STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00225655. Complaint IN00225655-Unsubstantiated due to lack of sufficient evidence. Survey dates: April 6, 7, 10, 11, 12, and 13, 2017. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census Bed Type: SNF/NF: 91 SNF: 16 Residential: 34 Total: 141 Census Payor Type: Medicare: 9 Medicaid: 74 Other: 58 Total: 141 These deficiencies reflect State Findings	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on April 21, 2017.			
F 0282 SS=D Bldg. 00	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview and record review, the facility failed to ensure care plan interventions were followed for 1 of 1 resident reviewed for hydration (Resident 55). Findings include: Resident 55's record was reviewed on 4/11/17 at 2:16 p.m. A care plan titled, "nutritional status," with approach start date 8/24/14 included, but was not limited to,"...resident and family desire that resident be left on current pureed diet with honey thickened liquids despite risks of choking/aspiration. Approach: No straws...." On 4/12/17 at 11:01 a.m., Resident 55 was observed in his room in geri chair with a table positioned in front of him. There were two styofoam cups with straws in each of the cups sitting on table. Resident 55 indicated at this time the cups belonged to him and that he had drank through the straws. During an interview on 4/12/17 at 11:05 a.m., LPN (Licensed Practical Nurse) 9 indicated Resident 55's diet consisted of honey thickened liquids and the resident was not to use straws when drinking fluids.	F 0282	1.Resident 55 receives interventions per plan of care. Resident 55's Care Plan was reviewed and revised appropriately. Resident 55 was assessed by Speech Therapy to ensure proper interventions. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing staff were provided inservice training related to the Care Plan policy including: insuring interventions are in place and being followed per Plan of Care. An audit has been completed to ensure that interventions are in place and being followed per Plan of Care by the DNS/Designee utilizing the individual Resident Profiles. 3.Nursing staff will be provided inservice training by the Director of Nursing/Designee on the Care Plan Policy including: ensuring interventions are in place and being followed per Plan of Care by 5-15-17. The Director of Nursing/Designee will conduct rounds on all shifts to ensure that interventions are in place and being followed per Plan of Care using the Accommodation of Needs CQI tool overseen by the Executive Director. 4.Results of the Accommodation of Needs CQI will be utilized daily x 4 weeks. The results of those audits will be summarized for review by the	05/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 4/12/17 at 11:15 a.m., CNA (Certified Nursing Assistant) 12 indicated Resident 55's diet consisted of thickened liquids and staff should not give straws with thickened liquids. During an interview on 4/13/17 at 9:45 a.m., the Rehabilitation Services Manager indicated due to a decrease in oral strength and overall oral control for Resident 55, he was not able to build up the pressure to use a straw because it would be more effortful and fatigue him. Also indicated, resident was on honey thickened liquids due to aspiration risk. On 4/12/17 at 2:15 p.m., the DNS (Director of Nursing Services) provided a policy titled "Resident Care and Safety," revised 4/14, and indicated was the one currently being used by the facility. The policy indicated, "Policy: ... The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical ... Procedure: ... Care plan interventions and changes impacting care provided by CNA's will be communicated to CNA via verbal report ...." 3.1-35(g)(2)		QAPI committee requiring 95% proficiency. The Accommodation of Needs CQI will then be utilized weekly for 6 additional months for review by the QAPI committee at 95% proficiency. Any issues that are discovered by the QAPI team will result in the development of a Corrective Action Plan to immediately address.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0333 SS=G Bldg. 00	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. Based interview and record review, the facility failed to prevent the administration of non-prescribed medications to a resident which resulted in the resident becoming unresponsive and requiring a transfer of care to the hospital intensive care unit for 1 of 5 residents reviewed for unnecessary medication use (Resident 30). Findings include: On 4/10/17 at 11:56 a.m., Resident 30 indicated a nurse had given him someone else's morphine medicine a couple of months ago. "I woke up in an ambulance and was told I had an overdose!" During an interview on 4/11/17 at 11:11 a.m., the DNS (Director of Nursing Services), indicated on 11/21/17 RN (Registered Nurse) 15 had prepared medications for another resident and realized the medications were not due yet; labeled the medications and placed them in the medication cart. The nurse then began preparing Resident 30's	F 0333	1. Resident #30 only receives medication prescribed to him. Corrective Action was initiated for RN #15. 2.All residents have the potential to be affected by this alleged deficient practice. Licensed Nurses were provided inservice training immediately following the events of 11-21-16 including: Med Pass policy and procedure, and the 5 rights of medication administration by the CEC/Designee. 3.Licensed Nurses were provided inservice training immediately following the events of 11-21-16 including: Med Pass policy and procedure, and the 5 rights of medication administration by the CEC/Designee. Licensed Nurses will be provided inservice training including: Med Pass policy and procedure, and the 5 rights of medication administration by the CEC/Designee by 5-15-17. All Licensed Nurses will have a Medication Pass observation via skills validation completed by 5-15-17 by the CEC/Designee. Medication Pass skills validation will be conducted on Licensed	05/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications. While preparing the medications, RN 15 assisted another resident and went back to the medication cart and grabbed the wrong medications that were intended for the other resident. Resident 30 received MSO4 (morphine sulfate) (extended release pain medication) 60 mg (milligrams), acyclovir (anti-viral medication) 400 mg, gabapentin (pain medication) 600 mg, metroprolol (blood pressure medication) 25 mg about 5:00 p.m., which were not prescribed/ordered for him. The MD (medical doctor) and family were notified and 15 minute checks were initiated. Resident 30 was found unresponsive on 11/21/16 at 9:58 p.m. He was sent to the emergency room. The record for Resident 30 was reviewed on 4/11/17 at 11:23 a.m. The Quarterly MDS (Minimum Data Set) Assessment, dated 2/22/17, indicated, "Active Diagnoses" included, but were not limited to, CAD (coronary artery disease), Type 2 diabetes, and congestive heart failure. Resident 30's BIMS (Brief Mental Status) indicated a score of 14 (cognitively intact). An ineffective tissue perfusion care plan, originally dated 4/27/16 and updated 3/23/17, indicated a goal for Resident 30 would be to maintain adequate tissue perfusion, as evidenced by blood pressure within		Nurses upon hire and annually by the CEC/Designee. A copy of the Pharmacy Policy and Procedure is available at the nurses stations for review and reference by the Licensed Nurses. 4.The DNS/Designee will run the Facility Medication Administration Compliance report 3 times daily (by shift) to check for medication administration accuracy. DNS/Designee will complete the Medication Error CQI tool will be utilized to ensure adherence to medication administration policy and procedure weekly for 4 weeks, monthly for 6 months thereafter, then quarterly for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If minimum threshold score of 95% is not achieved, a Corrective 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
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	normal limits for resident, no change in mental status, no complaints of dizziness/lightheadedness/syncope, no edema; with a nursing approach to administer medications as ordered. A Physician telephone order, noted by RN 15, on 11/21/16 at 5:20 p.m., indicated, "1) Hold all evening meds with the exception of bactrium (ointment). 2) Continue to monitor resident...with a care plan updated upon the same form, dated 11/21/16 at 5:30 p.m., "Problem: Risk for low BP (blood pressure) and low O2 (oxygen) sat; Goal: ensure resident safety; Intervention: follow above orders per MD (medical doctor)." A DNS Progress note, dated 11/21/16 at 5:33 p.m., indicated, "Charge nurse notified this writer that resident received Acyclovir 400 mg (milligrams), Gabapentin (pain medication) 600 mg, Metroprolol (blood pressure medication) 25 mg, and MSO4 (Morphine sulfate) (extended release pain medication), this day around 5:00 p.m. No adverse reactions noted at this time. Respirations are even and labored. Resident is alert per usual. Vitals are WNL (within normal limits). Provider made aware of the above. Made aware of allergy list. Provider wants administer antibiotic therapy as ordered and monitor to at this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	time. Notification to next of kin." RN 15 wrote a progress note, dated 11/21/16 at 9:58 p.m., indicated, "The writer of this note went to assess the resident and found the resident unresponsive. The writer of this note called emergency medical services immediately, sat resident up to 90 degrees, and noted pulse. The writer of this note stayed with resident until EMS (emergency medical services) arrived. Resident was sent to the ED (emergency department). Family notified. On call NP 17 (nurse practitioner) notified of resident worsening condition. DNS notified." The progress note, dated 11/21/16 at 11:19 p.m., written by RN 15, indicated, "The writer of this note called ED to give report, Nurse in ED reported to the writer of this note that the resident is in stable condition, resident is responding to staff, and resident is on a Narcan (opioid reversal) drip, resident will be admitted to ICU (intensive care unit)." An ED record document, dated 11/21/16 at 2235 (10:35 p.m.), indicated, "HPI (history of present illness) = 88 y.o. (year old), male, reported @ 1700 (5:00 p.m.) accidentally was given someone else's 60 mg morphine and 25 mg metoprolol, was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	found to be confused/low blood pressure...gave total of 6 mg Narcan, more awake..." A hospital admission summary document, dated 11/22/16, indicated, "...In the ER (emergency room) he was given a total of 8 mg of Narcan. He was still unarousable. He did become eventually more awake in the ED. He vomited in the ED. He was started on a Narcan drip in the ED and was transferred to the ICU. Patient was continued on a Narcan drip for several hours until he woke up. Patient's blood pressure was also slightly low but that resolved after metoprolol got out of his system...." A facility DNS progress note, dated 11/22/16 at 8:12 a.m., indicated, "Resident remains admitted the hospital in ICU. Nurse this a.m. reports he is stable. Call placed to (son) to discuss condition. This writer inquired of a time for IDT (interdisciplinary team) to meet with family to review findings. Son would like to speak with other siblings and will return call with a good time to meet. Son thanked this writer for call and plan to be in touch. Will continue to inquire of condition." The DNS provided a signed (by RN 15,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	DNS, and ADNS) interview document, dated 11/22/16, which indicated, "...I (RN 15) prepared medication for resident in room [room number]. I then realized the meds weren't due until 7-10 p.m. and noted one medication was a narcotic so I did not want to destroy; I labeled the medication cup with [room number] and put it in the cart. I then began to prepare medication for resident (Resident 30). I observed a resident attempting to stand who is a fall risk, I stopped what I was doing and responded to resident and in the mean time labeled that cup with [Resident 30's room number]. After I addressed the fall risk, I erroneously grabbed the cup labeled [room number] and gave it to [Resident 30's room number]. I immediately assessed resident in room [Resident 30's room number] and then made notification to supervisor, provider and next of kin. Provider gave an order to hold all evening shift medication with the exception of Bactrim and continue to monitor resident. I monitored him closely and assessed. At approximately 9:52 p.m., I observed him with a change in level of consciousness and decreased respirations. I initiated a call to 911 and remained with resident until EMS arrived...." On 4/11/17 at 11:35 a.m., the DNS provided and identified as current,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Medication Pass Procedure," dated 06/2016, indicated, "...Identified resident prior to administering...." 3.1-25(b)(9)			
F 0371 SS=D Bldg. 00	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 0371	1.Prepared Foods served in the Crystal Dining Room are free	05/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, interview, and record review, the facility failed to ensure prepared foods served in the "Crystal" dining room were free from the physical contamination of drywall dust for 45 out of 45 residents served food in the dining room. Findings include: 1. The main dining room, called the "Crystal" dining room, was observed on 4/6/17 at 10:55 a.m., the hand washing sink and floor near the stationary steam table was observed to be covered with drywall dust. During the lunch service, in the "Crystal" dining room, on 4/6/17 at 12:04 p.m., drywall dust was observed covereing the floor beside and in front of the stationary steam table with exposed food, the floor near the hand washing sink, and on a stainless steel table. The Social Services Director, was observed wiping up the drywall dust from the stainless steel table with wet paper towels. During the lunch service, in the "Crystal" dining room, on 4/6/17 at 12:17 p.m., an interview was conducted with the Maintenance Man, he indicated he had used the drill to hang up the soap and paper towel dispensers in the "Crystal"		from physical contamination of Drywall dust. The Crystal Dining Room has been deep cleaned and all drywall dust removed from the hand washing sink, steam table, floor, and stainless steel table. 2.All residents dining in the Crystal Dining Room have the potential to be affected by the alleged deficient practice. Dietary and Maintenance staff were provided inservice training on the Food Safety Policy including: ensuring foods are prepared and delivered in a way that protects them from contamination, and that no maintenance or other work that puts food safety at risk is to be done during meal times by 5-15-17. 3.Dietary and Maintenance staff were provided inservice training on the Food Safety Policy including: ensuring foods are prepared and delivered in a way that protects them from contamination, and that no maintenance or other work that puts food safety at risk is to be done during meal times by 5-15-17. The Dietary Manager/Designee will complete an environmental review before and during every meal service to ensure that foods are prepared and served in a way that protects from potential contamination. 4.A Kitchen Sanitation/Environment Review CQI tool will be utilized weekly for 4 weeks, monthly for 6 months,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dining room during lunch service. During an interview on 4/6/17 at 12:48 p.m., the Dietitian said there was an, "overlap of construction and dining services," during the lunch service. She indicated it was not ok to drill while food was open and that dust particles could have moved through the air to the open food. During an interview on 4/6/17 at 12:57 p.m., the Maintenance Manager indicated the Maintenance Man used the drill during dining services to back out the screws to hang the soap and paper towel dispensers. During an interview on 4/6/17 at 12:54 p.m., the Dietitian indicated the drywall particles should have been cleaned up prior to meal service. During an interview on 4/11/17 at 3:21 p.m., the Dietary Manager indicated that construction should have been delayed for meal service to proceed as not to inconvenience the residents. Once the drywall dust was discovered, all foods should have been covered while the clean up of dry wall dust was completed. A current policy, dated 01/14, titled, "Food Safety," received on 4/11/17 at		and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee monthly overseen by the Executive Director. Additionally, a full sanitation audit will be conducted by an American Senior Community consultant dietitian monthly with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2:09 p.m., from the Dietary Manager, indicated, "Good sanitary food handling practices with sanitary conditions maintained in the storage, preparation and servicing areas will be carried out at all times." 3.1-21(i)(2) 3.1-21(i)(3)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure	F 9999	1.Tuberculin skin test was redone for CNA #6, Dietary Aide #7, and LPN #8. 2.All residents have the potential to be affected by this alleged deficient practice. American Senior Communities Director of Nursing Specialist will educate the Clinical Education Coordinator and the Director of Nursing on Employee Screening by 5-15-17. An audit was completed by the Executive Director/Designee of all staff PPD/TB screening. All employees not having a second step PPD within the policy of Zionsville Meadows had a new PPD administered. 3.American Senior Communities Director of Nursing Specialist will educate the Clinical Education Coordinator and the Director of Nursing on Employee Screening by 5-15-17. An audit	05/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidence by: Based on record review and interview, the facility failed to ensure new employees had a second tuberculosis (TB) screening one to three weeks after their first TB screening for 3 of 10 employee records reviewed for tuberculosis screening. Findings include: On 4/7/17 at 1:40 p.m., State Form 5440, Employee Records," was provided by the Assistant Business Office Manager. Ten (10) employee records were reviewed for		was completed by the Executive Director/Designee of all staff PPD/TB screening. The CEC/Designee will administer the PPD skin test per facility policy. The CEC will maintain a separate file with all staff PPDs due each month. The form will be filled out completely and accurately per facility policy. 4.The personnel and Employee File Checklist will be used on all new employee files to ensure 1st and 2nd step per policy. The Employee File Checklist results will be presented to the Quality Assurance and Performance Improvement committee monthly for 6 consecutive months with 95% expected threshold. The Employee File Checklist results will be presented quarterly thereafter for one year. If minimum threshold score of 95% is not achieved, a Corrective Action Plan will be developed to ensure compliance. Employees without PPD per American Senior Communities will be removed from schedule	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	proof of tuberculin (TB) screening upon hire. 1. CNA (Certified Nursing Assistant) 6, with a hire date of 2/22/17, was administered the first step TB skin test on 2/20/17. The second step was not administered until 3/20/17. 2. Dietary Aide 7, with a hire date of 2/1/17, was administered the first step TB skin test on 1/3/17. The second step was not administered until 2/1/17. 3. LPN (Licensed Practical Nurse) 8, with a hire date of 2/15/17, was administered the first step TB skin test on 2/2/17. The second step was not administered until 2/28/17. During an interview on 4/7/17 at 1:50 p.m., the DNS (Director of Nursing Services) indicated she understood the employee's two step TB skin tests were out of compliance. The second steps tests should have been completed within 14 to 21 days from the first step. On 4/7/17 at 2:00 p.m., the DNS provided a document titled, "Tuberculosis (TB) Screening for Employees ," and indicated the policy was the one currently being used by the facility. The policy indicated, "POLICY:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	To promote resident and employee safety and well-being by screening employees for tuberculosis...1. Pre-employment screening...A two step screening is required...PROCEDURE for Tuberculin Skin Testing (TST)...4. a. Two-step procedure-initial injection followed by a second injection 1-3 weeks later...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjuction with the Investigation of Complaint IN00225655. Residential Census: 34 These State findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on April 21, 2017.	R 0000		
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure prepared foods served in the residential dining room were free from cross-contamination for 5 out of 35 residents served food in the residential dining room (Residents 1, 2, 3, 4, and 5). Findings include: 1. The residential dining room was observed on 4/6/17 at 11:36 a.m. Dietary Aide 3 entered the dining room, wearing disposable gloves, carrying a tray of individual soup servings. After setting the tray down on a residential table, took her cell phone out of her pocket, looked at it and replaced it back into her pocket. She proceeded to serve the soup to Resident 1, Resident 2, Resident 3, Resident 4 and Resident 5 without removing her contaminated gloves. During an interview on 4/11/17 at 3:21 p.m., the Dietary Manager indicated employees are not to use cell phones in dining service area. A current policy, dated March 2014, titled, "American Senior Communities	R 0273	1.The employee identified as having pulled out a cellphone during meal service on 4/6/17 at 11:36 (dietary aide #3) was corrected the instant the issue was identified. Residents 1, 2, 3, 4, 5 were addressed by the Dietary Manager after the issue was identified. 2.All dietary staff were provided inservice training regarding contamination, and cell phone policy of Zionsville Meadows by 5-15-17. All residents have the potential to be affected by this deficient practice. 3.All staff were provided inservice training related to contamination issues in the dining rooms. All staff were provided inservice training related to the cell phone policy of Zionsville Meadows. The employee identified as having pulled out a cellphone during meal service on 4/6/17 at 11:36 (dietary aide #3) was corrected the instant the issue was identified. 4.Dining Room service contamination issues and cell phone usage will be monitored via Dining Room Manager Observation checklist completed daily. Results of those checklists will be compiled monthly to the for review at the Quality Assurance and Performance Improvement meeting for 6 consecutive months 95%. Results of those checklists	05/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Facility/Community Employee Handbook," received on 4/11/17 at 2:09 p.m., indicated, "The use of personal pagers or cell phones is not permitted during working hours..." A current policy, dated March 2014, titled, "American Senior Communities Facility/Community Employee Handbook," received on 4/11/17 at 2:09 p.m., indicated, "Good sanitary food handling practice with sanitary conditions maintained in the storage, preparation and serving areas will be carried out at all times."		will be compiled quarterly for review at the Quality Assurance and Performance Improvement committee meeting for 2 additional quarters at 95%. Any issues that are discovered by the team will result in the development of a Corrective Action Plan to immediately address.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure new employees had a second tuberculosis (TB) screening one to three weeks after their first TB screening for 3 of 10 employee records reviewed for tuberculosis screening. Findings include: On 4/7/17 at 1:40 p.m., State Form 5440, Employee Records," was provided by the Assistant Business Office Manager. Ten (10) employee records were reviewed for proof of tuberculin (TB) screening upon hire. 1. CNA (Certified Nursing Assistant) 6, with a hire date of 2/22/17, was administered the first step TB skin test on 2/20/17. The second step was not administered until 3/20/17. 2. Dietary Aide 7, with a hire date of 2/1/17, was administered the first step TB skin test on 1/3/17. The second step was not administered until 2/1/17. 3. LPN (Licensed Practical Nurse) 8, with a hire date of 2/15/17, was	R 0410	1.Tuberculin skin test was redone for CNA #6, Dietary Aide #7, and LPN #8. 2.All residents have the potential to be affected by this alleged deficient practice. American Senior Communities Director of Nursing Specialist will educate the Clinical Education Coordinator and the Director of Nursing on Employee Screening by 5-15-17. An audit was completed by the Executive Director/Designee of all staff PPD/TB screening. All employees not having a second step PPD within the policy of Zionsville Meadows had a new PPD administered. 3.American Senior Communities Director of Nursing Specialist will educate the Clinical Education Coordinator and the Director of Nursing on Employee Screening by 5-15-17. An audit was completed by the Executive Director/Designee of all staff PPD/TB screening. The CEC/Designee will administer the PPD skin test per facility policy. The CEC will maintain a separate file with all staff PPDs due each month. The form will be filled out completely and accurately per facility policy. 4.The personnel and Employee File Checklist will be used on all	05/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	04/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administered the first step TB skin test on 2/2/17. The second step was not administered until 2/28/17. During an interview on 4/7/17 at 1:50 p.m., the DNS (Director of Nursing Services) indicated she understood the employee's two step TB skin tests were out of compliance. The second steps tests should have been completed within 14 to 21 days from the first step. On 4/7/17 at 2:00 p.m., the DNS provided a document titled, "Tuberculosis (TB) Screening for Employees ," and indicated the policy was the one currently being used by the facility. The policy indicated, "POLICY: To promote resident and employee safety and well-being by screening employees for tuberculosis...1. Pre-employment screening...A two step screening is required...PROCEDURE for Tuberculin Skin Testing (TST)...4. a. Two-step procedure-initial injection followed by a second injection 1-3 weeks later...."		new employee files to ensure 1st and 2nd step per policy. The Employee File Checklist results will be presented to the Quality Assurance and Performance Improvement committee monthly for 6 consecutive months with 95% expected threshold. The Employee File Checklist results will be presented quarterly thereafter for one year. If minimum threshold score of 95% is not achieved, a Corrective Action Plan will be developed to ensure compliance. Employees without PPD per American Senior Communities will be removed from schedule	