

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/25/2016
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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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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/25/16</p> <p>Facility Number: 012766 Provider Number: 155795 AIM Number: 201051640</p> <p>At this Life Safety Code survey, Avalon Springs Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with automatic smoke detection in the corridors, in spaces open to the corridors and in all resident sleeping rooms. The Health Campus building has five wings: the 100, 200 and 300 wings which are certified and the</p>	K 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 May 31, 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 8, 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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K 0018 SS=E Bldg. 01	<p>400 and 500 wings which are licensed residential. The facility has a certified capacity of 61 and had a certified census of 55 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review on 05/27/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 49 resident room corridor doors closed and latched into the door frame. This deficient practice could affect staff and up to 17 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 05/25/16 at 11:23 a.m., the Director of Plant Operations acknowledged the</p>	K 0018	-No residents were directly involved. The door to room 107 was fixed.-All other resident room corridor doors were tested and latched into the door frame when closed.-Executive Director/Designee will in-service Maintenance Department regarding ensuring resident room corridor doors latch into the door frame when closed. Maintenance Director/Designee will audit 5 resident room corridor doors weekly to ensure doors latch into the door frame when	06/08/2016

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K 0038 SS=E Bldg. 01	<p>corridor door to resident room 107 failed to latch into the frame when tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 Day room exit door was readily accessible at all times. This deficient practice could affect staff and up to 4 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 05/25/16 at 11:20 a.m., the Day room contained a set of exit doors. One of the two doors contained manual latching hardware that latched into the frame. Based on an interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Restorative Dining exit door was readily</p>	K 0038	<p>closed. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 6-8-16</p> <p>-No residents were directly involved.-The manual latching hardware that latched into the door frame on the Day room door was removed. The Restorative Dining exit door was repaired. All other exit doors were tested and repaired as needed. -Executive Director/Designee will inservice Maintenance Department on ensuring all exit doors are readily accessible as per regulation. Maintenance Director/Designee will audit exit doors 1x monthly to ensure they are readily accessible as per regulation.-Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 6-8-16</p>	06/08/2016	

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K 0045 SS=F Bldg. 01	<p>accessible at all times. This deficient practice could affect staff and up to 6 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 05/25/16 at 10:35 a.m., the Restorative Dining exit door required excessive force to open because the bottom of the door was dragging on the concrete. Based on an interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting for 10 of 10 exit discharges. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants.</p>	K 0045	-No residents were directly involved.-Maintenance verified through the facility blue prints the exterior discharge light fixtures would be powered by the generator in the event of a power loss. Maintenance disconnected landline power to emergency transfer switch in order to check exterior discharge light fixtures would be powered by the	06/08/2016	

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K 0062 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 05/25/16 between 10: 20 a.m. and 12:15 p.m., all the exit discharges contained light fixtures. Based on interview at the time of observation, the Director of Plant Operations was unable to confirm if the exterior discharge light fixtures would be powered by the generator in the event of power loss.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of 2 corroded sprinkler heads Work room. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25,</p>	K 0062	<p>generator in the event of power loss. The exterior discharge light fixtures were powered and illuminated by the emergency generator power when the transfer switch was pulled.</p> <p>-Executive Director/Designee will inservice Maintenance Department on the exterior discharge light fixtures will be powered by the generator in the event of power loss as per regulation. Maintenance Department will audit exterior discharge light fixtures 1x monthly to ensure they are still connected to the generator so to ensure they will be powered in the event of power loss. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 6-8-16</p> <p>-No residents were directly involved.-Maintenance Director has the corroded sprinkler head in the health center work room scheduled to be replaced by Korsen our Fire and alarm system company. All the other sprinkler heads were inspected</p>	06/08/2016			

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K 0147 SS=D Bldg. 01	<p>Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and at least 5 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 05/25/16 at 10:28 a.m., one sprinkler head was corroded in the Work room. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed</p>	K 0147	<p>with no issues noted.-Executive Director/Designee will inservice Maintenance Department on importance of replacing sprinkler heads which are corroded and do not meet life safety code. -Maintenance Director/Designee will audit sprinkler heads in 5 rooms inside the health center facility 1x monthly for needed replacement due to being corroded and not meeting life safety code.-Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 6-8-16</p> <p>-No residents were involved-The extension cord providing power to a coffee pot in the Director of Food Services office was removed. All other offices on health center were checked and are in compliance.-Executive Director/Designee will inservice staff of not using flexible cords as a substitute for fixed wiring as per</p>	06/08/2016

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	wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation with the Director of Plant Operations on 05/25/16 at 10:42 a.m., an extension cord was powering a coffee pot in the Director of Fund Services office. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned condition. 3.1-19(b)		regulation. -Maintenance Director/designee will audit 5 rooms 1x weekly for no extension cords being used for fixed wiring as per regulation-Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 6-8-16		