STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(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. 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 0000	FACILITY REQUESTS FACE TO FACE IDR FOR F698. THE FACILITY DISAGREES WITH SCOPE AND SEVERITY. REQUESTING DESK REVIEW	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview and record review, the facility failed to ensure nephrostomy care was provided for 2 of 2 residents reviewed (Resident 5 and Resident 41). Findings include: 1. Resident 5's record was reviewed on 11/1/24 at 10:51 AM. Diagnoses included chronic kidney	F 0690	1 rREQUESTING DESK REVIEW 1. Resident 5 and Resident 41 were immediately assessed to ensure nephrostomy tubes were properly cleansed and dressings applied per physician orders. Both residents had orders added for nephrostomy care to include directions for cleaning and	11/23/2024

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

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	disease and neuromuscular dysfunction of the bladder. Resident 5's Minimum Data Set (MDS), dated 10/3/24, indicated Resident 5's Quarterly Brief Interview for Mental Status (BIMS) score was 15 (no cognitive impairment). The MDS indicated Resident 5 had an indwelling urinary catheter. A physician order, dated 3/14/22, indicated the nephrostomy urine collection bags were to be changed monthly and as needed. A physician order, dated 7/29/22, indicated the nephrostomy tubes should be irrigated with 10 milliliters of normal saline every shift. A physician order, dated 10/2/24, indicated nephrostomy output should be recorded every shift. Resident 5's physician orders did not include directions for cleansing the nephrostomy tube sites or applying a dressing to the nephrostomy tube sites. Resident 5's Care Plan, dated 1/26/23, indicated the resident had bilateral nephrostomy tubes. The target goal was for nephrostomy care to be managed appropriately through 1/10/25. Interventions included avoidance of catheter obstruction, resident education related to infection control and encouragement of fluids. Resident 5's Care Plan, dated 2/26/24, indicated the resident was at risk for loud angry outbursts related to nephrostomy tube discomfort when the nephrostomy tubes were bumped into. Resident 5 became angry when the staff did not follow her demands of pulling on the nephrostomy tubes.		dressing changes. 2. 2. All other residents with nephrostomy tube had the potential to be affected. There were no other residents affected by this practice. 3. 3. Nursing staff was educated by DNS on nephrostomy care. All nephrostomy care orders will include directions for cleansing and applying dressing changes. . Residents will be reviewed by IDT upon admission, and with careplan reviews to ensure residents with nephrostomy tubes have orders that include cleansing the site and dressing changes. DNS/Designee will round daily to ensure nephrostomy care is provided per MD order. 4. 4. To ensure compliance, DNS or Designee is responsible for completing the nephrostomy CQI audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during facility QAPI meeting. If 100% threshold is not achieved an action plan will be developed. 5. 5. Completion date: 11/23/24 br="">	

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	The target goal was for the resident to not be distressed or cause others to become distressed through 1/10/25. Interventions included soaking the dressing and tape prior to removal, assessing pain related to the nephrostomy tubes, research and clarify best practice for nephrostomy tube care, utilizing an appropriate device to reduce movement of nephrostomy tubes, offering the resident the choice of sitting elsewhere and offering pain medications. Resident 5's Care Plan did not include nephrostomy tube insertion site care such as cleansing or applying a dressing to the areas. A progress note, dated 6/6/24 at 9:06 PM, indicated Resident 5 had been transferred to the hospital due to a nephrostomy tube being pulled out. A progress note, dated 6/15/24 at 7:30 PM, indicated Resident 5 returned from the hospital on antibiotics for a urinary tract infection (UTI). A progress note, dated 7/6/24 at 9:34 PM, indicated Residnet 5 had been transferred to the hospital due to their left nephrostomy tube being loose. Resident 5 had refused having the bandages at their nephrostomy tube sites changed. A progress note, dated 7/11/14 at 1:21 PM, indicated Resident 5 had reported itching on their lower back near their nephrostomy tube dressings. A progress note, dated 7/14/24 at 2:57 AM, indicated Residnet 5 was transferred to the hospital due to their left nephrostomy tube being out.			

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A progress note, dated 10/10/24 at 1:22 AM, indicated Residnet 5 had completed antibiotic therapy for a UTI.

A progress note, dated 10/25/24 at 2:44 PM, indicated Resident 5 was on antibiotics for a UTI. The note indicated bandages were in place on the nephrostomy tube sites. The wound nurse had evaluated Resident 5's back. No open areas were noted. Resident 5 was scratching at their skin while the NP was examining their skin. Bandages were in place at nephrostomy tube sites. Resident 5 complained of itching. Lotion was applied. The staff should encourage the resident to not scratch skin and ask staff for assistance.

A hospital discharge summary, dated 10/10/24, indicated the nephrostomy tube insertion sites should be cleansed every day with soap and water. The summary indicated the dressing around the nephrostomy tubes should be changed about every 3 days or as needed when the dressing becomes wet or soiled.

2. On 11/1/24 at 9:55 AM, Resident 41 was observed lying on the bed in their room with a urinary collection bag on their lap. A urinary collection bag was observed lying on the bed. Resident 41 indicated they had a urinary bladder catheter and a left nephrostomy tube. Resident 41 indicated it was their preference to have the collection bags with them instead of hanging from the bed.

Resident 41's record was reviewed on 11/1/24 at 10:15 AM. Diagnoses included chronic kidney disease and obstruction of urinary tract.

Resident 41's Quarterly Minimum Data Set, (MDS)

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	dated 8/21/24, indicated Resident 41's Brief Interview for Mental Status (BIMS) score was 13 (no cognitive impairment). The MDS indicated the resident had an indwelling catheter. A physician order, dated 4/15/24, indicated Resident 41's nephrostomy tube drainage bag was to be changed monthly. A physician order, dated 4/15/24, indicated Resident 41's nephrostomy tube output was to be recorded every shift. Resident 41's physician orders did not include directions for cleansing the nephrostomy tube sites or applying a dressing to the nephrostomy tube sites. A progress note, dated 4/13/24 at 11:41 AM, indicated Resident 41 had been transferred to the hospital due to their nephrostomy tube being damaged. A progress note, dated 5/16/24 at 1:50 PM, indicated Resident 41 had been transferred to the hospital due to their nephrostomy tube being dislodged. A progress note, dated 5/27/24 at 1:58 PM, indicated Resident 41 had been transferred to the hospital due to their nephrostomy tube sutures being out. A progress note, dated 7/12/24 at 5:40 PM, indicated Resident 41 had been transferred to the hospital due to their nephrostomy tube being dislodged. In an interview on 11/6/24 at 12:22 PM, Registered Nurse (RN) 3 indicated they were not aware of			

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	Resident 5 and Resident 41 having physician orders for nephrostomy tube care. RN 3 indicated they were not familiar with applying dressings to nephrostomy tube sites. In an interview on 11/6/24 at 1:04 PM, the Director of Nursing (DON) indicated they did not know if Resident 5 and Resident 41 had physician orders for nephrostomy tube site care. In an interview on 11/6/24 at 2:05 PM, the Administrator indicated they understood the concern related to providing care to nephrostomy tube sites, infection prevention and damage to the nephrostomy tubes. A current facility policy, dated 5/11 and revised 12/12, provided by the DON on 11/4/24 at 1:45 PM, indicated the facility would verify physician orders for nephrostomy tube care. The policy indicated the nephrostomy tube sites would be cleansed with normal saline, covered with sterile gauze or transparent dressing as directed by the physician. 3.1-41(a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review the facility failed to ensure medication disposition guidelines were followed for 1 of 5 residents reviewed (Resident 11). Findings include: During medication pass observation on 11/1/24 at 9:07 AM, Registered Nurse (RN) 3 prepared	F 0755	REQUESTING DESK REVIEW 1. Resident 11 was immediately assessed with no concerns noted and MD notified. RN 3 was immediately re-educated on medication administration and disposal methods for medications per policy. The medication room was stocked with drug buster per	11/23/2024

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	medication for Resident 11. During the preparation, RN 3 dropped a duloxetine 60 mg capsule on top of the medication cart. RN 3 picked up the capsule with ungloved fingers, placed it in the medication cup along with other medications due to be given that morning and administered them to Resident 11. During an interview on 11/1/24 at 9:25 AM, Licensed Practical Nurse (LPN) 2 indicated dropped pills should be placed in drug buster (a liquid chemical used to dissolve medications and render them unusable). She indicated drug buster should be available in the medication room. During an observation on 11/1/24 at 9:26 AM, LPN 2 opened all cabinets in the medication room and no drug buster was found. The 300-hall medication cart was inspected with LPN 2 and no drug buster was found in the cart. During an observation on 11/1/24 at 9:40 AM, the 200-hall medication cart was inspected with RN 3. No drug buster was observed in the cart. During an interview on 11/1/24 at 9:41 AM, RN 3 indicated he placed the capsule in the cup because he kept a clean medication cart. He indicated he should not have touched the pills with his ungloved fingers. He indicated the capsule should probably have been placed in the sharps container. He indicated the sharps container was the facility's method of disposing of discontinued or contaminated medications. Resident 11's record was reviewed on 11/4/24 at 2:10 PM. Diagnoses included major depressive disorder, chronic obstructive pulmonary disease, and dementia.		policy. 2. All residents have the potential to be affected by this practice. There were no other residents affected by this practice. Nursing staff was educated by the DNS on medication administration and disposal methods for medication per policy. 3. Nursing staff was educated by the DNS on medication administration and disposal methods for medication per policy. Medication rooms were stocked with drug buster. The nurse management team will check during GEMBA rounds to ensure medications are properly disposed of per facility policy. 4. To ensure compliance, DNS or Designee is responsible for completing the medication administration CQI audit tool and medication disposal CQI weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during the facility QAPI meeting. If 100% threshold is not achieved an action plan will be developed. 5. Completion date: 11/23/24	

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	Resident 11's current annual Minimum Data Set (MDS) dated 10/9/24 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). Physician orders dated 3/23/24 indicated duloxetine 60 milligram delayed release capsule should be given daily for major depressive disorder. In an interview on 11/4/24 at 2:09 PM, The Director of Nursing (DON) indicated nurses should dispose of dropped medications in drug buster which was kept in the medication room. She indicated she did not know why drug buster was not available in the medication room. A current policy dated 4/30/24 provided by the DON on 11/4/24 at 2:04 PM, indicated medications should not come into contact with any surface except for the medication cup. The policy also indicated facility staff should avoid touching medication with bare hands when opening unit dose packaging. The policy indicated facility staff should discard medications immediately after contamination. A current policy dated 7/1/24 provided by the DON on 11/4/24 at 2:04 PM indicated approved disposal methods for medications included the following: 1) Removing medications from their dispensing containers, placing them in a plastic bag or container and adding a substance rendering the medication unusable. 2) Packing in a sealed container clearly labeled "Medication for Destruction" and storing in a locked area until it is picked up by a licensed waste disposal company. 3) Facility approved, commercially available, drug			

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	disposal kits. 3.1-25(o)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, interview, and record review the facility failed to ensure a wound assessment was accurately recorded for 1 of 11 residents reviewed (Resident 15). Findings include: During a wound care observation on 11/4/24 at 9:41 AM, Resident 15 was observed lying on his right side with a heavily padded heel boot secured with a Velcro closure. Licensed Practical Nurse (LPN) 4 held Resident 15's foot up about 6 inches off the bed. LPN 5 removed Resident 15's heel boot. Resident 15 had a gauze dressing wrapped around his right foot covering his ankle and up to the base of his toes. The dressing was secured with a piece of tape dated 11/3/24. LPN 5 removed the dressing from his right ankle, placing it in a plastic bag on the bed next to his left leg and performed wound care, assessment and application of a new dressing. 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 nephropathy, and essential hypertension. Resident 15's current quarterly Minimum Data Set (MDS) dated 10/1/24 indicated his Basic Interview for Mental Status (BIMS) score was 15	F 0842	REQUESTING DESK REVIEW 1. Resident 15 was immediately assessed with no concerns noted. Documentation for this resident was reviewed by the wound nurse. RN 3 was immediately re educated on accurate documentation of a wound. 2. All other residents have the potential to be affected. The wound nurse completed a house wide audit of all wounds to ensure documentation was accurate. No other residents were affected by this practice. 3. Nursing staff was re educated by the DNS on accurate documentation of wounds. The wound nurse will review wound documentation in the clinical meeting to ensure that all wound documentation is accurate. 4. To ensure compliance, DNS or Designee is responsible for completing the wound CQI audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during the facility QAPI meeting. If 100% threshold is not achieved an action	11/23/2024

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	(cognitively intact). The MDS indicated Resident 15 had a venous stasis ulcer. Resident 15's current care plan titled Resident has impaired skin integrity ... indicated the resident had a problem of wounds on the right anterior ankle, with a goal date of 1/10/25. Interventions included observe for signs of infection: redness, pain, drainage, malodorous drainage, fever, increase in size/depth of wound and document. 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. Progress notes, documented by Registered Nurse (RN) 3, dated 11/4/24 at 9:24 AM indicated venous ulcers to the right ankle continued, treatment was in place, there was a moderate amount of drainage and no signs or symptoms of infection. The note indicated surrounding tissue was of normal color for the resident. In an interview on 11/4/24 at 12:37 PM, LPN 5 indicated the dressing she had removed from Resident 15's right foot earlier that morning had been dated 11/3/24. She indicated the dressing was changed daily and no other employee had changed the dressing that day. In an interview on 11/4/24 at 12:44 AM, RN 3 indicated he did not perform any assessments on Resident 15's wounds. He indicated he had recorded LPN 5's assessment. He was unable to account for how he obtained wound assessment		plan will be developed. 5. Completion date: 11/23/24	

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	information prior to the time of LPN 5's wound assessment that day. During an interview on 11/6/24, the Regional Nurse Consultant indicated there was no policy for accurate documentation available for review. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review the facility failed to ensure infection control practices were implemented regarding hair restraint during wound care for of 1 of 11 residents reviewed (Resident 15). Findings include: During a wound care observation on 10/4/24 at 9:41 AM, Resident 15 was observed lying on his right side. Licensed Practical Nurse (LPN) 4 held Resident 15's foot up about 6 inches off the bed while LPN 5 removed Resident 15's dressing from his right ankle, placing it in a plastic bag on the bed next to his left leg. LPN 5 leaned her head down to observe the wounds on the inner aspect of the right foot and ankle. LPN 5's shoulder length hair was not restrained and touched Resident 15's bedding and the top of the plastic bag containing the soiled dressing. LPN 5's hair touched the bedding and plastic bag during the loosening of a patch of HydroFera blue wound treatment (an antibacterial wound care application), during the cleansing of the wound, during the wound assessment, and during the application of the wound treatment. No attempt to restrain the hair was made.	F 0880	REQUESTING DESK REVIEW 1. Resident 15 was immediately assessed with no concerns noted. 2. All other residents have the potential to be affected. The wound nurse completed a house wide audit of all wounds with no concerns noted. There were no other residents affected by this practice. 3. The wound nurse was educated by the DNS on restraining her hair during wound care. Nursing staff was re educated by the DNS on restraint of their hair during wound care. The DNS/Designee will complete rounds during wound care to ensure staff are restraining their hair during wound care. 4. To ensure compliance, DNS or Designee is responsible for completing the wound CQI audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during	11/23/2024

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	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 nephropathy, and essential hypertension. 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, provided by the Administrator on 11/4/24 at 1:21 PM indicated hair should be kept neat and should not touch objects or residents. 3.1-18(a)		the facility QAPI meeting. If 100% threshold is not achieved an action plan will be developed. 5. Completion date: 11/23/24	