STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zionsville Meadows	675 S Ford Rd Zionsville, IN 46077

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38767 Based on observation, interview, and record review, the facility failed to adequately manage, supervise, monitor, and initiate interventions for a dementia resident with a known history of aggressive behaviors for 1 of 3 dementia residents reviewed for incidents (Residents L, K, N). Findings include: An Indiana State Department of Health Survey Report System report, dated 4/30/24 at 10:45 a.m., indicated Resident L made contact with Resident K. Resident L had a skin tear on his left hand and Resident K had a skin tear on her left forearm. Root cause was to be determined regarding resident engagement. A 5/3/24 follow -up indicated Resident L's care plan was updated with a new intervention of a sign on his door to redirect other residents from entering his room. 1. Resident L's record was reviewed on 5/15/24 at 2:45 p.m. Diagnoses on Resident L's profile included, but were not limited to, Alzheimer's disease, and dementia with severe mood disturbance (verbal and physical aggression and wandering) and psychotic disturbance (can become aggressive at times and have trouble regulating emotions). A hospital discharge summary, dated 3/11/24, indicated Resident L had recently completed a 14 day in-patient stay at a psychiatric hospital for psychosis and agitation. The day after his return to the facility, he had an aggressive episode with a female resident who was sitting near the nurse's station and grabbed her left arm and was yelling at her. Resident L was sent back to the in-patient psychiatric hospital for an additional 12 day stay, and the family was told to seek alternate placement. A Memory Care Initial Admissions Guidelines Checklist, dated 3/7/24, indicated the resident had a diagnosis of an irreversible form of Alzheimer's or dementia and met guidelines to be placed on the secured unit. The assessment did not document the resident having just been discharged from 2 back to back in-house psychiatric stays for physical aggression against his peers at his last facility. On 5/16/24 at 11:25 a.m., Resident L was observed being brought out of his room in a wheelchair (wc) propelled by Certified Nursing Aide (CNA) 10. The resident was placed at a table with another male peer, he was not observed to engage with others. (continued on next page)

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/24 at 9:37 a.m., Resident L was observed propelling himself in a wc with his feet into the activity/dining room among 5 peers. A physician's order, dated 3/11/24, indicated the resident resided on a secured unit, and his activity level was to be up as he wanted with assistance and use of a walker. The resident record lacked documentation a person centered care plan was initiated upon admission for a history of aggressive behaviors towards others, root cause of aggressive behaviors, or interventions initiated to assist staff in caring for the resident. A physician's progress note, dated 03/20/24 at 12:44 a.m., indicated Resident L was seen for his initial history and physical. The patient was status post hospitalization for increased agitation and aggressive episodes. He had medication adjustments completed with improvement in his behaviors. He was unable to return to his assisted living apartment due to requiring more supervision. A progress notes, dated 4/10/24 at 1:03 p.m., indicated the resident continued to attempt to stand independently. When staff attempted to assist the resident to either sit down or ambulate with his walker, he declined to use the walker even though he was unsteady standing. Resident L became agitated at times and hit a staff member during unsuccessful attempts at redirection. A care plan dated 4/11/24 indicated Resident L became aggressive with staff when trying to redirect to activity. The goal was for him to not become agitated. Approaches included administering medications as needed, redirect resident to activity of choice, assess resident for unmet needs, and labs will be drawn. A progress notes, dated 4/15/24 at 10:07 p.m., the resident had an agitated afternoon. He refuses to sit on several occasions and attempted to hit staff sometimes. A behavior review note, dated 4/16/24 at 1:36 p.m., indicated the resident refused to be redirected, to stay in his wheelchair, and continued to wander throughout the memory care unit. A behavior review note, dated 5/1/24 at 3:41 p.m., indicated 2 female residents (Residents K and L) entered the resident's room. Resident L became agitated and used part of his wheelchair to make contact with Resident K's left lower arm. A progress notes, dated 5/9/24 at 10:32 a.m., Resident L was passing through the dining room at the end of breakfast. He passed very close to Resident K and grabbed her by her left arm and held on. She yelled out from the contact and Resident L responded by yelling as well. The nurse came from behind the care station and a CNA came out of another resident's room. A therapist was also nearby and helped. Staff needed additional attempts to have Resident L release his grip on Resident K's arm when staff separated them. Resident K was taken to her room to finish her breakfast. Resident L was placed on one on one (1:1) supervison with staff after the event. He continued to move about the hallways in his wheelchair. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress notes, dated 5/09/24 at 11:09 a.m., indicated Resident L grabbed Resident K by the arm during breakfast time and threatened to harm her. He was moving around in his wheelchair, he then became aggressive towards Resident K thinking her chair was in his way, so he grabbed her by the left elbow area. The staff rushed there to separate them, Resident L was removed from the area and redirected. A progress notes, dated 5/14/24 at 2:43 p.m., indicated Resident L was observed to be agitated shortly after getting up that morning. He was wheeling his wc down the hallway, using the handrail to pull himself along, and when he came close to Resident N banged his wheelchair into hers instead of going around her. Resident N who was positioned half in her doorway and half out, was upset at this action and raised her voice at Resident L. He did not change direction, so staff immediately helped him move around stationary Resident N. Several times the day staff had to provide additional redirects for Resident L as he was easily agitated by others who would not move for him. An admission Minimum Data Set (MDS) assessment, completed 3/18/24, assessed Resident L as having the ability to sometimes make himself understood and to sometimes understand others. A Brief Interview for Mental Status (BIMS) score 4/15 indicated severe cognitive impairment. The resident had signs and symptoms of delirium to include evidence of an acute change in mental status from the resident's baseline, inattention, and disorganized thinking. The resident had no behavior to include physical or verbal symptoms towards others, rejection of care, or wandering. Mobility devices included a wheelchair and a walker. Partial assistance was needed for transfers, mobility, and ambulation. A care plan, dated 5/2/24, indicated Resident L experienced physical aggression, he made contact with another resident, and had a diagnosis of dementia with behaviors. The goal was for the resident not to experience lasting distress, not cause distress to others, and not cause harm to self or others. Approaches included the resident was to have a sign on his doorway to redirect others from entering his room, and staff were to assure the sign was in place as much as possible. Provide activities of interest, a psychiatric consultation, notify the NP/MD (nurse practitioner, physician), address any immediate needs (hunger, thirst, pain, boredom, loneliness, tiredness, etc.), and remove from immediate area to further evaluate needs. During an interview on 5/16/24 at 11:04 a.m., the Executive Director (ED) and Director of Nursing (DON) indicated the MDS Coordinator had completed the pre-admission assessment for Resident L to be admitted into the secured memory care unit, but she had made her determination by completing a review of the resident's prior records. There was no written information to show to others. The ED indicated Resident L liked to move down the hallway multiple times daily pulling himself with the railing, and Resident N liked to sit in the doorway of her room. On 5/14/24 Resident N was sitting in her doorway and in Resident L's way and he banged his wc wheel into her wc wheel. Resident N yelled at Resident L but there had not been any physical contact. The DON indicated Resident L had been admitted from an in-house psych unit, but she would have to look at his chart to determine what was put into place upon his admission. The ED and DON indicated there were currently 19 residents residing on the secured memory care unit, the resident record had been no care plan put into place upon Resident L's admission to protect other residents on the unit from Resident L's history of physical aggression. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 12:30 p.m., Licensed Practical Nurse (LPN) 8 indicated Resident L would make laps around the secured unit in his wc by pulling himself using the handrail. Recently he got upset and bumped into Resident N as he was pulling himself along and she was sitting in the doorway of her room with her legs out into the hallway. LPN 8 indicated, she did not think Resident L had anything against Resident N, she was just in his way. During an interview on 5/16/24 at 12:32 p.m., CNA 7 indicated Resident L could be easily diverted unless he was already mad when they got to him, then she would push him in his wc around the unit several times until he calmed. During an interview on 5/17/24 at 9:47 a.m., LPN 14 indicated, Resident L required total care with ADLs, except he could transfer with assistance and feed himself. The resident would propel himself in a wc with his feet, and he liked to propel himself in the hallways by grabbing the railing. Resident L displayed behaviors when he was agitated like when staff repeatedly encouraged him to sit down and not fall. To help calm the resident, the staff either let him roll around in the hallway, used conversation to divert him, give him a snack or drink, or put him at a table with things for him to handle and rummage through, it did not take a lot to distract and calm him. LPN 14 indicated in her opinion it was mostly about how others approached him. 2. An Indiana State Department of Health Survey Report System report, dated 5/12/24 at 6:32 p.m., indicated the nurse noted swelling and pain of Resident K's left arm. The NP ordered a stat (as soon as possible) x-ray and x-ray results indicated a fracture of the left ulnar shaft (the longer of the two bones in the forearm - helps to move the arm, wrist, and hand). Resident K was sent to the ER (emergency room) per the NP's orders. Root cause to be determined. A follow-up dated 5/16/24 indicated investigation continues. On 5/16/24 at 11:20 a.m., Resident K was observed seated in the dining room at a table with another female peer, her wc was positioned in the aisle with other residents passing in the narrow space behind her. Resident L was observed being propelled out of his room in a wc by an CNA 10, they passed behind Resident K on the way to seating him with a table between the two residents. Resident K and L's rooms were observed to be side by side within 6 feet of the dining room. On 5/16/24 at 11:25 a.m., Resident K was observed in the dining room at 1 of 5 tables within 15 feet of the doorway to her room. A white hard cast was observed on her left arm from below the elbow to mid fingers and around the thumb. A skin tear and purple discoloration were observed above and below her left elbow. Resident K pointed to the cast and indicated, it's swelled up and hurts in there. Resident K's record was reviewed on 5/16/24 at 2:00 p.m. Diagnoses on Resident K's profile included, but were not limited to, 4/1/24 unspecified dementia without behavior disturbance. Diagnoses added after identification of the ulna fracture included 5/13/24 other specified disorders of bone density and structure, unspecified site (osteopathies [disease of the bone] or chondropathy [disease or disorder that affects the cartilage in the body]), 5/14/24 unspecified fracture of lower end of left ulna, and 5/15/24 pain. A progress notes, dated 4/30/24 at 5:10 p.m., Resident K was walking in the hallway with Resident M this morning and followed her into Resident L's room. Resident L became agitated with them in his room and exhibited a physical behavior toward Resident K by using part of his wc and made contact to her left arm causing a skin tear. Staff did not witness the event. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An initial wound review, dated 5/01/24 at 12:15 p.m., indicated Resident K had a skin tear on her left forearm that measured 6.0 centimeters (cm) x (by) 2.0 cm, with bruising surround the area measuring 4 cm x 4 cm, caused from physical contact with a wc arm. The resident's care plan was updated for intrusive wandering. A progress notes, dated 5/09/24 at 12:05 p.m., indicated Resident K was grabbed by Resident L who became aggressive thinking this resident's wheelchair was in his way. No new skin areas noted, previous bruises remain and skin tear with steri strips intact to left lower arm. Complaint of pain and slight discomfort to dressing sight, Tylenol given with positive effect at this time. A progress notes, dated 5/09/24 at 12:35 p.m., indicated Resident K was seated at a table eating her breakfast when Resident L tried to pass by her in his wheelchair. He grabbed her left arm and tried to move behind her. Resident K yelled at him to let go and he then yelled back at her but did not release his grip. Staff immediately came to separate residents and needed extra time to redirect male resident to let go. Resident K was taken to her room to finish breakfast and to be checked by the nurse, and Resident L left the dining room in his wheelchair and moved down the hallway. An intervention was added that Resident K would be seated on the window side of the table where there was no pass-through for wheelchairs. A progress notes, dated 5/12/24 at 1:31 p.m., indicated Resident K's left arm had swelling especially to the wrist and forearm. The NP gave new orders to x-ray the arm stat. A radiology results notification, dated 5/12/24 at 9:15 p.m., indicated the left forearm had soft tissue swelling, and an acute left distal ulnar shaft fracture (on the pinky side of the arm and above the wrist). A physician's order, dated 5/15/24, give acetaminophen tablet (analgesic) 500 milligrams (mg) 2 tablets (1000 mg) by mouth three times daily for pain. A progress notes, dated 5/12/24 at 10:49 p.m., indicated the resident was observed with a clean dressing on her left forearm. There was swelling of the fingers and left hand, and the resident complained of pain in the left hand which worsens with movement. An X-ray done on the left hand showed the presence of a fracture at this level. The resident was referred to the hospital for better care, and left by ambulance at 10:35 p.m. A progress notes, dated 5/13/24 at 3:32 a.m., indicated the resident returned to the facility from the hospital with a splint on her left arm for comfort. No new orders given. Resident was to follow up with an orthopedic clinic within 3-5 days. A progress notes, dated 5/13/24 at 3:06 p.m., the resident's splint and sling were intact, the dressing was changed, and the steri-strips were intact. Limited range of motion, and increased assistance was required with ADL's (activities of daily living - i.e. bathing, dressing, eating, toilet use). A progress notes, dated 5/15/24 at 2:17 p.m., indicated the resident returned from her orthopedic appointment with a cast to the left forearm. The radiology report indicated the resident had an acute left distal ulnar shaft fracture. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress notes by the NP 15, dated 5/15/24, indicated Resident K was seen for evaluation and management of her left ulnar fracture and pain. She had complaints of increased pain, swelling and decreased range of motion to her left wrist over the weekend. An x-ray was completed that showed an acute left distal ulnar shaft fracture with mild displacement. She was sent to the ER for evaluation. She had a brace and sling placed with orders to follow up with orthopedics, scheduled for today. She was at high risk for fracture due to her advanced age and osteopenia. She was observed up in a wc, she did endorse discomfort with her left wrist. She was not currently on any scheduled pain relief. New orders were given to start Tylenol 1000 mg by mouth three times daily. An orthopedic MD history and physical, signed off 5/16/24, indicated this was a [AGE] year old patient who was in a group home. Another patient from the group home grabbed her hair and twisted the arm. Apparently, he was very aggressive. The patient after that started to have pain in the left upper extremity. Also, she had skin wounds in the proximal aspect of the forearm with a cut that was more superficial. She had basically a fracture of the distal 3rd of the ulna. There were some concerns of a possible fracture in the elbow. Procedure: A left fiberglass short arm cast with regular padding was applied and appropriately molded to maintain satisfactory alignment. The skin laceration that she had was glued with a wound glue to protect the area. An annual MDS review assessment completed on 3/13/24, assessed the resident as having the ability to make herself understand and to understand others. A BIMS score of 6/13 indicated severe cognitive impairment. No falls since prior assessment 12/15/23. During an interview on 5/16/24 at 11:00 a.m., the ED indicated Resident K was [AGE] years old with brittle bones. Staff had not reported a fall until the day before when the resident attempted to toilet independently and staff assisted her off the bathroom floor. The ED indicated she had no idea how Resident K obtained the ulnar fracture, the pain and swelling had not manifested until over the weekend. During an interview on 5/16/24 at 12:00 p.m., CNA 7 indicated the first encounter between Residents K and L happened on 5/1/24 when another resident entered Resident L's room thinking it was her room and Resident K followed her into the room. There was yelling but no physical contact among the residents. On 5/9/24 she was working but not within sight of resident's K and L when she heard yelling. She circled around the dining area to where she could see them and observed a therapist attempting to get Resident L's hands off of Resident K, he was holding tightly with both hands on her left forearm, one hand at the wrist and one hand below the elbow. CNA 7 indicated it took her and the therapist to pry Resident L's hands loose, and when they got his hands off her arm, there were red marks on Resident K's arm. CNA 7 indicated, staff attempted to keep an eye on Resident L when he was out of his room and used a lot of diversion as needed when he encountered other residents, he could get upset quickly when he perceived others to be in his way or bothering his things in his room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/24 at 3:40 p.m., Occupational Therapist (OT) 11 indicated, on 5/9/24 she was in the memory care unit dining room during breakfast working, when she was alerted to a situation between Residents K and L. OT 11 indicated, she was the only staff member in the dining room at the time, so she got up and immediately went to the residents to see what was happening. OT 11 observed Resident L was holding Resident K's left lower forearm. Both residents were screaming at each other non-sensicle verbiage but there was no real conversation happening between them. OT 11 indicated she got behind Resident K and tried to get Resident L to let go but he would not. The whole situation happened so fast, and OT 11 was focused on keeping Resident K's arm as straight as possible, so it was stabilized, as Resident K was attempting to get her arm away, and both residents were pulling in opposite directions. Soon after a CNA and a nurse approach, came around on her other side facing Resident L, and staff finally got Resident L to let go, and the residents were separated. During a phone interview on 5/16/24 at 5:15 p.m., Resident K's attending physician indicated he had not yet seen the final notes from the orthopedic specialist finalized that date. He indicated, NP 15 had seen Resident K on 5/9/24 soon after the altercation with the male resident, and at that time the resident had no obvious injury. However, that did not rule out an injury as anyone with dementia dependent on the day might not comprehend there was pain or an injury. A few days later when Resident K had symptoms of decreased mobility, pain, and edema in the left arm, x-rays were ordered with a return diagnosis of an ulna fracture. The attending physician indicated, it was hard to tell how the fracture happened, but if the final report from the orthopedic specialist documented a spiral fracture, he could not rule out the resident's injury was related to the altercation with the male resident. On 5/17/24 at 11:02 a.m., the Executive Director provided a policy, titled, Behavior Management & Monitoring Program, dated 8/22. The policy indicated, It is the policy of [facility name] to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non-pharmacological and part of a supportive physical and psychosocial environment that is directed towards preventing, relieving, and/or accommodating a resident's behavioral expressions. Procedure: 1. Care plans shall be initiated for any behavioral expression that is problematic or distressing to the resident, other resident, or caregivers. Care plan interventions should include individualized and non-pharmacological interventions which address both proactive and responsive interventions. 2. Care plans should be initiated when a resident is receiving psychotropic medication used to treat either mood or behavior. The care plan should clearly identify the specific mood, thought process or behavioral expression which the prescriber has identified as the indication for use of the psychotropic medication .7. Direct care staff will be educated as to the interventions for residents reviewed by the IDT [interdisciplinary team] On 5/17/24 at 11:02 a.m., the Executive Director provided a document, titled, Resident Rights, dated 11/15. The policy indicated, 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, and all residents shall be free from mental and physical abuse. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safety. 3.1-37(a)