STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Village	200 Kingston Cir Ligonier, IN 46767

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure medical records were complete and accurately reflected the resident's clinical status for 1 of 3 residents reviewed (Resident E). Findings include:On 2/25/26 at 11:56 A.M., Resident E's record was reviewed. Diagnoses included end-stage kidney disease with dependence on renal dialysis, stage 4 pressure wound to the sacrum, and history of multiple type cancers. He was alert, oriented and able to make daily decisions as well as healthcare decisions for himself. A care plan, dated 7/23/25, indicated Resident E had dermatitis with a raised lesion on his left lower extremity suspicious for cancer. He was diagnosed with Lichenoid Keratosis (benign skin lesion) and treated with chemotherapy cream for 4 weeks. Interventions included to assess and document the skin condition weekly and as needed; and observe for signs of infection. A dermatology note, dated 10/9/25, indicated the resident had been seen for a non-healing lesion to his left lower extremity. At his appointment, the area around the lesion was numbed and with a small blade, the lesion was scraped off (Dermablade) and sent for biopsy. He was to keep the area dry for 24 hours, wash with soap and water, apply Vaseline and cover with a Band-Aid daily until healed. On 2/25/26, Skin Biopsy information was retrieved from the American Academy of Dermatology or aad.org. The article indicated skin biopsies using a Dermablade, healed in 7-10 days. Review of Resident E's wound management documentation had not indicated he had an open wound to his left lower extremity as a result of the skin biopsy taken on 10/9/25. A nurse progress note, dated 1/26/26 at 11:25 p.m., indicated Resident E was observed with an open area to his left inner ankle The area had white to pale yellow drainage present. The facility wound nurse was to assess the wound the following day. A New Skin Event form, dated 1/26/26 at 11:24 p.m., indicated Resident E had a wound to the left inner ankle measuring 2 centimeters (cm) by 2 cm. No depth or other assessment of the wound was documented. An Interdisciplinary Team (IDT) note, dated 1/27/26 at 1:30 p.m., indicated Resident E had a new wound on his left inner ankle where a previous biopsy had been taken. The area indented inwards and had a white center in the middle of the wound with surrounding pink skin. There was clear drainage noted when cleansed. Root cause of the wound was due to a previous biopsy. There was no other assessment or investigation of the wound documented. A Treatment Administration Record, dated January 2026, indicated a treatment was started on 1/28/26, to cleanse the wound to Resident E's left inner ankle with soap and water, apply Opticell (gelling fiber dressing used for moderate to heavily draining wounds) and cover with Optifoam (outer dressing) daily. There was no documentation in the record, prior to 1/26/26, indicating the biopsy site from 10/9/25 had remained open, was monitored, and treated. There was no documentation indicating a new biopsy had been taken since 10/9/25 on any of the resident's skin. A wound clinic note, dated 2/5/26, indicated a biopsy site on his left lower extremity, covered with a dressing, was newly observed since the resident's last wound clinic visit on 1/22/26. The note indicated the resident had a new open area to his left lower extremity but hadn't indicated the wound clinic had assessed the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound or prescribed treatment due to their understanding the wound was the result of a biopsy. There was no documentation indicating a new biopsy had been taken of the resident's left medial ankle since 10/9/25. The open area was not a surgically incised biopsy site. An NP note, dated 2/3/26, indicated the resident was seen for chronic care management. During her visit, she observed an open wound to his left outer lateral lower leg. When asked, the resident couldn't recall how he'd gotten the wound. The wound had undefined edges and scant serous drainage. He continued with bruising to the left side of his back and left lateral abdomen and right forearm. He had a new wound to his left lateral lower extremity which resident reported was being managed by the wound clinic. The NP was going to try and get wound care notes from the wound clinic. Resident E's record indicated he had a wound to his left inner (medial) ankle observed on 1/26/26. The facility record hadn't indicated there had been a new wound observed on the resident's lateral (outer) left lower leg nor had the record indicated there were 2 separate wounds on the left lower leg; one on the left inner ankle and one on the lateral left lower leg observed by the NP during her visit. On 1/27/26, a Nurse Practitioner (NP) note indicated the resident was being seen to establish care for services provided by his insurance to manage chronic conditions. Resident E was alert and oriented. His skin assessment indicated the resident had bruising to the left side of his back, left lateral abdomen, and right forearm. Neither Resident E's skin, wound sheets, nor progress notes indicated he had bruising to the left back, lateral abdomen or right forearm. A nurse progress note, dated 1/28/26 at 5:57 p.m., indicated the resident's appointment for the wound clinic, scheduled on 1/29/26, had been cancelled. There was no further documentation of the appointment being re-scheduled nor were there any wound measurements or assessment completed for the week, found in the record. A nurse note, dated 2/3/26 at 7:55 p.m., indicated Resident E was observed with 2 skin tears on his right hip. The resident indicated they were tender to touch and he had bumped himself in the wheelchair. The record hadn't indicated size of the 2 skin tears, when the MD had been notified, and when treatment was administered. An IDT note, dated 2/4/26 at 7:58 p.m., indicated Resident E had a diffuse purple bruise to his right hip. The note indicated there were no skin tears or swelling to the area. The record hadn't indicated purple bruising to Resident E's right hip was assessed, measured and being monitored. There was no documentation of cause of bruising found in the record. A nurse progress note, dated 2/4/26 at 8:52 p.m., indicated skin tears continues. The record hadn't indicated where the skin tears were located. On 2/25/26 at 2:06 P.M., Nurse 5 was interviewed. They indicated when new areas of skin impairment were found, nurses were to document in the record, on a New Skin Event form. On the form, they were supposed to include measurements, wound assessment, treatment, and notifications to physician and family. Nurses were to assess and monitor pressure ulcers but also, non-pressure related wounds, skin tears, and bruises. The designated facility wound nurse was responsible for monitoring and measuring wounds weekly. They indicated resident records were to be accurately documented and complete in the resident's medical record. When asked about Resident E's wound to his ankle, the nurse indicated they hadn't changed the dressing because it was done on night shift. On 2/25/26 at 2:50 P.M., the Executive Director (ED), Director of Nursing (DON), and designated facility wound nurse were interviewed. The wound nurse indicated Resident E's wound management reports were not in the medical record because the resident was in the hospital. She provided a written copy of a wound management report for Resident E's wound to his left ankle. The report indicated it was a biopsy site. When asked, the wound nurse indicated the resident had his left ankle biopsied on 10/9/25 and the wound on his left ankle was in the same area. There was no documentation of the wound following the biopsy provided. There was no indication the biopsy site had healed nor when the site had potentially reopened. The provided wound (continued on next page)

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