STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155236	A. BUILDING 00 B. WING	11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the investigation of Complaints IN00419946, IN00417946 and IN00416459. Complaints IN00419946 - No deficiencies related to the allegations are cited. Complaints IN00417946 - No deficiencies related to the allegations are cited. Complaints IN00416459 - No deficiencies related to the allegations are cited. Survey dates: November, 13, 14, 15, 16, 17, and 20, 2023. Facility number: 000141 Provider number: 155236 AIM number: 100283860 Census Bed Type: SNF/NF: 110 SNF: 3 Residential: 27 Total: 140 Census Payor Type: Medicare: 10 Medicaid: 78 Other: 25 Total: 113 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mallory	Zehr	12/11/2023

Any defiencystatement 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.

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	Quality review completed on November 29, 2023.			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to accurately code the MDS (Minimum Data Set) with appropriate PASRR (Preadmission Screening and Resident Review) Level 2 information for 2 of 3 residents reviewed (Resident 17 and 68). Findings include: a.) A comprehensive record review was completed on 11/14/23 at 11:32 a.m. Resident 17 had the following diagnoses which included but were not limited to schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), auditory hallucinations, and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). Resident 17 had a level 2 related to her diagnoses which gave instructions to properly code her mental health status on the MDS. The MDS, dated 4/12/23, lacked documentation of the level 2 assessment. b.) A comprehensive record review was completed on 11/16/23 at 10:12 a.m. Resident 68 had the following diagnoses which included but were not limited to TBI (traumatic brain injury), dementia, and psychotic disorder. Resident 68 had a level 2 related to his diagnoses	F 0641	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. An MDS correction will be submitted for resident 68 and resident 17. 2. All residents with a Level II have the potential to be affected. An audit was completed to ensure all those residents Level II status has been coded accurately on his/her MDS. 3. The facility utilizes the RAI Manual for MDS guidance. The section related to PASAR will be reviewed with those staff who complete this portion of the MDS. The DON or her designee will review 5 MDS's weekly to ensure the PASAR section is coded accurately for 6 weeks and until 100% compliance is achieved, then 5 per month for 4 months and until 100% compliance is maintained, then 5 per quarter thereafter. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	12/19/2023

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	which gave instructions to properly code his mental health status on the MDS. The MDS, dated 10/5/23, lacked documentation of the level 2 assessment. During an interview with the DCS (Director of Clinical Services) on 11/20/23 at 12:15 a.m., she indicated the MDS department follow the RAI (Resident Assessment Instrument) manual for accuracy of assessments.			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to ensure a resident (Resident 112) was observed for adverse effects	F 0757	The facility will ensure this requirement is met through the following corrective measures:	12/19/2023

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	related to the use of an opiate medication, and failed to set parameters to ensure nursing staff were provided clear instructions on when to administer a medication and which medication was appropriate to address varying levels of pain for 1 of 5 residents reviewed for unnecessary medications. Finding include: On 11/15/23 at 10:00 a.m., a comprehensive record review was completed for Resident 112. She had the following diagnoses but were not limited to malignant neoplasm of the brain (abnormal masses of tissue that grow in the brain due to excessive overgrowth of brain cells), osteoarthritis, asthma, generalized anxiety disorder, hallucinations, delusional disorder, and malignant neoplasm of the lower lobe, unspecified bronchus, or lobe (cancer). Resident 112's physician's orders included but were not limited to the following "as needed" (PRN) pain medication. a. Dilaudid oral liquid 1mg/ml (hydromorphone) give 1.5ml by mouth every 2 hours as needed for pain or shortness of breath. Do not give within 1 hour of scheduled dose. b. Norco oral tablet 10/325mg (hydrocodone-acetaminophen) give 1 tablet by mouth every 4 hours as needed for pain not to exceed 4,000 mg of Tylenol in a day from all sources. c. Norco oral tablet 10/325mg (hydrocodone-acetaminophen) give 2 tablets by mouth every 4 hours as needed for pain not to exceed 4,000 mg of Tylenol in a day from all		1. No residents were harmed. Resident 112's medications were reviewed and clarified to ensure the appropriate medication was provided based upon pain level. 2. All residents have the potential to be affected. An audit has been completed reviewing all pain medication regimens to ensure the same. 3. The Unnecessary Medications policy was reviewed and no changes indicated. Licensed nursing staff will be educated on this policy. The DON or her designee will review 5 random residents weekly to ensure residents with multiple pain medications have instructions regarding pain levels. These reviews will continue weekly for 6 weeks and until 100% compliance is achieved, then 5 a month for 4 months and until 100% compliance is maintained, then monthly thereafter. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	sources. d. Percocet oral tablet 10-325mg (oxycodone with acetaminophen) give 1 tablet by mouth every 4 hours for moderate pain not to exceed 4,000 mg of Tylenol in a day from all sources. On 11/16/23 at 1:17 p.m. Hospice RN 19 was interviewed. He indicated nurses should assess the resident prior to administering medications for pain. There were no parameters on the as needed pain medications. He indicated through the nurse's assessment she should be able to make that determination. He would call the facility with new orders for the as needed medications. On 11/16/23 at 1:23 p.m. LPN 17 was interviewed. She indicated Resident 112 always wanted 2 Norco tablets. LPN 17 indicated she knew what the resident wanted. The order for Percocet was added when Norco was unavailable. The Percocet was never discontinued when the Norco became available. A policy titled, "Unnecessary Medications," was provided by the Director of Clinical Services (DCS) on 11/17/23 at 10:32 a.m., it indicated, " ...Proper medication selection and prescribing (including dose, duration, and type of medication(s) may help stabilize or improve a resident's outcome, quality of life and functional capacity. Any medication or combination of medications-or the use of a medication without adequate monitoring may increase the risk of a broad range of adverse consequences such as medication interactions, depression, confusion, immobility, falls, hip fractures, and death. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used a. In excessive dose (including			

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	duplicate drug therapy); or b. For excessive duration; c. Without adequate monitoring; or d. Without adequate indications for its use; or e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued, or f. Any combinations of the reasons stated ....". 3.1-48(a) 3.1-48(l) 3.1-48(6)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure the Memory Care (MC) residents received warm food during lunch services for 25 of 25 MC residents during 1 of 3 lunch observations. Findings include: On 11/13/23 at 11:53 a.m., Certified Nursing Aide (CNA) 15 indicated the MC residents were receiving glazed pork cutlet, cheesy potatoes, and green beans for lunch. The glazed pork cutlets were observed to be in a portable steam table. The green beans and cheesy potatoes were observed	F 0804	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Staff ensured all residents were offered a substantial snack on the afternoon of 11/13/23. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Food Temperature Monitoring policy was reviewed, and no changes indicated. Kitchen and memory care staff will	12/19/2023

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	in stainless steel hotel pans on the second shelf. On 11/13/23 at 11:54 a.m., CNA 13 indicated the cheesy potatoes and green beans did not have a heating device below them to keep them warm during serving. On 11/13/23 at 12:03 p.m., CNAs 15 and 13 finished serving lunch, with the residents needing assistance with eating being served last. At the same time, Cook 14 entered the MC dining room to check the temperature of the food. Cook 14 indicated the food left the kitchen at the temperature of 165 Fahrenheit (F) or higher. The cheesy potatoes were 79 F and the green beans were 113 F. She indicated the food temperatures were too low for the food to be served to residents. The glazed pork cutlets were 136 F. She indicated she usually put all the food in the portable steam table, but was in a hurry today and did not do it, and it was her fault the food temperatures were served too low. On 11/13/23 at 12:09 p.m., the residents as the last table served were unable to communicate whether the did not like the food being too cold. It was observed that the residents did not eat their food well. On 11/14/23 at 11:29 a.m., after all the residents were served, the Dietary Director (DD) indicated the chicken noodles were at 168 F and the broccoli at 197 F. On 11/15/23 at 11:10 a.m., an observation of portable steamer being used for MC lunch foods: country fried steak, mashed potatoes, and stewed tomatoes. White bread and coconut bars were also served. The residents who needed assistance with eating were served first.		be educated on this policy. The Dietary Manager or her designee will monitor food service and temperatures three times weekly, alternating meal times, to ensure food temperatures are adequate for 6 weeks and until 100% compliance is achieved, then 5 times a month for 4 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	A policy titled, "Food Temperature Monitoring," dated 5/16/23, was provided by the Director of Nursing (DON), on 11/15/23 at 10:33 a.m. A review of the policy, indicated, " ...Proper food handling techniques, per regulatory requirements, are used in the preparation and serving of food ...." 3.1-21(a)(2)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure staff washed their hand appropriate while assisting Memory Care (MC) resident with eating for 2 of 3 lunch observations (Resident 50, 52, 60, 76, and 111).	F 0812	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. 2. All Memory Care residents	12/19/2023

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	Findings include: On 11/13/23 at 11:31 a.m., Certified Nursing Aide (CNA) 15 was observed serving the MC residents food, CNA 13 was providing it to the residents, and the MC Director (MCD) followed behind and cut-up the resident's food as needed. On 11/13/23 from 12:11 to 12:19 p.m., CNA 15 was observed to assist several MC resident with eating but did not wash her hands between touching the resident, their wheelchair, or their utensils before moving onto the next resident. a. She touched Resident 111's spoon, then touched Resident 60's spoon in her vanilla pudding dessert. b. She assisted Resident 111 with eating by holding his spoon with cheesy potatoes. Then, touching the arm rest of an Resident 60's wheelchair and then assisting her with eating. On 11/13/23 from 12:14 to 12:19 p.m., CNA 13 was observed to assist two MC residents with eating. She assisted Resident 60 by providing a bite of food, then offered Resident 52 a bite of food, and back to Resident 60 to offer a bite of food. She did not sanitize or wash her hands between residents. Resident 52 was visually impaired with blindness. On 11/15/23 at 11:09 a.m., the resident that required assistance with eating were served first. Five resident were observed not eating. The lunch included country fried steak, mashed potatoes, bread, stewed tomatoes, and a coconut bar. On 11/15/23 at 11:15 a.m., CNA 19 was observed standing and leaning her body over the lunch table to assist Resident 52 with opening her barbeque container on the other side of the table.		have the potential to be affected. See below for corrective measures. 3. The policy Meal Service to Dining Rooms or Resident Rooms was reviewed and no changes indicated. Memory Care staff will be educated on this policy. The Memory Care Director or her designee will observe 4 meals weekly, varying times, to ensure staff are sanitizing hands when indicated for 6 weeks and until 100% compliance is achieved, then 5 times a month for 4 months and until compliance is maintained. 4. Ther findings of these observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	She leaned over Resident 50's and Resident 76's food, while they were sitting at the table waiting for assistance with eating. She did not do hand hygiene and assisted Resident 50 with a bite of food and a drink. Then, she walked away from the table to get milk for Resident 60. She did not do hand hygiene and provided Resident 50 with a bite of food. On 11/15/23 at 11:18 a.m., Activity Assistant 12 was observed to touch Resident 52's sleeve and manual guiding her hand to her drink. She did not do hand hygiene and touched the silverware of Resident 111. She came back to Resident 52's table and touched her sleeve again to manually guide her to the chicken nuggets on her plate. She was overheard saying to an aide, Resident 52 can only see shadows. She did no hand hygiene and at 11:30 a.m., she touched Resident 60's plate, did no hand hygiene afterward, and assisted Resident 52 with a bite of her coconut bar. On 11/15/23 at 11:19 a.m., CNA 19 went back to assist the residents will eating. First, she assisted Resident 76, she touched her plate to turn it. Then, provided 2 bites of food to Resident 50. She did not do hand hygiene between residents. On 11/15/23 at 11:31 a.m., CNA 19 was observed to scratch her back, she did not do hand hygiene, then returned to assisting residents with eating. On 11/15/23 at 11:40 a.m., CNA 15 was observed touching Resident 60's silverware to try and get her to eat more food. Without using hand hygiene between residents, at 11:43, she started assisting Resident 76 with eating her dessert. On 11/15/23 at 11:49 a.m., CNA 15 was observed touching Resident 60's wheelchair handles to			

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	move her closer to the table. She did not do any hand hygiene and started assisting Resident 52 with eating for dessert. On 11/15/23 at 11:44 a.m., CNA 19 was assisting Resident 111 with bites of food. She put her hands in her lap, then continued with assisting him with lunch by offering bites of food again. On 11/13/23 at 12:23 p.m., CNA 15 indicated she was trained to wash her hands between resident when assisting them with eating. On 11/15/23 at 11:55 a.m., Licensed Practical Nurse (LPN) 11 indicated the MC staff should have been performing hand hygiene between residents when assisting residents with eating and would educate the staff accordingly. A current policy, titled, "Meal Service to Dining Rooms or Resident Rooms," dated 3/2020, was provided by the Director of Nursing (DON), on 11/15/23 at 1:29 p.m. A review of the policy indicated, " ...Dining service to residents will be provided in an efficient manner, using standard sanitary procedures and providing residents with the assistance and attention they need to enjoy their meals ...." 3.1-21(i)(2) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00419946,	R 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as**	

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	IN00417946, and IN00416459. Complaints IN00419946 - No deficiencies related to the allegations are cited. Complaints IN00417946 - No deficiencies related to the allegations are cited. Complaints IN00416459 - No deficiencies related to the allegations are cited. Survey dates: November 13, 14, 15, 16, 17, and 20, 2023. Facility number: 000141 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 29, 2023.		**evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires			

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	change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure Residents and/or their representatives, were provided a copy of their most recent Service Plan with a signature of acknowledgement of the services to be provided for 8 of 8 residents reviewed. Findings include: On 11/20/23 at 10:00 a.m., Residents 1, 6, 8, 18, 19, 22, 27, and 29's Service Plan records were reviewed with the Director of Clinical Services (DCS). Although the service plans had been completed, there was no evidence that a copy of the Service Plan had been provided to/signed by the Residents, and/or their representatives. The DCS indicated there had been an ongoing issue with the previous Residential Assisted Living Director, who had failed to ensure the service plans were signed and then added to the Residents' records for proof of acknowledgement. During an interview on 11/20/23 at 10:18 a.m., Resident 18 indicated she understood what a Service Plan was, but had not signed hers and	R 0217	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Residents 1, 6, 8, 18, 19, 22, 27, and 29 service plans will be reviewed to ensure signatures are obtained and scanned into the EHR and copies provided. 2. All residents have the potential to be affected. All resident's service plans will be reviewed to ensure signatures are obtained and scanned into the EHR and copies provided. 3. The policy on Resident Evaluation was reviewed and no changes were indicated. The new AL Director will be educated on this policy. The DON or her designee will randomly select 5 residents weekly for review to ensure there is a signed Service Plan in the EHR and that a copy is provided to the	12/19/2023

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	155236	A. BUILDING 00 B. WING	11/20/2023

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	was not provided a copy. During an interview on 11/20/23 at 10:30 a.m., Resident 22 indicated she had just been offered consent or refusal for a Covid-19 vaccination booster and that she would be provided a copy of her decision. When asked if she had also been offered a copy of her Service Plan to sign her understanding of the services she received, Resident 22 indicated no. She did not know what level of service she currently received. On 11/20/23 at 11:32 a.m., the DCS provided a copy of current facility policy titled, "Evaluation," revised 11/2019. The policy indicated, " ...The service plan will be signed by the resident and a copy will be given to them if requested. A copy of the signed service plan will be maintained in the medical record.		resident/responsible party. These reviews will continue weekly for 6 weeks and until 100% compliance is achieved, then 10 residents a month for 4 months and until 100% compliance is maintained, then quarterly thereafter. 4. The findings of these reviews will be presented to the QAPI committee at the facility's monthly meetings and the plan of action adjusted accordingly.	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observations, interview, and record review, the facility failed to ensure over the counter (OTC) medications were properly labeled for 11 of 27 residents. Findings include: On 11/17/23 at 12:25 p.m., a medication storage observation was conducted, and multiple medications were found and lacked appropriate labeling, as follows.	R 0302	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. All medications were removed and labeled appropriately before being placed back in the medication cart. 2. All residents taking over-the-counter medications have the potential to be affected.	12/19/2023

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	a. Resident 16 had four medications in the medication cart that lacked labeling. b. Resident 10 had four medications in the medication cart that lacked labeling. c. Resident 21 had seven medications in the medication cart that lacked labeling. d. Resident 24 had four medications in the medication cart that lacked labeling. e. Resident 3 had five medications in the medication cart that lacked labeling. f. Resident 1 had one medication in the medication cart that lacked labeling. g. Resident 18 had five medications in the medication cart that lacked labeling. h. Resident 12 had four medications in the medication cart that lacked labeling. i. Resident 17 had one medication in the medication cart that lacked labeling. j. Resident 7 had three medications in the medication cart that lacked labeling. k. Resident 13 had 10 medications in the medication cart that lacked labeling. A policy titled, "Guidelines for medication storage and labeling," was provided by the DCS (Director of Clinical Services) on 11/20/23 10:23 a.m., it indicated, " ...Medications and biologicals are labeled in accordance with currently accepted professional principles and include: Although medication delivery and labeling systems may vary, the medication label at a minimum includes the medication name (generic and/or brand), prescribed dose, strength, the expiration date when applicable, the resident's name and the route of administration. The medication should be labeled with or accompanied by appropriate instructions and precautions (such as shake well, take with meals, do not crush, special storage instructions ...."		Medication carts have been checked again to ensure all OTC medications are labeled accordingly. 3. The policy Medication Guidelines for Storage and Labeling was reviewed and a new policy Assisted Living Medication Labeling was developed. Licensed staff and QMA's will be educated on this policy. The new AL Director will complete visual inspections twice weekly to ensure no medications are stored in the medication carts without being labeled. These inspections will continue twice weekly for 6 weeks and until 100% compliance is achieved, then 4 per month for 4 months and until 100% compliance is maintained, then once a month thereafter. 4. The findings of these audits will be presented to the QAPI Committee during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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