| | | | | | | PRIN | ΓED: | 12/30/2024 | |
|---|---------------------|-----------------------------|--|---------------------------|--|------------|---------------|------------|--|
| DEPARTMENT | OF HEALTH AND HUN | MAN SERVICES | | | | | FORM APPROVED | | |
| CENTERS FOR | MEDICARE & MEDIC | AID SERVICES | | | | OM | B NO. 0 | 938-039 | |
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) | | | (X2) MU | X2) MULTIPLE CONSTRUCTION | | | SURVE | Y | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | ETED | | |
| | | 155286 | B. WING | | | 11/06/2024 | | | |
| | | | | | | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 200 KINGSTON CIR | | | | | | |
| AVALON VILLAGE | | | LIGONI | ER, IN 46767 | | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMP | PLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | D/ | ATE | |

| PREFIX | (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
|--|------------|---|--------|--|------------|
| F 0000 Bidg. 00 This visit was for a Recertification and State Licensure Survey. Survey dates: October 31, November 1, 4, 6, 2024. Facility number: 000184 Provider number: 155286 AIM number: 100267210 Census Bed Type: SNF/NF: 31 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bidg. 00 Bidg. 00 F 0000 FACILITY REQUESTS FACE TO FACE IDR FOR F698. THE FACILITY DISAGREES WITH SCOPE AND SEVERITY. REQUESTING DESK REVIEW P 0000 F 0000 F 0000 F 0000 FACILITY REQUESTS FACE TO FACE IDR FOR F698. THE FACILITY DISAGREES WITH SCOPE AND SEVERITY. REQUESTING DESK REVIEW F 0000 F 0000 F ACILITY REQUESTS FACE TO FACE IDR FOR F698. THE FACILITY DISAGREES WITH SCOPE AND SEVERITY. REQUESTING DESK REVIEW | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION |
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| Licensure Survey. Survey dates: October 31, November 1, 4, 6, 2024. Facility number: 000184 Provider number: 155286 AIM number: 100267210 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record F 0690 T rREQUESTING DESK REVIEW FACE IDR FOR F698. THE FACILITY DISAGREES WITH SCOPE AND SEVERITY. REQUESTING DESK REVIEW | Blag. 00 | This wisit for a December 2 and 2 a | E 0000 | | |
| Survey dates: October 31, November 1, 4, 6, 2024. Facility number: 000184 Provider number: 155286 AIM number: 100267210 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record F 0690 T rREQUESTING DESK REVIEW REQUESTING DESK REVIEW F 0690 T rREQUESTING DESK REVIEW | | | F 0000 | | |
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| Facility number: 000184 Provider number: 155286 AIM number: 100267210 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 F 0690 Based on observation, interview and record REQUESTING DESK REVIEW REQUESTING DESK REVIEW | | Survey dates: October 31 November 1 4 6 2024 | | | |
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| SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record F 0690 T rREQUESTING DESK REVIEW | | | | | |
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| Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record F 0690 T REQUESTING DESK REVIEW 11/23/2024 | | Total: 51 | | | |
| Medicare: 3 Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record F 0690 T REQUESTING DESK REVIEW 11/23/2024 | | Company Dorson Trungs | | | |
| Medicaid: 35 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record F 0690 1 rREQUESTING DESK REVIEW 11/23/2024 | | * ** | | | |
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| accordance with 410 IAC 16.2-3.1. Quality review completed November 7, 2024 F 0690 SS=D Bldg. 00 Based on observation, interview and record A83.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI F 0690 1 rREQUESTING DESK REVIEW | | | | | |
| F 0690 SS=D Bldg. 00 Respectively. Solution of the second serior of the second second serior of the second second serior of the second | | These deficiencies reflect State Findings cited in | | | |
| F 0690 SS=D Bldg. 00 Based on observation, interview and record 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI F 0690 1 rREQUESTING DESK REVIEW | | accordance with 410 IAC 16.2-3.1. | | | |
| F 0690 SS=D Bldg. 00 Based on observation, interview and record 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI F 0690 1 rREQUESTING DESK REVIEW | | | | | |
| SS=D Bowel/Bladder Incontinence, Catheter, UTI Bldg. 00 Based on observation, interview and record F 0690 1 rREQUESTING DESK REVIEW | | Quality review completed November 7, 2024 | | | |
| SS=D Bowel/Bladder Incontinence, Catheter, UTI Bldg. 00 Based on observation, interview and record F 0690 1 rREQUESTING DESK REVIEW | E 0600 | 493 25(a)(1) (3) | | | |
| Bldg. 00 Based on observation, interview and record F 0690 1 rREQUESTING DESK REVIEW 11/23/2024 | | | | | |
| Based on observation, interview and record F 0690 1 rREQUESTING DESK REVIEW 11/23/2024 | | bower bladder moontinence, Gatheter, GT | | | |
| Based on observation, interview and record REVIEW | 1 -1 -1 -1 | | F 0690 | 1 rREQUESTING DESK | 11/23/2024 |
| review, the facility failed to ensure nephrostomy 1. Resident 5 and | | Based on observation, interview and record | 1 0050 | | 11/23/2021 |
| | | · | | | |
| care was provided for 2 of 2 residents reviewed Resident 41 were immediately | | | | | |
| (Resident 5 and Resident 41). assessed to ensure nephrostomy | | (Resident 5 and Resident 41). | | assessed to ensure nephrostomy | |
| tubes were properly cleansed and | | | | | |
| Findings include: dressings applied per physician | | Findings include: | | | |
| orders. Both residents had orders | | 1.0.11.61.11.11.11.11.11.11.11.11.11.11.11. | | | |
| 1. Resident 5's record was reviewed on 11/1/24 at added for nephrostomy care to | | | | The state of the s | |
| 10:51 AM. Diagnoses included chronic kidney include directions for cleaning and | | 10:31 AM. Diagnoses included chronic Kidney | | include directions for cleaning and | |

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

TITLE

(X6) DATE

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: DX2H11 Facility ID: 000184 If continuation sheet Page 1 of 12

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | (X3) DATE | (3) DATE SURVEY | | |
|--|--|--------------------------------|-------|-----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | |
| | | 155286 | B. WI | NG | | 11/06/ | 2024 |
| NAME OF I | PROVIDER OR SUPPLIE | D. | • | STREET A | ADDRESS, CITY, STATE, ZIP COD | • | |
| | | | | | IGSTON CIR | | |
| AVALON | I VILLAGE | | | LIGONI | ER, IN 46767 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | nuscular dysfunction of the | | | dressing changes. | | |
| | bladder. | | | | 2. 2. All other residents with | | |
| | | | | | nephrostomy tube had the | | |
| | | num Data Set (MDS), dated | | | potential to be affected. There | | |
| | | Resident 5's Quarterly Brief | | | were no other residents affect | :ed | |
| | | al Status (BIMS) score was 15 | | | by this practice. | | |
| | | irment). The MDS indicated | | | 3. 3. Nursing staff was educat | | |
| | Resident 5 had an i | indwelling urinary catheter. | | | by DNS on nephrostomy care | . All | |
| | | 1 . 12/14/22 : 1: . 1.1 | | | nephrostomy care orders will | | |
| | | dated 3/14/22, indicated the | | | include directions for cleansin | - | |
| | - | collection bags were to be | | | and applying dressing change | | |
| | changed monthly a | nd as needed. | | | Residents will be reviewed by | | |
| | A mbrosicion anden | dated 7/29/22, indicated the | | | upon admission, and with care reviews to ensure residents w | | |
| | | should be irrigated with 10 | | | | | |
| | - | al saline every shift. | | | nephrostomy tubes have orde that include cleansing the site | | |
| | | a same every sinit. | | | dressing changes. DNS/Desig | | |
| | Δ physician order | dated 10/2/24, indicated | | | will round daily to ensure | Juee | |
| | | it should be recorded every | | | nephrostomy care is provided | ner | |
| | shift. | a should be recorded every | | | MD order. | pei | |
| | | | | | 4. 4. To ensure compliance, I | ONS | |
| | Resident 5's physic | ian orders did not include | | | or Designee is responsible for | | |
| | | sing the nephrostomy tube | | | completing the nephrostomy (| | |
| | | dressing to the nephrostomy | | | audit tool weekly times 4 wee | | |
| | tube sites. | | | | then every 2 weeks times 4 w | | |
| | | | | | then monthly for at least 6 | | |
| | | Plan, dated 1/26/23, indicated | | | months. The form will be revie | | |
| | the resident had bil | ateral nephrostomy tubes. The | | | during facility QAPI meeting. I | f | |
| | | nephrostomy care to be | | | 100% threshold is not achieve | ed an | |
| | ~ | tely through 1/10/25. | | | action plan will be developed. | | |
| | | ded avoidance of catheter | | | 5. 5. Completion date: 11/23/2 | 24 | |
| | · · | nt education related to | | | | | |
| | infection control ar | nd encouragement of fluids. | | | br=""> | | |
| | Resident 5's Care F | Plan, dated 2/26/24, indicated | | | | | |
| | | risk for loud angry outbursts | | | | | |
| | | omy tube discomfort when the | | | | | |
| | _ | were bumped into. Resident 5 | | | | | |
| | became angry when the staff did not follow her | | | | | | |
| | demands of pulling on the nephrostomy tubes. | | | | | | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|-----------|--|---------------------------------|----------------------------|----------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | | |
| | | 155286 | B. W | ING | | 11/06/ | 2024 | |
| | | l . | | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | IGSTON CIR | | | |
| Δ\/ΔΙ ΩΝ | VILLAGE | | | | ER, IN 46767 | | | |
| AVALON | VILLAGE | | _ | LIGOIVI | LIX, IIV 40707 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | _ | TAG | DEFICIENCY) | | DATE | |
| | | for the resident to not be | | | | | | |
| | | others to become distressed | | | | | | |
| | - | terventions included soaking | | | | | | |
| | | be prior to removal, assessing | | | | | | |
| | - | nephrostomy tubes, research | | | | | | |
| | | ctice for nephrostomy tube | | | | | | |
| | | propriate device to reduce | | | | | | |
| | - | rostomy tubes, offering the | | | | | | |
| | offering pain medic | of sitting elsewhere and | | | | | | |
| | offering pain medic | cations. | | | | | | |
| | Resident 5's Care P | lan did not include | | | | | | |
| | | nsertion site care such as | | | | | | |
| | | ng a dressing to the areas. | | | | | | |
| | creamsing or appryin | ing a dressing to the areas. | | | | | | |
| | A progress note, da | ted 6/6/24 at 9:06 PM, | | | | | | |
| | | 5 had been transferred to the | | | | | | |
| | hospital due to a ne | phrostomy tube being pulled | | | | | | |
| | out. | | | | | | | |
| | | | | | | | | |
| | A progress note, da | ted 6/15/24 at 7:30 PM, | | | | | | |
| | | 5 returned from the hospital on | | | | | | |
| | antibiotics for a urii | nary tract infection (UTI). | | | | | | |
| | | . = | | | | | | |
| | | ted 7/6/24 at 9:34 PM, | | | | | | |
| | | 5 had been transferred to the | | | | | | |
| | ^ | r left nephrostomy tube being | | | | | | |
| | | ad refused having the | | | | | | |
| | | ephrostomy tube sites | | | | | | |
| | changed. | | | | | | | |
| | A progress note do | ted 7/11/14 at 1:21 PM, | | | | | | |
| | | 5 had reported itching on their | | | | | | |
| | | eir nephrostomy tube | | | | | | |
| | dressings. | in hepinostomy tube | | | | | | |
| | areonings. | | | | | | | |
| | A progress note. da | ted 7/14/24 at 2:57 AM, | | | | | | |
| | | 5 was transferred to the | | | | | | |
| | hospital due to their | r left nephrostomy tube being | | | | | | |
| | out. | | | | | | | |
| | | | 1 | | | | | |

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

Event ID:

DX2H11 Facility ID: 000184

If continuation sheet Page 3 of 12

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|---------------------------------|----------|---------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILD | DING | 00 | COMPL | ETED |
| | | 155286 | B. WING | | | 11/06/ | /2024 |
| | | | 1 00 | TDEET : | DDDESS OF VICTARE ZIP COP | | |
| NAME OF F | PROVIDER OR SUPPLIER | 3 | | | DDRESS, CITY, STATE, ZIP COD | | |
| A \ / A O \ | \/!!! A O E | | | | | | |
| AVALON | VILLAGE | | | IGONII | ER, IN 46767 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | II | D | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PRE | EFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | T | AG | DEFICIENCY) | | DATE |
| | | | | | | | |
| | A progress note, da | ted 10/10/24 at 1:22 AM, | | | | | |
| | | 5 had completed antibiotic | | | | | |
| | therapy for a UTI. A progress note, dated 10/25/24 at 2:44 PM, | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | 5 was on antibiotics for a UTI. | | | | | |
| | | bandages were in place on the | | | | | |
| | | sites. The wound nurse had | | | | | |
| | | 5's back. No open areas were | | | | | |
| | | vas scratching at their skin | | | | | |
| | while the NP was e | xamining their skin. Bandages | | | | | |
| | | phrostomy tube sites. Resident | | | | | |
| | | hing. Lotion was applied. The | | | | | |
| | | age the resident to not scratch | | | | | |
| | skin and ask staff fo | _ | | | | | |
| | | | | | | | |
| | A hospital discharg | e summary, dated 10/10/24, | | | | | |
| | | ostomy tube insertion sites | | | | | |
| | _ | every day with soap and | | | | | |
| | | y indicated the dressing | | | | | |
| | 1 | tomy tubes should be | | | | | |
| | _ | y 3 days or as needed when | | | | | |
| | the dressing become | • | | | | | |
| | and aresoing even | | | | | | |
| | 2. On 11/1/24 at 9:5 | 55 AM, Resident 41 was | | | | | |
| | | he bed in their room with a | 1 | | | | |
| | 1 | ag on their lap. A urinary | | | | | |
| | | observed lying on the bed. | | | | | |
| | _ | ed they had a urinary bladder | | | | | |
| | | rephrostomy tube. Resident 41 | | | | | |
| | | ir preference to have the | | | | | |
| | | them instead of hanging from | | | | | |
| | the bed. | moode of hanging from | | | | | |
| | ine oca. | | | | | | |
| | Resident 41's record | d was reviewed on 11/1/24 at | | | | | |
| | | ses included chronic kidney | 1 | | | | |
| | _ | tion of urinary tract. | | | | | |
| | uisease and obstruc | non or urmary tract. | | | | | |
| | Resident 41's Quart | terly Minimum Data Set, (MDS) | | | | | |

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

Event ID:

DX2H11 Facility ID: 000184

If continuation sheet Page 4 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155286 | r í | UILDING | nstruction <u>00</u> | (X3) DATE COMPL 11/06/ | ETED |
|--------------------------|----------------------------------|--|-----|---------------------|--|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER VILLAGE | | • | 200 KIN | ADDRESS, CITY, STATE, ZIP COD IGSTON CIR ER, IN 46767 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY 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 APPROPRI DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Interview for Menta | cated Resident 41's Brief al Status (BIMS) score was 13 rment). The MDS indicated the welling catheter. | | | | | |
| | | dated 4/15/24, indicated rostomy tube drainage bag was hly. | | | | | |
| | | dated 4/15/24, indicated costomy tube output was to be t. | | | | | |
| | directions for clean | cian orders did not include sing the nephrostomy tube dressing to the nephrostomy | | | | | |
| | indicated Resident | ted 4/13/24 at 11:41 AM, 41 had been transferred to the r nephrostomy tube being | | | | | |
| | indicated Resident | ted 5/16/24 at 1:50 PM, 41 had been transferred to the r nephrostomy tube being | | | | | |
| | indicated Resident | ted 5/27/24 at 1:58 PM, 41 had been transferred to the r nephrostomy tube sutures | | | | | |
| | indicated Resident | ted 7/12/24 at 5:40 PM, 41 had been transferred to the r nephrostomy tube being | | | | | |
| | | 11/6/24 at 12:22 PM, Registered ated they were not aware of | | | | | |

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Event ID:

DX2H11 Facility ID: 000184

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|---------------------------------|--|--------|---|-----------|------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDI | NG | 00 | COMPLETED | |
| | | 155286 | B. WING | | | 11/06/ | 2024 |
| | | | сті | DEET A | DDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | | | |
| A\/AI | VILLAGE | | 200 KINGSTON CIR LIGONIER, IN 46767 | | | | |
| AVALON | VILLAGE | | LIC | JOINIE | ER, IN 40707 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREF | ΊX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TF | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | G | DEFICIENCY) | | DATE |
| | Resident 5 and Resi | dent 41 having physician | | | | | |
| | orders for nephrosto | omy tube care. RN 3 indicated | | | | | |
| | they were not famil | iar with applying dressings to | | | | | |
| | nephrostomy tube s | ites. | | | | | |
| | | | | | | | |
| | | 1/6/24 at 1:04 PM, the Director | | | | | |
| | • • • | ndicated they did not know if | | | | | |
| | | dent 41 had physician orders | | | | | |
| | for nephrostomy tub | pe site care. | | | | | |
| | | | | | | | |
| | | 1/6/24 at 2:05 PM, the | | | | | |
| | | ated they understood the | | | | | |
| | | roviding care to nephrostomy | | | | | |
| | · | prevention and damage to the | | | | | |
| | nephrostomy tubes. | | | | | | |
| | | 1. 1. 15/11 | | | | | |
| | | olicy, dated 5/11 and revised | | | | | |
| | | the DON on 11/4/24 at 1:45 | | | | | |
| | | acility would verify physician | | | | | |
| | _ | omy tube care. The policy | | | | | |
| | - | ostomy tube sites would be | | | | | |
| | | al saline, covered with sterile | | | | | |
| | | t dressing as directed by the | | | | | |
| | physician. | | | | | | |
| | 2 1 41(-)(1) | | | | | | |
| | 3.1-41(a)(1) | | | | | | |
| F 0755 | 483.45(a)(b)(1)-(3 | 1 | | | | | |
| SS=D | Pharmacy |) | | | | | |
| Bldg. 00 | • | /Pharmacist/Records | | | | | |
| Diag. 00 | Orves/r roccdures/ | Tialinacist/Tecords | F 0755 | | REQUESTING DESK REVIEW | W | 11/23/2024 |
| | Based on observation | on, interview, and record | 1.0/33 | | REGULUTINO DESKINEVIEV | ٧ | 11/43/4U2 4 |
| | | ailed to ensure medication | | | 1. Resident 11 was immediate | alv | |
| | _ | es were followed for 1 of 5 | | | assessed with no concerns no | - | |
| | residents reviewed (| | | | and MD notified. RN 3 was | ica | |
| | | (| | | immediately re-educated on | | |
| | Findings include: | | | | medication administration and | | |
| | | | | | disposal methods for medicati | | |
| | During medication | pass observation on 11/1/24 at | | | per policy. The medication roo | | |
| | | d Nurse (RN) 3 prepared | | | was stocked with drug buster | | |
| | , 8 | () - 1 -F | 1 | | c.cca arag bactor | r -· | |

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Event ID:

DX2H11 Facility ID: 000184

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE | SURVEY | |
|--|----------------------|----------------------------------|------|-----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 00 | COMPL | ETED |
| | | 155286 | B. W | 'ING | | 11/06/ | /2024 |
| | | | | CTD FFT A | ADDRESS OF A STATE SID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | ADDRESS, CITY, STATE, ZIP COD | | |
| A) (A) O) | \//III | | | | IGSTON CIR | | |
| AVALON | VILLAGE | | | LIGONI | ER, IN 46767 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | medication for Resi | dent 11. During the | | | policy. | | |
| | preparation, RN 3 d | ropped a duloxetine 60 mg | | | 2. All residents have the poter | ntial | |
| | | e medication cart. RN 3 | | | to be affected by this practice. | | |
| | | le with ungloved fingers, | | | There were no other residents | | |
| | | ication cup along with other | | | affected by this practice. Nurs | | |
| | - | be given that morning and | | | staff was educated by the DNS | - | |
| | administered them t | - | | | medication administration and | | |
| | | | | | disposal methods for medicati | | |
| | During an interview | on 11/1/24 at 9:25 AM, | | | per policy. | | |
| | ~ | Nurse (LPN) 2 indicated | | | 3. Nursing staff was educated | bv | |
| | | d be placed in drug buster (a | | | the DNS on medication | ~, | |
| | | d to dissolve medications and | | | administration and disposal | | |
| | _ | le). She indicated drug buster | | | methods for medication per | | |
| | | in the medication room. | | | policy. Medication rooms were | e | |
| | | | | | stocked with drug buster. The | | |
| | During an observati | on on 11/1/24 at 9:26 AM, | | | nurse management team will | | |
| | _ | abinets in the medication room | | | check during GEMBA rounds | to | |
| | - | was found. The 300-hall | | | ensure medications are prope | | |
| | - | s inspected with LPN 2 and no | | | disposed of per facility policy. | | |
| | drug buster was fou | - | | | 4. To ensure compliance, DNS | S or | |
| | 8 | | | | Designee is responsible for | J 01 | |
| | During an observati | on on 11/1/24 at 9:40 AM, the | | | completing the medication | | |
| | _ | a cart was inspected with RN 3. | | | administration CQI audit tool a | and | |
| | | observed in the cart. | | | medication disposal CQI week | | |
| | The army custor was | | | | times 4 weeks then every 2 w | - | |
| | During an interview | on 11/1/24 at 9:41 AM, RN 3 | | | times 4 weeks then monthly fo | | |
| | - | the capsule in the cup | | | least 6 months. The form will | | |
| | _ | lean medication cart. He | | | reviewed during the facility QA | | |
| | - | not have touched the pills | | | meeting. If 100% threshold is | | |
| | | ingers. He indicated the | | | achieved an action plan will be | | |
| | - | pably have been placed in the | | | developed. | 7 | |
| | | le indicated the sharps | | | 5. Completion date: 11/23/24 | | |
| | - | acility's method of disposing of | | | 5. Completion date. 11/23/24 | | |
| | | taminated medications. | | | | | |
| | discontinued of Coll | tammateu meuteations. | | | | | |
| | Resident 11's record | d was reviewed on 11/4/24 at | | | | | |
| | | s included major depressive | | | | | |
| | _ | estructive pulmonary disease, | | | | | |
| | and dementia. | ostructive pullionary disease, | | | | | |
| | and dementia. | | | | | | |
| | | | | | | | |

PRINTED: 12/30/2024 FORM APPROVED

| CENTERS FO | ERS FOR MEDICARE & MEDICAID SERVICES | | | | | OM | IB NO. 0938-039 | |
|------------|---|--|---|---------|---|---|----------------------|--|
| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155286 | | JILDING | onstruction 00 | (X3) DATE SURVEY COMPLETED 11/06/2024 | | |
| | PROVIDER OR SUPPLIEF | · | • | 200 KIN | ADDRESS, CITY, STATE, ZIP COD IGSTON CIR ER, IN 46767 | | | |
| | SUMMARY (EACH DEFICIENT REGULATORY OF Resident 11's currer (MDS) dated 10/9/2 Interview for Menta (cognitively intact). Physician orders dated duloxetine 60 milling should be given dated disorder. In an interview on 1 Director of Nursing should dispose of disorder which was keen she indicated she disorder. A current policy date DON on 11/4/24 at should not come interview on 1 1 disorder with the medication with bated dose packaging. The should discard medicontamination. | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Int annual Minimum Data Set 24 indicated their Basic al Status (BIMS) score was 15 | | 200 KIN | IGSTON CIR | | (X5) COMPLETION DATE | |
| | DON on 11/4/24 at disposal methods for following: 1) Removing medic containers, placing container and addin medication unusable | 2:04 PM indicated approved or medications included the cations from their dispensing them in a plastic bag or ag a substance rendering the | | | | | | |
| | "Medication for De | struction" and storing in a is picked up by a licensed | | | | | | |

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waste disposal company.

3) Facility approved, commercially available, drug

Event ID:

DX2H11

Facility ID: 000184

If continuation sheet

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| CENTERS FOR | R MEDICARE & MEDIC | | | | OMB NO. 0938-039 | |
|----------------------------|--|--|-----------------|---|------------------|--|
| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155286 | B. WING | | 11/06/2024 | |
| | PROVIDER OR SUPPLIEF | R | 200 KI | ADDRESS, CITY, STATE, ZIP COD NGSTON CIR IIER, IN 46767 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE | |
| | disposal kits. | | | | | |
| | 3.1-25(o) | | | | | |
| F 0842 SS=D Bldg. 00 | 483.20(f)(5), 483. Resident Records | 70(i)(1)-(5) s - Identifiable Information | | | | |
| J | | | F 0842 | REQUESTING DESK REVIEW | V 11/23/2024 | |
| | Based on observation | on, interview, and record | 1 00 12 | | 11/25/2021 | |
| | | failed to ensure a wound | | 1. Resident 15 was immediate | elv | |
| | - | curately recorded for 1 of 11 | | assessed with no concerns | ., | |
| | residents reviewed | | | noted. Documentation for this | | |
| | residents feviewed | (resident 13). | | resident was reviewed by the | | |
| | Findings include: | | | wound nurse. RN 3 was | | |
| | rindings include. | | | immediately re educated on | | |
| | During a wound an | re observation on 11/4/24 at | | accurate documentation of a | | |
| | _ | 15 was observed lying on his | | | | |
| | | | | wound. | | |
| | _ | avily padded heel boot secured | | 2. All other residents have the | | |
| | | re. Licensed Practical Nurse | | potential to be affected. The | | |
| | | lent 15's foot up about 6 inches | | wound nurse completed a hou | | |
| | | removed Resident 15's heel | | wide audit of all wounds to ens | | |
| | boot. | | | documentation was accurate. | | |
| | | | | other residents were affected | by | |
| | _ | gauze dressing wrapped around | | this practice. | | |
| | | ing his ankle and up to the | | 3. Nursing staff was re educat | ed | |
| | | ne dressing was secured with a | | by the DNS on accurate | | |
| | | 11/3/24. LPN 5 removed the | | documentation of wounds. The | ie | |
| | | ght ankle, placing it in a plastic | | wound nurse will review woun | d | |
| | | to his left leg and performed | | documentation in the clinical | | |
| | wound care, assessi | ment and application of a new | | meeting to ensure that all wou | nd | |
| | dressing. | | | documentation is accurate. | | |
| | | | | 4. To ensure compliance, DNS | S or | |
| | | d was reviewed on 10/31/24 at | | Designee is responsible for | | |
| | | ses included peripheral vascular | | completing the wound CQI au | dit | |
| | disease, type 2 diab | etes mellitus with diabetic | | tool weekly times 4 weeks the | n | |
| | nephropathy, and es | ssential hypertension. | | every 2 weeks times 4 weeks | then | |
| | | | | monthly for at least 6 months. | | |
| | Resident 15's curren | nt quarterly Minimum Data Set | | The form will be reviewed duri | ng | |
| | (MDS) dated 10/1/2 | 24 indicated his Basic Interview | | the facility QAPI meeting. If 1 | _ | |

for Mental Status (BIMS) score was 15

threshold is not achieved an action

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|----------------------------------|----------|----------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | LETED |
| | | 155286 | B. W | ING | | 11/06 | /2024 |
| | | | <u> </u> | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | IGSTON CIR | | |
| Δ\/Δ1 ΩNΙ | VILLAGE | | | | ER, IN 46767 | | |
| AVALON | VILLAGE | | | LIGUNI | LIX, IIN 40707 | | _ |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | ` • • • | The MDS indicated Resident | | | plan will be developed. | | |
| | 15 had a venous sta | sis ulcer. | | | 5. Completion date: 11/23/24 | | |
| | | | | | | | |
| | Resident 15's current care plan titled Resident has | | | | | | |
| | impaired skin integrity indicated the resident | | | | | | |
| | _ | ounds on the right anterior | | | | | |
| | _ | ate of 1/10/25. Interventions | | | | | |
| | | or signs of infection: redness, | | | | | |
| | 1 - | odorous drainage, fever, | | | | | |
| | increase in size/dep | th of wound and document. | | | | | |
| | Physician orders da | ted 10/25/24 indicated | | | | | |
| | 1 | wound should be cleansed | | | | | |
| | | r, an application of HydroFera | | | | | |
| | _ | ould be applied to the wound, | | | | | |
| | | dominal (a thick padded, | | | | | |
| | | overing) pad and wrapped | | | | | |
| | | uze, used to wrap around a limb) | | | | | |
| | daily. | uzz, uzza te map ureuna a inite) | | | | | |
| | ĺ | | | | | | |
| | Progress notes, doc | umented by Registered Nurse | | | | | |
| | _ | 24 at 9:24 AM indicated venous | | | | | |
| | ulcers to the right a | nkle continued, treatment was | | | | | |
| | in place, there was | a moderate amount of drainage | | | | | |
| | and no signs or sym | nptoms of infection. The note | | | | | |
| | indicated surroundi | ng tissue was of normal color | | | | | |
| | for the resident. | | | | | | |
| | | | | | | | |
| | | 11/4/24 at 12:37 PM, LPN 5 | | | | | |
| | | ng she had removed from | | | | | |
| | 1 | foot earlier that morning had | | | | | |
| | | She indicated the dressing | | | | | |
| | | and no other employee had | | | | | |
| | changed the dressin | g that day. | | | | | |
| | | | | | | | |
| | | 11/4/24 at 12:44 AM, RN 3 | | | | | |
| | | t perform any assessments on | | | | | |
| | | ds. He indicated he had | | | | | |
| | | ssessment. He was unable to | | | | | |
| | account for how he | obtained wound assessment | 1 | | | | 1 |

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Event ID:

DX2H11 Facility ID: 000184

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE S | | | SURVEY | | |
|--|-----------------------|--|-------|----------|---|----------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155286 | B. W | NG | | 11/06/ | /2024 |
| | | <u> </u> | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | L. | | | IGSTON CIR | | |
| AVALON | VILLAGE | | | LIGONI | ER, IN 46767 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LISC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | - | the time of LPN 5's wound | | | | | |
| | assessment that day | | | | | | |
| | During an interview | on 11/6/24, the Regional | | | | | |
| | | idicated there was no policy | | | | | |
| | | entation available for review. | | | | | |
| | | | | | | | |
| | 3.1-50(a)(2) | | | | | | |
| F 0880 | 483.80(a)(1)(2)(4) | (a)(f) | | | | | |
| SS=D | Infection Prevention | | | | | | |
| Bldg. 00 | iniconon i revenue | on a control | | | | | |
| 2.49.00 | | | F 0 | 880 | REQUESTING DESK REVIEW | V | 11/23/2024 |
| | Based on observation | on, interview, and record | | 300 | | • | 11/23/2021 |
| | | ailed to ensure infection | | | 1. Resident 15 was immediate | ely | |
| | _ | ere implemented regarding hair | | | assessed with no concerns | , | |
| | restraint during wou | and care for of 1 of 11 | | | noted. | | |
| | residents reviewed (| (Resident 15). | | | 2. All other residents have the | | |
| | | | | | potential to be affected. The | | |
| | Findings include: | | | | wound nurse completed a hou | ise | |
| | | | | | wide audit of all wounds with r | 10 | |
| | _ | re observation on 10/4/24 at | | | concerns noted. There were r | าด | |
| | | 15 was observed lying on his | | | other residents affected by this | S | |
| | | l Practical Nurse (LPN) 4 held | | | practice. | | |
| | | p about 6 inches off the bed | | | 3. The wound nurse was educ | | |
| | | ed Resident 15's dressing from | | | by the DNS on restraining her | | |
| | • • • | ing it in a plastic bag on the | | | during wound care. Nursing st | | |
| | | leg. LPN 5 leaned her head | | | was re educated by the DNS of | | |
| | | e wounds on the inner aspect | | | restraint of their hair during wo | ouna | |
| | - | l ankle. LPN 5's shoulder | | | care. The DNS/Designee will | ٨ | |
| | _ | restrained and touched ng and the top of the plastic | | | complete rounds during wound | | |
| | | soiled dressing. LPN 5's hair | | | care to ensure staff are restraitheir hair during wound care. | iiiig | |
| | | g and plastic bag during the | | | 4. To ensure compliance, DNS | Sor | |
| | | of HydroFera blue wound | | | Designee is responsible for | J 01 | |
| | treatment (an antiba | | | | completing the wound CQI au | dit | |
| | , | the cleansing of the wound, | | | tool weekly times 4 weeks the | | |
| | | ssessment, and during the | | | every 2 weeks times 4 weeks | | |
| | - | ound treatment. No attempt to | | | monthly for at least 6 months. | · - | |
| | restrain the hair was | _ | | | The form will be reviewed duri | na | |

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Event ID:

DX2H11 Facility ID: 000184

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|------------------------------|---|--------------------------------|----------------------------|---------------------------|---|------------------|------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | | 00 | COMPLETED | | |
| 155286 | | B. W. | B. WING | | 11/06/2024 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| AVALON VILLAGE | | | | 200 KINGSTON CIR | | | | |
| AVALON VILLAGE | | | | LIGONIER, IN 46767 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID PROVIDER'S PLAN OF COR | | | (X5) | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) the facility QAPI meeting. If 100% | | COMPLETION | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | | | DATE | |
| | Resident 15's record was reviewed on 10/31/24 at 11:03 AM. Diagnoses included peripheral vascular disease, type 2 diabetes mellitus with diabetic | | | | threshold is not achieved an action | | | |
| | | | | plan will be developed. | | Clion | | |
| | | | | | 5. Completion date: 11/23/24 | · • | | |
| | nephropathy, and essential hypertension. | | | | 11 2 1p. 2 2 1 1/20/2 1 | | | |
| | | | | | | | | |
| | Resident 15's current quarterly Minimum Data Set | | | | | | | |
| | (MDS), dated 10/1/24, indicated his Basic | | | | | | | |
| | Interview for Mental Status (BIMS) score was 15 | | | | | | | |
| | (cognitively intact). The MDS indicated Resident | | | | | | | |
| | 15 had a venous stasis ulcer. | | | | | | | |
| | Resident 15's current care plan titled at risk for | | | | | | | |
| | transferring or colonized with MDRO | | | | | | | |
| | (multi-drug-resistant organism) indicated the | | | | | | | |
| | resident had a problem of a chronic wound | | | | | | | |
| | requiring a dressing, with a goal date of 1/10/25. | | | | | | | |
| | Interventions included use standard precautions including hand hygiene in addition to EBP. | | | | | | | |
| | | | | | | | | |
| | Physician orders, dated 10/25/24, indicated | | | | | | | |
| | Resident 15's ankle wound should be cleansed | | | | | | | |
| | with soap and water, an application of HydroFera | | | | | | | |
| | Blue, cut to size should be applied to the wound, | | | | | | | |
| | covered with an abdominal (a thick padded, absorbent wound covering) pad and wrapped with Kerlix (roll gauze, used to wrap around a limb) | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | daily. | | | | | | | |
| | In an interview, on 11/4/24 at 1:20 PM, the | | | | | | | |
| | Administrator indicated hair should be restrained | | | | | | | |
| | and should not touch residents or objects. | | | | | | | |
| | | | | | | | | |
| | A current policy, undated, titled Dress Code, | | | | | | | |
| | | ministrator on 11/4/24 at 1:21 | | | | | | |
| | PM indicated hair should be kept neat and should | | | | | | | |
| | not touch objects or | - | | | | | | |
| | | | | | | | | |
| 3.1-18(a) | | | | | | | | |
| | | | 1 | | | | | |

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

Event ID:

DX2H11 Facility ID: 000184

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