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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Nursing Home Complaints IN00251416, IN00249582, IN00251128, and IN00253912. Complaint IN00251416 - Substantiated. No defiencies related to the allegations are cited. Complaint IN00249582 - Unsubstantiated due to lack of suffcient evidence. Complaint IN00251128 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00253912 - Unsubstantiated due to lack of sufficient evidence . Survey dates: February 13, 14, 15, 16, 19, and 20, 2018. Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census Bed Type: SNF/NF: 93 SNF: 0 NF: 0 Residential: 27 Total: 120 Census Payor Type: Medicare: 7 Medicaid: 70 Other: 16	F 0000	March 7, 2018 Mr. Matthew Foster Indiana State Department of Health 2 North Meridian St. Indianapolis, IN 46204 Dear Mr. Foster: Please accept this 2567 Plan of Correction for the Recertification and State Licensure Survey ending February 20, 2018 as our Letter of Credible Allegation and this facility respectfully request a Desk Review in lieu of a post survey revisit on or after March 22, 2018. Thank you for your time in reviewing our plan of correction and please call with any questions.	

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

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2018.		Respectfully, Cathy S. Greene Executive Director Zionsville Meadows Enclosure	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to maintain the dignity for 1 of 1 resident reviewed for dignity (Resident 46). Findings include: 1. During an initial tour on 2/13/18 from 11:20 a.m. until 12:47 p.m., a continuous observation of Resident 46 was completed and the following was observed. At 11:20 a.m., Resident 46 was first observed reclined back in a broda wheelchair with her eyes closed in the T.V. lounge across from the nurses' station. She was positioned leaning on her left side so that her right hip, thigh and bottom were vertically inclined. She was observed wearing pink long pants with the right pants pocket ripped open, so that the skin of her thigh was visible. Her pants were observed scrunched down so that her brief was observed visibly soiled with a dark yellowish and brown stains that had soaked through her brief, so that her pants were also	F 0550	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 respectfully request a Desk Review in lieu of a post survey revisit on or after March 22, 2018. **F 550 Resident Rights/Exercise of Rights** It is the practice of this	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed visibly soiled with a dark yellowish and brown stain. There was a strong odor of urine and feces emanating from Resident 46. At 11:57 a.m., the Social Service Assistant/Chaplin was observed assisting Resident 46 to the assistive dining room. He began pushing her wheelchair out of the T.V. lounge, but stopped and bent over to reposition the residents feet which were hanging to the side of her wheelchair, then continued to wheel her down to the dining room. At 11:59 a.m., Resident 46 was observed placed at a table in the assistive dining room. She scratched and tugged her pants on her right side. At 12:22 p.m., Resident 46 continued scratch at her pants, and bottom, and lift her right leg. At 12:24 p.m., the Minimum Data Set (MDS) Coordinator placed a beverage in front of Resident 46 and addressed her by name. At 12:31 p.m., Certified Nursing Assistant (CNA) 21 removed Resident 46 from the dining room and took her to her room and left. At 12:42 p.m., CNA 21 returned with CNA 23 and they began the process to transfer Resident 46 from her wheelchiar to her bed in order to change her soiled brief. At 12:47 p.m., CNA 23 indicated that in order to have soaked through her brief, pants, and wheelchair cushion, Resident 46 had probably been soiled for a couple of hours. In an interview with the Director of Nursing Services (DNS) on 2/13/18 at 12:50 p.m., she		provider to treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. And to protect and promote the rights of the resident. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Certified Nursing Assistants (C.N.A) #21, #23 and #25 and Licensed Practical Nurse (LPN) #26 were re-educated on resident's rights and dignity, for appropriate checking and changing of incontinent residents, positioning, appropriate dress and identification of residents. •□□□□□□□□ Resident #46 profile was reviewed and updated for resident's toileting pattern.	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated residents who were incontinent should be checked regularly enough to prevent having an accident that soaks through her brief, pants, and wheelchair cushion. 2. On 2/15/18 at 1:47 p.m. Resident 46 was observed sitting in the T.V. lounge with her eyes closed. Liscensed Practical Nurse (LPN) 26 was observed as she attempted to identify Resident 46. LPN 26 called out loudly down the hall to CNA 25 as she approached the nurses' station. LPN 26 asked CNA 25 as she pointed at Resident 46 who the resident was, called her by the wrong name, and asked that she be removed from the TV lounge and taken back to her room to lay down. CNA 25 removed Resident 46 from the TV lounge. On 2/15/18 at 1:50 p.m., in an interview with LPN 26, she indicated she was not familiar with Resident 46 and preferred to keep only her residents near her nurses' station, because she knew them better. On 2/20/18 at 11:25 a.m., in an interview with CNA 25, she indicated it was not appropriate to call a resident by name, or point across the hall or open areas which would have identified a resident. CNA 25 indicated staff should pull each other to the side and speak quietly and privately about the concern or issue, to protect the resident's privacy and dignity. On 2/16/18 at 2:06 p.m., a complete medical chart review for Resident 46 was completed. A most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment, dated 11/21/17. The MDS indicated that Resident 46 was staff assessed to be severely cognitively impaired, required extensive assistance from staff		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** •□□□□□□□□ Residents that require staff assistance with toileting, checking and changing have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Resident profile were reviewed and updated. •□□□□□□□□ Nursing staff was re-educated on Resident Rights and Dignity for appropriate checking and changing of incontinent residents, positioning, appropriate dress and identification of residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Resident profile were reviewed and updated.	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for all transfers, was not steady and only able to stabilize with staff assistance, and was incontinent of bowel and bladder. The MDS indicated active diagnosis' for Resident 46 included but was not limited to: arthritis, osteoporosis, Alzheimer's disease, and contracture of the right and left knee. Care plans for Resident 46 included but were not limited to: "..."[Resident 46] is totally incontinent of bowel and bladder and does not indicate the need to toilet or that incontinence has occurred...." the care plan goal indicated, "...resident will be free from adverse effects of incontinence...." and interventions included but were not limited to, "...check every 2 hours for incontinence..." On 2/13/18 at 1:48 p.m., the Director of Nursing Services (DNS) provided a copy of a current facility policy titled, "Resident Rights" dated, 11/2016. The policy indicated, "...all staff members recognize the rights of residents at all times and resident assume their responsibilities to enable personal dignity, well being, and proper delivery of care... 3.1-3(t)		•□□□□□□□□ Nursing staff was re-educated on Resident Rights and Dignity for appropriate checking and changing of incontinent residents, positioning, appropriate dress and identification of residents, by Clinical Education Coordinator (CEC)/Director of Nursing Services (DNS) 3/22/2018. •□□□□□□□□ Customer Care Representatives round daily Monday through Friday and review at morning IDT meeting of any Resident Rights or Dignity issues. **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.** •□□□□□□□□ The QA tool “Resident Rights“ will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The DNS	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to ensure resident preferences were being followed for 1 of 1 residents being reviewed for preferences (Resident 74). Findings include: During an interview on 2/13/18 at 11:05 a.m., Resident 74 indicated her right arm and leg were not functional, and she was not getting good help with bathing. During a record review on 2/15/18 at 2:19 p.m., Resident diagnoses, included, but were not limited to, " ...hemiplegia, right side dominant, unspecified cerebrovascular disease, unsteadiness on feet, aphasia following cerebral infarction, paralytic gait, abnormal gait and mobility, and muscle weakness." During a record review on 2/15/18 at 2:26 p.m., Resident care plan, revised date 2/15/18, indicated, "Self care deficit ...requires physical assist from staff for ADL's." A document, titled, "ACS Preferences for Customary Routine and Activities," dated 1/24/18,	F 0561	**F 561 Self Determination** It is the practice of this provider to ensure resident preferences are being followed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Resident #74's "ASC Preferences for Customary Routine and Activities" form was reviewed immediately, resident was interviewed for specific shower days and the profile, shower schedule and the Care Plan was updated for the resident's preference of showers. •□□□□□□□□ LPN #14 was in-serviced on monitoring	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was provided by the Director of Nursing Services (DNS) on 2/15/18 at 3:15 p.m. Regarding showers, it indicated Resident 74 requested, "more than twice per week in the AM." During an interview on 2/15/18 at 3:25 p.m., Licensed Practical Nurse (LPN) 14 indicated Resident 74 currently received showers on Wednesdays and Saturdays. During a record review of shower sheets provided by the facility, it was found the shower sheets during the time Resident 74 had requested 2 showers per week were completed, except for the following: she received a shower on 12/24/17, and not again until 1/3/18, a lapse of 10 days and showered on 1/21/18, and not again until 1/27/18, a lapse of 6 days. During the time, after the change of preferences on 1/24/18, to showers more than twice a week, the showers were completed, except for the following: the week of 1/28/18 to 2/3/18: she received 2 showers on 1/28/18 and 1/31/18, the week of 2/4/18 to 2/10/18: she received 2 showers on 2/4/18 and 2/10/18. During an interview on 2/15/18 at 3:31 p.m., the DNS indicated Resident 74 was not getting showered according to her preferences, more than 2 per week. This was because the facility had not updated the Resident's preferences for the rest of the staff on 1/24/18. The resident should have been showered per her preference. All shower sheets should have been in the shower sheet binder at the nurse's station. During an interview on 2/19/18 at 11:34 a.m., the DNS indicated prior to the updated resident preference sheet on 1/24/18, the resident should have received showers twice a week on Wednesdays and Saturdays.		preference sheets, profiles and shower schedule immediately. •□□□□□□□□ New and updated preference forms will be brought to morning meeting to review and update profiles and care plans by the IDT team. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** •□□□□□□□□ Residents who have specific preferences have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Resident profile and preference forms were reviewed and updated. •□□□□□□□□ Nursing staff was in-serviced on monitoring preference sheets, profiles and shower schedule, by Clinical Education Coordinator (CEC)/Director of Nursing	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 2/19/18 at 12:13 p.m., Resident 74 indicated regarding her showering schedule; she was "afraid of smelling bad in front of other people, ...it was significant because she felt very dirty and rotten, ...it was awful not to get showers, and it was just very dirty." A policy, titled, "Preferences for Daily Routine," revision date, 12/2015, was provided by the Executive Director on 2/19/18 at 3:37 p.m. It indicated the, "Activity Director or designee will complete the Preferences for Daily Customary Routines worksheet upon admission of a new resident, quarterly and upon significant change of a resident. ...The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences." 3.1-38(a)(3)		Services (DNS) 3/22/2018. •□□□□□□□□ New and updated preference forms will be brought to morning meeting to review and update profiles and care plans by the IDT team. •□□□□□□□□ Customer Care Representatives round daily Monday through Friday and review at morning IDT meeting of any Resident Rights or Dignity issues. •□□□□□□□□ Customer Care Representatives round daily Monday through Friday and review at morning IDT meeting of any residents preference in regards to showers. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ New and updated preference forms will be brought to morning meeting to review and update profiles and care plans by the IDT team.	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			•□□□□□□□□ Nursing staff was in-serviced on monitoring preference sheets, profiles and shower schedule, by Clinical Education Coordinator (CEC)/Director of Nursing Services (DNS) 3/22/2018. •□□□□□□□□ During daily rounds will review shower book to ensure showers are being given by IDT team. **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.** •□□□□□□□□ The QA tool "Resident Rights" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans 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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review, and interview, the facility failed to ensure services were provided according to a plan of care for 1 or 6 residents reviewed for falls, resulting in a fall with injury (Resident 15). Findings include: A record review for Resident 15, was completed on 2/16/18 at 9:57 a.m. The record indicated the resident had diagnosis to include but were not limited to: Alzheimer's disease, a history of syncope (loss of consciousness) and collapse, and status post fracture of the right femur from a fall. A Situation-Background-Assessment-Recommendation (SBAR), dated 2/11/18 at 7:36 a.m. indicated, "Resident 15 had an unwitnessed fall with a right head laceration, obtain neuro checks every 4 hours, and call the physician with changes." A fall event form, dated 2/11/18 at 6:40 a.m., indicated, the Resident 15 experienced an unwitnessed fall. The resident was observed	F 0656	**F 656 Develop/Implement Comprehensive Care Plan** It is the practice of this provider to ensure services are provided according to Plan of Care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Resident #15 bed was immediately placed against the wall for fall prevention intervention. •□□□□□□□□ LPN #6, #18, #35 and Unit Manager #17 were re-instructed on reviewing and following Resident Profile form, by	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sitting on the floor, upright next to the bed. The resident could not state how the fall occurred, a gash above right eyebrow with a small skin tear measuring 3 cm (centimeter) x 1 cm x 0.3 cm deep. Dysem (non-slip material) was placed underneath the mattress to maintain resident safety. On 2/19/18 at 2:07 p.m., a Johns Hopkins Fall Risk Assessment Tool, indicated a score of 11 points. A score of 6-13 total points indicated the resident was a moderate fall risk. On 2/19/18 at 9:30 a.m., Director of Nursing Services (DNS) provided copy of a document, titled, "Event Report", dated 2/11/18. The report indicated, "Resident reviewed for unwitnessed fall...Resident was found by the assigned aide sitting upright beside bed, resident could not state what happened...Noted with two lacerations with swelling and small amount of bleeding noted to right eye lid...This writer and charge nurse inspected room and noted mattress slightly dislodged...Team determined root cause of fall possibly related to sliding off bed during transfer due to shifted mattress...." On 2/19/18 at 9:30 a.m., the DNS provided a document, titled, "Care Plan History", dated 12/20/17. The care plan indicated, "Problem: Sadie is a fall risk related to Osteoporosis, and impaired gait/balance, dementia, and Alzheimer's disease. She does have a history of falls. She is able to voice her needs to staff but due to dementia process staff must also anticipate her needs, she sometimes attempts to transfer self despite history of falls and staff encouragement to request assist...Goal: Res will have no injury related to falls. Approaches: Dycem under mattress, fall risk, bed against wall, offer assist to lie down after meals, call light in reach, non-skid socks or shoes,		CEC/DNS immediately and by 3-22-18. **How will you identify other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ Residents with fall interventions have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Resident profile and preference forms were reviewed and updated. •□□□□□□□□ Nursing staff was in-serviced on monitoring preference sheets, profiles and following Care Plans by Clinical Education Coordinator (CEC)/Director of Nursing Services (DNS) 3/22/2018. •□□□□□□□□ New and updated preference forms will be brought to morning meeting to review and update profiles and care plans by the IDT team. **What measures will be put into place or what**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provide assist as needed for toileting, and refer to therapies for screening ..." On 2/13/18 at 10:35 a.m., Resident 15 was observed with steri strips above her right eye, and crusted blood around the strips. Licensed Practical Nurse (LPN) 35 indicated, the resident had fallen on 2/2/18. An observation of her room indicated her bed was in the middle of her side of the room. On 2/14/18 at 9:33 a.m., Resident 15 was observed, propelling herself out of the dining/activity room, and indicated to staff she was going to the bathroom. An observation of her room indicated her bed was positioned in the middle of her side of the room. On 2/16/18 at 11:24 a.m., the resident was observed propelling herself out of the dining/activity room after indicating she needed to go to the bathroom, staff prompted her with her room number. An observation of her room indicated her bed was positioned in the middle of her side of the room. On 2/19/18 at 11:12 a.m., an observation of Resident 15's room, the bed was positioned in the middle of her side of the room. On 2/19/18 at 11:21 a.m., Unit Manager 17, provided a copy of documents, titled, "Resident Profile", dated 9/8/17 and 2/19/18. Both profiles indicated, 5/7/15 bed against wall. On 2/16/18 at 9:35 a.m., Unit Manager 17 indicated, "Resident 15 doesn't have falls often, she routinely transfers in and out of bed, and to and from her wheelchair. She can ambulates short distances such as few steps independently by		**systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Resident profile and preference forms were reviewed and updated, Customer Care Representatives validate profile interventions in place for residents. •□□□□□□□□ Nursing staff was in-serviced on monitoring preference sheets, profiles and following Care Plans by Clinical Education Coordinator (CEC)/Director of Nursing Services (DNS) 3/22/2018. •□□□□□□□□ New and updated Customer Care Representatives forms will be brought to morning meeting to review and update profiles and care plans by the IDT team. **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
	155620	A. BUILDING 00 B. WING	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	grabbing bed rails, bars or the bed, and will transfer independently in the bathroom. She can propel herself from her room to the dining room, but likes staff to push her. There was a recent fall on 2/12/18 when the resident was transferring out of the bed into her wheelchair." On 2/16/18 at 9:41 a.m., LPN 6 indicated, "Resident 15 fell on 2/12/18 transferring out of bed, possibly because the mattress slid. The resident was found on the floor sitting by the bed, she had a laceration to her head. Fall precaution now include a low bed, dysem under the mattress, locked wheels on the bed, we monitor her, and therapy is to evaluate and possibly pick up for positioning and transfers." On 2/19/18 at 11:15 a.m., LPN 18 indicated, fall interventions were relayed to the care staff during report, and interventions were then put onto the staff care sheet. On 2/19/18 at 11:18 a.m., Unit Manager 17 indicated, "a Resident Profile binder at the nurse's station is utilized for line staff to reference for care and fall preventions. The Minimum Data (MDS) nurse updates the Resident Profile form, and the Unit Manager is probably responsible for printing it off and putting it in the binder. She indicated the resident profile for Resident 15 was not the most up to date, but the most up to date information would be on the computer. Observation of the resident profile in the computer was also in error. She does not remember Resident 15's bed ever being against the wall on this unit." On 2/19/18 at 11:53 a.m., the Director of Nursing Services (DNS) indicated, "when a resident falls, the Interdisciplinary Team (IDT) meets and tries to		•□□□□□□□□ The QA tool "Fall Management" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	determine the cause of the fall. The care plan and resident profile may or may not be updated at that time by the DNS or MDS nurse, the resident profile is not always printed off and placed in the binder although some nurses do. Having the bed against the wall for Resident 15 possibly could have prevented the mattress from dislodging but she was not for sure. The DNS and MDS nurses are responsible for updating care plans, the DNS was not aware Resident 15 had been care planned to have her bed against the wall since 5/7/15." 3.1-35(d)(2)(B)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview, the facility failed to ensure a plan of care was updated to include a mood stabilizing drug for 1 or 4 residents reviewed for behaviors (Resident 83). Findings include: On 2/13/18 at 11:05 a.m., Resident 83 was not observed, the door to his room was closed. Unit Manager 17 indicated, he rarely came out of his room and not to activities. On 2/14/18 at 10:05 a.m., Resident 83 was observed ambulating to the nurse's desk, and requested to use the phone, indicated he had to get out of here. The resident repeated several times, I'm ready to get out of here, I'm packing my suitcase. On 2/14/18 10:13 a.m., Unit Manager 17 indicated, upon admission to the facility, Resident 83 was aggressive towards others, especially when assistance was offered by staff or other residents entered his room. A record review for Resident 83 was completed on 2/15/18 at 1:36 p.m. The resident had diagnosis to include but were not limited to: dementia with behavioral disturbance. Physician's orders indicated, on 10/26/17, Depakote (mood stabilizer) 125 mg (milligrams) daily was ordered. On 11/22/17 the order was increased to Depakote 125 mg twice daily.	F 0657	**F 657 Care Plan Timing and Revision** It is the practice of this provider to ensure a plan of care is reviewed and revised by the Interdisciplinary Team after each assessment. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Resident #83's Care Plan was updated to include his Depakote (mood stabilizer) and Depakote Laboratory work was ordered for baseline and then every 6 months on 2-19-18. •□□□□□□□□ Unit manager #17 was re-in serviced on obtaining lab work for Depakote and updating Care Plans. **How will you identify other residents having the potential to be affected**	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Observation of the electronic record indicated, "Behavior Monitoring", dated, 2/6/18 to 2/19/18. The record indicated, "#1 Res has the potential to become agitated and verbally aggressive towards other residents when they wander into his room, #2 if resident appears agitated while interacting with peers, redirect peer to an activity of their preference. Interventions: #1 Ask resident if he would like his door closed at times, #2 encourage him to participate in activities of his preferences, and #3 remove other residents who might wander in his room immediately." A review was completed of Resident 83's progress notes, dated 10/23/17 to 2/15/18. The notes indicated, aggressive behavioral signs and symptoms to include but were not limited to: a. "On 11/8/17 Resident 83 became agitated when a male peer wandered into his room, he refused to close door for privacy, and indicated, if he comes in here again, he will leave in a body bag... b. On 11/14/17 the resident became agitated and was yelling at a peer to get out of his room... On 11/14/17 the resident became agitated when two males entered his room...does not wish to close his door ... On 11/20/17 the resident was witnessed by activity staff hitting another resident in the trunk. The resident became agitated when the other resident stood next to him and would not move... On 12/20/17, upon entering the dining room, the resident appeared agitated and was walking fast, he hit a couple of chairs that were on his path with his walker..." On 2/19/18 at 9:30 a.m., the DNS provided a document, titled, "Care Plan History", dated 11/20/17. The care plan indicated, Care Plans: Problem: Resident had the potential to become		**aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ Residents who are on Depakote have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Residents who are on Depakote have been reviewed and lab work obtained for baseline and for every six months follow up and Care Plans have been updated. •□□□□□□□□ Nurses, Unit managers, and MDS Coordinators have been in serviced on updating Care Plans and obtaining appropriate lab work for mood stabilizer medications by 3/22/18 by CEC/DNS. •□□□□□□□□ Physicians orders are reviewed every morning in morning meeting and will be monitored for Care Plan updates and appropriate lab work needs for medications by IDT/DNS. **What measures will be put into place or what**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	agitated and aggressive towards other residents when they wandered into his room or enter their personal space. Goal: Resident will not become agitated and will continue to keep his privacy. Approach: If resident appears agitated while interacting with peers, redirect peers to an activity of their preference. Ask the resident if he would like his door closed at times. Encourage him to participate in activities of his preference. Remove other residents who might wander in his room immediately ..." ON 2/16/18 AT 09:49 a.m., LPN 6 indicated, Resident 83 would come out for meals, but liked to keep food in his room. He did not like assistance with care, he liked to keep to himself, and if he went to the dining room he sat by himself. The resident was not aggressive towards other residents, he just didn't like to talk to them, and would keep his door shut as he didn't like other residents in his room ad he didn't interact with them. The resident indicated to everyone he did not want to be here, and he did not participate in activities. The Depakote was increased to 250 mg last month. On 2/19/18 at 2:01 p.m., the DNS indicated, Resident 83 was on Depakote for a mood stabilizer. Upon observation of the care plan, she indicated the Depakote was not addressed. On 2/19/18 02:08 PM DNS indicated, Depakote laboratory levels were not obtained or tracked during the admission from the date the Depakote was initiated, or after the dosage was increased. On 1/31/18 a quarterly Minimum Data Set (MDS assessment was completed. The Brief Interview for Mental Status (BIMS) score of 10, indicated moderately impaired. Extensive assistance of staff		**systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Nurses, Unit managers, and MDS Coordinators have been in serviced on updating Care Plans and obtaining appropriate lab work for mood stabilizer medications by 3/22/18 by CEC/DNS. •□□□□□□□□ Physicians orders are reviewed every morning in morning meeting and will be monitored for Care Plan updates and appropriate lab work needs for medications by IDT/DNS. **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.** •□□□□□□□□ The QA tool "Labs & Diagnostics" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter.	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was required for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. Supervision was required for walking in the room and corridor, and locomotion on and off the unit. The resident was total dependence for shower. The resident experienced behavioral symptoms towards others (e.g., threatening others, screaming at others, and cussing at others). The behaviors put the resident at significant risk for physical illness or injury, the behaviors significantly interfered with the resident's care and participation in activities, put others at significant risk for physical injury, significantly interfered on the privacy or activity of others, and significantly disrupted the care or living environment. On 2/20/18 at 12:24 p.m., the Administrator provided a policy, title, "IDT Comprehensive Care Plan Review", dated 11/2017. The policy indicated, "Policy: It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. 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, nursing, mental and psychosocial needs ...Procedure: Care plan review will be interdisciplinary and should include to the extent possible nursing, social services, activities, dietary, therapy, pharmacy ...Care plan problems, goals and interventions will be updated based on changes in resident assessment/condition, resident preference or family input." 3.1-35(d)(2)(B)		•□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	
F 0684 SS=D	483.25 Quality 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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	§ 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 ensure Physician's orders were followed for 1 of 8 residents reviewed for accidents (Residents 55). Findings include: On 2/14/18 at 11:13 a.m. Resident 55's empty room was observed. A portable oxygen tank was observed sitting on the bedside table in the off position. On 2/13/18 at 11:44 a.m., Resident 55 was observed in the assisted dining room across from the nurses station. She was observed restless, anxious, and had a worried facial expression. She was not observed wearing oxygen. On 2/14/18 at 11:14 a.m. during an attempted interview, Resident 55 was observed sitting in her wheelchair in her room. She was not wearing oxygen and the portable oxygen tank remained off and unused on her bedside table. On 2/15/18 at 10:35 a.m., Resident 55 was observed in the activity room sitting up in her wheelchair. She was not wearing oxygen. On 2/16/18 at 9:32 a.m., Resident 55 was observed	F 0684	**F 684 Quality of Care** It is the practice of this provider to ensure Physician's Orders are followed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Resident #55 oxygen saturation was checked and oxygen applied immediately. •□□□□□□□□ Nurses were instructed on following Physicians orders for oxygen saturation and oxygen application and appropriate documentation immediately. **How will you identify other residents having the potential to be affected by the same deficient**	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in assisted dining room lounge area watching TV. She was not wearing oxygen. On 02/14/18 11:40 a.m. a complete medical chart review was completed for Resident 55. A most recent comprehensive assessment was an admission Minimum Data Set (MDS) assessment, dated 1/13/18. The MDS indicated Resident 55 was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15. Active diagnosis for Resident 55 included but was not limited to: Influenza due to identified novel influenza A virus with pneumonia, and had received antibiotics for 3 of the 7 assessment look back days. The MDS indicated Resident 55 had received oxygen therapy before her admission, and during the 7 day look back period. Physician orders for Resident 55 included but were not limited to, "...check oxygen saturation levels every shift..." ordered on 1/11/18 to continue through 2/18/18, and, "...[to wear] oxygen at per nasal cannula (a device used to deliver supplemental oxygen) titrate (continual measurement and adjustment) up to 4 liters to keep saturation above 90% on every shift...." On 2/19/18 at 2:00 p.m., the Director of Nursing Services (DNS) provided a copy of Resident 55's vitals report since her admission on 1/6/18. The report indicated the Resident's oxygen saturation levels had only been checked and recorded 3 times; 1/8/18, 1/12/18, and 2/15/18. The DON indicated she could not find additional oxygen saturation levels for Resident 55, and that they should have been recorded as ordered so staff could verify Resident 55's oxygen saturation levels were above 90% and would have known		**practice and what corrective action will be taken.** •□□□□□□□□ Residents that are receiving oxygen have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Residents who have oxygen orders have been reviewed, ensured oxygen saturation tasks activated and care plans updated. •□□□□□□□□ Nurses were instructed on following Physicians orders for oxygen saturation and oxygen application and appropriate documentation immediately and by 3/22/18 by CEC/DNS. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Nurses were instructed on following Physicians orders for oxygen saturation and oxygen application and appropriate	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	when Resident 55 needed to be were oxygen or not. In an interview with the Executive Director on 2/19/18 at 3:37 p.m., she indicated there was no facility policy for following physician orders. She indicated, following physician orders was standard practice for quality of care, and all physician orders should be followed at all times. 3.1-37(a)		documentation immediately and by 3/22/18 by CEC/DNS. •□□□□□□□□ Oxygen Saturations and oxygen application will be monitored weekly by unit manager/Medical Records for proper documentation per electronic report. •□□□□□□□□ Oxygen Care Plan added to profile **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.** •□□□□□□□□ The QA tool "Oxygen Therapy" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to follow care planned interventions to prevent falls resulting in an injury for 1 of 8 residents reviewed for accidents (Resident 15), and failed to ensure bed rails were properly installed to prevent injury for 1 of 1 residents reviewed for bed rails (Resident 76), and failed to follow physician orders for transfers to prevent the possibility of accidents for 1 of 8 residents reviewed for accidents (Resident 46). Findings include: 1. On 2/13/18 at 10:35 a.m., Resident 15 was	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** It is the practice of this provider to ensure Care Plan interventions are followed to prevent falls resulting in injury. **What corrective action(s) will be accomplished for**	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed with steri strips above her right eye, and crusted blood around the strips. Licensed Practical Nurse (LPN) 35 indicated, the resident had fallen on 2/2/18. An observation of her room indicated her bed was in the middle of her side of the room. On 2/14/18 at 9:33 a.m., Resident 15 was observed, propelling herself out of the dining/activity room, and indicated to staff she was going to the bathroom. An observation of her room indicated her bed was positioned in the middle of her side of the room. On 2/16/18 at 11:24 a.m., the resident was observed propelling herself out of the dining/activity room after indicating she needed to go to the bathroom, staff prompted her with her room number. An observation of her room indicated her bed was positioned in the middle of her side of the room. On 2/19/18 at 11:12 a.m., an observation of Resident 15's room, the bed was positioned in the middle of her side of the room. A record review for Resident 15, was completed on 2/16/18 at 9:57 a.m. The record indicated the resident had diagnosis to include but were not limited to: Alzheimer's disease, a history of syncope (loss of consciousness) and collapse, and status post fracture of the right femur from a fall. A Situation-Background-Assessment-Recommendation (SBAR), dated 2/11/18 at 7:36 a.m. indicated, Resident 15 had an unwitnessed fall with a right head laceration, obtain neuro checks every 4 hours, and call the physician with changes.		**those residents found to have been affected by the deficient practice.** •□□□□□□□□ Resident #15 bed was immediately placed against the wall for fall prevention intervention. •□□□□□□□□ Resident #76 bed rail secured immediately. •□□□□□□□□ LPN #6, #18, #35 and Unit Manager #17 and C.N.A #21, #21 were re-instructed on reviewing and following Resident Profile form and following care plans related to Hoyer Lift, by CEC/DNS immediately and by 3-22-18. **How will you identify other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ Residents with fall interventions have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Resident profile and preference forms	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A fall event form, dated 2/11/18 at 6:40 a.m., indicated, the Resident 15 experienced an unwitnessed fall. The resident was observed sitting on the floor, upright next to the bed. The resident could not state how the fall occurred, a gash above right eyebrow with a small skin tear measuring 3 cm (centimeter) by 1 cm by 0.3 cm deep. Dysem (non-slip material) was placed underneath the mattress to maintain resident safety. On 2/19/18 at 2:07 p.m., a Johns Hopkins Fall Risk Assessment Tool, indicated a score of 11 points. A score of 6-13 total points indicated a resident was a moderate fall risk. On 2/19/18 at 9:30 a.m., Director of Nursing Services (DNS) provided copy of a document, titled, "Event Report", dated 2/11/18. The report indicated, "Resident reviewed for unwitnessed fall...Resident was found by the assigned aide sitting upright beside bed, resident could not state what happened...Noted with two lacerations with swelling and small amount of bleeding noted to right eye lid...This writer and charge nurse inspected room and noted mattress slightly dislodged...Team determined root cause of fall possibly related to sliding off bed during transfer due to shifted mattress..." On 2/19/18 at 9:30 a.m., the DNS provided a document, titled, "Care Plan History", dated 12/20/17. The care plan indicated, "Problem: Sadie is a fall risk related to Osteoporosis, and impaired gait/balance, dementia, and Alzheimer's disease. She does have a history of falls. She is able to voice her needs to staff but due to dementia process staff must also anticipate her needs, she sometimes attempts to transfer self despite history		were reviewed and updated. •□□□□□□□□ Safety audit of bed rails was completed by Maintenance Director by 3-22-18. •□□□□□□□□ All current residents were reviewed for transfer status orders, profiles updated and care plans reviewed and updated. •□□□□□□□□ Nursing staff was in-serviced on monitoring preference sheets, profiles, and following Care Plans related to Hoyer Lift by Clinical Education Coordinator (CEC)/Director of Nursing Services (DNS) by 3/22/2018. •□□□□□□□□ New and updated preference forms will be brought to morning meeting to review and update profiles and care plans by the IDT team. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Resident	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of falls and staff encouragement to request assist...Goal: Res will have no injury related to falls. Approaches: Dycem under mattress, fall risk, bed against wall, offer assist to lie down after meals, call light in reach, non-skid socks or shoes, provide assist as needed for toileting, and refer to therapies for screening ..." On 2/19/18 at 11:21 a.m., Unit Manager 17, provided a copy of documents, titled, "Resident Profile", dated 9/8/17 and 2/19/18. Both profiles indicated, 5/7/15 bed against wall. On 2/16/18 at 9:35 a.m., Unit Manager 17 indicated, Resident 15 didn't have falls often, she would routinely transfer in and out of bed, and to and from her wheelchair. She could ambulate short distances such as a few steps independently by grabbing bed rails, bars or the bed, and could transfer independently in the bathroom. She could propel herself from her room to the dining room, but liked staff to push her. There was a recent fall on 2/12/18 when the resident was transferring out of the bed into her wheelchair. On 2/16/18 at 9:41 a.m., Licensed Practical Nurse (LPN) 6 indicated, Resident 15 fell on 2/12/18 transferring out of bed, possibly because the mattress slid. The resident was found on the floor sitting by the bed, she had a laceration to her head. Fall precaution now included a low bed, dysem under the mattress, locked wheels on the bed, monitoring her, and therapy was to evaluate and possibly pick up for positioning and transfers. On 2/19/18 at 11:15 a.m., LPN 18 indicated, fall interventions were relayed to the care staff in report, and interventions were then put onto the staff care sheet.		profile and preference forms were reviewed and updated. •□□□□□□□□ Nursing staff was in-serviced on monitoring preference sheets, profiles, reporting maintenance issues immediately and following Care Plans by Clinical Education Coordinator (CEC)/Director of Nursing Services (DNS) by 3/22/2018. **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.** •□□□□□□□□ The QA tool "Bed Rails and Fall Management" will be utilized by the Interdisciplinary Team weekly for four weeks, , Dietary aide #10, #12, Cook #36, Dietary Manager, were instructed I •□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 2/19/18 at 11:18 a.m., Unit Manager 17 indicated, a Resident Profile binder at the nurse's station was utilized for line staff to reference for care and fall preventions. The Minimum Data (MDS) nurse updated the Resident Profile form, and the Unit Manager was probably responsible for printing it off and putting it in the binder. She indicated the resident profile for Resident 15 was not the most up to date, but the most up to date information would be on the computer. Observation of the resident profile in the computer was also in error. She did not remember Resident 15's bed ever being against the wall on this unit. On 2/19/18 at 11:53 a.m., the Director of Nursing Services (DNS) indicated, when a resident falls, the Interdisciplinary Team (IDT) meets and tries to determine the cause of the fall. The care plan and resident profile may or may not be updated at that time by the DNS or MDS nurse, the resident profile was not always printed off and placed in the binder although some nurses did. Having the bed against the wall for Resident 15 possibly could have prevented the mattress from dislodging but she was not for sure. The DNS and MDS nurses were responsible for updating care plans, the DNS was not aware Resident 15 had been care planned to have her bed against the wall since 5/7/15. On 2/19/18 at 1:55 p.m., the DNS provided a policy, titled, "Fall Management Program", dated 11/2017. The policy indicated, "Policy: It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls... Facilities must implement comprehensive, resident-centered fall		Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	prevention plans for each resident at risk for or with a history of falls...4. All residents with a score greater than 0 are considered at risk for falls. 5. Residents who are categorized as moderate to high risk shall have fall interventions implemented based on resident specific risk factors. 6. The resident specific care requirements will be communicated to the assigned caregiver utilizing resident profile or Certified Nursing Assistant (CNA) assignment sheet. 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. The fall event will be reviewed by the team, IDT note will be written, the care plan will be reviewed and updated as necessary." 2. On 2/16/18 at 9:05 a.m., Resident 76 was observed laying in bed. Bed rails were observed, and the right half rail was observed to be very lose. The rail wobbled back and forth, and when pulled upward, it would stick momentarily, then fall back down. Resident 76 indicated she had received the bed rails late Wednesday night (2/14/18) and noticed the rails were lose and asked for them to be tightened. Resident 76 indicated, the night after the rails were installed, she used them to reposition in bed, and the right half rail fell on her hand which had been resting at the edge of the bed. A dark purple bruise the size of a half dollar coin, was observed on the back of Resident 76's right hand between her pointer and middle finger knuckles. Resident 76 indicated it was sore to the touch but she did not want to complain. In an interview with the Director of Nursing Services (DNS), on 2/19/18 at 4:11 p.m. she indicated she had visited with Resident 76 the day before but had not noticed the bruise on her hand and in a subsequent follow up visit, the DNS			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she spoke with Resident 76 about her hand, and was told by Resident 76 how she received the injury from the lose bed rail falling on the back of her hand. The DNS indicated upon installation the bed rails should have been installed properly to prevent any injuries to the resident. On 2/15/18 at 9:11 a.m., a complete medical chart review for Resident 76 was completed. A most recent complete comprehensive assessment was a 14 day Minimum Data Set (MDS) assessment dated 2/3/18. The MDS indicated Resident 76 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out of 15, and needed extensive assistance of two or more staff for bed mobility. The MDS indicated Resident 76 had active diagnosis to include but not limited to: heart failure, shortness of breath, and muscle weakness. Resident 76 had physician orders to include but not limited to: positioning devices bilateral 1/2 side rails while in bed to enhance bed mobility, ordered on 2/14/18. Care plans for Resident 76 included but were not limited to needing assistance with bed mobility, which included the goal for improved functional status with an intervention of using bilateral half bed rails for bed mobility and positioning. On 2/20/18 at 12:10 p.m., the Executive Director provided a copy of a current policy titled, "Bed Rail Safety Assessment" dated 11/2017. The policy indicated it was the facilities responsibility, "...to ensure bed rails utilized in the facility are safely and appropriately secured to the bed...the bed rails safety check will be completed upon initiation or change of any bed rail..."			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. On 2/13/18 at 12:42 p.m., during a resident transfer observation, Certified Nursing Assistants (CNA) 21, and 23 entered Resident 46's room. CNA 21 indicated the resident had a soiled brief and needed to be changed before lunch. He indicated he asked CNA 23 to come help because Resident 46 was a 2-person lift/transfer. CNA 21 and 23 begun to sit the resident up in her broda wheel chair, and grasped her by the upper arms and shoulders. CNA 23 stopped the process, and prompted CNA 21 to use a gait belt. CNA 21 asked if he needed to use a gait belt for this transfer, and indicated he did not know, and had not previously used the gait belt for this resident. CNA 23 indicated he did need to use the gait belt and they proceeded to place a gait belt around the residents waist. Once the gait belt was secured, CNA 21 grasped the residents left upper arm and shoulder, while CNA 23 grasped the residents right upper arm and shoulder. On the count of three, both CNAs 21 and 23 lifted Resident 46 off and out of her broda chair, by her arms and shoulder. Her feet were observed to dangle and not tough the ground. CNAs 21, and 23 transferred her diagonally onto her bed. During the transfer, neither CNA held the gait belt, because they were grasping the residents arms and shoulders. During the transfer, Resident 46 yelled out in a startled grabbled voice, the expression on her face changed from calm with her eyes closed, to startled with her eyes open and darting. In an interview with the DON on 2/13/18 at 12:50 p.m. and she indicated Resident 46 was non-weight being and required a Hoyer lift and transfer at all times. In an interview with CNA 24 on 2/20/18 at 9:34			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a.m., she indicated staff should never lift someone who was non-weight bearing by the arms or shoulders, because it could have the potential to cause soreness, bruising, or possible dislocation of the shoulder depending on the frailty of the resident. In an interview with the Clinical Education Coordinator on 2/20/18 at 9:55 a.m., she indicated Resident 46 was non-weight bearing and much too frail to be grasped on the arm and a Hoyer lift should have been used. On 2/16/18 at 2:06 p.m., a complete medical chart review for Resident 46 was completed. A most recent comprehensive assessment was a quarterly MDS assessment, dated 11/21/17. The MDS indicated Resident 46 was staff assessed to be severely cognitively impaired, and required extensive assistance from staff for all transfers and was not steady and only able to stabilize with staff assistance. The MDS indicated active diagnosis' for Resident 46 included but was not limited to: arthritis, osteoporosis, Alzheimer's disease, contracture of the right and left knee. Physician orders for Resident 46 included but were not limited to: "...positioning devices, transfer with Hoyer lift with assistance of 2 staff members...." ordered on 5/13/2016. Care plans for Resident 46 included but were not limited to: "... [Resident 46] is at risk for injury due to history of falls, unable to ambulate (walk or move about), requires extensive assist from staff for transfers...." her care plan intervention included but was not limited to: "... use Hoyer lift for transfers...." On 2/13/18 at 1:48 p.m., the DON provided a copy			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the facilities current policy titled, "Transfer to Chair/Wheelchair- Two Person" dated, 4/2012. The policy indicated, "...Resident must be able to stand or partially stand with assistance. If unable to stand a mechanical lift should be used..." 3.1-45(a)(2)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure staff washed their hands for the recommended amount of time, after touching residents and soiled objects, and before assisting residents with their meals and feeding residents their meals for 2 of 2 observations (Residents 293, 30, 64, 42, and 28).	F 0812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** It is the practice of this provider to ensure staff wash their hands for the	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The facility further failed to ensure beard covers and hair nets were worn in the kitchen during food preparation and service. This deficient practice had the potential to affect 93 of 93 residents who received food and beverages prepared, and served, to the residents out of the kitchen. Finding include: 1a. On 2/13/18 at 11:40 a.m., Certified Nursing Assistant (CNA) 19 and Activity Aide 20 were observed washing their hands in the Cottage unit dining room. CNA 19 did not use paper towel to turn the faucet off, Activity Aide 20 did not use paper towel to turn the water off, and washed her hands less than 10 seconds. Both employees proceeded to serve drinks to the 23 residents that resided on the unit. On 2/13/18 at 11:44 a.m., Activity Aide 20 was observed to reposition Resident 92's wheel chair, then poured and served drinks to Residents 8 and 62. On 2/13/18 at 11:47 a.m., CNA 34 was observed rubbing her face and pushing her hair back, then she served soup to residents in the Cottage dining room, she was not observed washing her hands during the meal service. On 2/13/18 at 11:49 a.m., CNA 19 and Activity Aide 20 were observed washing their hands in the Cottage dining room, paper towel was not utilized to turn the faucet on or off. Activity Aide 20 repositioned Resident 22 in her wheel chair and then resumed serving the dining room. CNA 19 sat down to feed Resident 22. On 2/13/18 11:53 a.m., Activity Aide 20 was observed washing her hands without using paper		recommended amount of time, after touching residents and soiled objects, and before assisting residents with their meals and feeding residents their meals. Also, to ensure beard covers and hair nets are worn in the kitchen during food preparation and service. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Residents #8, #28, #30, #42, #62, #92 all had the potential to be affected by the alleged deficient practice. •□□□□□□□□ C.N.A. #19, #34, #7, #6, Activity Aide #20, LPN #6, #14, were instructed on proper handwashing with the handwashing skills validation form by CEC/DNS immediately •□□□□□□□□ Dietary aide #10, #12, Cook #36, Dietary Manager, were instructed on proper wearing of hair nets	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	towel and used her bare hands to turn the faucet off, she flipped the water off her hands, then continued to serve soup and drinks. On 2/14/18 at 1:50 p.m., Licensed Practical Nurse (LPN) 6 indicated, "handwashing should take between 45-60 seconds from start to finish. The process is to wet hands with water, a temperature agreeable to you, apply soap, briskly rub hands together between fingers and on top, bottom, the knuckles, rub the fingernails and palm backs, it's good to sing happy birthday about 3 times, rinse, grab paper towel and dry hands, then use a clean paper towel to turn off the faucet. Hands should be washed again usually after every 3rd tray and use gel in between, or if helping a resident and contact is made with the resident or wheelchair the hands wound need to be washed again. If hand gel is used rub hands briskly for 23-30 seconds." On 2/20/18 at 12:19 p.m., the Administrator (ADM) provided a document, titled, "Midnight Census Worksheet, dated 2/13/18. The document listed the 23 residents that were present in the Cottage dining room for lunch on 2/13/18.1b. During an observation on 2/13/18 at 12:52 p.m., in the Maple dining room, Licensed Practical Nurse (LPN) 14 rubbed her nose with her right hand, then assisted Resident 293 with drinking fluids from a glass with her right hand. 1c. During an observation on 2/13/18 at 12:45 p.m., in the Sycamore dining room, CNA 6 washed her hands for 8 seconds, then assisted Resident 30 by wiping his mouth, without further handwashing, she assisted Resident 64 by cutting his sandwich in half. During an observation on 2/13/18 at 12:48 p.m., in		and beard nets while in the kitchen and service areas by CEC/RD. **How will you identify other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ All Residents have the potential to be affected by the alleged deficient practice. •□□□□□□□□ All staff were instructed on proper handwashing with the handwashing skills validation form by CEC/DNS immediately and by 3/22/18 •□□□□□□□□ Dietary staff, were instructed on proper wearing of hair nets and beard nets while in the kitchen and service areas by CEC/RD immediately and by 3/22/18. •□□□□□□□□ Staff will be monitored for proper handwashing and Hair restraint use during all meals and in food prep areas by	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Sycamore dining room, CNA 6 washed her hands for 9 seconds, then proceeded to assist Resident 42 with eating. During an observation on 2/14/18 at 8:54 a.m., CNA 7 pushed Resident 28's wheelchair to the Sycamore dining room, afterward she washed her hands for 5 seconds. During an observation on 2/14/18 at 8:54 a.m., CNA 7 washed her hands for 7 seconds before assisting Resident 28 with eating breakfast in the Sycamore dining room. During an interview on 2/19/18 at 9:27 a.m., the Director of Nursing Services (DNS) indicated hand washing from start to finish should have been 40-60 seconds, with a hand lather of 20 seconds or sing Happy Birthday three times. On 2/19/18 at 3:37 p.m., the Administrator provided a document, titled, "Your 5 Moments for Hand Hygiene by the World Health Organization", undated. The document indicated, "1. Before touching a patient, to protect the patient against harmful germs carried on your hands. 2. Before clean/aseptic procedure, to protect the patient against harmful germs, including the patient's own, from entering his/her body. 3. After body fluid exposure risk, to protect yourself and the health-care environment from harmful patient germs. 4. After touching a patient, to protect yourself and the health-care environment from harmful patient germs. 5. After touching patient surroundings, to protect yourself and the health-care environment from harmful patient germs." The Indiana State Department of Health, "Retail Food Establishment Sanitation Requirements-		managers on walking rounds. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ All staff were instructed on proper handwashing with the handwashing skills validation form by CEC/DNS immediately and by 3/22/18 •□□□□□□□□ Dietary staff were instructed on proper wearing of hair nets and beard nets while in the kitchen and service areas by CEC/RD immediately and by 3/22/18. •□□□□□□□□ Staff will be monitored for proper handwashing and hair restraint use during all meals and in food prep areas by managers on walking rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Title 410 IAC 7-24," dated November 13, 2004, indicated "410 IAC 7-24-128: Hand cleaning and drying procedure., Sec. 128. (a) Food employees shall, except as specified in section 343(c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified under section 342(a) of this rule by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water having a temperature of at least one hundred (100) degrees Fahrenheit and thoroughly rinsing with clean water." 2. During an observation on 2/13/18 at 12:20 p.m., the Kitchen manager was in the kitchen with the front of her hair out of the hair net. During an observation on 2/13/18 at 12:25 p.m., Dietary Aide 10 was in the kitchen with a hair net only covering the top of her head, the sides and back of long braids were out of the hair net. During an interview on 2/13/18 at 12:31 p.m., the Registered Dietician (RD) indicated the kitchen manager and Dietary Aide 10 should have had all their hair covered while in the kitchen. During an observation on 2/13/18 at 12:34 p.m., while in the kitchen, the front of the Kitchen Manager's hair was out of the hair net and Dietary Aide 12 was not wearing a beard cover. During an interview on 2/13/18 at 12:35 p.m., the Kitchen Manager indicated all of her hair should have been covered in the kitchen, and Dietary Aide 12 was non-compliant with the beard cover around his neck and not covering his beard. During an interview on 2/19/18 at 9:23 a.m., the		**program will be put into place.** •□□□□□□□□ The QA tool "Infection Control Review & Appropriate Use of hair coverings" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Executive Director (ED) indicated all hair should have been covered while staff was in the kitchen. On 2/19/18 at 3:14 p.m. Cook 36 was observed not properly wearing a beard restraint so that long facial hair on his cheecks and mustache were not covered as he handled clean dishes. A policy was provided by the Executive Director on 1/17/18 at 2:43 p.m. It was titled, "Hair/Beard Policy," dated 10/13. The policy indicated, "Anyone entering a kitchen area will locate a hairnet and/or beard guard and wear it throughout their time in the kitchen and/or while handling food. ...Beard guards will be available to men with beards." 3.1-21(a)(3)			
F 0880 SS=E 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			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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; (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.			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§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 observation, interview, and record review, the facility failed to ensure adequate hand wash during medication administration for 3 of 7 residents observed for medication administration (Resident 11, 45, and 87). Findings include: During an observation of medication administration on 2/15/18 at 8:20 a.m., Licensed Practical Nurse (LPN) 5 washed her hands for 10 seconds after she provided blood glucose monitoring for Resident 45, then went back to the medication cart. During an observation of medication administration on 2/15/18 at 8:32 a.m., Licensed Practical Nurse (LPN) 5 washed her hands for 13 seconds before giving Resident 87 an injection of insulin. During an observation of medication administration on 2/15/18 at 8:35 a.m., Licensed Practical Nurse (LPN) 5 washed her hands for 10 seconds after giving Resident 87 an injection of insulin. Without further hand washing, LPN 5 gave medications to Resident 11. During an interview on 2/19/18 at 9:27 a.m., the Director of Nursing Services (DNS) indicated	F 0880	**F 880 Infection Control & Prevention** It is the practice of this provider to ensure adequate handwashing during medication administration. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ Residents #11, #45, #87, all had the potential to be affected by the alleged deficient practice. •□□□□□□□□ LPN #5, were instructed on proper handwashing with the handwashing skills validation form by CEC/DNS immediately **How will you identify other residents having the**	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hand washing from start to finish should have been 40-60 seconds, with a hand lather of 20 seconds. Or sing Happy Birthday three times. A policy, titled, "Hand Hygiene," revision date, 12/2015, was provided by the DNS on 2/19/18 at 10:25 a.m. It indicated the duration of the entire hand washing procedure should have been 40 -60 seconds, with the five moments for hand hygiene as: before touching a patient, before clean/aseptic procedure, after body fluid exposure risk, after touching a patient, and after touching patient surroundings. 3.1-18(l)		**potential to be affected aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ All Residents have the potential to be affected by the alleged deficient practice. •□□□□□□□□ All staff were instructed on proper handwashing with the handwashing skills validation form by CEC/DNS immediately and by 3/22/18 •□□□□□□□□ Staff will be monitored for proper handwashing during medication administration by managers on walking rounds. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ All staff were instructed on proper handwashing with the handwashing skills validation form by CEC/DNS immediately and by 3/22/18	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			•□□□□□□□□ Staff will be monitored for proper handwashing during medication administration by managers on walking rounds. **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.** •□□□□□□□□ The QA tool "Infection Control Review" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The DNS and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			22, 2018	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaints IN00251416, IN00249582, IN00251128, and IN00253912. Complaint IN00251416 - Substantiated. No defiencies related to the allegations are cited. Complaint IN00249582 - Unsubstantiated due to lack of suffcient evidence. Complaint IN00251128 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00253912 - Unsubstantiated due to lack of sufficient evidence . Survey dates: February 13, 14, 15, 16, 19, and 20, 2018. Facility number: 000538 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	March 7, 2018 Mr. Matthew Foster Indiana State Department of Health 2 North Meridian St. Indianapolis, IN 46204 Dear Mr. Foster: Please accept this 2567 Plan of Correction for the Recertification and State Licensure Survey ending February 20, 2018 as our Letter of Credible Allegation and this facility respectfully request a Desk Review in lieu of a post survey revisit on or after March	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			22, 2018. Thank you for your time in reviewing our plan of correction and please call with any questions. Respectfully, Cathy S. Greene Executive Director Zionsville Meadows Enclosure	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or			

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a minimum of one awake person, with first aid certification was available for 5 of 21 shifts reviewed for staffing. This deficient practice had the potential to affect 27 out of 27 residents residing in the facility. Finding includes: On 02/20/18 at 11:00 a.m., employee records, and staffing sheets, dated 02/13/17 through 02/19/17, were reviewed. The records lacked indication facility staff had first aid certification for the following shifts. 02/14/18: 3rd shift- no first aid coverage 02/15/18: 2nd shift- no first aid coverage 02/15/18: 3rd shift- no first aid coverage 02/17/18: 1st shift- no first aid coverage 02/18/18: 3rd shift- no first aid coverage On 02/20/18 at 1:32 p.m.,during an interview, the Clinical Director of Residential Care indicated, nursing staff had been scheduled for Cardiopulmonary Resuscitation (CPR), she had been unaware the staff was required to have first aid training. On 02/20/18 at 1:45 p.m., during an interview, the	R 0117	**R 117 Personnel** It is the practice of this provider to ensure a minimum of one awake person, with first aid certification is available. Facility staffs Licensed Nurses. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ All residents residing in the Assisted Living (AL) have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Not all staff on AL are first aid certified, although there was a licensed nurse assigned on every shift. All nursing staff will attend First aid certification by 3-22-18. **How will you identify**	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	General Manager indicated, they did not have a policy on CPR/ first aid traing, the facility follows the State Rules for CPR and first aid training. He was unaware that all shifts were not covered by first aid trained personal.		**other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ All residents residing in the Assisted Living (AL) have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Not all staff on AL are first aid certified, although there was a licensed nurse assigned on every shift. All nursing staff will attend First aid certification by 3-22-18. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Not all staff on AL are first aid certified, although there was a licensed nurse assigned on every shift. All nursing staff will attend First aid certification by 3-22-18. **How the corrective action(s) will be monitored**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. •□□□□□□□□ Facility HR will audit all employee files to ensure files are in compliance with first aid certification by 3-22-18 •□□□□□□□□ The HR and/or Designee is responsible to monitor for compliance. . **Compliant Date: March 22, 2018**	
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 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 beard covers and hair nets were worn in the kitchen during food preparation and dining service. This deficient practice had the potential to affect 27 of 27 residents who received food and beverages prepared, and served, by the facility, in the Villa Dining Room. Findings include:	R 0273	**R 273 Food and Nutritional Services** It is the practice of this provider to ensure staff wash their hands for the recommended amount of time, after touching residents and soiled objects, and	03/22/2018

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1.On 2/20/18 at 11:45 a.m., during an observation in the Villa Dining Room, Cook 28 was observed in the dining room. She was wearing a bouffant cap with her bangs and the sides of her hair protruding out of the cap. She took lunch orders from 4 residents, then entered the kitchen. At 11:52 a.m., Cook 28 returned to the dining room, from the kitchen. The sides of her hair were inside the bouffant cap, her bangs were still partially protruding . She continued to take lunch orders and serve meals from the kitchen, throughout the observation. 2. During an observation on 2/13/18 at 12:20 p.m., the Kitchen Manager was in the kitchen with the front of her hair out of the hair net. During an observation on 2/13/18 at 12:25 p.m., Dietary Aide 10 was in the kitchen with a hair net only covering the top of her head, the sides and back of long braids were out of it. During an observation and interview on 2/13/18 at 12:34 p.m., the Kitchen Manager indicated Dietary Aide 12 was not wearing a beard cover while in the kitchen, and the front of her hair was out of the hair net while she was in the kitchen. During an interview on 2/13/18 at 12:31 p.m., the Registered Dietician (RD) indicated the Kitchen Manager and Dietary Aide 10 should have had all their hair covered while in the kitchen. During an interview on 2/13/18 at 12:35 p.m., the Kitchen Manager indicated Dietary Aide 12 was non-compliant with the beard cover around his neck and not covering his beard, and the front of her hair should have been covered while she was in the kitchen.		before assisting residents with their meals and feeding residents their meals. Also, to ensure beard covers and hair nets are worn in the kitchen during food preparation and service. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** •□□□□□□□□ All residents in the Villa Dining Room had the potential to be affected by the alleged deficient practice. •□□□□□□□□ Dietary aide #10, #12, Cook #28, Dietary Manager, were instructed on proper wearing of hair nets and beard nets while in the kitchen and service areas by CEC/RD. **How will you identify other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** •□□□□□□□□ All Residents	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 2/19/18 at 9:23 a.m., the Executive Director (ED) indicated all hair should have been covered while staff was in the kitchen. 3. On 2/19/18 at 3:14 p.m. Cook 36 was observed not properly wearing a beard restraint so that long facial hair on his cheecks and mustache were not covered as he handled clean dishes. A policy was provided by the Executive Director on 1/17/18 at 2:43 p.m. It was titled, "Hair/Beard Policy," dated 10/13. The policy indicated, "Anyone entering a kitchen area will locate a hairnet and/or beard guard and wear it throughout their time in the kitchen and/or while handling food...Beard guards will be available to men with beards."		have the potential to be affected by the alleged deficient practice. •□□□□□□□□ Dietary staff, were instructed on proper wearing of hair nets and beard nets while in the kitchen and service areas by CEC/RD immediately and by 3/22/18. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** •□□□□□□□□ Dietary staff were instructed on proper wearing of hair nets and beard nets while in the kitchen and service areas by CEC/RD immediately and by 3/22/18. •□□□□□□□□ Staff will be monitored for proper wearing of hairnets and beard nets throughout shifts by managers on walking rounds. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.,**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			what quality assurance program will be put into place. •□□□□□□□□ The QA tool "Infection Control Review" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. •□□□□□□□□ The Dietician and/or Designee is responsible to monitor for compliance. •□□□□□□□□ The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: March 22, 2018**	

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	02/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE