CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u> B. WING		COMPLETED 11/16/2023	
		155286	B. WI	NG		11/16	/2023
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
AVALON	I VILLAGE				IER, IN 46767		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
			F 00	000	Submission of this plan of		
		ne Annual Recertification and			correction does not constitute		
	State Licensure sur	vey.			admission or agreement by the	ıe	
	C 1-4 N	-112 12 14 15116 2022			provider of the truth of facts		
	Survey date: Nover	mber 12, 13, 14, 15, and 16, 2023			alleged or correction set forth the statement of deficiencies.		
	Facility number: 00	00184			plan of correction is prepared		
	Provider number: 1				submitted because of require		
	AIM number: 1002				under state and federal law.		
					Please accept this plan of		
	Census Bed Type:				correction as our credible		
	SNF/NF: 52				allegation of compliance		
	Total: 52						
					Requesting Desk Review		
	Census Payor Type Medicare: 5	::					
	Medicaid: 36						
	Other: 11						
	Total: 52						
	Avalon Village was	s found to be in compliance					
		83, Subpart B and 410 IAC					
	_	o the Annual Recertification					
	and State Licensure	e survey.					
	Quality review com	npleted November 21, 2023.					
F 0558	483.10(e)(3)						
SS=D	Reasonable Acco	mmodations					
Bldg. 00	Needs/Preference						
	§483.10(e)(3) The	e right to reside and receive					
		cility with reasonable					
		f resident needs and					
		pt when to do so would					
	_	Ith or safety of the resident					
	or other residents		- 1		Î		I

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

Based on observation, interview, and record

TITLE

Requesting Desk Review

(X6) DATE

12/08/2023

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 disclodays 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: TOUE11 Facility ID: 000184 If continuation sheet Page 1 of 24

F 0558

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. WI	NG		11/16	/2023
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					NGSTON CIR		
AVALON	I VILLAGE			LIGONI	IER, IN 46767		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINERIC DI AMI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		failed to ensure an adaptive call					
	I	and within reach for 1 of 15			F558 Reasonable Accommod	ation	
	residents reviewed				of Needs/Preferences		
		(			Residents 30, was immedia	telv	
	Findings include:				assessed to ensure an adaptive	-	
	i mamga meraati				call light was available and with		
	During an observat	ion on 11/12/23 at 10:13 AM,			resident reach. Careplan was		
	_	oserved lying in bed in her			updated.		
		had severe contractures of her			2. There were no other reside	nte	
		s. Her elbows were bent at a			affected by this practice. All o		
		hands were in a tight fist			residents were assessed by s		
		s were positioned near her			to ensure call light was	lali	
	face. Her call light cord was observed against the				appropriate and within reach.		
	wall behind the bed. The call light activation					tis co	
	handle was observed lying on the floor. The call				Residents who prefer an adap		
					call light were given the call lig		
	_	to be a standard call light.			and a careplan that accurately	′	
		ed she could not reach her call			reflect this preference.	4	
	light.				3. Staff educated by the Direc		
	Danis a an internal	11/12/22 -+ 10-25 AM			of Nursing on call light place	nent	
	_	v on 11/12/23 at 10:35 AM,			to ensure within reach and	e.	
		de (CNA) 4 indicated the call			reporting any need for an ada		
	1 -	hin Resident 30's reach. CNA 4			call light to the nurse. Nurses		
		t on resident's upper torso.			educated on providing adaptiv	e call	
		e Resident 30 demonstrate			lights as needed along with		
		ll light, CNA 4 placed the call			therapy referrals as needed.		
	_	30's right hand. Resident 30			Residents will be reviewed by		
		nable to activate the call light			upon admission, and with care	•	
		needed to use her mouth to			reviews to ensure resident has	5	
		ht. CNA 4 placed the call light			appropriate call light and		
		wer lip and Resident 30			careplans are updated. Frequ	ient	
	_	te the call light without			rounds will be completed to		
	success.				ensure residents have an		
					appropriate call light in reach.	_	
	_	ion and interview on 11/12/23			4. To ensure compliance, DNS	3 or	
		dent 30 was observed lying in			Designee is responsible for		
	_	sition as observed earlier that			completing the call light CQI a		
		uch call light with a gripper			tool weekly times 4 weeks the		
		lying on Resident 30's lower			every 2 weeks times 4 weeks		
		sked to activate her call light,			monthly for at least 6 months.		
	Resident 30 indicat	red she could not reach it. The			form will be reviewed during fa	acility	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155286	B. W	B. WING 11/16/2023			
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			IGSTON CIR		
AVALON	VILLAGE			LIGONIER, IN 46767			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Minimum Data Set	(MDS) Coordinator indicated			CQI meeting. If 100% threshol	ld is	
	Resident 30 would	not be able to reach the call			not achieved an action plan wi	ill be	
	light where it was p	positioned. The MDS			developed.		
	Coordinator placed	the call light near her right			5. Completion date: 12/8/23		
	hand and then unde	er the left side of her chin.					
	Resident 30 made r	novements in attempt to					
	activate the light w	ithout success.					
	During an observat	ion on 11/15/23 at 2:59 PM, A					
	grey angled pressur	re activated call device was					
		w the left side of Resident 30's					
chin. Resident 30 could then activate the call light.							
	Resident 30's record	d was reviewed on 11/13/23 at					
	2:45 PM. Diagnose	es included spastic quadriplegic					
	cerebral palsy, cont	tracture of the right hand,					
	contracture of the le	eft hand, contracture of					
	muscle, multiple sit	tes, other reduced mobility, and					
	need for assistance	with personal care.					
	A review of Reside	ent 30's current quarterly					
	Minimum Data Set	(MDS) dated 10/19/23					
	indicated her Basic	Interview for Mental Status					
	(BIMS) score was 1	12 (mild cognitive impairment).					
	The MDS indicated	d Resident 30 hand					
	contractures of both	h upper extremities and was					
	totally dependent in	n rolling back and forth in the					
	bed.						
	A review of Reside	ent 30's current care plan titled					
		for fallsdated 6/1/22 indicated					
	Resident 30 was at	risk for falls with a goal date of					
		ons included call light in reach.					
		tled resident utilized adaptive					
		1/12/23 indicated Resident 30					
	-	e call light with a goal date of					
	_	ons included a soft touch call					
	pad initiated on 11/						

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A document titled Activity Detail Report dated

Event ID:

T0UE11

Facility ID: 000184

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155286	B. W	ING		11/16	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹	200 KINGSTON CIR					
AVALON	VILLAGE			LIGONIER, IN 46767				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		3 was received from the Social 3 at 2:03 PM. The Social						
		ne document detailed all						
		all light in the noted time frame.						
		ecorded on 11/12/23 at 2:19 PM						
		8 AM. No records of call light						
		23 2:19 PM were recorded on						
	the call light systen	1.						
	A review of a physi	ical therapy evaluation and						
		ne dates of 10/10/23 to 11/8/23						
	indicated Resident	30 had contractures. These						
		nal abilities. The evaluation and						
	1 ^	address Resident 30's ability						
	to use her call light.	•						
		upational therapy evaluation						
	1 -	om the dates of $4/22/23$ to						
		desident 30 had contractures						
		nal abilities. The evaluation						
	and plan of care did ability to use her ca	l not address Resident 30's						
	ability to use her ca	m ngnt.						
		tled Resident Rights, undated,						
		rector of Nursing on 11/15/23 at						
		residents have the right to						
	reasonable accomo	dations of needs.						
	In an interview on 1	11/16/23 at 11:34 AM the						
		cated the facility did not have a						
	policy for call light	s or use of adaptive call lights.						
	3.1-3(v)(1)							
F 0561	483.10(f)(1)-(3)(8)	)						
SS=D	Self-Determination							
Bldg. 00	§483.10(f) Self-de							
		the right to and the facility						
	1	facilitate resident						
	self-determination	through support of resident						

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Event ID:

T0UE11 Facility ID: 000184

If continuation sheet Page 4 of 24

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED		
		155286	B. W	B. WING			/2023	
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			NGSTON CIR			
Δ\/ΔΙ ΩΝ	I VILLAGE				IER, IN 46767			
7,17,12011	· VIEE/(OE			EIGGINER, IN 40707			ı	
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		but not limited to the rights						
	1	raphs (f)(1) through (11) of						
	this section.							
	\$492 10/f\/1\ The	racidant has a right to						
	- ',','	resident has a right to schedules (including						
		ing times), health care and						
		h care services consistent						
	l •	erests, assessments, and						
		other applicable provisions of						
	this part.	other applicable provisions of						
	uno part.							
	8483.10(f)(2) The	resident has a right to make						
	,,,	pects of his or her life in the						
		gnificant to the resident.						
		•						
	§483.10(f)(3) The	resident has a right to						
	- ',','	bers of the community and						
	participate in com	munity activities both inside						
	and outside the fa	acility.						
	§483.10(f)(8) The	resident has a right to						
	participate in othe	er activities, including social,						
	religious, and con	nmunity activities that do						
	not interfere with	the rights of other residents						
	in the facility.							
			F 05	561	Requesting Desk Review		12/08/2023	
		on, interview, and record						
	review the facility				F561 Self Determination			
		of visitors for 2 of 15 residents			Resident 30 was immediate	ely		
	reviewed (Resident	30 and Resident 35).			assessed and interviewed by			
					DNS/SSD to ensure that resid	ent		
	Findings include:				rights were in place for			
	1) Dynin1	viction on 11/12/22 -4 10:12 AB4			self-determination of visitors.	al		
		vation on 11/12/23 at 10:13 AM,			Appropriate call light in place			
		served lying in bed in her			in reach. Careplan reviewed a	and		
		was observed standing beside			accurate for this resident.			
		onsensically to Resident 30			Resident 35 was immediately			
	_	sic playing on her radio.			assessed by DNS/SSD to ens			
	Kesident 30 had se	vere contractures of her			careplan was appropriate and		İ	

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Event ID:

T0UE11 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. BUILDING <u>00</u>		COMPLETED		
		155286	B. WING			11/16/2023	
				CTREET	ADDRESS STEW STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
A) /A1 O)	\//\		200 KINGSTON CIR				
AVALON	VILLAGE			LIGONIER, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	bilateral upper arms	s. Her elbows were bent at a			accurate for this resident. As	top	
	tight angle and her	hands were in a tight fist			sign was placed on the resider	•	
		s were positioned near her			door.		
	1 ~	cord was observed against the			2. All other residents have the		
	_	. The call light activation			potential to be affected by this		
		d lying on the floor. Resident			practice. All residents were		
		uld not reach her call light.			reviewed to ensure resident rig	ghts	
		ed Resident 35 had not			for self determination of visitor	-	
	touched her, but she	e did not invite him into the			were in place and preferences		
		nce made her uncomfortable.			accurately reflect plan of care.		
	_	d been in her room the prior			resident have appropriate call		
	night also.	•			lights in place to alert staff if		
					needed.		
	Resident 30's record was reviewed on 11/13/23 at				3. Staff educated by the Socia	I	
	2:45 PM. Diagnoses included spastic quadriplegic				Services Director on resident		
	_	racture of the right hand,			rights and self determination o	f	
		eft hand, contracture of			visitors. Staff educated on		
		tes, other reduced mobility, and			careplan approaches/intervent	ions	
	need for assistance	-			r/t intrusive wandering. Residents		
		-			will be reviewed by IDT members		
	A review of Reside	nt 30's current quarterly			upon admission review, annua		
	Minimum Data Set	(MDS) dated 10/19/23			significant changes, quarterly	,	
	indicated her Basic	Interview for Mental Status			MDS assessments to ensure		
	(BIMS) score was 1	12 (mild cognitive impairment).			approaches remain effective.		
	The MDS indicated	Resident 30 hand			Frequent rounds will be compl	eted	
	contractures of both	upper extremities and was			to ensure resident intervention		
		rolling back and forth in the			intrusive wandering remain		
	bed.				effective. If interventions are		
					ineffective, an action plan will l	be	
	A review of Reside	nt 30's current care plan titled			developed.		
	psychosocial well-b	being dated 6/1/23 indicated			4. To ensure compliance, the	SSD	
	she had a problem of	of a history of sexual abuse,			or Designee is responsible for		
	with a goal date of	1/25/24. Interventions included			completing the CQI dignity and		
	ensure resident has	a sense of emotional and			privacy audit tool weekly times		
	physical safety. A c	current care plan titled			weeks then every 2 weeks tim		
		for fallsdated 6/1/22 indicated			weeks then monthly for at leas		
	Resident 30 was at	risk for falls with a goal date of			months. The form will be revie		
	1/25/24. Intervention	ons included call light in reach.			during facility CQI meeting. If		
		-			100% threshold is not achieve	d an	
	2) Resident 35's rec	ord was reviewed on 11/15/23			action plan will be developed.		

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Event ID:

T0UE11 Facility ID: 000184

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED	
		155286	B. W	B. WING 11/16/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 200 KINGSTON CIR LIGONIER, 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	TF.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	ses included Diagnoses			5. Completion date: 12/8/23			
		's disease with late onset,						
	-	cation deficit, and generalized						
	anxiety disorder.							
	A review of Resider	nt 35's current quarterly						
		(MDS) dated 11/1/23 indicated						
	his Basic Interview for Mental Status (BIMS) score was 3 (cognitively impaired).							
	-	plan titled Resident is at risk for						
	_	indicated Resident 35 had a						
		the wrong room with a goal						
		proaches included providing nversation as needed.						
	1:1 attention and co	nversation as needed.						
	In an interview on 1	1/14/23 at 2:23 PM, Licensed						
		N) 5 indicated staff tried to						
	· ·	Resident 35 when he was up						
		to keep him from going in						
	other resident's roor	ns.						
		led Resident Rights, undated, ector of Nursing on 11/15/23 at						
		residents have the right to						
	choose to receive or	deny visitors.						
	3.1-3(u)3							
F 0699	483.25(m)							
SS=D	Trauma Informed	Care						
Bldg. 00	§483.25(m) Traum							
J. 22	` ` '	ensure that residents who						
		ors receive culturally						
	competent, trauma	•						
		rofessional standards of						
	-	unting for residents'						
		preferences in order to						
	_	ate triggers that may cause						
	re-traumatization	of the resident.						

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

Event ID:

T0UE11

Facility ID: 000184

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155286		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/16/2023			
	PROVIDER OR SUPPLIEI	?	STREET ADDRESS, CITY, STATE, ZIP COD 200 KINGSTON CIR LIGONIER, IN 46767				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE		
mo	REGGENTORT	CESC IDENTIFY THIS BY ORGANIZATION	_	Requesting Desk Review			
	review the facility was made aware of resident with a hist residents reviewed.  Findings include:  On 11/12/23 at 11:: observed ambulatin. Resident 48 had their chest. Resider downward at the container of apples and clutched the container of apples and anxiety disorder of the container of the container of apples and anxiety disorder of the container of the contai	59 AM, Resident 48 was ag with bare feet in the hallway neir arms folded tightly across at 48's lips were turned orners. Resident 48 grabbed a sauce from a medication cart intainer to their chest. A de (CNA) was overheard stating imbative.  In the description of the description	F 0699	Requesting Desk Review  F 699 Trauma Informed Care 1. Resident 48 was immediate assessed to ensure behavioral interventions are appropriate a effective. Care sheets and careplans updated with trigger trauma and appropriate interventions for resident. 2. All other residents have the potential to be affected by this practice. All residents were reviewed to ensure trauma informed careplan reflects trigger from assessment and interventions reflected on the careplan and interventions on care sheets. 3. SSD educated by ED on trauma informed care. Staff educated by the SSD on traum informed care and behavioral interventions of residents. Sta educated on utilizing resident careplans and caresheets for approaches/interventions r/t behavior management and tra (if identified). Residents will be reviewed by IDT members upda admission review, annual, significant changes, quarterly MDS assessments to ensure approaches remain effective.	I and I and I so for		
	behaviors of wande than daily.	Assessment dated 9/27/23 at		Frequent rounds will be completed to ensure resident intervention remain effective. If intervention are ineffective, an action plant be developed.	ns ns		

10:06 AM indicated Resident 48 had experienced

4. To ensure compliance, the DNS

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		155286	B. W	'ING		11/16/	/2023
		<u> </u>		CTREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	1					
A\/A\ O\\	\/!!!		200 KINGSTON CIR				
AVALON	VILLAGE			LIGUNI	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
	trauma in their life.	The assessment indicated			or Designee is responsible for		
	Resident 48 may fe	el uncomfortable around males.			completing the CQI behavior a		
	The assessment ind	icated loud noises were a			tool weekly times 4 weeks the		
	trigger that made R	esident 48 feel unsafe or			every 2 weeks times 4 weeks		
	stressed.				monthly for at least 6 months.		
					form will be reviewed during fa		
	A current care plan	focus of mood state dated			CQI meeting. If 100% thresho	-	
		on 11/14/23 indicated			not achieved an action plan w		
		istory of sexual abuse trauma			developed.		
		e-traumatization, feeling unsafe			5. Completion date: 12/8/23		
		distressed. The goal was to					
	eliminate or reduce triggers that may cause						
re-traumatization by 12/27/23. Interventions							
included encouragement of socialization,							
	communication, physical safety, emotional safety,						
		in the care plan as the					
		held a PhD in psychology.					
	_	ot include resident specific					
	_	f loud noises and males. These					
	triggers could cause						
		The care plan did not include					
		viors of refusal of care or					
	combativeness.						
	Resident 48's record	d did not include					
	documentation of b						
	A physician order d	lated 9/21/23 indicated					
		ceive psychiatric services.					
	A progress note ent	ered by Male Nurse 1 dated					
		indicated Resident 48 had					
		f violence against the staff.					
		and scratched 5 staff					
		48 had attempted to bite the					
		ogress note indicated it had					
		ers to get Resident 48 into the					
	shower room.	6					
	A progress note dat	ed 9/23/23 at 8:45 AM					

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Event ID:

T0UE11 Facility ID: 000184

If continuation sheet Page 9 of 24

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155286		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/16/2023	
	PROVIDER OR SUPPLIER VILLAGE		200 KIN	ADDRESS, CITY, STATE, ZIP COD NGSTON CIR IER, IN 46767	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
		48 had struck staff members			
	A progress note dat indicated Resident 4 been combative tow to understand their note indicated Residupdated and interve applicable.  A progress note ent 9/26/23 at 11:16 AN bitten a staff member A progress note dat indicated Resident 4 to any approaches the resident during epis wandering.  A progress note ent 10/20/23 at 8:09 AN	ed 9/25/23 at 1:59 PM 48 disliked direct care, had vards the staff and was unable environment. The progress dent 48's care plan had been ntions were revised as  ered by Male Nurse 2 dated M indicated Resident 48 had er.  ed 10/2/23 at 2:57 PM 48's son in law had no insight hat could help settle the odes of restlessness and  ered by Male Nurse 1 dated M indicated they had been sident 48 after they had fallen			
	A progress note dat indicated Resident 4 agitation and restles shower.  A Behavioral Healt dated 11/10/23 at 12 had not had any nev review indicated the restlessness and diff present environmen	ed 11/3/23 at 4:15 PM 48 had displayed increased seness after having had a h Monthly Review (review) 2:51 PM indicated Resident 48 or or worsening behaviors. The eresident had a high risk for ficulty understanding their t. The review indicated blan had been updated with			

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Event ID:

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Facility ID: 000184

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155286		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/16/2023	
	PROVIDER OR SUPPLIER		200 KII	ADDRESS, CITY, STATE, ZIP COD NGSTON CIR IER, IN 46767	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG		ed 11/14/23 at 2:40 PM	TAG	DEFICIENCY)	DATE
		48's daughter declined facility			
	counseling services	for the resident. The progress			
		esident's other daughter had a			
		and would assure Resident 48			
	would have counseling services as needed.				
		1/14/23 at 3:42 PM the Social			
		SD) indicated Resident 48 did			
		na Informed Care assessment			
	•	the resident's daughter was a			
		g service and was qualified to he SSD indicated Resident 48's			
		ed the Trauma Informed Care			
	_	The SSD indicated they did not			
		et care staff were made aware of			
		haviors. The SSD indicated			
	_	ask the Director of Nursing			
	(DON).				
	In an interview on 1	11/15/23 at 2:40 PM the DON			
	indicated the facility	y no longer used behavior			
	_	DON indicated new or			
		rs were documented in the			
		DON indicated they were			
		ect care staff knew resident			
	specific benaviors v	were new or worsening.			
	In an interview on 1	1/15/23 at 2:42 PM the SSD			
	indicated they colle	cted behavior information from			
		D indicated new or worsening			
		orded in the progress notes			
		ogress notes. The SSD			
		a monthly behavior template			
		ors in the progress notes. The			
		e was no behavior information			
		station. The SSD indicated of how direct care staff knew			
		haviors were common, new or			
	worsening.	na. 1515 were common, new or			
			1	1	l l

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	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  AVALON VILLAGE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  AVALON VILLAGE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident	11/16/2023	
AVALON VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident		
AVALON VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  In an interview on 11/15/23 at 2:44 PM Resident  48's daughter indicated the resident became  agitated and combative when water was sprayed  directly on them. The daughter indicated Resident		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident	(X5)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  In an interview on 11/15/23 at 2:44 PM Resident 48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident	COMPLETION	
48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident	DATE	
48's daughter indicated the resident became agitated and combative when water was sprayed directly on them. The daughter indicated Resident		
agitated and combative when water was sprayed directly on them. The daughter indicated Resident		
directly on them. The daughter indicated Resident		
48 had bitten a staff member during a shower. The		
T		
daughter indicated they had made the staff		
member aware of Resident 48's preference of not		
having water sprayed directly on them. The		
daughter indicated the staff member now sprays		
water onto wash clothes instead of placing the		
resident under the water stream and the resident		
has not become agitated during showers provided		
by that particular staff member. The daughter		
indicated Resident 48 became fearful and nervous		
around men and became anxious when they heard		
loud noises.		
11/1//02 / 11 /5 / 11/2		
In an interview on 11/16/23 at 11:45 AM CNA 2		
indicated their resident assignment sheets did not		
include specific resident behaviors or interventions. CNA 2 indicated there was no		
information for resident specific behaviors or interventions at the nurse station. CNA 2		
indicated they were to verbally report observed behaviors to the nurse. CNA 2 indicated they		
were unaware of how to determine specific		
behaviors of new residents. CNA 2 indicated they		
were unaware of how to determine if a resident's		
behavior was common, new or worsening.		
behavior was common, new or worsening.		
A current policy dated 2/20 provided by the DON		
on 11/14/23 at 12:50 PM indicated each resident		
would be screened for trauma during the Social		
Services Assessment upon admission. The policy		
indicated the plan of care would be routinely		
evaluated to determine if the interventions had		
been effective in reducing the impact of identified		
triggers that may cause re-traumatization.		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	00	COMPL	ETED
		155286	B. W	ING		11/16/	2023
	PROVIDER OR SUPPLIER		<u> </u>	200 KIN	ADDRESS, CITY, STATE, ZIP COD NGSTON CIR IER, IN 46767		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
F 0740	483.40						
SS=D	Behavioral Health	Services					
Bldg. 00	§483.40 Behaviora	al health services.					
Ŭ	•	st receive and the facility					
		necessary behavioral health					
	care and services to attain or maintain the						
	highest practicable physical, mental, and						
	psychosocial well-being, in accordance with						
	the comprehensive assessment and plan of						
		health encompasses a					
		motional and mental					
		includes, but is not limited					
to, the prevention and treatment of mental							
	and substance use						
			F 0	740	Requesting Desk Review		12/08/2023
	Based on observation	on, interview and record					
	review the facility f	ailed to ensure behavioral care			F740 Behavioral Health Service	ces-	
	plan interventions w	vere followed for 1 of 5			1. Resident 35 was immediately		
	residents reviewed.	(Resident 35)			assessed by DNS and SSD to	•	
					ensure careplan was appropri		
	Findings include:				and accurate for this resident.		
					Careplan was updated with ne	ew	
	During an observati	on on 11/12/23 at 10:13 AM,			interventions to address reside		
	Resident 30 was obs	served lying in bed in her			behaviors.		
	room. Resident 35	was observed standing beside			2. All other residents have the		
	her bed speaking no	onsensically to Resident 30			potential to be affected by this		
		ic playing on her radio.			practice. An audit was conduc	cted	
	Resident 35 placed	Resident 30's trash can on top			to ensure residents with behav	vioral	
	of her overbed table	and pushed it around the			careplans were assessed and		
	room while mumbli	ng non-sensical words.			careplans were accurate and		
	Resident 35 walked	out to the hallway and			appropriate for these residents	s.	
		large mechanical device used			3. Staff educated by SSD on		
	to lift dependent res	sidents) lift device that was			behavioral interventions and		
		y and began pushing it down			reflection of behaviors and		
		identified CNA approached			interventions on the resident		
	Resident 35 and red	lirected him away from the			careplans and caresheets. An		
	hoyer lift device.				audit was completed to ensure	e all	
					behavioral interventions were	listed	
	Resident 35's record	d was reviewed on 11/15/23 at			on the resident careplans and		
	1:31 PM. Diagnoses	s included Diagnoses included			caresheet for all residents.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155286	B. W	ING		11/16/	/2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
A) /A1 ON	\/\/\				IGSTON CIR		
AVALON	VILLAGE			LIGUNI	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	Alzheimer's disease	with late onset, cognitive			Residents will be reviewed by	IDT	
	communication def	icit, and generalized anxiety			members upon admission revi	ew,	
	disorder.				annual, significant changes,		
					quarterly MDS assessments to	)	
	A review of Resident 35's current quarterly				ensure approaches remain		
	Minimum Data Set	(MDS) dated 11/1/23 indicated			effective. Frequent rounds wil	l be	
	his Basic Interview	for Mental Status (BIMS)			completed to ensure resident		
	score was 3 (cognitively impaired).				interventions remain effective.	If	
					interventions are ineffective, a	n	
	A review of progress notes dated 11/4/23 at 4:25				action plan will be developed.		
	AM indicated Resident 35 had wandered into a				4. To ensure compliance, the I	ONS	
	female resident's room, laid down in the extra bed				or Designee is responsible for		
	in the room and attempted to pull down his brief				completing the CQI Social		
	and urinate on the f	loor.			Services Careplan audit tool		
	Resident 35's care p	olan titled Behavioral			weekly times 4 weeks then even	ery	
		d 8/16/23, with a goal date of			2 weeks times 4 weeks then		
		d. The care plan indicated the			monthly for at least 6 months.	The	
	following problems				form will be reviewed during fa	cility	
		00 noon increased agitation as			CQI meeting. If 100% threshol		
	_	l aggression toward staff;			not achieved an action plan wi	ll be	
		PM following lunch and			developed.		
	-	physical agitation toward staff			5. Completion date: 12/8/23		
	with physical comb						
		d nurse's hand when					
	attempting to replace						
	4. 8/22/23 sexual						
		tional response to staff					
		gressive and holding on to a					
	staff's shirt collar;	are a same as					
		ered into another resident's					
		a brief and gripper socks;					
		l proposition of female staff;					
	1	cal aggression and					
	inappropriate speec	n toward staff; cally combative toward staff.					
	9. 10/9/23 Physic	cany combanive toward stair.					
	Annroaches inch-1-	ad areating a safe space for the					
		ed creating a safe space for the If about while promoting					
		ing staff supervision and					
	1	on by staff as needed.					
	mereased supervision	on by starr as needed.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155286	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  11/16/2023				
	PROVIDER OR SUPPLIEF	R	200 KII	ADDRESS, CITY, STATE, ZIP CO NGSTON CIR IIER, IN 46767	D .		
(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 CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	intrusive wandering problem of entering date of 2/1/24. App 1:1 attention and co In an interview on 1 Practical Nurse 5 in close eye on Reside	plan titled Resident is at risk for gindicated Resident 35 had a g the wrong room with a goal proaches included providing proversation as needed.  11/14/23 at 2:23 PM, Licensed adicated staff tried to keep a cent 35 when he is up walking in m from going in other resident					
	indicated they prov residents according sheets. CNA 2 indic not included on the sheets. CNA 2 indic behavior was obser reported to the nurs unaware of how to behaviors were con	11/15/23 at 11:45 AM CNA 2 ided direct care to the to resident care assignment cated resident behaviors were resident care assignment cated when an unusual ved, the behavior was verbally e. CNA 2 indicated they were determine when resident mon for the specific resident. ey were not aware of a nethod.					
	revised 8/22 provid on 11/15/23 at 1:08 interdisciplinary tea having potential for intrusive wandering should be educated	led Behavior Management, last ed by the Director of Nursing PM indicated the am should review all behaviors risks to others including and the direct care staff as to the interventions for by the interdisciplinary team.					
F 0745 SS=D Bldg. 00		cally Related Social Service cility must provide					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155286	B. WI	NG		11/16/	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	₹			NGSTON CIR		
AVALON	I VILLAGE				IER, IN 46767		
					I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	1	social services to attain or					
	_	est practicable physical,					
		osocial well-being of each					
	resident.	on interview and record	EAS	7.4.5	Degraphing Deak Deview		12/09/2022
	Based on observation, interview and record review the facility failed to ensure resident specific, non-pharmacological interventions were		F 07	/45	Requesting Desk Review		12/08/2023
					E745 Provision of Madically		
	attempted for 1 of 2 residents reviewed. (Resident				F745 Provision of Medically Related Social Services		
	48)	residents reviewed. (Resident			Resident 48 was immediate	alv.	
	70)				assessed by SSD to ensure a	•	
	Findings include:				behavioral interventions are list		
	i mamga merade.				on the careplan, accurate for		
	On 11/12/23 at 11:4	59 AM, Resident 48 was			resident and reflected on the		
	observed ambulating in the hallway with bare feet.				sheet. The careplan was upda		
		eir arms folded tightly across			to include resident specific	itou	
		at 48's lips were turned			triggers of loud noises and me	en e	
		orners. Resident 48 grabbed a			and interventions to address t		
		auce from a medication cart			triggers. These interventions v		
		ntainer to their chest. A			be implemented prior to the us		
		de (CNA) was overheard stating			pharmacological interventions		
	the resident was con				2. All residents have the poter		
					to be affected by this practice.		
	Resident 48's record	d was reviewed on 11/14/23 at			audit was conducted to ensure	е	
	10:33 AM. Diagnos	ses included hallucinations,			appropriate triggers careplane	÷d	
	unspecified dement	tia with psychotic disturbances			and interventions were effective	ve	
	and anxiety disorde	er.			and implemented and listed o	n the	
					care sheets.		
		nt Comprehensive Minimum			3. Staff educated by the SSD	on	
	` ′	ted 9/27/23 indicated the			implementation on non		
		cognitive impairment. The			pharmacological intervention	(O	
		sident 48's communication was			behaviors. Residents will be		
	1 -	erstood. The MDS indicated			reviewed by IDT members up	on	
		hibited behavioral symptoms			admission review, annual,		
	1	scratching self, pacing,			significant changes, quarterly		
		sexual acts, disrobing in public,			MDS assessments to ensure		
	1	ng food or bodily wastes,			approaches remain effective.		
	_	ing disruptive sounds daily.			Frequent rounds will be comp		
		Resident 48 exhibited			to ensure resident intervention		
		ering and refusal of care less			remain effective. If interventio		
	than daily.				I are ineffective, an action plan	will	

PRINTED: 12/12/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB N	O. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETI	ED
		155286	B. WING		11/16/20	123
					,, _	
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
	ing viben on sorree.		200 KIN	NGSTON CIR		
AVALON	I VILLAGE		LIGON	IER, IN 46767		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		I	(X5)
				PROVIDER'S PLAN OF CORRECTION		
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION	TAG			DATE
		Assessment dated 9/27/23 at		be developed.		
		d Resident 48 had a history of		4. To ensure compliance, the	DNS	
	trauma and may fee	el uncomfortable around males.		or Designee is responsible for		
	The assessment ind	icated loud noises were a		completing the CQI psychoact	tive	
	trigger that made R	esident 48 feel unsafe or		management tool weekly time		
	stressed.			weeks then every 2 weeks tim		
				weeks then monthly for at least		
	A current care plan	focus of mood state dated		months. The form will be revie		
	_	Lesident 48 had a risk of signs		during facility CQI meeting. If		
		nxiety such as wandering,		100% threshold is not achieve	nd an	
		on, worried facial expressions,		action plan will be developed.	d an	
		, insomnia, nausea, sweating,		_ ·		
	•			5. Completion date: 12/8/23		
		and sweating with a goal				
	1 ~	/23. The care plan focus did				
		nt 48's identified stressors of				
	loud noises and bei	ng around men.				
	_	focus of mood state dated				
		I on 11/14/23 at 3:25 PM				
		48 had a history of sexual				
		sk of feeling unsafe, untrusting				
		he goal was to eliminate or				
	reduce triggers that	may cause re-traumatization				
	by 12/27/23. Interv	entions included				
	encouragement of s	ocialization, communication,				
	physical safety, em-	otional safety, family				
	participation in the	care plan as the resident's				
		nD in psychology. The care				
		e resident specific identified				
	*	ses and men that could cause				
		ome distressed. The care plan				
		ident 48's behaviors of refusal				
	of care or combativ					
	of care of combativ	eness.				
	A physician order d	lated 9/21/23 indicated				
		ceive psychiatric services.				
	l indicate to may to	poj emante services.				
	A progress note ent	ered by Male Nurse 1 dated				
		indicated Resident 48 had				

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multiple episodes of violence against the staff.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155286	B. WING		11/16/2023
	PROVIDER OR SUPPLIER	3	200 K	FADDRESS, CITY, STATE, ZIP COD INGSTON CIR NIER, IN 46767	
(X4) ID	CIMMADV	STATEMENT OF DEFICIENCIE	ID		(V5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	ì ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
		and scratched 5 staff			
	members. Resident	48 had attempted to bite the			
	male nurse. The pro	ogress note indicated it had			
	taken 4 staff membe	ers to get Resident 48 into the			
	shower room.				
		10/02/02 + 0.45 +24			
	A progress note dated 9/23/23 at 8:45 AM indicated Resident 48 had struck staff members				
	while resisting care				
	winic resisting care				
	A progress note dated 9/25/23 at 1:59 PM				
	indicated Resident	48 disliked direct care, had			
	been combative tow	vards the staff and was unable			
		environment. The progress			
		dent 48's care plan had been			
	_	entions were revised as			
	applicable.				
	A progress note ent	ered by a Male Nurse 1 dated			
		M indicated Resident 48 had			
	bitten a staff memb				
	A progress note dat	ed 9/26/23 at 3:29 PM			
		48 had continued to be			
	restless, agitated an	d combative with the staff.			
	A magazaa mata 1-4	ad 0/27/22 at 0.20 AM			
		ed 9/27/23 at 9:20 AM 48 had benefitted from a new			
	topical anti-anxiety				
	F and anniety				
	A physician order	dated 9/27/23 indicated			
		be administered lorazepam			
		ation) 1 milligram by rubbing			
	onto the resident's s	kin twice daily.			
	A mmo cmo :t 1 .	ad 10/2/22 at 2.57 DM			
	A progress note dated 10/2/23 at 2:57 PM indicated Resident 48's son in law had no insight				
		hat could help settle the			
		sodes of restlessness and			
	wandering.	odes of restressitess and			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	r í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		LETED
		155286	B. WING		11/16	6/2023
	PROVIDER OR SUPPLIER		200	ET ADDRESS, CITY, STATE, ZIP KINGSTON CIR DNIER, IN 46767	COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDEDIC DI AN OF CO	PRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	ALTROPRIATE	DATE
	10/20/23 at 8:09 AN unable to assess Residue the resident being A progress note data indicated Resident 4 agitation and restless shower.  A Behavioral Health dated 11/10/23 at 12 had not had any new review indicated the restlessness and difference and the restlessness and difference are effective intervention. A progress note data indicated Resident 4 facility counseling similaries in counseling and we would have counsel in an interview on 1 Service Director (Staughter had a PhD was qualified to treat indicated they were identify specific trig preceded the resider indicated they did not staff were made awas stressors or behavior would have to ask the staff were made as the staff were made awas stressors or behavior would have to ask the staff were made as the staff were made as the staff were made awas tressors or behavior would have to ask the staff were made as the staff were made as the staff were made awas tressors or behavior would have to ask the staff were made as the staff were made as the staff were made awas tressors or behavior would have to ask the staff were made as the sta	ed 11/3/23 at 4:15 PM 48 had displayed increased seness after having had a h Monthly Review (review) 2:51 PM indicated Resident 48 or worsening behaviors. The eresident had a high risk for ficulty understanding their t. The review indicated plan had been updated with				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	LETED
		155286	B. W	ING		11/16	/2023
				CTDEET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8					
A\/AI	\/II				GSTON CIR		
AVALON	VILLAGE			LIGUNII	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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	services had been o	btained for the resident.					
		1/15/23 at 2:40 PM the DON					
	·	y no longer used behavior					
	_	DON indicated new or					
	I -	s were documented in the					
		DON indicated they were					
		at 48's specific stressors that					
		iors. The DON indicated they					
		w direct care staff knew					
	_	haviors were new or					
	worsening.						
		11/15/20 0. 40 D) (					
		11/15/23 at 2:42 PM the SSD					
	1	cted behavior information from					
		D indicated new or worsening					
		orded in the progress notes					
		ogress notes. The SSD					
	1	a monthly behavior template					
		ors in the progress notes. The					
		e was no behavior information station. The SSD indicated					
		of how direct care staff knew					
	1	haviors were common, new or					
		D indicated she was unaware					
	of any psychiatric s						
	or any psychiatrics	services notes.					
	In an interview on 1	1/15/23 at 2:44 PM Resident					
		ated the resident became					
	_	tive when water was sprayed					
	l -	he daughter indicated Resident					
		f member during a shower. The					
		they had made the staff					
		esident 48's preference of not					
		ed directly on them. The					1
		the staff member now sprays					
	_	othes instead of placing the					
		vater stream and the resident					1
		tated during showers provided					1
		aff member. The daughter					
	l , , , , , , , , , , , , , , , , , , ,						1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155286		(X2) MULTIPLE C A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 11/16/2023		
	PROVIDER OR SUPPLIER		200 KI	ADDRESS, CITY, STATE, ZIP COD NGSTON CIR IIER, IN 46767	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		48 became fearful and nervous came anxious if they heard			
		ughter did not indicate the			
		psychiatric services for the			
	resident from the fa	mily member.			
	In an interview on 1	11/16/23 at 11:45 AM CNA 2			
		lent assignment sheets did not			
include specific resident behaviors or interventions. CNA 2 indicated there was no information for resident specific behaviors or interventions at the nurse station. CNA 2					
	indicated they were to verbally report observed behaviors to the nurse. CNA 2 indicated they were unaware of how to determine specific				
		esidents. CNA 2 indicated they			
		w to determine if a resident's			
		non, new or worsening. CNA 2			
		ny specific stressors that could sident 48's behaviors.			
		ted 2/22 provided by the DON			
		0 PM indicated each resident vioral health services to attain			
		nest practicable physical,			
	mental and psychos				
	3.1-37				
	3.1-43				
F 0921	483.90(i)				
SS=D		anitary/Comfortable Environ			
Bldg. 00	- ',	Environmental Conditions provide a safe, functional,			
		fortable environment for			
	residents, staff an				
			F 0921	Requesting Desk Review	12/08/2023
		on, interview, and record ailed to ensure a clean call light		F921-	
		vere provided to 2 of 15		Safe/Functional/Sanitary/Comf	orta
		(Resident 1, and Resident 30).		ble Environment	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155286	B. W	ING		11/16	/2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	2			NGSTON CIR		
AVALON	VILLAGE				IER, IN 46767		
	T	CTATEMENT OF DEPOSITYON			<u> </u>		(V.f.)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG	Residents 1 was immediate	dv.	DATE
	Findings include:				given a new urinal. The call lig	•	
	Tindings include.				for resident 30 was immediate		
	1) During an observ	vation on 11/13/23 at 9:47 AM			cleaned and placed appropria	-	
	Resident 1 was lying in bed with a urinal on the				within reach.	tery	
	left side of his bed. The urinal was a whitish				2. There were no other reside	nte	
	translucent plastic with brown debris around the				affected by this practice. All of		
	opening. A 3mm and a 2 mm round pieces of				residents were assessed by s		
	brown debris were noted on the side of the urinal.				to ensure urinals are free from		
	brown debris were noted on the side of the drinar.				discoloration or debris. All cal		
	During an observation on 11/14/23 at 9:34 AM,				lights were cleaned and given		
	the urinal was observed in about the same place				attachment devices to ensure		
	beside the resident	with the debris appearing			do not fall on the floor.	•	
	unchanged from the	previous day's observation.			3. Staff educated by the Direc	tor	
					of Nursing on urinal cleaning	and	
	During an interview	and observation on 11/14/23			cleaning a call light routinely a	nd if	
	at 9:37 AM Nurse A	Aide in Training (NAIT) 3			it falls on the floor. Frequent		
	indicated Resident	l could use his urinal, but staff			rounds will be completed to		
	managed the empty	ing task due to Resident 1's			ensure residents utilizing		
	I -	s. NAIT 3 indicated the urinal at			attachment devices and that o	all	
		e was dirty and the staff			lights are not on the floor and		
	_	ed his urinal after the last use			cleaned routinely. Frequent ro		
	_	ed the resident with a clean			also completed to ensure urin	als	
	urinal instead of ret	urning it to him dirty.			are without discoloration or		
					debris.		
		was reviewed on 11/14/23 at			4. To ensure compliance, DNS	S or	
	_	ses included paraplegia,			Designee is responsible for		
	_	cture of muscle, multiple sites,			completing the environmental		
	l - ·	traumatic brain injury, and			rounds CQI audit tool weekly		
	need for assistance	with personal care.			times 4 weeks then every 2 w		
	A CD				times 4 weeks then monthly fo		
		nt 1's current quarterly,			least 6 months. The form will I	oe	
		(MDS) indicated his Basic			reviewed during facility CQI	not	
		al Status (BIMS) score was 10			meeting. If 100% threshold is		
	(cognitively impaired). The MDS indicated the resident needed substantial assistance with				achieved an action plan will be	<del>=</del>	
	toileting hygiene ta				developed.		
	onemig nygiene ta				5. Completion date: 12/8/23		
	A review of Resider	nt 1's current care plan titled					
		o keep his urinal near him					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155286		A. BUILDING B. WING	00	COMPLETED  11/16/2023	
	ROVIDER OR SUPPLIER VILLAGE		200 KIN	ADDRESS, CITY, STATE, ZIP COD NGSTON CIR ER, IN 46767	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR indicated the residen	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION nt had a problem of wishing to	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	1/19/24. Interventio clean and within rea	in reach, with a goal date of ns included ensure urinal is ach with nursing rounds.			
	Administrator indicates have his urinal remo	1/15/23 at 3:15 PM, the ated Resident 1 did not wish to oved from his bedside, but it turned to him clean after use.			
	Resident 30 was observed. The call light observed lying on the observed to be a star.	ration on 11/12/23 at 10:13 AM, served lying in bed in her t activation handle was ne floor. The call light was ndard call light. Resident 30 not reach her call light.			
	Certified Nurse Aid light should be with reached over the be- off the floor by the	on 11/12/23 at 10:35 AM, e (CNA) 4 indicated the call in Resident 30's reach. CNA 4 d and pulled the call light up cord. CNA 4 placed the call b's upper torso. When asked			
	call light, CNA 4 pl Resident 30's right l she was unable to ach hand and needed to call light. CNA 4 p 30's lower lip. CNA	demonstrate activation of her aced the call light near nand. Resident 30 indicated ctivate the call light with her use her mouth to activate the laced the call light on Resident 4 did not clean the call light at			
	Minimum Data Set Worker both indicat	on 11/14/23 at 10:00 AM, the Coordinator and the Social ted the call light should have to CNA 4 placing the call light			
		I was reviewed on 11/13/23 at s included spastic quadriplegic			

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155286	X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/16/2023		
	ROVIDER OR SUPPLIER			200 KIN	ADDRESS, CITY, STATE, ZIP COD IGSTON CIR ER, IN 46767		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<u> </u>	ID	PROVIDENCE N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	cerebral palsy, cont	racture of the right hand,					
	contracture of the le	eft hand, contracture of					
	muscle, multiple sit	es, other reduced mobility, and					
	need for assistance	with personal care.					
	Minimum Data Set indicated her Basic (BIMS) score was 1 The MDS indicated of both upper extrer dependent in rolling In an interview on 1 Administrator indic policy for call lights A current policy titl and Policy, last revi Administrator on 11 address instructions lights.	int 30's current quarterly (MDS) dated 10/19/23 Interview for Mental Status 2 (mild cognitive impairment). Resident 30 had contractures mities and was totally a back and forth in the bed.  1/16/23 at 11:34 AM the ated the facility did not have a sor use of adaptive call lights.  ded Infection Control Program sed 5/2023 provided by the 1/12/23 at 11:33 AM did not for cleaning urinals or call were received at the time of					
	3.1-18(a)						

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