

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Zionsville Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents residing on the secured memory care unit, who were dependent on staff for dental care, received those services for 7 of 9 residents reviewed for Activities of Daily Living (ADL) assistance (Residents B, D, F, J, G, P, and H). Findings include: An anonymous concern during the survey indicated, a resident representative did not believe staff were brushing the residents' teeth. 1. On 8/20/25 at 12:25 p.m., Resident B was observed sitting at a dining room table among her peers. The resident's natural bottom teeth were barely visible when she spoke, and unable to determine if the teeth looked recently brushed/cleaned. Resident B's clinical record was reviewed on 8/20/25 at 1:30 p.m. Diagnoses on Resident B's profile included dementia. A nursing progress note, dated 8/1/25 at 12:59 p.m., indicated Resident B was seen by the dental hygienist on 7/31/25. Continue with the current plan of care. A dentist's progress note, dated 8/18/25, indicated tissues were red and inflamed, had heavy plaque, and poor oral hygiene. A nursing progress note, dated 8/20/25 at 11:39 a.m., indicated Resident B was seen by the dentist on 8/18/25. The resident had gross decay and areas too large to restore teeth #9, #10, and #12. Continue with the current plan of care. 2. Resident D's clinical record was reviewed on 8/21/25 at 9:30 a.m. Diagnoses on Resident D's profile included dementia and psychotic disorder with delusions. A nursing progress note, dated 8/20/25 at 11:42 a.m., indicated Resident D was seen by the dentist on 8/18/25. Procedures performed included he scaled implants and polished. Continue with current plan of care. A dental exam report, dated 8/18/25, indicated the resident was edentulous with implants at #2 and #27. Area for implant retained the lower denture. Full upper and lower appliance. Tissues were red and inflamed, had heavy plaque, and poor oral hygiene. Oral hygiene instructions included, remove dentures nightly and soak. 3. On 8/20/25 at 11:45 a.m., random observation of residents included, a. Resident F, broken front natural teeth with dark discoloration. b. Resident J, build-up of plaque on the bottom front natural teeth. On 8/20/25 at 12:34 p.m., during the initial facility tour observations included, a. Resident G had no oral supplies in her room. b. Resident J had no oral supplies in his room. c. Resident P had a toothbrush and tube of toothpaste stored in a wash pan on a closet shelf, stored under clothing. d. Resident D had a toothbrush and tube of toothpaste in a wash pan on a closet shelf, stored under a blanket and 2 pillows, and among personal items to include a pair of [NAME] socks and a shoe insole. e. Resident H had a tube of toothpaste in a wash pan on a closet shelf, stored with a pair of socks. There was no toothbrush in his room. During an interview on 8/20/25 at 11:58 a.m., Licensed Practical Nurse 9 indicated she worked full time on the secured memory care unit. There were currently 21 residents residing in the unit, and they all received assistance with care from the staff. The residents' bathing supplies and toiletries were stored in the resident rooms. During an interview on 8/20/25 at 12:59 p.m., Certified Nursing Assistant (CNA) 10 indicated the residents were washed up daily in their rooms and received a shower in the shower room on assigned days. Oral care was provided daily as part of the resident's morning care. During the exit conference on 8/20/25 at 11:40 a.m., the DNS indicated there was a large quantity of bathing and oral supplies stored on the secured memory care unit. The supplies were within easy access to staff providing care to residents on the unit. There were shower/bathing sheets that documented the residents were receiving routine baths and oral care. The DON indicated she had observed supplies for bathing and oral care in the resident's rooms and believed they had been taking care of. On 8/21/25 at 9:45 a.m., the Executive Director provided an AM Care Nursing Skills Competency check list, dated 3/2023. The procedure steps indicated, .7. Assist resident with oral hygiene [including denture care if applicable] On 8/21/25 at 9:45 a.m., the Executive Director provided a HS/PM Care Nursing Skills Competency check list, dated 3/2023. The procedure steps indicated, .8. Assist resident with oral hygiene [including denture care if applicable] This citation relates to Intake 2588701.3. 1-38(a)(3)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all aerosol disinfectant sprays and medications were secured in the resident rooms, for 3 random observations for potential accidents (Residents H, M, and N). Findings include: On 8/20/25 at 12:48 p.m., during the initial facility tour observations included, a. Resident H, residing on the secured memory care unit, had a large can of generic disinfectant spray. The disinfectant spray was visible from the hallway door sitting on the top shelf of an open closet. The can's caution label indicated, store preferably under lock. Hazardous if absorbed through the skin or inhaled. b. Resident M, who had a roommate, had a large can of Febreze spray, an odor eliminator. The spray can was sitting on top of a dresser, visible from the hallway. The can's caution label indicated, do not spray toward face, if eye contact occurred, rinse well with water and seek medical attention as needed. c. Resident N, had a bottle of selenium sulfide lotion 2.5 %, an antifungal medicated shampoo. The bottle with the top missing was observed sitting on top of a dresser, visible from the hallway. The resident's clinical record lacked documentation of an order for may keep medications at bedside. d. Resident N, who was in the hospital, had an opened bottle of Pepto Bismol liquid, a medication used to treat digestive ailments. The bottle was observed sitting on her bedside stand and had no prescription label with the resident's name or direction for use. The resident's clinical record lacked documentation of an order for Pepto Bismol or for an order for may keep medications at bedside. On 8/21/25 at 10:45 a.m., a second observation of the aerosol sprays in the resident rooms and medication at bedside with the Executive Director, who indicated the items had not been stored properly. On 8/21/25 at 9:45 a.m., the Executive Director provided a Safety - Cleaning Products policy, dated 8/17, and indicated the policy was the one currently being used by the facility. The policy indicated, All cleaning chemicals must be kept in locked storage rooms when not in use. Cleaning chemicals in remote locations, i.e. activity room, shower/spa rooms, nurse's stations, public areas, etc. should be in locked storage when not in use. On 8/21/25 at 11:35 a.m., the Director of Nursing Services (DNS) provided a Medication Storage and Expiration Policy, dated 11/2024, and indicated the policy was the one currently being used by the facility. The policy indicated, Medications including treatment items should be stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 20. Facility should not provide medications without a Physician's order. 21. Bedside medications should be stored in a locked compartment within the resident's room. This citation relates to Intake 2588701.3.1-45(a)(1)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, and interview, the facility failed to maintain a clean, safe, and sanitary environment on 1 of 4 hallways (Auguste's Cottage - a secured memory care unit) observed for cleanliness. Findings include: On 8/20/25 at 12:48 p.m., during the initial facility tour observations included: a. A PTAC heating and cooling unit in the memory care unit dining room, was observed in the wall under the dining room window. The plaster board base under the PTAC unit was chipped, peeling, and white debris was observed on the floor. b. A cove base strip of trim that had been installed where the wall met the floor, was pulled from the wall, exposing chipped paint to the wall. An approximate 3 foot of cove base, still attached to the wall on one end, was observed laying on the floor near dining room tables where residents walked to be seated for meals and activities. b. An electrical outlet with a missing face plate was observed in the hallway on the front side of the nurse's desk. The exposed outlet was observed to be approximately 1 foot from the floor, and within sight and reach of anyone ambulating by or seated in a wheelchair. On 8/20/25 at 12:56 p.m., observation of a supply storage area located in the back hallway of the secured memory care unit. Supplies were observed to be disorganized, some boxes on the floor versus pallets, and packages of oxygen tubing and boxes of bandages on the floor in the aisle. An environmental safety policy was not received during the survey process. This citation relates to Intake 2588701.3.1-19(f)(5)</p>