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	06/13/2019

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 6, 7, 10, 11, 12 and 13, 2019 Facility number: 000184 Provider number: 155286 AIM number: 100267210 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 4 Medicaid: 32 Other: 18 Total: 54 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 19, 2019.	F 0000	**Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.** **This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.** Requesting Desk Review	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only			

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

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	at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on record review and interview the facility failed to ensure resolve the resident council's concern for 4 of 5 residents reviewed. Findings include: The Resident Council Meeting Minutes were received from the Health Facility Administrator (HFA) on 06/11/19 at 9:30 A.M. The Resident Council Meeting Minutes were reviewed on 6/11/19 at 10:16 A.M., and indicated	F 0565	Requesting Desk Review 1. Alert and oriented residents were interviewed to ensure their bed linens were changed. An audit was completed to ensure all bed linen was changed immediately. 2. All residents have the potential to be affected by this practice. Staff was educated by the CEC/Designee on changing bed linens on shower days or per	07/05/2019

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	the following: On 4/23/19 at 1:30 P.M., the residents present in the meeting had a concern bed linens were not being changed and the beds were not made. The Resident Council Meeting Follow Up form dated 4/26/19 indicated bed linens are to be changed with the resident shower and as requested by the resident. On 5/23/19 at 2:30 P.M., the notes indicated the residents present still had a concern with the beds not being made. The Resident Council Meeting Follow Up form dated 5/23/19, indicated for beds not made under "Action Taken: Added to GEMBA (means go to the actual place) following morning meeting. (Employees name) will round the facility." On 6/11/19 at 1:39 P.M., a Resident Council Meeting was conducted, residents were interviewed, and 4 of 5 residents present indicated their beds were still not being made and bed linens had not been changed on a regular basis. One resident indicated their bed linens had not been changed in the last 6 weeks. On 6/12/19 at 12:27 P.M., during an interview, the HFA indicated after the Resident Council meeting held on 4/23/19 to address the resident's concern in regard to bed linens not changed routinely, the bed linen change was added to GEMBA which was their Quality Assurance Performance and Improvement process. The HFA indicated after the Resident Council meeting held on 5/23/19, to address the resident's continued concerns in regard to bed linens, the unit manager rounds would every day utilize the GEMBA form. On 6/13/19 at 12:43 P.M., during an interview with the Nurse Consultant indicated there was no policy on when to change bed linens. The Nurse Consultant indicated bed linens should be changed once a week with the resident shower		resident preference. Nurse managers were educated by the ED on following up with resident council recommendations and addressing any concerns timely. 3. Rounds will be conducted daily by the nurse manager Monday through Friday to ensure all bed linens are being changed per resident preference. The DNS/Designee will review all resident council concerns and report to the resident council president with her follow up. All follow up will be reviewed by the DNS/Designee to ensure timeliness and completion. 4. A care rounds audit tool will be conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. A resident council audit tool will be conducted monthly x 6 months then quarterly thereafter. If the threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion Date: 7/5/19	

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	and as needed. 3.1-3(g)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed ensure timely notification of the physician for a recommendation for multivitamin for a resident with a pressure ulcer.(Resident 51) Findings include: The clinical record of Resident 51 was reviewed on 6/10/19 at 10:06 A.M. The resident's diagnoses included, but were not limited to hemiplegia (paralysis of 1 part of the body) and hemiparesis (weakness on 1 side of the body). A Progress Note dated, 5/24/19 at 11:37 A.M., by the Registered Dietician (RD) indicated Resident 51 had a current pressure ulcer being treated by	F 0686	Requesting Desk Review 1. Resident # 51 had no negative outcomes from this practice. Orders were reviewed with the MD and no new orders were obtained. 2. All other residents have the potential to be affected by this practice. All residents that have wounds were reviewed to ensure that dietary recommendations were implemented per policy. Nurse managers will be educated by the ED on following dietary recommendations per policy. 3. Nurse managers will be educated by the ED on following dietary recommendations per policy. Nursing notes will be	07/05/2019

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	nursing. The resident's appetite was good and they currently received double meat and egg portions and milk with all meals for increased daily protein. The RD recommended a multivitamin with minerals to help promote wound healing. A Physician's Order dated 5/30/19, indicated to administer 1 multivitamin with minerals tablet to Resident 51 once a day. On 6/11/19 at 2:39 P.M., during an interview, the Director of Nursing Service (DNS) indicated the RD recommendation for the multivitamin with minerals was written on 5/24/19. The Interdisciplinary Team did not meet until 5/30/19, when the RD recommendation was reviewed, the resident's Physician was notified and an order was received for the multivitamin. The most current Nutritional Recommendations policy dated 02/02 and revised on 07/15, was received from the DNS. The Nutritional Recommendations policy indicated the RD recommendations "...will be followed through with and implemented within three (3) business days." On 6/11/19 at 3:10 P.M., during an interview with the DNS indicated Resident 51's Physician should had been notified within 3 days of the RD recommendation for the multivitamin. On 6/11/19 at 9:22 A.M., an observation was conducted with Assistant Director of Nursing Service (ADNS) during Resident 51's wound care a pressure ulcer located on the resident's coccyx was measured by the ADNS at 0.7 centimeters (cm) by 0.9 cm. The resident's pressure ulcer, located on the coccyx, had granulation tissue present.		reviewed by a nurse manager Monday through Friday for any dietary recommendations made by the RD to ensure complete follow through. 4. A dietary recommendation CQI tool will be conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion date: 7/5/19	

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	3.1-40			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure timely occupational therapy services were provided for 1 of 2 residents reviewed (Resident 26). Findings include: The clinical record for Resident 26 was reviewed on 6/7/19 at 10:35 A.M. Diagnoses included, but were not limited to, need for assistance with personal care, cerebral infarction (stroke), Alzheimer's Disease, and stiffness of joint. Resident 26's family was interviewed on 6/11/19 at 10:34 A.M. During the interview Resident 26's	F 0688	Requesting Desk Review 1. Resident #26 currently has her splint per orders. An audit was conducted to ensure all other residents have their splints per their orders. 2. All residents that have splints have the potential to be affected by this practice. An audit was conducted to ensure all residents with splint orders have their splints. Nursing staff will be educated on applying splints per orders and ensuring therapy is notified. The Nurse manager team will be educated by the ED/	07/05/2019

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	family indicated Resident 26 was not able to move her left side, she had limited range of motion in her left hand and wore a splint. A Physician's order dated 1/23/19, indicated Resident 26 was to have a slim grip splint on her left hand; it was to be put on in the A.M. and taken off in the P.M. A care plan problem initiated on 1/23/19, indicated Resident 26 had impaired mobility related to decreased range of motion to both her knees, ankles and the left upper extremity. Interventions included, but were not limited to, apply splints as ordered. An Occupational Therapy discharge summary dated 1/29/19, indicated Resident 26 was discharged with a goal met status of tolerating a left upper resting hand/wrist splint for up to 8 hours during the daytime hours. A computerized nursing to therapy referral note dated 4/25/19, indicated Resident 26 was referred to therapy because staff had been non-compliant in applying the resident's left hand splint and the splint had vanished. The referral was for the left hand to be re-evaluated by therapy. Certified Occupational Therapy Assistant 6 (COTA) was interviewed on 6/11/19 at 11:25 A.M. During the interview COTA 6 indicated the way they find out about referrals to therapy from facility staff is by a paper form that is filled out and put in a mail box. Occupational Therapist (OT) 5 was interviewed on 6/11/19 at 11:45 A.M. During the interview OT 5 indicated therapy received a paper form when there was a referral to therapy from facility staff		Designee on ensuring that therapy has timely follow up to any splint that is marked as missing on the treatment record. When a change in resident functional status in noted a member of the nursing team will open up and complete a 'Nursing Referral to Therapy Observation' in Matrix EMR for therapy communication. The Director of Therapy/Designee will run the Matrix Observation Report daily to identify any new referral from nursing to therapy. During the daily Clinical Meeting the Director of Therapy/Designee will report back to clinical team about the outcome of the referral. 3. Nursing staff will be educated by the CEC/Designee on applying splints per orders and ensuring therapy is notified if unavailable. The Nurse manager team will be educated on ensuring that therapy has timely follow up to any splint that is marked as missing on the treatment record. The wellness aide/Designee will follow splints to ensure application and report to therapy when a splint is missing. The MD and POA will immediately be notified. Therapy will be educated on running the Matrix Observation Report Monday through Friday to identify any new referral from nursing to therapy. During the Clinical Meeting the Director of Therapy/Designee will report back to clinical team about the outcome of the referral."	

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	and they are not able to see anything on the computer or progress notes from nursing. A Treatment Administration Record (TAR) dated April 1 to June 10, 2019, indicated on 4/24/19 Resident 25's left hand splint was missing and that staff could not apply it. According to the TAR the splint was recorded as missing on April 24, 25, 27, 29, and 30, 2019. The splint was also recorded as missing on May 1, 2, 6, 7, 8, 9, 13, 14, 15, 16, 20, 21, 23, 24, 28, 29, and 30, 2019. Qualified Medication Aid 2 was interviewed on 6/11/19 at 10:34 A.M. During the interview QMA 2 indicated Resident 26's left hand splint had been lost a while ago and after it was lost they had been putting a wash rag in her left hand. Therapy had to retrain her hand to work with a splint again after it was lost and they were currently retraining her hand.QMA 2 indicated therapy had put the splint on Resident 26's left hand. On 6/11/19 at 10:34 A.M.. Resident 26 was observed with QMA 2 Resident 26 had a splint applied to her left hand. There was no documentation indicating a wash cloth had been being placed in Resident 26's left hand after the left hand splint was reported as lost to therapy on 4/25/19. An Occupational Therapy plan of care dated 5/21/19, indicated Resident 26 was referred to therapy for an evaluation and treatment of her left hand. Nursing staff had reported to therapy that they were unable to locate her left hand splint that had been issued in January/February of 2019. A missing splint put the resident at risk for increased hand contractures. The initial assessment indicated Resident 26 had a goal of tolerating a		4. A care rounds CQI audit tool will be conducted daily x 4 weeks, weekly x 4 weeks and then monthly x 3 months, then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion date: 7/5/19	

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	left upper extremity orthotic to provide correct contracture management up to 1 hour daily. There was no documentation indicating Resident 26 had been seen for a missing left hand splint by occupational therapy prior to 5/21/19. OT 5 was interviewed on 6/11/19 at 10:46 A.M. During the interview OT 5 indicated Resident 26 was currently being seen by Occupational Therapy and was using a new left hand splint. OT 5 saw Resident 26 for an evaluation after it was brought to her attention that Resident 26 had a decline and a change in condition in her left hand from when she was discharged from Occupational Therapy in January 2019. OT 5 indicated Resident 26 was picked up in Occupational Therapy on 5/21/19, which was the day OT 5 indicated she had found out Resident 26's left hand splint was missing. OT 5 indicated Resident 26's left hand had been tight and they could not put a new splint on her left hand right away. OT 5 indicated they needed to retrain her left hand with the new splint. OT 5 indicated they wanted to avoid pressure and any development of wounds that could be caused by a new splint. OT 5 indicated since picking Resident 26 up in therapy on 5/21/19, Resident 26 had currently gotten to the point where she was able wear the new splint for about 6 hours a day. OT 5 indicated if a resident who had limited range of motion had lost a splint she would expect to be notified as soon as possible about it and she would evaluate them as soon as possible. She also indicated there was no documentation indicating Resident 26 had been seen by occupational therapy for a missing left hand splint prior to 5/21/19 when an evaluation had been done. An Occupational Therapy discharge summary			

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	dated 1/29/19, indicated Resident 26 had a goal met status of demonstrating passive range of motion of her left upper extremity index finger from 0 to 95 without discomfort. An Occupational Plan of Care evaluation dated 5/21/19, indicated Resident 26 was demonstrating passive range of motion of her left upper extremity index finger from 0 to 80 degrees with facial grimacing. The Director of Nursing Services (DNS) was interviewed on 6/11/19 at 12:55 P.M. During the interview the DNS indicated therapy was notified of the missing splint on 4/25/19 and it is therapy's responsibility to follow through after that. The DNS indicated there is no particular time frame as to when a resident should be seen after a referral. The times on the Medication Administration Record (MAR) when it was recorded that the splint was applied after 4/25/19 could have been because the splint was soiled and it was being laundered. The splint could have been found and lost again and the referral was made at a time when the splint was lost. She also indicated a cloth had been being placed in Resident 26's hand after the splint was lost, but there was no documentation indicating a wash cloth had been being placed in Resident 26's hand after the left and splint was missing. COTA 6 was interviewed on 6/11/19 at 11:18 A.M. During the interview COTA 6 indicated she would expect Occupational Therapy to be notified of and to evaluate a resident as soon as possible if a resident was missing a hand splint. OT 5 was interviewed on 6/11/19 at 1:23 P.M., and the DNS was present during the interview. During the interview, OT 5 indicated they do use a			

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	computerized therapy referral form. It would be the Therapy Managers job to let OT 5 know if there was a referral for a resident to be seen by Occupational Therapy. OT 5 was not aware of Resident 26's referral for an Occupational Therapy evaluation until 5/21/19. When she knew of the referral, she saw Resident 26 as soon as she could, which was the same day. OT 5 indicated Resident 26 had limited range of motion in her left hand and it was important to see her to prevent any negative effects from not having a left hand splint. The Therapy Manager that had been working at the facility at the time the 4/25/19 referral was made, was no longer working at the facility. A policy for therapy referrals and evaluations was requested from the DNS and OT 5 on 6/11/19 at 11:18 A.M. OT 5 was interviewed on 6/13/19 at 8:23 A.M. During the interview OT 5 indicated she had checked with corporate for policies from the therapy department and there were no policies regarding therapy referrals or evaluations. A policy, dated 5/2018, was provided by the DNS on 6/11/19 at 3:15 P.M., titled "Nursing Referrals to Therapy". The DNS indicated it was the policy currently used by the facility. The policy indicated "Purpose: To ensure that there is standardized communication to the therapy department when a screen is being requested. Process: The 'Nursing Referral to Therapy Observation' will be completed by a member of the nursing team for any change in resident status warranting a referral to therapy. Procedure: When a change in resident functional status in noted a member of the nursing team will open up and complete a 'Nursing Referral to Therapy Observation' in Matrix EMR for			

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	therapy communication. The Director of Therapy/Designee will run the Matrix Observation Report daily to identify any new referral from nursing to therapy. During the daily Clinical Meeting the Director of Therapy/Designee will report back to clinical team about the outcome of the referral." 3.1-42(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review the facility failed to ensure medication was decreased per physician order for 1 of 5 residents reviewed (Resident 7).	F 0757	Requesting Desk Review 1. Resident # 7 had no negative outcomes from this practice. Orders were reviewed with the MD	07/05/2019

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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
	Findings include: The clinical record for Resident 7 was reviewed on 6/10/19 at 10:08 A.M. Diagnoses included, but were not limited to, gastro-esophageal reflux disease (GERD). A Pharmacy Consultation Report dated 3/22/19, indicated Resident 7 had been taking ranitidine (a medication for heartburn) 150 milligrams twice daily for several years. The Pharmacy recommended that Resident 7's ranitidine dose be changed to 150 milligrams once daily at bedtime. The Pharmacy Recommendation was signed and accepted by the Physician at an undated time. A Physician's order dated 5/6/19, indicated Resident 7's dose of ranitidine was changed from 150 milligrams twice daily to ranitidine 150 milligrams once daily at bedtime. The Director of Nursing Services (DNS) was interviewed on 6/12/19 at 11:40 A.M. During the interview the DNS indicated Pharmacy Recommendations should be reviewed and implemented within a 30 day time period according to policy. A policy, dated 11/17, was provided by the DNS on 6/12/19 at 12:02 P.M., titled "Medication Regimen Reviews and Pharmacy Recommendations" and she indicated it was the policy currently used by the facility. The policy indicated " ...Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving. Once reviewed by the Physician the pharmacy recommendations will be filed in the resident's medical record."		and no new orders were obtained. 2. All other residents have the potential to be affected by this practice. An audit has been completed for pharmacy recommendations to ensure compliance. Nurse managers will be educated by the ED on following pharmacy recommendations per policy. 3. Nurse managers will be educated by the ED on following pharmacy recommendations per policy. Pharmacy recommendations will be added to the daily clinical meeting review sheet to ensure compliance. The daily clinical review sheet will be utilized by a nurse manager Monday through Friday to ensure recommendations made by the pharmacist have been implemented. 4. A pharmacy recommendation CQI audit tool will be conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion date: 7/5/19	

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	3.1-48(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review the facility failed to ensure insulin was not expired prior to use for 2 of 2 reviewed. (Resident 39, and Resident 22) Findings include: During an observation of Medication Cart 1 with	F 0761	Requesting Desk Review 1. The two insulin vials found to be dated past 28 days were immediately discarded. Resident #39 and #22 had no negative effects. MD was notified immediately with no new orders. 2. All residents that receive	07/05/2019

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	Qualified Medication Aide (QMA) 2 on 6/13/19 at 12:25 P.M., an opened bottle of Resident 39's Humalog insulin had an open date of 5/8/19 marked on the box. QMA 2 indicated the insulin was still in use if it was in the cart and that she was not sure how long insulin lasted because she was a QMA and she did not administer insulin. The Director of Nursing Services observed the medication at this time. During an observation of Medication Cart 2 with Registered Nurse (RN) 12 on 6/13/19 at 12:40 P.M., a used bottle of Resident 22's Lantus insulin had an opened date of 5/12/19 marked on the bottle. RN 12 indicated if the medication was in the cart it was being used and she was unsure of how long the insulin lasted after being opened because different kinds of insulin could be used for different amounts of time. The Nurse consultant observed the medication at this time. The Nurse Consultant was interviewed on 6/13/19 at 2:02 P.M. During the interview the Nurse Consultant indicated the Humalog insulin should not have been used after the insulin vial had been open 28 days and the Lantus insulin should not have been used after 28 days after opening. A Medication Administration (MAR) dated 6/1/19 to 6/13/19, indicated Resident 39 received 4 units of Humalog insulin 2 times after the insulin had been opened for 28 days. An MAR dated 6/1/19 to 6/13/19, indicated Resident 22 received 20 units of Lantus 4 times after the insulin had been opened for 28 days. An undated Clinical Pharmacology information page supplied by the Nurse Consultant on 6/13/19 at 2:00 P.M., indicated unrefrigerated Humalog		insulin have the potential to be affected by this practice. All medication carts were audited to ensure insulin was not expired. Nursing staff will be educated by the CEC/Designee on discarding any insulin after expiration date. 3. Nursing staff will be educated by the CEC/Designee on discarding any insulin after expiration date. Medication cart to be inspected daily by designated nurse manager Monday through Friday to ensure all insulin is within appropriate usage dates. 4. A medication storage tool will be used to audit weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion date: 7/5/19	

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	insulin should be used within 28 days or be discarded. It also indicated Lantus insulin can be stored for 28 days after opening. 3.1-25(o)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying			

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	those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to ensure timely follow up regarding lower dentures for 1 of 1 residents reviewed (Resident 3). Findings include: The clinical record for Resident 3 was reviewed on 6/10/19 at 10:08 A.M. Diagnoses included, but were not limited to, need for assistance with personal care, reduced mobility, and multiple sclerosis. A Minimum Data Set (MDS) assessment dated 5/20/19, indicated Resident 3 had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). Resident 3 was interviewed on 6/6/19 at 11:08 A.M. During the interview Resident 3 indicated her bottom teeth had been extracted and she was supposed to get bottom dentures, but she had not gotten them. A limited oral evaluation note from Dental Services dated 4/3/19, indicated Resident 3 had lower extractions done on 3/20/19. Resident 3 still had some healing to go and the area was slightly	F 0791	Requesting Desk Review 1. Resident #3 has a current dental appointment scheduled. This resident was immediately screened by Speech Therapy to ensure appropriate diet. 2. All residents have the potential to be affected by this practice. An audit has been completed to ensure all residents have had timely follow up on dental services. There were no residents found upon audit that have not had follow up with dental services. SSD has been educated on following up with dental services in a timely manner. 3. . SSD has been educated by the ED on following up with dental services in a timely manner. Dental Services will be added to the daily clinical review sheet to ensure there is a review of any resident that requires follow up with dental services Monday through Friday. SSD will review the clinical sheet daily Monday through Friday and follow up with	07/05/2019

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	red in appearance. Dental Services would recheck the resident in about 4 weeks or so and once healed they would start the lower denture process. There was no documentation to indicate Resident 3 had been seen about 4 weeks after the 4/3/19 appointment. There was no documentation to indicate there was any follow up after Dental Services did not see Resident 3 about 4 weeks after the 4/3/19 appointment. The Social Service Director (SSD) was interviewed on 6/11/19 at 9:25 A.M. During the interview the SSD indicated she was looking to see if there had been follow up after Dental Services had seen Resident 3 on 4/3/19. The SSD was interviewed on 6/11/19 at 11:10 A.M. During the interview the SSD indicated Dental Services was going to see Resident 3 on the 25th of June. Resident 3 was interviewed on 6/12/19 at 10:20 A.M. During the interview Resident 3 indicated Dental Services had not seen her in a while and her bottom gums were healed. She had been having trouble eating and tearing food without dentures, she was getting tired of eating soft foods and could not wait to eat something besides soft food. She also indicated the SSD had stopped by her room on 6/11/19 and told her she had an appointment with Dental Services on the 25th of June. She was really hoping she would finally get her bottom dentures. The SSD was interviewed on 6/12/19 at 11:14 A.M. During the interview the SSD indicated it is the SSD's responsibility to make sure residents get the services they need regarding dentures. She		any resident that requires services in a timely manner. 4. A dental services CQI audit tool will be conducted by the SSD/Designee weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 6. Completion Date: 7/5/19	

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	also indicated Resident 3 was on a denture track so it was the responsibility of the Dental Service staff to make sure Resident 3 was seen about 4 weeks after the 4/3/19 appointment. She indicated there was no documentation indicating there was any follow up regarding why Resident 3 had not been seen about 4 weeks after her last appointment. During an observation on 6/12/19 at 12:30 P.M., Resident 3 was in the dining room eating lunch which consisted of two muffins, ice cream, sliced tomatoes, salad and fruit. The Director of Nursing Services was interviewed on 6/13/19 at 8:32 A.M. During the interview the DNS indicated it was the SSD's responsibility to make sure residents get the services they needed regarding dentures. Dental Service Staff 3 was interviewed on 6/13/19 at 9:38 A.M. During the interview Dental Service Staff 3 indicated an appointment was put into the computer recently for Resident 3 to be seen on June 28th for lower denture impressions. After Dental Services saw the resident on 4/3/19, she was to be seen in about 4 weeks, which is not something they schedule often. The scheduler was not aware that Dental Services was to follow up with Resident 3 in about four weeks so the appointment was missed. The Nurse Consultant was interviewed on 6/13/19 at 9:57 A.M. During the interview the Nurse Consultant indicated it would be the SSD's responsibility to follow up when Dental Services did not see the resident in about 4 weeks after the 4/3/19 appointment. A policy, dated 9/17, was provided by the DNS on			

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	6/12/19 at 8:05 A.M., titled "Dental Services/Missing Dentures" and she indicated it was the policy currently used by the facility. The policy indicated "The facility obtains needed dental services, including routine and emergency dental services; assists in providing these services and makes prompt referrals for dental services as needed ...4. The facility will assist in scheduling and transporting residents to dental appointments as needed." 3.1-24(a)(1)(b)			
F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-			

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	(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed			

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	professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure a resident's clinical record was complete for1 of 22 residents reviewed. (Resident 1) Finding include: The Clinical Record of Resident 1, reviewed on 6/10/19 at 12:19 P.M., indicated diagnosis included, and were not limited to, delusions, psychosis, panic disorder and anxiety. Two Physician's Orders for the resident indicated the following: 1. dated 11/10/17, administer Lamictal (medication used to treat extreme mood swings) 100 milligrams (mg) once a day in the morning and 75 mg once a day in the evening. 2. dated 5/4/19, the Lamictal dosage to administer once a day in the morning was to continue to administer 100 mg and to increase the Lamictal 100 mg once a day in the evening. There was no documentation in Resident 1's Clinical Record to indicate why the Lamital medication was increased on 5/4/19. A Nurses Note dated 5/4/19 at 10:31 A.M., indicated "Res (Resident) with clarification order for Lamictal 100 mg BID (2 times a day)." On 6/11/19 at 3:03 P.M., an interview was conducted with the Social Services Director (SSD) indicated Resident 1 is seen at the Physician's office and she was unable to find documentation on the resident's clinical record as to why the Lamictal medication was increased.	F 0842	Requesting Desk Review 1. Resident #1 medications were reviewed with the provider and no new orders were obtained. There were no negative outcomes for this resident. 2. All other residents receiving psychotropic medications have the potential to be affected by this practice. An audit has been completed to ensure a progress note is present for any increase in psychotropic medications. 3. SSD will be educated by the ED on obtaining progress notes from the physician with any psychotropic medication increase. The SSD will monitor daily Monday through Friday that the physician has provided appropriate documentation for any increase in medication. 4. A psychotropic CQI audit tool will be conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion Date: 7/5/19	07/05/2019

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	On 6/12/19 at 9:32 A.M., an interview was conducted with the SSD indicated the Physician's office was contacted and would fax a document to the facility in regard to Resident 1's Physician's visit on 5/4/19. On 6/12/19 at 10:28 A.M., and interview with the Director of Nursing Services (DNS) with the Health Facility Administrator (HFA) present the DNS indicated a packet was sent with the resident to the Physician's visit which included a physicians telephone order. The HFA indicated at the daily meeting it was discussed to follow up on documentation of the Physician's visit and was documented on a form that is not part of Resident 1's Clinical Record. The HFA indicated it was the responsibility of the Medical Records Coordinator to follow up with with the Physician. On 6/12/19 at 11:54 A.M., received a faxed document from the SSD who was interviewed and indicated the faxed document was from Resident 1's Physician's visit on 5/4/19. The document from the resident's physician was dated 6/12/19, indicated the Lamictal had been increased to 100 mg "...to help alleviate delusions, anxiety and overall mood distress." 3.1-50(a)			
F 9999 Bldg. 00	410 IAC 16.2-3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD),	F 9999	Requesting Desk Review 1. The employee in question was immediately taken off the schedule and an x ray was obtained. There were no residents affected by this practice. 2. All residents have the potential	07/05/2019

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	administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. This state rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a new employee who was a positive reactor to tuburculin testing had a chest xray done for 1 of 5 new employees reviewed. This had the pitential to affect all residents residing in the facility		to be affected by this practice. An audit was completed to ensure all staff members that are a reactor to the TB serum have x rays obtained and in their files. The BOM and HR manager have been educated on the new hire policy and obtaining x rays for any employees that are allergic to the TB serum. 3. BOM and HR manager have been educated by the ED on the new hire policy and obtaining x rays for any employee that is a reactor to the TB serum. The BOM will review all new hire paperwork prior to any new employee starting work to ensure compliance. 4. A new hire audit tool will be conducted weekly x 4 weeks, monthly x 6 months and then quarterly thereafter. If threshold of 90% is not achieved, an action plan will be developed to ensure compliance. Findings will be submitted to the CQI committee for review and follow up. 5. Completion Date: 7/5/19	

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	Findings include: On 6/13/19 at 2:05 P.M., CNA's employee file was reviewed and indicated they started working at the facility on 3/21/19. Certified Nursing Assistant (CNA) 25 had a Post-Offer Health Physical form indicated the following: The form was signed by a Nurse Practitioner on 3/15/19 with the statement "I certify that this employee is free from any communicable and/or infectious disease, including tuberculosis (TB). On the form was a hand written note "No TB/chest x-ray unavailable." The Tuberculosis Screening Questionnaire For Residents/Employees/Volunteers form dated 3/12/19 indicated the following: CNA 25 had a history of a significant reaction to a tuberculin test so a TB skin test should not be done. The form asked a series of questions to evaluate the employees current health status. The form asked 11 questions in regard to your current health status. Some of the questions asked do you have a cough lasting more than 3 week, have you coughed up blood more than 1 time, do you have unexplained weight loss in which CNA 25 had answered all 11 questions with a response of no. There was no chest x-ray report in CNA 25's employee file. On 6/13/19 at 2:12 P.M., an interview was conducted with the Business Office Manager (BOM) who indicated Employee 25 was a positive reactor to the TB skin test and did the TB screening done but there was no chest x-ray available. The Tuberculin (TB) Control Program policy dated 12/2011, was received from the BOM did not			

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	06/13/2019

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

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	address employees eho had a positive TB test.			