STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDEPENDENCE VILLAGE OF AVON	182 S COUNTY ROAD 550 E AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414265, IN00414512, IN00414863, and IN00414933. Complaint IN00414265 - No deficiencies related to the allegations are cited. Complaint IN00414512 - State Residential Findings related to the allegations are cited at R0117. Complaint IN00414863 - No deficiencies related to the allegations are cited. Complaint IN00414933 - No deficiencies related to the allegations are cited. Survey dates: August 9, 10, and 11, 2023 Facility Number: 003902 Residential Census: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 14, 2023.	R 0000	ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123 Dear Ms. Buroker, On August 11, 2023, a Complaint survey with complaint no. (IN00414265, IN00414512, IN00414863, IN00414933) and Survey Event ID B1RH11 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Romeo Behl	Executive Director	08/25/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Sept 07, 2023. Please feel free to call me with any further questions at 317-745-2766 Respectfully submitted, Romeo Behl Independence Village of Avon 182 S County Road 550 E Avon, IN 46123	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the			

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	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure licensed nursing staff were available in the facility in order to address a resident's dislodged indwelling urinary catheter (a tube which is inserted into the bladder to drain urine) in a timely manner for 1 of 3 residents reviewed for quality of care (Resident D). Finding includes: Resident D's record was reviewed on 8/10/23 at 10:40 a.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional)	R 0117	**R117 Personal Deficiency** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.***	09/07/2023

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	and retention of urine. A service plan, dated 1/18/22, indicated the resident required assistance with his urinary catheter. The record indicated the resident received home health care services. A progress note, dated 7/29/23 at 8:17 p.m., indicated the resident had pulled out his catheter with the bulb (the balloon-like device a the end of the urinary catheter that holds the tubing in place) inflated. The physician and the Wellness Director were notified. The resident used a home health agency, which was currently closed. The note lacked documentation that the nurse had attempted to call the home health agency. A progress note, dated 7/31/23 at 1:39 a.m., indicated the resident had pulled out his catheter. An attempt was made to contact the home health agency, but there had been no answer. A message had been left. A progress note, dated 7/31/23 at 4:36 p.m., indicated the writer had called the home health agency again and was awaiting a return call. A progress note, dated 7/31/23 at 5:16 p.m., indicated the home health agency returned the call to the facility. A nurse would be sent to the facility to fix the resident's catheter. A progress note, dated 7/31/23 at 6:04 p.m., indicated a home health nurse attempted to hook the resident's catheter back, but was not able to do so. The nurse indicated they would come back tomorrow to finish the job.		***1)Immediate actions taken for those residents identified:*** Resident D cath has been reinserted by urologist and intact . ***2)How the facility identified other residents:*** Any resident residing in the facility had the potential to be affected. Audits will be conducted on all residents with foley cath and will be checked for placement of foley cath. **3)Measures put into place/ System changes:** In-service and education will be provided to all nursing staff to immediately notify DON/Designee/charge nurse with any change in condition and transfer resident to ER immediately. Don/designee will check 3 residents with foley Cath for placement one time weekly for 4 weeks and then 2 residents record one-time weekly x 4 weeks and then 1 resident one time weekly for 4 weeks thereafter to ensure compliance and update service plans as indicated. **4)How the corrective actions will be monitored:** Don/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6	

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	A progress note, dated 8/2/23 at 10:15 a.m., indicated the home health nurse was at the facility and was not able to fix the resident's catheter. The resident was sent to the hospital. The hospital was not able to fix the resident's catheter. The family indicated to the writer that the hospital recommended the resident be taken to a urologist (a medical doctor specializing in conditions that affect the urinary tract in men, women, and children) to put the resident's catheter back in. A progress note, dated 8/2/23 at 11:12 a.m., indicated the resident was taken to the urologist by his son. The catheter had been reinserted. During an interview, on 8/10/23 at 2:23 p.m., the Wellness Director indicated the nursing staff at the facility were not allowed to provide any services related to resident's urinary catheters. At the time the resident had pulled the catheter out, there was only a Qualified Medication Aide (QMA) in the building. When the staff were unable to reach the home health service, the staff should have sent the resident out to the hospital immediately. The QMA in charge had not followed the facility protocol. During an interview, on 8/11/23 at 9:30 a.m., the Property Administrator indicated she had not been able to locate any specific policy regarding the facility staff not being able to address catheter issues. The facility would follow the state residential guidelines. The staff should have sent the individual out to the hospital when the home health agency could not be reached. This state tag relates to Complaint IN00414512.		months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 9/7/2023**	