PRINTED: 03/27/2018

	T OF HEALTH AND HU R MEDICARE & MEDIO						FORM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  03/06/2018	
NAME OF	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD FORD RD		
ZIONSVILLE MEADOWS				SVILLE, IN 46077			
(X4) ID				ID PROVIDER'S PLAN OF ( EACH CORRECTIVE ACTIO			(X5)
PREFIX TAG	·	NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)		COMPLETION DATE
E 0000							
Bldg	conducted by the In Health in accordant Survey Date: 03/0 Facility Number: Provider Number: AIM Number: 100 At this Emergency Zionsville Meadow compliance with E Requirements for In Participating Provides 3.73  The facility has 18 the survey, the cent Quality Review conduction of the International Conduction of the I	000538 155620 0267290  Preparedness survey, ws was found in substantial Emergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR  S certified beds. At the time of issus was 126.  Impleted on 03/12/18 - DA  t 42 CFR, Subpart 483.73 is NOT	E 00	000	March 23, 2018  Mr. Matthew Foster Indiana State Department Health 2 North Meridian St. Indianapolis, IN 46204  Dear Mr. Foster; Please accept this 2567 P Correction for the Life Safe with Emergency Prepared Survey ending March 6, 2 our Letter of Credible Allegand this facility respectfully request a Desk Review in post survey revisit on or at 5, 2018.  Thank you for your time in reviewing our plan of correand please call with any questions.  Respectfully,  Cathy S. Greene Executive Director Zionsville Meadows	Plan of fety Code Iness 018 as gation y lieu of a fter April	
E 0018 SS=C					Enclosure		
Bldg	I		- 1				I

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

Based on record review and interview, the facility

failed to ensure emergency preparedness policies

and procedures include a system to track the

TITLE

The creation and submission of

this Plan of Correction does not

constitute an admission by this

(X6) DATE

04/05/2018

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZGDL21 Facility ID: 000538 If continuation sheet Page 1 of 23

E 0018

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/06/2018	
PROVIDER OR SUPPLIEI	<b>R</b>	STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077				
SUMMARY (EACH DEFICIENT REGULATORY OF The Properties of the record residents are relocated as a coordance with deficient practice of the record residents are resident practice of the record resident properties of the recor	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION staff and sheltered residents is care during and after an auty staff and sheltered ted during the emergency, the document the specific name and iving facility or other location 42 CFR 483.73(b) (2). This bould affect all occupants.  Wiew with the Administrator on .m., the facility failed to ensure dness policies and procedures track the location of on-duty residents in the LTC facility's er an emergency. If on-duty residents are relocated during LTC facility must document and location of the receiving ation. Based on inter vie at the eview, the Administrator the facility emergency ailed to ensure emergency es and procedures include a location of on-duty staff and in the LTC facility's care		675 S F	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  provider of any conclusion set in the statement of deficiencie of any violation of regulation. This provider respectfully request 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 April 5, 2018  E018 Procedure for tracking Staff and Patients It is the practice of this provide ensure emergency prepared in policies and procedures included system to track the location of duty staff and sheltered reside in our facility's care during and after an emergency  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  No direct resident affected this alleged deficient practice.	forth s, or lests on  g of er to ess de a f on ents d	(X5) COMPLETION DATE
				Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed boar as well as the Evacuation Tractog will be utilized as a means track the staff and residents dithe emergency  How will you identify other residents having the potentiato be affected by the same deficient practice and what	cking s to uring	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21 Facility ID: 000538

If continuation sheet Page 2 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/06/2018		
	PROVIDER OR SUPPLIE	R	•	675 S F	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					corrective action will be take All residents have the poter to be affected by the alleged deficient practice. Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed boar well as the Evacuation Trackir Log will be utilized as a means track the staff and residents de the emergency  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed boar well as the Evacuation Trackir Log will be utilized as a means track the staff and residents de the emergency Above mentioned forms will updated monthly by Maintenan Director/Designee Staff will be re-educated on tracking procedure by Maintenance Director/SDC/Designee at Disaster training by 4-5-18.	rd as ng s to uring  rd as ng s to uring	
					How the corrective action(s) will be monitored to ensure t deficient practice will not recur, i.e., what quality assurance program will be p		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 000538

ZGDL21

into place.

If continuation sheet

Page 3 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155620	A. BUILDING B. WING			COMPLETED 03/06/2018	
		100020	12		DDDDGG GWY GTATE TID GOD	00/00/	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
ZIONSVI	LLE MEADOWS				/ILLE, IN 46077		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	P	REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
E 0030 SS=C Bldg	Based on record rev failed to ensure the communication plar contact information Entities providing stresidents' physiciar Volunteers in accord (1). This deficient p occupants.  Findings include:  Based on record rev 10:37 a.m. on 03/06 the emergency prep includes (1) Names	iew and interview, the facility emergency preparedness includes (1) Names and for the following: (i) Staff (ii) ervices under arrangement (iii) as (iv) Other LTC facilities (v) dance with 42 CFR 483.73(c) ractice could affect all iew with the Administrator at /18, the facility failed to ensure aredness communication plan and contact information for aff (ii) Entities providing	E 003	30	The QA tool "Disaster and Emergency Preparedness" wi utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter.  The Maintenance Director/Designee is responsit to monitor for compliance mor on Preventive Maintenance rounds.  The QAPI Team reviews the audits monthly and action plar are developed as needed if threshold of 90% is not met to ensure continual compliance.  Compliant Date: April 5, 201  E030 Names and Contact Information It is the practice of this provide ensure the emergency preparedness communication includes names and contact information for the following, Sentities providing services und arrangement, Residents' physicians, other LTC facilities and volunteers.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	ble athly ens 8	04/05/2018

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21 Facility ID: 000538

If continuation sheet Page 4 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/06/2018
	PROVIDER OR SUPPLIE	R	675 S	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE OPRIATE COMPLETION DATE
	physicians (iv) Oth Based on interview the Building Mana failed to ensure en communication pla contact information Entities providing	ingement (iii) Residents' her LTC facilities (v) Volunteers. It at the time of record review, her ger acknowledged the facility hergency preparedness her includes (1) Names and her for the following: (i) Staff (ii) hervices under arrangement (iii) hers (iv) Other LTC facilities (v)		No direct resident affect this alleged deficient practives arrangements, Resident physicians, volunteers, other facilities and Resident bed through our Communication will be utilized as a means track the staff and resident the emergency  How will you identify other residents having the potto be affected by the sand deficient practice and with corrective action will be affected by the alleged deficient practice.  Staffing schedule, staffing phone numbers, matrix fa sheets and Resident bed through our Communication will be utilized as a means track the staff and resident through our Communication will be utilized as a means track the staff and resident the emergency  Above mentioned forms updated monthly  Staff will be re-educate tracking procedure by Maintenance Director  SDC/Designee at Disaste training by 4-5-18.  What measures will be publice or what systemic changes you will make to	tice.  ting  ce  tin), s under  her LTC d board on Plan s to tis during  er  ential he hat taken. botential hed  ing ce board on Plan s to tis during  se will be d on the  er  ut into

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21 Facility ID: 000538

If continuation sheet Page 5 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/06/2018	
	PROVIDER OR SUPPLIE	R	675 S I	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION DATE
				ensure that the deficient practice does not recur.  Staffing schedule, staffir phone numbers, matrix fact sheets (including next of kit Entities providing services arrangements, Resident physicians, volunteers, oth facilities and Resident bed through our Communicatio will be utilized as a means track the staff and resident the emergency  Above mentioned forms updated monthly  Staff will be re-educated tracking procedure by Maintenance Director SDC/Designee at Disaster by 4-5-18.  How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place.  The QA tool "Disaster are Emergency Preparedness utilized by the Interdiscipling Team weekly for four week monthly for three months a quarterly thereafter.  The Maintenance Director/Designee is respote to monitor for compliance or on Preventive Maintenance or on Preventive Maintenan	e n), under er LTC board n Plan to s during will be on the training  (s) re the e put e ary ss, and e ary ss, and e stee e monthly e stee e the e the e monthly e stee e the e e the e e monthly e stee e the e e e the e e e the e e e the e e e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

If continuation sheet

Page 6 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION (X3	(X3) DATE SURVEY  COMPLETED  03/06/2018				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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			
				are developed as needed if threshold of 90% is not met to ensure continual compliance.				
E 0035 SS=C				Compliant Date: April 5, 2018				
Bldg	failed to ensure the communication plan information from the facility has determined accordance with 42 deficient practice of Findings include:  Based on record revelocity 10:47 a.m. on 03/06 the emergency prepincludes a method of the emergency plan determined is approfamilies or represented time of record reacknowledged that communication plan sharing information the facility has determined to the f	wiew and interview, the facility emergency preparedness in includes a method for sharing the emergency plan that the med is appropriate with families or representatives in CFR 483.73(c)(8). This could affect all occupants.  Wiew with the Administrator at 6/18, the facility failed to ensure aredness communication plan for sharing information from that the facility has opriate with residents and their statives. Based on interview at the emergency preparedness in failed to include a method for a from the emergency plan that remined is appropriate with families or representatives.	E 0035	Plan with Patients It is the practice of this provider to ensure the emergency preparedness communication play includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  No direct resident affected by this alleged deficient practice. A letter will be sent out to family/responsible parties concerning our procedure for Natural Disasters and other Emergencies annually, it will also be placed in the admission packet for new admits and will be given the residents as well as reviewed with residents at residents council. Staffing schedule, staffing	et to			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $ZGDL21 \qquad {\it Facility ID:} \quad 000538$ 

If continuation sheet

Page 7 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155620	B. WI	ING		03/06	/2018
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					FORD RD		
ZIONSVILLE MEADOWS				ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					phone numbers, matrix face		
					sheets (including next of kin),		
					Entities providing services und	aer	
					arrangements, Resident physicians, volunteers, other I	TC	
					facilities and Resident bed bo		
					will be utilized as a means to	ara	
					track the staff and residents d	urina	
					the emergency	g	
					How will you identify other		
					residents having the potential	al	
					to be affected by the same		
					deficient practice and what		
					corrective action will be take		
					·All residents have the poter	ntial	
					to be affected by the alleged		
					deficient practice.	46.0	
					Staff will be re-educated on	rtie	
					tracking procedure by Maintenance Director/		
					SDC/Designee at Disaster tra	inina	
					by 4-5-18.	g	
					·Staffing schedule, staffing		
					phone numbers, matrix face		
					sheets (including next of kin),		
					Entities providing services und	der	
					arrangements, Resident		
					physicians, volunteers, other l		
					facilities and Resident bed bo	ard	
					will be utilized as a means to		
					track the staff and residents d	uring	
					the emergency		
					·A letter will be sent out to		
					family/responsible parties concerning our procedure for		
					Natural Disasters and other		
					Emergencies annually, it will a	also	
					be placed in the admission pa		
					for new admits and will be give		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21 Facility ID: 000538

If continuation sheet Page 8 of 23

PRINTED: 03/27/2018

DEPARTMENT		FORM APPROVED OMB NO. 0938-039					
STATEMEN	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED 03/06/2018	
NAME OF PROVIDER OR SUPPLIER  ZIONSVILLE MEADOWS			675	ET ADDRESS, CITY, STATE, ZIP COD S FORD RD ISVILLE, IN 46077			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  the residents as well as reviewed with residents at residents		(X5) COMPLETION DATE	
				what measures will be purplace or what systemic changes you will make to ensure that the deficient practice does not recur.  Staffing schedule, staffin phone numbers, matrix face sheets (including next of kir Entities providing services arrangements, Resident physicians, volunteers, othe facilities and Resident bed will be utilized as a means to track the staff and residents the emergency  Above mentioned forms updated monthly  Staff will be re-educated tracking procedure by Maintenance Director/ SDC/Designee at Disaster by 4-5-18.  A letter will be sent out to family/responsible parties concerning our procedure for Natural Disasters and other Emergencies annually, it will be placed in the admission for new admits and will be given a staffing the sent out to the sent out	g e n), under er LTC board to s during will be on the training or fill also packet		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

the residents reviewed with residents at residents council.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality

If continuation sheet

Page 9 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/06/2018	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
140	REGULATORY	K LSC IDENTIFY TING INFORMATION		TAG	assurance program will be pinto place.  The QA tool "Disaster and Emergency Preparedness" with utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter.  The Maintenance Director/Designee is responsite to monitor for compliance monon Preventive Maintenance rounds.  The QAPI Team reviews the audits monthly and action planare developed as needed if threshold of 90% is not met to ensure continual compliance.  Compliant Date: April 5, 201	ble nthly	
K 0000							
Bldg. 01	Licensure Survey of State Department of CFR 483.90(a).  Survey Date: 03/0  Facility Number: Provider Number: AIM Number: 100  At this Life Safety	000538 155620 0267290 Code survey, Zionsville and not in compliance with	K 0	000	March 23, 2018  Mr. Matthew Foster Indiana State Department of Health 2 North Meridian St. Indianapolis, IN 46204  Dear Mr. Foster; Please accept this 2567 Plan Correction for the Life Safety with Emergency Preparednes Survey ending March 6, 2018 our Letter of Credible Allegation	Code s as	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $ZGDL21 \qquad {\it Facility ID:} \quad 000538$ 

If continuation sheet

Page 10 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY  COMPLETED  03/06/2018			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation of the two flood determined to be of fully sprinklered. The system with smoke in all areas open to smoke detectors har system in all residenthas a capacity of 18 the time of this visit All areas where residently were sprinklered. The building providing the was not sprinklered.	dents have customary access he facility has one detached facility storage services which		and this facility respectfully request a Desk Review in lieu post survey revisit on or after 5, 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	April		
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 7.1 Based on observation failed to ensure 2 of were continuously robstructions. This discontinuous is continuously robstructions.	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 110.1 on and interview, the facility 12 corridor means of egresses	K 0211	K211 Means of Egress - General It is the practice of this providensure corridor means of egreare continuously maintained f	ess		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

If continuation sheet

Page 11 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 03/06/2018			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 675 S FORD RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O  Findings include:  Based on an obser Director 03/06/18 and 12:56 p.m., the a) at 11:04 a.m., the of the hall and a H the hall near reside b) at 12:50 p.m. the corridor immediate area	vation with the Maintenance between the hours of 10:44 a.m. e following was noted: ere was a bed stored on one side over lift on the opposite side of ent rooms #136 and #138. ere as a floor scale stored in the ely outside the Cottage dining	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA DEFICIENCY)  of obstructions.  What corrective action(s) wil be accomplished for those residents found to have been affected by the deficient practice.  ·No direct resident affected this alleged deficient practice. ·Egress by room #136 was cleared immediately of the been	I n by		
	observation, the Macknowledged that	vs at the time of each faintenance Director teach of the aforementioned to be kept or stored out in		Dining room, the scale was removed by the Maintenance Director.  How will you identify other residents having the potentiato be affected aby the same deficient practice and what corrective action will be take All residents have the potent to be affected by the alleged deficient practice.  Egress by room #136 was cleared immediately of the beand hoyer. Egress by Cottage Dining room, the scale was removed by the Maintenance Director.  All other egresses were assessed for the same alleged deficient practice by the Maintenance Director immediately. Any other egres that was that was obstructed we cleared immediately by Maintenance Director 3-6-18.  Staff was re-educated on maintaining egresses free of	ntial d		

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP COL		(X3) DATE SURVEY COMPLETED 03/06/2018	
	PROVIDER OR SUPPLIE	R	675 S F	FORD RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				obstructions.	ble nthly  d ss was	
				How the corrective action(s) will be monitored to ensure a deficient practice will not recur, i.e., what quality assurance program will be p into place.  The QA tool "Disaster and Emergency Preparedness" we utilized by the Interdisciplinary	the out ill be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

If continuation sheet

Team weekly for four weeks,

Page 13 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED  03/06/2018
NAME OF P	ROVIDER OR SUPPLIEF	<b>.</b>		ADDRESS, CITY, STATE, ZIP COFORD RD	OD
ZIONSVII	LLE MEADOWS			SVILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) OULD BE PPROPRIATE COMPLETION DATE
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special loc clinical security ne used, only one loc permitted on each be made for the ra by: remote control locks or keys carri other such reliable staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEEDS	d means of egress shall not a latch or a lock that if a tool or key from the susing one of the following rangements: SOR SECURITY THREAT king arrangements for the reds of the patient are eking device shall be a door and provisions shall apid removal of occupants and follocks; keying of all fied by staff at all times; or emeans available to the calc. 2.2.6, 19.2.2.2.5.1,	TAG	monthly for three month quarterly thereafter.  The Maintenance Director/Designee is re to monitor for complian on Preventive Maintenarounds.  The QAPI Team revaudits monthly and act are developed as need threshold of 90% is not ensure continual comp  Compliant Date: April	sponsible ce monthly ance liews the ion plans ed if met to liance.
	ARRANGEMENT	S			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21 Facility ID: 000538

If continuation sheet Page 14 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>01</u>			ETED	
		155620	B. WI	B. WING			/2018
				CTDEET A	DDBECC CITY CTATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ZIONOVI					ORD RD		
ZIONSVI	LLE MEADOWS			ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Where special lo	cking arrangements for the					
	safety needs of the	ne patient are used, all of					
	the Clinical or Se	curity Locking requirements					
	are being met. In	addition, the locks must be					
	electrical locks th	at fail safely so as to					
		s of power to the device; the					
		ted by a supervised					
		er system and the locked					
		d by a complete smoke					
		(or is constantly monitored					
	1	cation within the locked					
	space); and both	the sprinkler and detection					
		nged to unlock the doors					
	upon activation.						
		2.2.2.5.2, TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
		delayed-egress locking					
		in accordance with					
	_ ·	permitted on door					
		ng low and ordinary hazard					
		ngs protected throughout by					
		pervised automatic fire					
		or an approved, supervised					
	automatic sprinkl						
	18.2.2.2.4, 19.2.2	-					
		ROLLED EGRESS					
	LOCKING ARRA						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	224					
		BY EXIT ACCESS					
	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in						
	_	7.2.1.6.3 shall be permitted					
		les in buildings protected					
		approved, supervised					
		tection system and an					
		rised automatic sprinkler					
	approved, superv	noca automatic opinikiei					

FORM CMS-2567(02-99) Previous Versions Obsolete

 ${\tt Event \, ID:} \qquad {\tt ZGDL21} \qquad {\tt Facility \, ID:} \qquad {\tt 000538}$ 

If continuation sheet Page 15 of 23

03/27/2018 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/06/2018 155620 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE MEADOWS ZIONSVILLE, IN 46077 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility K 0222 **K222 Egress Doors** 04/05/2018 failed to ensure the means of egress through 1 of It is the practice of this provider to 8 delayed egress locks was readily accessible for ensure the means of egress all residents, staff, and visitors. LSC 7.2.1.6.1.(3) through the delayed egress locks (4) states a readily visible, durable sign in letters is readily accessible for all not less than 1 in. (25mm) high and not less than residents, staff, and visitors. 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located What corrective action(s) will on the door leaf adjacent to the release device in be accomplished for those the direction of egress: residents found to have been "PUSH UNTIL ALARM SOUNDS, DOOR CAN affected by the deficient BE OPENED IN 15 SECONDS". practice. This deficient practice could affect 25 residents in ·No direct resident affected by the community room. this alleged deficient practice. ·Exit door by resident room Findings include: #146 and #147 egress signage was ordered immediately and Based on observations during tour of the facility placed on door 3-12-18 by the with the Maintenance Director on 03/06/18 at Maintenance Director. 11:06 a.m., the exit door near resident room #146 and #147 was provided with delayed egress locks, How will you identify other but lacked the proper signage indicating the doors residents having the potential can be opened in 15 seconds by pushing on the to be affected by the same door. Based on interview at the time of deficient practice and what observation, the Maintenance Director corrective action will be taken. acknowledged the door was equipped with a ·All residents have the potential delayed egress and lacked the proper signage. to be affected by the alleged deficient practice. 3.1-19(b) Exit door by resident room

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

If continuation sheet

#146 and #147 egress signage was ordered immediately and placed on door 3-12-18 by the

immediately. Any other exit door

Maintenance Director. ·All other exit doors were assessed for the same alleged deficient practice by the Maintenance Director

Page 16 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COME		(X3) DATE SURVEY COMPLETED 03/06/2018
	PROVIDER OR SUPPLIEF	<b>\</b>	675 S F	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL DUSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	KEGULATURY OF	R LSC IDENTIFYING INFORMATION	TAG	requiring this egress signage the signage place by Maintena Director 3-12-18.  The Maintenance Director/Designee is responsit to monitor for compliance mor on Preventive Maintenance rounds  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.  All other exit doors were assessed for the same alleged deficient practice by the Maintenance Director immediately. Any other exit dorequiring this egress signage the signage place by Maintena Director 3-12-18.  The Maintenance Director/Designee is responsit to monitor for compliance mor on Preventive Maintenance rounds  How the corrective action(s) will be monitored to ensure a deficient practice will not recur, i.e., what quality assurance program will be pinto place.  The QA tool "Disaster and Emergency Preparedness" wuitlized by the Interdisciplinary Team weekly for four weeks, monthly for three months and	had ance ble hthly http://www.html.nto

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

quarterly thereafter.

If continuation sheet Page 17 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155620	JILDING	01	COMPL 03/06/	ETED
	ROVIDER OR SUPPLIER		675 S F	ADDRESS, CITY, STATE, ZIP COD ORD RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - 2012 EXISTING Nursing homes, an by construction type throughout by an a sprinkler system in 13, Standard for th Systems. In Type I and II co protection measur substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprint Standard for Insta Systems. 19.3.5.1, 19.3.5.2,	Installation Installation Installation Ind hospitals where required be, are protected approved automatic accordance with NFPA he Installation of Sprinkler Instruction, alternative hes are permitted to be inkler protection in specific or local regulations prohibit alers are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers that as required by NFPA 13,		The Maintenance Director/Designee is responsit to monitor for compliance mon on Preventive Maintenance rounds. The QAPI Team reviews the audits monthly and action plan are developed as needed if threshold of 90% is not met to ensure continual compliance.  Compliant Date: April 5, 2018	thly e s	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZGDL21 Facility ID: 000538

If continuation sheet Page 18 of 23

PRINTED: 03/27/2018 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155620 B. WING 03/06/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 675 S FORD RD ZIONSVILLE. IN 46077 ZIONSVILLE MEADOWS

ZIONSV	ILLE MEADOWS	ZIONS	ZIONSVILLE, IN 46077				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
	Based on observation and interview, the facility	K 0351	K351 Sprinkler System -	04/05/201			
	failed to ensure steel armover sprinkler pipes in 1		Installation				
	of 8 mechanical rooms were installed in		It is the practice of this provider to				
	accordance with the requirements of NFPA 13,		ensure sprinkler pipes are				
	Standard for the Installation of Sprinkler Systems.		installed in accordance with the				
	NFPA 13, 2010 edition, at 9.2.3.5.1 states the		requirements of NFPA 13,				
	cumulative horizontal length of an unsupported		standard for the Installation of				
	armover to a sprinkler, sprinkler drop, or sprig-up		Sprinkler Systems.				
	shall not exceed 24 inches for steel pipe or 12		'				
	inches for copper tube. This deficient practice		What corrective action(s) will				
	could affect mostly staff while in the mechanical		be accomplished for those				
	room.		residents found to have been				
			affected by the deficient				
	Findings include:		practice.				
			No direct resident affected by				
	Based on observations on 03/06/18 at 12:16 p.m.		this alleged deficient practice.				
	with the Maintenance Director, the steel sprinkler		Sprinkler pipe armover in				
	pipe armover in the mechanical room next to		mechanical room next to resident				
	resident room #153 had a 9 foot unsupported		room #153 part to repair was				
	section near the H.V.A.C. ductwork in the back of		ordered immediately and repaired				
	the room. The support section was still hanging		by 3-23-18 by the Maintenance				
	on the pipe, but the top had been detached from		Director.				
	the ceiling. Based on interview at the time of the						
	observation, the Maintenance Director		How will you identify other				
	acknowledged the unsupported section of steel		residents having the potential				
	sprinkler pipe, and the unattached hanger.		to be affected aby the same				
			deficient practice and what				
	3.1-19(b)		corrective action will be taken.				
			·All residents and more so the				
			staff have the potential to be				
			affected by the alleged deficient				
			practice.				
			·Sprinkler pipe armover in				
			mechanical room next to resident				
			room #153 part to repair was				
			ordered immediately and repaired				
			by 3-23-18 by the Maintenance				
			Director.				
			·The Maintenance				
			B: ( /B : : : : : : : : : : : : : : : : : :				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

If continuation sheet

Director/Designee is responsible

Page 19 of 23

PRINTED: 03/27/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  03/06/2018	
	PROVIDER OR SUPPLIE	R		675 S I	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  to monitor for compliance mor on Preventive Maintenance rounds		(X5) COMPLETION DATE
					What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur.  ·Sprinkler pipe armover in mechanical room next to resid room #153 part to repair was ordered immediately and repair by 3-23-18 by the Maintenance Director.  ·The Maintenance Director/Designee is responsite to monitor for compliance more on Preventive Maintenance rounds	lent ired e	
					How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pointo place.  The QA tool "Disaster and Emergency Preparedness" woutilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and	<b>he</b> ut ill be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

rounds.

quarterly thereafter. ·The Maintenance

Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance

·The QAPI Team reviews the

If continuation sheet

Page 20 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

		IDENTIFICATION NUMBER  155620	A. BUILDING B. WING	01	COMPLETED 03/06/2018
	PROVIDER OR SUPPLIER		675 S I	ADDRESS, CITY, STATE, ZIP COD FORD RD SVILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				audits monthly and action plan are developed as needed if threshold of 90% is not met to ensure continual compliance.	S
				Compliant Date: April 5, 2018	В
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a p used for compone patient-care-relate (PCREE) assembl assembled by qua the conditions of 1 the patient care via non-PCREE (e.g., except in long-tern do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care ro other UL standard used with general cords are not used wiring of a structur temporarily are rer completion of the p installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3() Based on observation	ed electrical equipment les that have been alified personnel and meet 10.2.3.6. Power strips in cinity may not be used for personal electronics), m care resident rooms that E. Power strips for PCREE r UL 60601-1. Power strips the patient care rooms meet UL 1363. In coms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. p), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility	K 0920	K920 Electrical Equipment -	- 04/05/2018
	failed to ensure in 1	of 66 resident rooms, flexible		Power Cords and Extension	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21 Facility ID: 000538

If continuation sheet

Page 21 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155620		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/06/2018	
	PROVIDER OR SUPPLIER	L	675	EET ADDRESS, CITY, STATE, ZIP COD 5 S FORD RD NSVILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRODE	ION (X5) D BE COMPLETION DATE
	cords were not used wiring. LSC 9.1.2 r equipment shall be National Electrical Article 400.8 requir permitted, flexible cused as a substitute This deficient pract and staff.  Findings include:  Based on observation Director on 03/06/1 #208 had an extension outlet operating a dat the time of the observation.	as a substitute for fixed equires electrical wiring and in accordance with NFPA 70, Code. NFPA 70, 2011 Edition, res that, unless specifically cords and cables shall not be for fixed wiring of a structure. ice affects up to 3 residents  on with the Maintenance 8 at 12:17 a.m., resident room ion cord plugged into a wall esk lamp. Based on interview observation, the Maintenance ged the use of the extension		It is the practice of this pro- ensure flexible cords are ras a substitute for fixed wi What corrective action(s) be accomplished for those residents found to have I affected by the deficient practice.  The extension cord was removed immediately from lamp of resident #208 and directly in the wall outlet. Resident #208 was info that extension cords cannoted.  How will you identify oth residents having the pote to be affected by the sam deficient practice and wh corrective action will be re- Residents who have ele devices have the potential affected by the alleged de practice. Resident rooms were a checked for use of extensicords and removed if foun Staff was re-educated of extension cords are not to used in the facility immediand by 4-5-18, by SDC/Maintenance Director  What measures will be purplace or what systemic changes you will make to ensure that the deficient practice does not recur.	evider to not used ring.  will se peen  the plugged rmed plugged rmed pot be  er ential ne nat taken. Petrical to be ficient  li on d. On be pately r

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZGDL21

Facility ID: 000538

If continuation sheet

Page 22 of 23

PRINTED: 03/27/2018 FORM APPROVED OMB NO. 0938-039

T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155620	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 03/06/2018
ROVIDER OR SUPPLIEI	3	675 S	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077	
LLE MEADOWS  SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	675 S	FORD RD	DATE  COMPLETION DATE  On Determined the put Determ

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $ZGDL21 \qquad {\it Facility ID:} \quad 000538$ 

If continuation sheet

Page 23 of 23