

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 4/4/16. This visit included a PSR to the State Residential Licensure Survey completed on 4/4/16.</p> <p>Survey date: June 2, 2016.</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Census bed type: SNF: 17 SNF/NF: 36 Residential: 59 Total: 112</p> <p>Census payor type: Medicare: 31 Medicaid: 11 Other: 11 Total: 53</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 6/6/16.</p>	F 0000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies cited during the Recertification and State survey which was conducted on June 2, 2016. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective June 11, 2016. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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F 0167 SS=C Bldg. 00	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on record review and interview, the facility failed to post the most recent Survey in the Survey Book.</p> <p>Finding includes:</p> <p>On 6/02/16 at 2:30 p.m., the State Survey binder was reviewed, the survey binder was not updated with the most current survey completed on 4/04/16.</p> <p>Interview with the Administrator on 6/02/16 at 4:57 p.m., indicated she was not aware the State Survey binder did not contain the most recent survey and it should have been in place in the binder for review.</p> <p>3.1-3(b)(1)</p>	F 0167	<p>1. No residents were cited in the 2567.2. All residents had the potential to be effected. The 2567 for 4/4/16 was placed in the public survey binder as per regulation.3. Executive Director was re-inserviced by Division Vice President on having the most recent State 2567 available in public area for viewing as per regulation. Executive Director or designee will monitor binder 1x monthly to ensure 2567 is in the public survey binder as per regulation.4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate.5. Date of Compliance 6.11.2016</p>	06/11/2016

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F 0441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash</p>			

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	<p>their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to maintain infection control practices and standards related to nursing staff not washing their hands between resident contact during medication pass for 2 of 5 residents observed during medication pass. (Residents #60 and #196)</p> <p>Finding includes:</p> <p>On 6/04/16 at 11:20 a.m., LPN #1 was observed preparing medications for Resident #196. She opened her medication cart and retrieved a Humalog Pen (a prefilled syringe containing insulin to treat diabetes for the control of blood sugar). She then closed her medication cart and walked to the resident's room. At the time the LPN indicated she was administering 8 units of insulin. She was observed placing a glove on her right hand, she place her ungloved left hand on the residents stomach and proceeded to administer the medication with her gloved right hand. Before exiting the room the LPN removed her glove and</p>	F 0441	<p>1. Resident #60 and #196 had no adverse side effects noted.2. All residents had the potential to be effected. LPN#1 was immediately counseled on handwashing between administration of medications.3. Licensed Nurses were re-inserviced on washing hands between residents getting medications by Clinical Support or designee. Director of Health Services or designee will monitor 5 resident's medication passes, to include all 3 shifts, 1x weekly to ensure compliance with handwashing for 6 months or until QAA states otherwise.4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate.5. Date of Compliance 6.11.2016</p>	06/11/2016

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R 0000 Bldg. 00	<p>walked back to her medication cart. The LPN was not observed to wash her hands with soap and water or use an alcohol based hand sanitizing gel.</p> <p>At that time the LPN proceeded to prepare and administer Resident #60's medications as well, without washing her hands or using an alcohol based gel.</p> <p>Interview with the Assistant Director of Health Services (ADHS) on 6/02/16 at 5:00 p.m., indicated LPN #1 should have washed her hands between direct resident contact.</p> <p>The current 5/2016 Guideline for Handwashing policy provided by the ADHS on 6/02/16 at 5:09 p.m., indicated health care workers shall wash hands at times such as: Before and after having direct physical contact with residents.</p> <p>This deficiency was cited on 4/4/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-18(l)</p>			
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R 0354 Bldg. 00	<p>This visit was for a Post Revisit (PSR) to the State Residential Licensure Survey completed on 4/4/16.</p> <p>Residential Census: 59</p> <p>Sample: 11</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 32883 on 6/6/16.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data.</p>	R 0000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the Recertification and State survey which was conducted on June 2, 2016. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective June 11, 2016. Considering the volume, scope, and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</p>		

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	<p>(2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview, the facility failed to ensure a Resident Transfer Form was completed for 2 of 3 closed records reviewed. (Resident #9 & #8)</p> <p>Findings include:</p> <p>1. The closed record for Resident #9 was reviewed on 6/2/16 at 3:25 p.m. The resident was discharged to a different assisted living facility on 5/26/16.</p> <p>The record lacked any indication a Resident Transfer Form had been completed.</p> <p>Interview with the Assistant Director of Health Services (ADHS) on 6/2/16 at 3:40 p.m., indicated the nurse did not fill out a Resident Transfer Form for</p>	R 0354	<p>1. Resident #8 and #9 both have been discharged from the campus2. All residents in Assisted Living that have transferred out of the campus have been reviewed and any issues were addressed.3. Licensed Nurses were re-inserviced on transfer form completion prior to the resident being transferred or discharged from the facility by the Clinical Support or designee. Director of Health Services or designee will audit all residents in Assisted Living transferred out to ensure all forms are completed as required.4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate.5. Date of Compliance 6.11.2016</p>	06/11/2016

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	<p>Resident #9.</p> <p>2. The closed record for Resident #8 was reviewed on 6/2/16 at 3:30 p.m. The resident was discharged to a different assisted living facility on 5/20/16.</p> <p>The record lacked any indication a Resident Transfer Form had been completed.</p> <p>Interview with the ADHS on 6/2/16 at 3:40 p.m., indicated the nurse did not fill out a Resident Transfer Form for Resident #8.</p> <p>This deficiency was cited on 4/4/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			