothes and went to other res room to get back her clothes. Both res flighted [sic] with each other and other res hit her and then res fell. Checked vitals WNL [within normal limits,] but res has pain in both arms, Left shoulder and back pain. Gave her Tylenol for pain and res resting in her bed. Will continue to monitor." Resident 89's 1/15/24, 11:56 a.m. nurse's note, written by LPN (Licensed Practical Nurse) 7, read, "This writer called back to the 200 hall by QMA [Qualified Medication Aide.] this writer was asked to assess resident at this time. Resident displaying s/s [signs/symptoms] of pain when AROM/PROM [active range of motion/passive range of motion] performed to left shoulder. This writer then palpated left shoulder and resident grimaced as if in pain. NP [Nurse Practitioner] notified at this time and this writer given verbal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	order for STAT [immediately] XR [x-ray] of left shoulder." The 1/15/24, 10:59 a.m. fall event indicated Resident 89 had an unwitnessed fall in another resident's room (Resident 92.) It read, "Res was in her bedroom and other res took some clothes from her bedside drawer and took in in room. That time res was going to other res room to get back her clothes and other res hit her [sic] she fell by hitting." Resident 89's 1/16/24 IDT note for Resident 89, written by the SSDF (Social Services Director Float,) read, "Description of behavior: Peer believed resident had peer's clothing and peer entered room and this resident pushed peer. Immediate interventions: Peer was assisted out of the room immediately. Assessment of potential correlation to root cause: Cognitive level (dementia staging, BIMS [brief interview for mental status] assessment), Environment (over/under stimulation, approach, positioning, other resident behavior.) Potential correlation(s) to root cause: Peer entering resident's room caused behavior. Root cause of behavioral expression: Peer entered this resident's room accusing [sic] her of having peer's clothing. Describe preventative intervention relating to above root cause: Ensure resident's name is on her door. Allow resident to express frustration and provide space Care plan updated and current interventions revised as applicable: Yes." The 1/15/24 psychiatry progress note for Resident 92 read, "Per staff reports, the resident had wandered into another resident's room and was then accused of taking that resident's clothes. The two residents got into a verbal altercation and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	then the staff discovered the other resident on the on the floor. She continues to have episodes of anxiety and agitation, as well as intrusive wandering." An interview was conducted with QMA 3 on 1/29/24 at 2:37 p.m. after she got up from sitting on a rolling stool in the hallway in front of the nurses station. She indicated she'd worked at the facility for 9 months as a float, but on the memory care unit consistently for the past 2 weeks, usually on day shift. She didn't always have time to sit in the hallway and monitor, like she just was. It depended a lot on who was working on the unit and if the staff was more consistent. Resident 89 and Resident 92 had "a few altercations." It was usually just words, but sometimes one of them would end up "getting hurt." The last one was during breakfast time. It really helped to have a third CNA on the unit. She worked the evening shift the other day and could have used a third CNA then too. What happened during breakfast was that all the residents had to be up and dressed for breakfast, so the 2 CNAs that were working were assisting residents in their rooms, so they weren't available to monitor what's going on in the hallway. She thought it would help if the staff coordinated and communicated with each other better too. Like, there couldn't be 2 staff behind the nurses desk at the same time, because that took one off the floor. Perhaps just one behind the desk at a time would work better. They also needed to communicate with each other about what each of them were doing and where they were going to be. An interview was conducted with the SSDF on 1/29/24 at 3:02 p.m. in the hallway between the dining room and main hallway of the unit. She indicated she'd been working at the facility 4 times			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a week on the memory care unit as the SSD since 12/27/23. There was a MCD (Memory Care Director) prior to her starting, but there was not one currently. She saw residents getting irritable, but care plans were in place for all of them. It was "tricky" trying to find the right roommate for everyone. LPN 12, who worked the unit regularly, had recently reduced her hours. The set up on the unit "definitely needs work....It gets real congested in this hallway area. It gets busy, especially at activity times." A resident just got her wheel chair "tangled up." Another resident became agitated a couple of weeks ago, because she felt like there was "too many people in her way." Sometimes Resident 89 thought other people had her things, even though they didn't. They made sure residents names were on bright pieces of paper on their door, a sign on Resident 89's closet door, and that everyone's clothes were labeled. She hadn't witnessed Resident 89 accuse other residents of having her things, but speaking with other staff, they had observed it, including LPN 12, Activity Assistant 6, and RN 4. Regarding the altercation between Resident 89 and Resident 92 on 1/15/24, RN 4 thought she had redirected after seeing it earlier in the day. She felt like residents going into other residents rooms had gone down a bit. They tried to have staff at the end of the hallways, and she thought the stop signs were helping. "It's a goal we're working towards." She helped serve breakfast, as the CNAs (Certified Nursing Assistants) were doing patient care, so they were not always available during that time. Once an MCD was in place, she thought things would be a little more cohesive on the unit. 4. The clinical record for Resident 29 was reviewed on 1/26/24 at 2:30 p.m. Her diagnoses included, but were not limited to: dementia,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychotic disorder with delusions, and depression. The 8/22/23 behavioral symptoms care plan for Resident 29 indicated she intrusively wanders with purpose to exit seek. The 5/30/23 behavioral symptoms care plan for Resident 29 indicated she may have episodes of anxiety such as interfering with other peers and episodes of verbal aggression. The 1/5/24 fall event for Resident 89, created by LPN 12, indicated she had an unwitnessed fall in her bedroom. She was found sitting on her buttock in her room with her roommate. "Resident stated that she and her roommate were tugging over the same shirt then lost her balance and fell backwards." She had pain in her lower lumbar/spine and sacrum/coccyx. She also had pain with range of motion. The 1/5/24, 10:20 a.m. nurse's note for Resident 89, written by LPN 12 indicated staff heard loud screaming coming from Resident 89's room. Staff went to the room and found both Resident 89 and her roommate, Resident 29, on the floor sitting on their buttock areas. Resident 89 had a shirt that belonged to her roommate in her hand. The 1/5/24, 10:39 a.m. behavior note for Resident 89, written by LPN 12, indicated Resident 89 attempted to grab another resident's shirt from her thinking that it belonged to her. Resident 89 was accusing the other resident of stealing her things. Writer notified psych due to Resident 89's increased hallucinations and delusions. Resident 89 just returned back from psyche stay for increased hallucinations, delusions, and suicidal ideation.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The 1/8/24 IDT (Interdisciplinary Team) note read, "Resident observed on the floor on her buttocks. Resident stated she and her roommate had a disagreement over an item of clothing and were both pulling on said item at which time she fell to her buttocks, Resident assessed by staff and neuro checks initiated. Resident reported pain to her lower lumbar spin, sacrum and coccyx areas. Injuries sustained: Pain to lower lumbar spine, sacrum and coccyx areas....X-rays obtained: Yes. X-Ray results: Modest osteoarthritis of the lumbar spine. No fracture seen. Old right hip fixation...Determined root cause of fall: Resident and roommate had a disagreement over an item of clothing. Intervention put in place to address root cause of fall: Resident's roommate moved to a new room."5. The clinical record for Resident 100 was reviewed on 1/29/24 at 9:00 a.m. The diagnosis for Resident 100 included, but was not limited to, dementia without behavioral disturbances. A Quarterly MDS (Minimum Data Set) assessment dated 11/14/23 indicated the resident was moderately impaired. A reportable incident dated 12/23/23 indicated Resident 100 had reported her roommate, Resident 89 had made physical contact with her head. After assessment to Resident 100, she had no noted injuries. Resident 89 was moved to another room. Preventative measures that was implemented both residents will remain separated during meals and activities. The follow up to the investigation indicated Resident 89 was transferred to a psych facility. The investigation of the incident was provided by the Regional Director of Clinical Care (RDCC) on 1/29/24 at 2:14 p.m. A statement by Resident 100			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated Resident 89 and herself were in their room; Resident 89 was mean and pulled her hair. Resident 89 was unable to recall the incident. An Interdisciplinary Team (IDT) note for Resident 89 dated 12/26/23 indicated "On 12/23/23, resident was noted to have several behaviors. Earlier in the day, resident was noted to have paranoia/delusional thinking about roommate. Then at 1:30 p.m., resident was noted to be verbally agitated with roommate, raising voice and trying to grab roommate's wheelchair...Earlier in the day, staff provided redirection with an activity, which was noted to be effective. In the afternoon, staff and family agreeable to room change, as behaviors were being directed toward roommate. Later in the evening, resident was sent out to hospital for further mental health evaluation. A nursing progress note for Resident 100 dated 12/23/23 indicated "Resident denies any pain or discomfort....Resident stated, 'I'm a tough gal and I'll be ok.' An interview was conducted with Float Social Services Director on 1/29/24 at 3:03 p.m. She indicated Resident 89 does become irritable and believes other residents have her belongings. The resident's behaviors have improved; she currently resides in a room by herself. 6. The clinical record for Resident 4 was reviewed on 1/24/24 at 3:00 p.m. The diagnosis for Resident 4 included, but was not limited to, dementia with psychotic disturbances. A care plan dated 1/12/24 indicated "Resident (4) has exhibited physical aggression when peers enter her room....Approach...Assist residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	away from her room when they begin walking towards [Resident 4's] doorway...Assure resident that staff can assist others out of her room, encourage resident to notify staff...Have a stop sign in her door way to help prevent other residents wandering in her room. A care plan dated 7/24/23 indicated "...Resident has a diagnosis of psychotic D/O [disorder] with delusions. She may experience delusional thinking, paranoia, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, negative symptoms...Approach...Attempt to re-orient resident, if not upsetting to resident...provide calm approach..." 7. The clinical record for Resident 63 was reviewed on 1/24/24 at 3:15 p.m. The diagnoses for Resident 63 included, but was not limited to, dementia. A care plan dated 12/8/23 indicated Resident 63 intrusive wanders in hall and other peer's rooms uninvited. The approach on the plan was to "Assist resident with redirection to her room...Resident will reside in room near nursing desk to allow her to locate her room and dining area easier to help prevent intrusive wandering..." 8. The clinical record for Resident 64 was reviewed on 1/29/24 at 9:30 a.m. The diagnoses for Resident 64 included, but was not limited to, dementia. A medical provider progress note dated 12/5/23 indicated Resident 4 "...did have inpatient geriatric psych stay after she had increasing behaviors with verbal and physical aggression over the past 72 hours prior to her admission and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	combativeness towards other residents...Since her return patient has been having episodes of agitation per nursing..." A nursing behavior progress note for Resident 4 dated 1/11/24 indicated Resident 4 had pushed Resident 63, because she had wandered into her room. A social services behavior progress note for Resident 4 dated 1/12/24 indicated "...a peer [Resident 63) entered resident's room uninvited, which upset resident. Resident then made unwanted physical contact with peer to try to get peer out of room. Immediate interventions: Staff intervened immediately and assisted peer out of resident's room...Root cause of behavioral expression: Root cause is related to peer entering resident's room uninvited...Describe preventative intervention relating to above root cause: Will place stop sign on resident's door to deter peers from entering room uninvited..." A social services behavior progress note for Resident 4 dated 1/15/24 indicated "...Resident has not exhibited aggression towards others. Writer talked to her about the incident and she denies aggression towards others, but did state she would not like for anyone to come in her room not invited. Writer validated frustrations. Resident does like having the stop sign up in her doorway and states it does not get in her way..." An event dated 1/11/24 indicated Resident 63 had a witnessed fall. "The resident will be relocated to a room closer to the nurse's station, so the staff members can monitor her to prevent from going into a wrong room." An IDT progress note dated 1/12/24 for Resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	63 indicated "...date/time of fall: 1/11/24 5:50 p.m. Description of incident: Witnessed fall without injury - the resident entered a wrong room (next to her room) and the occupant (Resident 4) of the room attempted to remove her from the room when she fell. Injuries sustained: none noted....Resident and fall location has been evaluated by IDT since time of fall: yes. Any change of condition including new pain noted by IDT since fall: No...Determine root cause of fall: The resident wandered into a wrong room. Intervention put in place to address root cause of fall: The resident will be relocated to a room closer to the nurse's station so the staff member can monitor her to prevent from going into a wrong room..." An observation was made of Resident 4 in her room on 1/25/24 at 10:39 a.m. Resident 4 was observed lying in bed by window with eyes closed. The bed by the door also had a resident lying in bed with her eyes closed. There was no observation of a stop sign hanging at door. At that time, QMA 3 was asked to observe Resident 4's room to identify the other resident in the bed by the door. An observation was made of Resident 4 in her room with Qualified Medication Aide (QMA) 3 on 1/25/24 at 10:41 a.m. QMA 3 identified the resident lying in the bed by the door as Resident 64. She indicated Resident 64 previously resided in Resident 4's room, but has been moved to another room approximately 2 weeks ago. She gets confused at times and still goes in there. Resident 64 was redirected out of Resident 4's room at that time. An observation was made of Resident 4 in her room on 1/29/24 at 9:22 a.m. The resident was observed lying in the bed by the window with her			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	eyes closed. There was no observation of a stop sign at the door. At 9:26 a.m., a staff person passed Resident 4's room and entered another resident's room down the hall. At 9:35 a.m., Registered Nurse (RN) 4 was observed in Resident 4's room obtaining the resident's vitals. After leaving, RN 4 went into another resident's room. She did not place stop sign on the resident's door. An interview was conducted with Float Social Services Director on 1/29/24 at 3:13 p.m. She indicated she had noticed Resident 4's stop sign was not up and was unable to locate it. After searching, the stop sign was located in the resident's drawer. It currently has been placed on. An "Ideas for Interventions for Common Behaviors" document was provided by the RDCC on 1/29/24 at 11:54 a.m. It indicated "...Always consider need for increased supervision to ensure safety of other residents. 15 minute checks, One on one supervision (doesn't have to be a nurse or CNA [Certified Nursing Aide] Remember that we need an IDT note explaining why 15 minute checks or one on ones have been discontinued (have to show that the safety risk is no longer present)." A Behavior Management policy with a revision date of 8/22 was provided by the RDCC on 1/29/24 at 11:54 a.m. It indicated "...Policy: It is the policy of American Senior Communities to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	expressions. Procedure: 1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other resident or caregivers. Care plan interventions should include individualized and non pharmacological interventions which address both proactive and responsive interventions...3. When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix. 4. If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT for assessment and preventative actions. New/Worsening Behaviors include: a. Behaviors that are new for the resident b. Behaviors that are directed at another resident (Note: Follow abuse reporting and prohibition protocols) c. Behaviors that are increasing in either frequency or severity d. Behaviors that have potential for risk to others including sexual advances, intrusive wandering, exit seeking and chronic combativeness with care. The IDT review is a discussion with the team as to the behavioral expression, an evaluation of interventions, presentation of new interventions if applicable and an assessment of any underlying causes of the behavior (ie pain, environmental stressor, medical illness, etc.,) The root cause and preventative interventions will be included in the resident's plan of care. 5. If the behavioral expression is not new, worsening or high risk; the nurse will record the behavior in the progress note using the Behavior Communication Note. The IDT will review progress notes the next business day to determine if immediate follow up action is required for the Behavior Communication. If the behavior requires an interdisciplinary response as described above, the IDT will complete the IDT			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Behavior Review. If not, the plan of care will be reviewed and updated if needed to include a description of the behavior and effective interventions. 6. Residents with documented behaviors will have a Behavioral Health Monthly Review. This review includes evaluation of behaviors which have occurred that month and that interventions for behavioral expressions are current and effective. 7. Direct care staff will be educated as to the interventions for residents reviewed by the IDT." 3.1-37			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure there were staff available to access medications in the emergency drug kit (EDK) regarding antianxiety medication for a resident experiencing anxiety for 1 of 5 residents reviewed for mood/behavior. (Resident E) Findings include: The clinical record for Resident E was reviewed on 1/26/24 at 3:13 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, dementia, mood disorder, depressive disorder, and anxiety disorder. A care plan for anxiety, revised 12/29/23, indicated Resident E displayed anxiety and agitation towards others and utilized antianxiety medication. A progress note, dated 3/27/23 at 1:26 p.m., indicated the following, " ...Writer contacted Dtr. [daughter] in regards to med [medication] changes ...Psych [mental health services] gave order to add Ativan [antianxiety medication] PRN [as needed] x 14 days to residents [sic] medications r/t [related to] increased anxiety and med [medication] seeking behavior ...." A physician order, dated 3/27/23, was noted for	F 0755	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. F755 Pharmacy Services/Procedures/Pharmacist/ Records. Failed to ensure there were staff available to access medications in the emergency drug kit regarding antianxiety medications for a resident experiencing anxiety. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	lorazepam (generic name for Ativan) 0.5 milligrams every 6 hours as needed for anxiety disorder. The prescription fax request for such medication was dated for 3/27/23 at 12:28 p.m. A progress note, dated 3/28/23 at 6:35 a.m., indicated the following, "" ...Patient has been up in w/c [wheelchair], back et [and] forth, in et out of her bed into w/c, approaching writer et CNA [certified nursing assistant] all night about her medication "missing from her drawers", et also accusing staff of "taking her medication." Writer attempted to redirect patient et inform her that medication is kept in the nurses med [medication] cart et that no one has taken her medication ...When writer checked, patient has prn [as needed] orders for Ativan 0.5mg i [one] po [by mouth] q6hours [every 6 hours] prn. Medication not in cart. Writer placed call to pharmacy et spoke to Pharmacist [Name of Pharmacist]. Writer requested auth [authorization] code to obtain Ativan from pixis [emergency drug kit], per facility nurses. Auth code received ...Writer went to other units in facility to tray to obtain med via facility nurses; unable to get med from pixis through nurses ....nurses unavailable on unit, et no authorization ...Finally pharmacy arrived with patient's Ativan medication between 5:30 et 6:00 a.m. et medication was administered to patient immediately upon receiving ...." A list of authorized personnel who had the ability to access the EDK was provided by the Regional Director of Clinical Care on 1/26/24 at 4:00 p.m. The daily nursing schedules were reviewed on 1/29/24 at 1:00 p.m. The following date(s) did not have 2 facility staff who had the ability to access the EDK for narcotic medication retrieval:		identifier given. Prior to survey exit access updated for all nurses currently working in the facility. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. Prior to survey exit access updated for all nurses currently working in facility. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** ·All licensed nurses to be trained on and get access to the EDK during orientation process. ·DNS/Designee to check monthly to ensure all nurses working in the facility have access to the EDK. ·All current nurses to be able to identify they have a login and are able to gain access of needed. **1.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?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/11/23 on night shift, 12/30/23 on night shift, 1/2/24 on night shift, 1/8/24 on night shift, 1/15/24 on night shift, & 1/22/24 on night shift. An interview conducted with the Interim Director of Nursing Services, on 1/29/24 at 11:23 a.m., indicated there was no policy for following physician orders. It was a standard of care. A follow-up interview, on 1/29/24 at 1:40 p.m., indicated the list of authorized personnel for the EDK utilization was updated periodically depending on what new staff are hired and what staff no longer work at the facility. A policy titled "Automated Medication Dispensing Systems (AMDS)", revised 1/4/23, was provided by the Interim Director of Nursing Services on 1/29/24 at 1:40 p.m. The policy indicated the following, " ...8. Facility should ensure that only licensed Facility personnel who have the approval of the Director of Nursing and who have received appropriate training have access to medications in the AMDS ...8.4 When a facility that has adopted a policy to have another nurse witnesss the removal of a controlled substance from the AMDS, but a witness is unavailable before the dose is administered, the nurse removing the dose should have a nurse on the unit or the nursing supervisor verify ...the medication ...the strength ...dosage form, and ...the quantity removed ...12.2 Controlled substances for interim or emergency orders must be authorized by the pharmacist before removal ...." This citation relates to Complaint IN00406679. 3.1-25(a)		Omnicell Access QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not testing a resident with signs and/or symptoms of COVID- 19 timely for 1 of 1 residents reviewed during a random observation for respiratory care. (Resident Q). Findings include:	F 0880	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests	02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record for Resident Q was reviewed on 1/29/24 at 12:10 p.m. Resident Q's diagnoses included, but not limited to, chronic kidney disease, Rheumatoid arthritis, congestive heart failure, generalized muscle weakness, and low back pain. An interview and observation were conducted with Resident Q on 1/25/24 at 10:18 a.m. During the interview, Resident Q indicated, she had been experiencing sneezing, a sore throat, congestion, and a runny nose for a couple days. During the interview, it was observed that Resident Q needed to blow her nose and did not have any facial tissue to use, so she took a piece of clothing within her reach and blew her nose into it. She then indicated, she was unable to wash her hands without assistance to get up and out of bed nor did she have any hand sanitizer to utilized within her reach. An interview with RDCC (Regional Director of Clinical Care) conducted on 1/26/24 at 10:30 a.m. indicated, Resident Q had not been tested for COVID-19 despite having signs/symptoms of COVID. RDCC indicated, any resident who exhibits any signs/symptoms of COVID-19 should have a swab test for COVID-19. RDCC further indicated, Resident Q would be re-tested for COVID-19 on day 3 of her symptoms as well. A COVID-19 policy, last revised on 7/2023, was received on 1/26/24 at 11:38 a.m. from Director of Nursing (DON). The policy indicated, "...f. Source control for residents and staff should be used in the following circumstances: i. Have suspected or confirmed COVID-19 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze)...SARS-CoV2		that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. F880 Infection Prevention and Control. Failed to properly prevent and/or contain COVID-19 by not testing a resident with signs and or/symptoms of COVID-19 timely. **1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident Q) Any resident with COVID symptoms are tested immediately to ensure transmission based precautions are implemented. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. Regional Clinical Consultant/Designee to provide education to nurse management regarding COVID-19 and policy related to testing. **1.What measures will be put into place or what systemic**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Viral Testing... Anyone with even with mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for COVID-19. " The Centers for Diseases and Control's (CDC) Respiratory Illness Symptoms when SARS-CoV-2 and Influenza Viruses are Co-circulating guidance, last reviewed: November 14, 2023, from Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD) website, last accessed 1/31/24 at 3:44 p.m. indicated, " Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for care of a resident with suspected SARS-CoV-2 infection... Because some of the signs and symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two respiratory diseases based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in their current room, pending results of viral testing. They should not be placed in a room with new roommates, nor should they be moved to a COVID-19 care unit (if one exists), unless they are confirmed to have COVID-19 by SARS-CoV-2 testing...Test any resident with symptoms of COVID-19 or influenza for both viruses. Because SARS-CoV-2 and influenza virus co-infection can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection, and a positive SARS-CoV-2 test result without influenza testing does not exclude influenza virus infection... Placement Decisions A) Residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with		**changes will you make to ensure that deficient practice does not recur?** Facility IP/Designee to review documentation and orders daily to identify those that need tested for COVID-19. Those that need testing are tested immediately and transmission based precautions are implemented per COVID policy and CDC guidelines. All licensed nurses to be educated on signs/symptoms of COVID and policy/CDC guidelines related to testing. **1.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?** COVID-19 Resident QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	only SARS-CoV-2 infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation). Residents found to have SARS-CoV-2 and influenza virus co-infection should be placed in a single room or housed with other co-infected residents. These residents should continue to be cared for using all recommended PPE for the care of a resident with SARS-CoV-2 infection. If single room isolation or cohorting of residents with SARS-CoV-2 and influenza virus co-infection is not possible, consult with public health authorities for guidance on other management options (e.g., transferring the resident; placing physical barriers between beds in shared rooms and initiating antiviral chemoprophylaxis for roommates to reduce their risk of acquiring influenza, improving ventilation by adding HEPA filters). B) Residents confirmed to have influenza virus infection only should be placed in a single room, if available, or housed with other residents with only influenza virus infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation, antiviral chemoprophylaxis for exposed roommates). Residents with influenza should be placed in Droplet Precautions, in addition to Standard Precautions. As part of Standard Precautions, eye protection should be worn if splashes or sprays are anticipated (e.g., the resident is coughing or sneezing). Because it can be difficult to anticipate		oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit. **Date of Compliance: 02/22/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	potential for coughs and sneezes, facilities might consider having healthcare personnel routinely wear eye protection for the care of residents with influenza. C) Residents with symptoms of acute respiratory illness who are determined to have neither SARS-CoV-2 nor influenza virus infection should be cared for using Standard Precautions and any additional Transmission-Based Precautions based on their suspected or confirmed diagnosis." This tag relates to Complaint IN00406737 and IN00427339. 3.1-18(b) 3.1-18(l)			