

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155286	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/02/2015
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NAME OF PROVIDER OR SUPPLIER  AVALON VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 KINGSTON CIR LIGONIER, IN 46767
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 26, 27, 28, 29, and June 1, and 2, 2015.</p> <p>Facility number: 000184 Provider number: 155286 AIM number: 100267210</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 6 Medicaid: 32 Other: 7 Total: 45</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3-1.</p>	F 000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Requesting Desk Review</p>	
F 280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to</p>			

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

TITLE

(X6) DATE

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.

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	<p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to update a health care plan after an increase in urinary incontinence for 1 of 3 residents (#66) reviewed for urinary incontinence.</p> <p>Findings include:</p> <p>Resident #66's clinical record was reviewed on 5/28/15 at 1:30 P.M. and indicated the resident was admitted to the facility on 1/16/15.</p> <p>On 1/21/15 a Minimum Data Set (MDS) was completed and indicated Resident #66 was occasionally incontinent of urine (less than 7 episodes of incontinence). On the quarterly MDS on 4/16/15, the MDS indicated Resident #66 was frequently incontinent of urine (7 or more episodes</p>	F 280	<p>Requesting Desk Review</p> <ol style="list-style-type: none"> <li>Resident in question no longer resides at the facility. Nursing staff was educated by the Director on 6/10/15 on Bladder Program Policy.</li> <li>All residents have the potential to be affected by this practice. Changes in incontinent status for those residents who had a significant change in the last 30 days as well as new admissions were reviewed to ensure a 3 day voiding pattern was completed and toileting schedules adjusted as needed. If necessary Care plans were updated.</li> <li>Nursing staff was educated by the Director on 6/10/15 on Bladder Program Policy. The DNS/Designee will review 3 day bowel and bladder forms daily to ensure forms are complete.</li> <li>The DNS/Designee will monitor daily that any change in</li> </ol>	06/10/2015

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	<p>of incontinence with at least one episode of continent voiding).</p> <p>Review of a health care plan from 1/22/15 provided by the Director of Nursing Services (DNS) on 6/1/15 at 1:45 P.M., indicated Resident #66 was occasionally incontinent of bladder and required a toileting program. The toileting program was identified as: Toileting program #2: toilet upon rising, before or after meals, at bed time, and at night as needed.</p> <p>An interview with LPN #3, the MDS nurse, on 5/28/15 at 2:03 P.M., indicated during the 7 day look review period for the MDS of 1/22/15 (1/15/15-1/21/15), Resident #66 had 5 episodes of urinary incontinence. LPN #3 indicated during the 7 day review period for the MDS of 4/16/15 (4/9/15-4/15/15), Resident #66 had 18 episodes of urinary incontinence. LPN #3 indicated after a significant change in the urinary incontinence of Resident #66, the resident had been on toileting program #2 since admission, which is toileting upon rising, before or after meals and at bedtime.</p> <p>An interview with LPN #3 on 5/28/15 at 2:58 P.M. indicated a 3 day voiding pattern assessment was completed for Resident #66 on 5/12/15, 5/13/15 and</p>		<p>incontinent status is assessed by the IDT utilizing a 3 day voiding pattern and scheduled toileting program adjusted as needed. Nursing staff was educated by the Director on 6/10/15 on Bladder Program Policy.</p> <p>5. To ensure compliance, the DNS/Designee is responsible for the completion of Bladder Program CQI tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>6. Completion Date: 6/10/15</p>		

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	<p>5/14/15. LPN #3 provided a copy of the 3 day voiding pattern assessment for Resident #66 which was blank in 35 of 72 hour spaces. The instructions for completion of the form indicated: "Beginning at Midnight check residents hourly and document if they are wet or dry. During waking hours assist resident to use toilet, commode, bedpan or urinal and document results once they are assisted to toilet, commode, bedpan or urinal." LPN #3 indicated she did not know why the 3 day voiding pattern assessment was not completed for the full 3 days.</p> <p>Review of an Interdisciplinary Team (IDT) Bladder Continence Review from 5/15/15 (provided by the nurse consultant on 6/2/15 at 2:45 P.M.) indicated: Resident #66 was frequently incontinent (7 or more episodes of urinary incontinence, but at least on episode of continent voiding); Resident #66 was mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan; Resident #66 was not mentally and physically able to resist voiding to attempt a bladder retraining program. The Bladder Continence Review section for Toileting Program indicated: Resident #66 "does not have an identified pattern and has been placed on a scheduled program as</p>			

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F 282 SS=D Bldg. 00	<p>follows: toilet upon rising, before or after meals and at bedtime."</p> <p>An interview with the nurse consultant on 6/2/15 at 2:45 P.M. indicated the IDT Bladder Continence Review of 5/14/15 was not correct as the 3 day Voiding Pattern Assessment form from 5/12/15-5/14/15 was not completed correctly and could not indicate any patterns due to incomplete information.</p> <p>A current Bladder Program Policy, most recently revised 11/2014, provided by the DNS on 6/2/15 at 3:10 P.M., indicated under procedure: "#1. Each resident will have a 3-day voiding pattern initiated within 72 hours of admission and/or any change in continence status."</p> <p>3.1-35(g)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident received the correct dosage of</p>	F 282	Requesting Desk Review1. Resident in question no longer resides at the facility. Nursing staff was educated by the	06/10/2015

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	<p>medication.</p> <p>This deficiency affected 1 of 4 residents observed during medication administration (Resident #73).</p> <p>Findings include:</p> <p>On 5/28/15 at 8:58 A.M. during medication administration LPN #1 was observed to check the Medication Administration Record against the blister package of Keppra (anti-seizure medication) for Resident #73. LPN #1 was observed to remove 2 tablets of Keppra 1000 milligrams (mg) each from the resident's blister package. LPN #1 was observed to give the resident 2 tablets of Keppra 1000 mg each by mouth.</p> <p>The Physician's Order dated 4/28/15 indicated "Keppra... tablet 500 mg; amt (amount): 1,000 mg; oral...twice a day...."</p> <p>On 5/28/15 at 11:45 A.M. the resident's blister package was observed and indicated Keppra 1000 mg take 1 tablet by mouth twice a day.</p> <p>On 05/28/2015 at 10:42 A.M. an interview with LPN #1 indicated she should have only given the resident one tablet of Keppra 1000 mg and not 2 tablets of 1000 mg of Keppra.</p>		<p>Director on 6/10/15 on medication administration. Physician was notified of medication error and new orders were received. 2. All residents have the potential to be affected by this practice. Nursing staff was educated by the Director on 6/10/15 on medication administration. DNS/Designee will conduct skills validation for all licensed nurses on medication administration. 3. The DNS/Designee will monitor daily that nurses are following proper medication administration procedures. Nursing staff was educated by the Director on 6/10/15 on medication administration. DNS/Designee will conduct skills validation for all licensed nurses on medication administration. 4. To ensure compliance, the DNS/Designee is responsible for the completion of Medication administration skills validations monthly x 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these validations will be audited and reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.5. Completion Date: 6/10/15</p>		

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F 315 SS=D Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview the facility failed to properly assess urinary incontinence status after an increase in urinary incontinence for 1 of 3 residents (#66) reviewed for urinary incontinence.</p>	F 315	<p>1. Resident in question no longer resides at the facility. Nursing staff was educated by the Director on 6/10/15 on Bladder Program Policy.</p> <p>2. All residents have the</p>	06/10/2015

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	<p>Findings include:</p> <p>Resident #66's clinical record was reviewed on 5/28/15 at 1:30 P.M. and indicated the resident was admitted to the facility on 1/16/15.</p> <p>On 1/21/15 a Minimum Data Set (MDS) was completed and indicated Resident #66 was occasionally incontinent of urine (less than 7 episodes of incontinence). On the quarterly MDS on 4/16/15, the MDS indicated Resident #66 was frequently incontinent of urine (7 or more episodes of incontinence with at least one episode of continent voiding).</p> <p>Review of a health care plan from 1/22/15 provided by the Director of Nursing Services (DNS) on 6/1/15 at 1:45 P.M., indicated Resident #66 was occasionally incontinent of bladder and requires a toileting program. The toileting program was identified as: Toileting program #2: toilet upon rising, before or after meals, at bed time, and at night as needed.</p> <p>An interview with LPN #3, the MDS nurse, on 5/28/15 at 2:03 P.M., indicated during the 7 day look review period for the MDS of 1/22/15 (1/15/15-1/21/15), Resident #66 had 5 episodes of urinary</p>		<p>potential to be affected by this practice. Changes in incontinent status for those residents who had a significant change in the last 30 days as well as new admissions were reviewed to ensure a 3 day voiding pattern was completed and toileting schedules adjusted as needed. If necessary Care plans were updated.</p> <p>3. Nursing staff was educated by the Director on 6/10/15 on Bladder Program Policy. The DNS/Designee will review 3 day bowel and bladder forms daily to ensure forms are complete.</p> <p>4. The DNS/Designee will monitor daily that any change in incontinent status is assessed by the IDT utilizing a 3 day voiding pattern and scheduled toileting program adjusted as needed. Nursing staff was educated by the Director on 6/10/15 on Bladder Program Policy.</p> <p>5. To ensure compliance, the DNS/Designee is responsible for the completion of Bladder Program CQI tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>6. Completion Date: 6/10/15</p>		

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	<p>incontinence. LPN #3 indicated during the 7 day review period for the MDS of 4/16/15 (4/9/15-4/15/15), Resident #66 had 18 episodes of urinary incontinence. LPN #3 indicated after a significant change in the urinary incontinence of Resident #66, the resident had been on toileting program #2 since admission, which is toileting upon rising, before or after meals and at bedtime.</p> <p>An interview with LPN #3 on 5/28/15 at 2:58 P.M. indicated a 3 day voiding pattern assessment was completed for Resident #66 on 5/12/15, 5/13/15 and 5/14/15. LPN #3 provided a copy of the 3 day voiding pattern assessment for Resident #66 which was blank in 35 of 72 hour spaces. The instructions for completion of the form indicated: "Beginning at Midnight check residents hourly and document if they are wet or dry. During waking hours assist resident to use toilet, commode, bedpan or urinal and document results once they are assisted to toilet, commode, bedpan or urinal." LPN #3 indicated she did not know why the 3 day voiding pattern assessment was not completed for the full 3 days.</p> <p>Review of an Interdisciplinary Team (IDT) Bladder Continence Review from 5/15/15 (provided by the nurse consultant</p>			

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	<p>on 6/2/15 at 2:45 P.M.) indicated: Resident #66 was frequently incontinent (7 or more episodes of urinary incontinence, but at least on episode of continent voiding); Resident #66 was mentally and physically aware of the need to void and able to use a toilet, commode, urinal or bedpan; Resident #66 was not mentally and physically able to resist voiding to attempt a bladder retraining program. The Bladder Continence Review section for Toileting Program indicated: Resident #66 "does not have an identified pattern and has been placed on a scheduled program as follows: toilet upon rising, before or after meals and at bedtime."</p> <p>An interview with the nurse consultant on 6/2/15 at 2:45 P.M. indicated the IDT Bladder Continence Review of 5/14/15 was not correct as the 3 day Voiding Pattern Assessment form from 5/12/15-5/14/15 was not completed correctly and could not indicate any patterns due to incomplete information.</p> <p>A current Bladder Program Policy, most recently revised 11/2014, provided by the DNS on 6/2/15 at 3:10 P.M., indicated under procedure: "#1. Each resident will have a 3-day voiding pattern initiated within 72 hours of admission and/or any change in continence status."</p>			

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