

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: June 23, 24, 25, 26, 27, and 30, 2014</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Julie Ferguson, RN</p> <p>Census bed type: SNF: 38 SNF/NF: 20 Residential: 64 Total: 122</p> <p>Census Payor type: Medicare: 28 Medicaid: 18 Other: 76 Total: 122</p> <p>Residential sample: 9</p>	F000000	<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 30, 2014. 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 July 30, 2014. 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>	

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.

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000157 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 5, 2014, by Janelyn Kulik, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's family/responsible party of a new order for therapy for 1 of 1 residents reviewed for notification of change. (Resident #46)</p> <p>Findings include:</p> <p>An interview with Resident #46's family member on 6/25/14 at 1:50 p.m. indicated resident #46 was hospitalized recently and returned to the facility following his stay in the hospital. Resident #46's family member indicated upon Resident #46's return to the facility the family was not notified Resident #46 was eligible for therapy. It was further indicated the family was unaware Resident #46 was receiving therapy until they were notified they needed to sign a form regarding the end of therapy.</p> <p>The record for Resident #46 was reviewed on 6/24/14 at 4:11 p.m. The resident's diagnosed included, but were not limited to, diabetes mellitus, hypertension, and congestive heart failure.</p> <p>Review of the Physician's orders indicated the resident was re-admitted to</p>	F000157	<p>1. Resident #46's family has been notified of therapy services received. 2. Other residents receiving therapy were audited for family notification; notification made as needed. 3. Director of Nursing/Designee will in-service licensed nursing staff regarding notification and documentation of notification of therapy orders . Director of Nursing/Designee will audit therapy orders for family/responsible party notification 3 times weekly in Clinical Meeting for 2 months; then weekly thereafter until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months and then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. 5. Date of compliance 7.30.14</p>	07/30/2014	

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the facility on 5/13/14. A Physician's order dated 5/14/14 indicated the resident was to receive PT (physical therapy) 5 times a week for 30 days. The family notification area on the physician's order was blank. A Physician's order dated 5/14/14 indicated the resident was to receive OT (occupational therapy) 5 days a week for 30 days. The family notification area on the physician's order was blank.</p> <p>Review of the Progress Notes dated 5/13/14 through 6/24/14 lacked evidence of family notification of the physician's orders for PT and OT.</p> <p>Review of the Therapy Progress Notes dated 5/14/14 through 6/6/14 indicated the resident had received therapy from 5/14/14 through 5/28/14 and 5/30/14 through 6/4/14. The resident was discharged from therapy on 6/5/14.</p> <p>An interview with the Director of Health Services (DHS) on 6/26/14 at 11:38 a.m. indicated there was a section on physician's orders where the nurse should indicate what family member was notified of the order. She further indicated the nurse should contact the resident's family/responsible party with any new order.</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

F000225 SS=D	<p>Continued interview with the DHS on 6/26/14 at 3:35 p.m. indicated she could not find any documentation that the family was notified of the therapy orders. She further indicated the nurse should have attempted to notify the family/responsible party.</p> <p>A facility policy titled "Guidelines for Responsible Party Notification", dated 11/08/2010, and received as current from the DHS, indicated, "...2. The responsible party should be notified of change in condition or diagnostic testing results in a timely manner...5. Documentation of notification or notification attempts should be recorded in the resident medical record."</p> <p>3.1-5(2) 3.1-5(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide</p>			
-----------------	--	--	--	--

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to report allegations of abuse timely to the Executive Director of the facility for 2 of 3 abuse allegations reviewed. (Resident #46 and #96)</p> <p>Findings include:</p> <p>1. During an interview on 6/23/14 at 11:12 a.m., Resident #46 indicated there had been an incident recently with a</p>	F000225	<p>1. Resident # 46's concern regarding care was investigated and reported to ISDH 6/25/14 after Executive Director was informed of concern. CNA # 4 was no longer working at facility at the time concern was reported. CNA #3 received counseling regarding reporting allegations of abuse to the Executive Director immediately. Resident # 96 had been discharged from facility. Concern was reported to ISDH and</p>	07/30/2014

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>female CNA who refused to assist him with care during the midnight shift because her back hurt. Resident #46 indicated he had reported the incident to the Administrator and was told the CNA no longer worked at the facility. He indicated he could not remember the CNA's name but had not had any further problems.</p> <p>The record for Resident #46 was reviewed on 6/24/14 at 4:11 p.m. The resident's diagnosed included, but were not limited to, diabetes mellitus, hypertension, and congestive heart failure.</p> <p>The resident's Admission Minimum Data Set (MDS) Assessment, dated 6/3/14, indicated the resident was cognitively intact.</p> <p>Further interview with Resident #46 on 6/25/14 at 11:05 a.m. indicated he had not reported the incident to the Administrator but had reported it to CNA #3 who usually worked the midnight shift. He indicated CNA #3 had told him the female CNA was no longer at the facility. He further indicated he could not remember the name of the female CNA who had refused to care for him. He indicated, "It was a colored woman, that's all I know." He further indicated</p>		<p>investigated 4/22/14. Staff was in-serviced on reporting of abuse to Executive Director immediately. 2. Social Services/Designee will re-in-service staff on reporting allegations or suspicions of abuse to Executive Director immediately. 3. Social Services/Designee to interview/audit 5 residents weekly regarding concerns with care; and 5 staff members regarding abuse reporting, rotating shifts weekly to cover all shifts for 2 months; then one staff and one resident weekly thereafter 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 7.30.14</p>				

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the incident happened a few weeks to a month ago.</p> <p>In an interview with the Executive Director (ED) on 6/25/14 at 11:43 a.m., she indicated she was not aware of any concerns about care or concerns with any CNAs involving Resident #46 and nothing had been reported to her. Resident #46's concerns were reported to the ED at this time. She further indicated she would look into Resident #46's concerns.</p> <p>In an interview with the ED and DHS on 6/25/14 at 2:50 p.m. they indicated they had spoken with CNA #3 and he indicated Resident #46 had reported to him CNA #4 refused to assist him with care on the midnight shift about a week or two ago. CNA #3 indicated he reported this to LPN #3 who was working that night. The DHS indicated she spoke to LPN #3 who indicated CNA #3 reported the incident to him and he went and assisted Resident #46 himself. LPN #3 indicated he did not report the incident to the ED because CNA #4 had already left for the day.</p> <p>Continued interview with the ED indicated LPN #3 should have reported the incident to her immediately. She further indicated CNA #4 no longer</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>works for the facility.</p> <p>2. The closed record for Resident #96 was reviewed on 6/27/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, coronary artery disease, diabetes mellitus, and hyperlipidemia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 4/6/14, indicated the resident was cognitively intact.</p> <p>Review of an incident investigation dated 4/23/14, indicated an incident was reported by Resident #96 that occurred on 4/22/14 at 7:30 p.m. Resident #96 reported she had a run in with a nurse the previous night. She reported her bed alarm kept going off each time she rolled over she wanted to inform the nurse she was not trying to get out of bed. She further reported when she informed the nurse of this the nurse's response was "shut up and leave me alone."</p> <p>The immediate action taken included CNA #5 (the staff member described by Resident #96) was removed from the facility schedule pending investigation.</p> <p>Upon further investigation by the facility it was found CNA #6 was present during</p>			

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000226 SS=D	<p>the incident on 4/22/14. CNA #6 indicated Resident #96's alarm was going off and CNA #5 walked in the resident's room and stated "Oh no! We are not doing this tonight. We are not doing this getting up and down crap tonight." CNA #6 indicated she had asked CNA #5 to leave the room and CNA #5 left the room. CNA #6 then reported the incident to Unit Manager #1. Unit Manager #1 had not reported the incident to the ED.</p> <p>In an interview with the ED on 6/24/14 at 4:50 p.m., she indicated she was aware Unit Manager #1 had not reported the incident timely and should have reported the incident immediately.</p> <p>Continued interview with the ED on 6/25/14 at 8:45 a.m. indicated she was out of town when the incident occurred and the Administrator in Training (AIT) was covering for her. She further indicated the AIT had re-educated Unit Manager #1 and CNA #5.</p> <p>3.1-28(c) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p>				

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the facility's abuse policy, related to reporting allegations of abuse to the Executive Director immediately for 2 of 3 abuse allegations reviewed. (Resident #46 and #96)</p> <p>Findings include:</p> <p>1. During an interview on 6/23/14 at 11:12 a.m., Resident #46 indicated there had been an incident recently with a female CNA who refused to assist him with care during the midnight shift because her back hurt. Resident #46 indicated he had reported the incident to the Administrator and was told the CNA no longer worked at the facility. He indicated he could not remember the CNA's name but had not had any further problems.</p> <p>The record for Resident #46 was reviewed on 6/24/14 at 4:11 p.m. The resident's diagnosed included, but were not limited to, diabetes mellitus, hypertension, and congestive heart failure.</p>	F000226	<p>1. Resident # 46's concern regarding care was investigated and reported to ISDH 6/25/14 after Executive Director was informed of concern. CNA # 4 was no longer working at facility at the time concern was reported. CNA #3 received counseling regarding reporting allegations of abuse to the Executive Director immediately. Resident # 96 had been discharged from facility. Concern was reported to ISDH and investigated 4/22/14. Staff was in-serviced on reporting of abuse to Executive Director immediately. 2. Social Services/Designee will re-in-service staff on reporting allegations or suspicions of abuse to Executive Director immediately. 3. Social Services/Designee to interview/audit 5 residents weekly regarding concerns with care; and 5 staff members regarding abuse reporting, rotating shifts weekly to cover all shifts for 2 months; then one staff and one resident weekly thereafter 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</p>	07/30/2014

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>The resident's Admission Minimum Data Set (MDS) Assessment, dated 6/3/14, indicated the resident was cognitively intact.</p> <p>Further interview with Resident #46 on 6/25/14 at 11:05 a.m. indicated he had not reported the incident to the Administrator but had reported it to CNA #3 who usually worked the midnight shift. He indicated CNA #3 had told him the female CNA was no longer at the facility. He further indicated he could not remember the name of the female CNA who had refused to care for him. He indicated, "It was a colored woman, that's all I know." He further indicated the incident happened a few weeks to a month ago.</p> <p>In an interview with the Executive Director (ED) on 6/25/14 at 11:43 a.m., she indicated she was not aware of any concerns about care or concerns with any CNAs involving Resident #46 and nothing had been reported to her. Resident #46's concerns were reported to the ED at this time. She further indicated she would look into Resident #46's concerns.</p> <p>In an interview with the ED and DHS on 6/25/14 at 2:50 p.m. they indicated they had spoken with CNA #3 and he</p>		changes as appropriate. 5. Date of compliance 7.30.14	

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>indicated Resident #46 had reported to him CNA #4 refused to assist him with care on the midnight shift about a week or two ago. CNA #3 indicated he reported this to LPN #3 who was working that night. The DHS indicated she spoke to LPN #3 who indicated CNA #3 reported the incident to him and he went and assisted Resident #46 himself. LPN #3 indicated he did not report the incident to the ED because CNA #4 had already left for the day.</p> <p>Continued interview with the ED indicated LPN #3 should have reported the incident to her immediately. She further indicated CNA #4 no longer works for the facility.</p> <p>2. The closed record for Resident #96 was reviewed on 6/27/14 at 1:00 p.m. The resident's diagnoses included, but were not limited to, coronary artery disease, diabetes mellitus, and hyperlipidemia.</p> <p>Review of the Admission Minimum Data Set (MDS) Assessment, dated 4/6/14, indicated the resident was cognitively intact.</p> <p>Review of an incident investigation dated 4/23/14, indicated an incident was reported by Resident #96 that occurred</p>			

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>on 4/22/14 at 7:30 p.m. Resident #96 reported she had a run in with a nurse the previous night. She reported her bed alarm kept going off each time she rolled over she wanted to inform the nurse she was not trying to get out of bed. She further reported when she informed the nurse of this the nurse's response was "shut up and leave me alone."</p> <p>The immediate action taken included CNA #5 (the staff member described by Resident #96) was removed from the facility schedule pending investigation.</p> <p>Upon further investigation by the facility it was found CNA #6 was present during the incident on 4/22/14. CNA #6 indicated Resident #96's alarm was going off and CNA #5 walked in the resident's room and stated "Oh no! We are not doing this tonight. We are not doing this getting up and down crap tonight." CNA #6 indicated she had asked CNA #5 to leave the room and CNA #5 left the room. CNA #6 then reported the incident to Unit Manager #1. Unit Manager #1 had not reported the incident to the ED.</p> <p>In an interview with the ED on 6/24/14 at 4:50 p.m., she indicated she was aware Unit Manager #1 had not reported the incident timely and should have reported the incident immediately.</p>				

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000241 SS=D	<p>Continued interview with the ED on 6/25/14 at 8:45 a.m. indicated she was out of town when the incident occurred and the Administrator in Training (AIT) was covering for her. She further indicated the AIT had re-educated Unit Manager #1 and CNA #5.</p> <p>A facility policy titled "Abuse and Neglect Procedural Guidelines", dated 2011, and received as current from the ED, indicated, "...4...d...ii. Any person with knowledge or suspicion of suspected violations shall report immediately...iv. Immediately notify the Executive Director. If the Executive Director is absent they may appoint a designee..."</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure residents were treated with dignity related to calling residents "feeders" by a staff member for 5 of 8 residents random observations</p>	F000241	Residents who dine in the rehab dining room were audited for change in meal consumption following notification that the term "feeders" had been used, with no concerns identified. Staff were	07/30/2014

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>during dining in the private dining room. (CNA #1)</p> <p>Findings include:</p> <p>During a continuous observation on 06/23/14 in the "Private Dining" room from 12:00 p.m. to 12:45 p.m., the following was observed: four residents present, 3 in wheelchairs, one in a chair at dining room table, and the fifth resident wheeled in via a broda chair (speciality wheelchair) at 12:07 p.m.</p> <p>An interview with CNA #1 at 12:07 p.m., indicated the Private Dining room was for "feeders."</p> <p>An interview with DHS (Director of Health Services) on 06/23/14 at 1:44 p.m., s indicated no that was where we assist people with dining. We do not call them "feeders."</p> <p>During an interview with the ED (Executive Director) on 06/30/14 at 4:25 p.m., she indicated the staff was in-serviced, tested and given examples of preferred terminology that should be used when speaking to residents.</p> <p>On 06/30/14 at 4:25 p.m., the ED indicated staff was in-serviced on quality of life for residents rights in a learner</p>		<p>in-serviced immediately regarding dignity and preferred terminology to identify residents who require assist with meals.2. Other residents were interviewed regarding dignity with no concerns identified.3. Director of Nursing/Designee to re-in-service staff on dignity and preferred terminology used to identify residents who require assist with meals. Social Services/Designee to interview/audit 5 residents weekly regarding dignity; and 5 staff members regarding dignity and preferred terminology, rotating shifts weekly to include all shifts for 2 months; then 1 resident and 1 staff weekly thereafter 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 7.30.14</p>		

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000250 SS=D	<p>workbook. "TRAINING & (AND) LEADERSHIP DEVELOPMENT, revised 12/05/12" learner workbook indicated "...Quality of Life: 35. Dignity/Self Determination and Participation: You have the right to receive care from the facility in a manner that is a safe environment and that promotes, maintains, or enhances your dignity and respect in full recognition of your individuality...."</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident, related to not providing timely and accurate information to a resident's family/responsible party about a leave of absence for 1 of 1 resident's reviewed for social services. (Resident</p>	F000250	<p>1. Residents # 46's family has received LOA information. 2. No other residents are on LOA at this time. 3. Executive Director/Designee will in-service Social Services on providing timely notification of accurate information regarding LOA. Social Services/Designee to audit LOA notification weekly for 2 months; then monthly thereafter until QAA states otherwise. 4. Audits to be</p>	07/30/2014

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>#46)</p> <p>Findings include:</p> <p>The record for Resident #46 was reviewed on 6/24/14 at 4:11 p.m. The resident's diagnosed included, but were not limited to, diabetes mellitus, hypertension, and congestive heart failure.</p> <p>An interview with Resident #46's family member on 6/25/14 at 1:50 p.m. indicated on 5/28/14 Resident #46 had gone on an honor flight to Washington D.C. accompanied by his son. Resident #46's son had come to pick him up from the facility in the evening on 5/27/14. Resident #46's family member indicated when he arrived to the facility to pick up his father, he was informed by the Social Services Aide that she had just been in a meeting and needed to inform him if he took Resident #46 out of the facility prior to 5/28/14 the resident would lose his Medicare benefits, the facility might not be able to hold his bed, and the resident would have to be re-admitted upon his return to the facility. Continued interview with Resident #46's family member indicated the Social Service Aide told him if he were to pick up the resident after midnight the resident would not lose his Medicare benefits. Resident</p>		<p>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 7.30.14</p>		

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>#46's family member indicated he returned to the facility at 1:00 a.m. to pick up Resident #46 for the honor flight.</p> <p>Further interview with Resident #46's family member researched the Medicare leave of absence policy/procedures and indicated the facility gave them "bogus" information. He indicated the resident could have left the facility anytime the previous day. He further indicated the facility caused stress to the resident by providing the incorrect information and not notifying the family/responsible party of the leave of absence policy/procedures prior to the day before the honor flight.</p> <p>In an interview with the Social Service Aide (SSA) with the Social Service Director present, on 6/26/14 at 1:15 p.m., she indicated she had spoken with Resident #46's son when he arrived to pick the resident up on 5/28/14. She further indicated she had just come out of a Medicare meeting and everything was sort of rushed to notify the family when they came in. She indicated she told the resident's son if the resident was not in his bed at midnight he would be considered discharged from the facility and Medicare. She further indicated she was new to working in long term care and was unaware of the rules about a</p>			

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000279 SS=D	<p>leave of absence. She indicated she had provided the wrong information to the family and should have notified the family sooner.</p> <p>3.1-34(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure a care plan and monitoring system was initiated related to range of motion for 1 of 30 residents reviewed for range of motion. (Resident #100)</p>	F000279	<p>1. Resident #100's care plan has been updated to include ROM. 2. Other residents were audited for contractures. Care Plans updated to include ROM as needed. 3. Director of Nursing/Designee will in-service MDS regarding addressing ROM on care plans for residents with</p>	07/30/2014			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>On 6/25/14 at 11:20 a.m. Resident #100 was sitting in her Broda chair (specialty support wheelchair) in the unit lounge area sleeping on and off in front of the TV. The resident's arms and legs were visibly bent at the elbows and knees respectively. No splints were in use.</p> <p>On 6/25/14 at 1:30 p.m., the resident was sitting in her Broda chair in her room. The resident's arms and legs were visibly bent at the elbows and knees respectively. No splints were in use.</p> <p>On 6/26/14 at 8:45 a.m., the resident was still asleep in her bed positioned on her left side. The resident's arms and legs were visibly bent at the elbows and knees respectively. No splints were visibly in use.</p> <p>On 6/27/14 at 8:50 a.m., Resident #100 was lying elevated in bed with a nurse feeding her breakfast one on one. The resident's arms and legs were visibly bent at the elbows and knees respectively. No splints were visibly in use.</p> <p>The record for Resident #100 was reviewed on 6/25/14 at 11:20 a.m. The resident's diagnoses included, but were not limited to, Parkinson's, dementia,</p>		<p>contractures. MDS will audit new residents for contractures and address ROM on care plans weekly for 2 months; then monthly thereafter until QAA states otherwise: MDS will audit existing residents quarterly for contractures and address ROM on care plan as needed. 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 7.30.14</p>	

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>hypertension, depression, and osteoporosis.</p> <p>The Quarterly MDS (Minimum Data Set) Assessment dated 4/3/14 indicated a "Functional Status Limitation in Range of Motion: Impairment on both sides for Upper & Lower extremities."</p> <p>The Annual Comprehensive MDS dated 12/31/13 indicated a "Functional Status Limitation in Range of Motion: Impairment on both sides for Upper & Lower extremities." The CAA (Care Area Assessment) indicated the following care areas triggered:</p> <ul style="list-style-type: none"> - Delirium - Cognitive loss - ADL's (Activities of Daily Living) - Urinary incontinence - Falls - Dehydration - Pressure ulcers - Psychotropic medication use <p>All of the above areas were documented as care planned . The ADL functional status worksheet indicated physical limitations included weakness, limited range of motion, poor coordination, poor balance, visual impairment, or pain based on CRCA (certified resident care assistant) care tracker charting.</p> <p>Review of the current care plans</p>			

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F000280 SS=D	<p>indicated lack of a care plan addressing limited range of motion. There were current care plans for Parkinson's disease and ADL self care deficit, but both lacked mention of limited range of motion or contractures.</p> <p>Interview with RN #1 on 6/23/14 at 11:30 a.m., indicated the resident had contractures to both knees and both arms - "more so on the right side" and did not receive range of motion services or have a splint device in place.</p> <p>Interview with the DHS on 6/25/14 at 3:15 p.m., indicated the resident does have contractures. She was not currently on therapy services & the facility had no restorative program. The CRCA's do not necessarily have any set ROM (range of motion) program that they complete with the residents during daily care. She was not aware the resident lacked a care plan for ROM and was unsure why she did not have one based on the MDS charting.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be</p>				

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure a resident's Responsible Party had been invited timely to participate in the resident's care plan review and failed to ensure follow up with the Responsible Party was completed after the care plan review, for 1 of 1 resident reviewed for participation in care planning. (Resident #46)</p> <p>Findings include:</p> <p>An interview with Resident #46's family member on 6/25/14 at 1:50 p.m. indicated the family received a call recently on a Sunday evening to invite them to a care plan meeting on Monday. Resident #46's family member indicated family was unable to attend the meeting with such short notice and was never</p>	F000280	<p>1. Resident #46's family has been informed of care plan meeting agenda. 2. No other residents/families had concerns with care plan meetings 3. Director of Nursing/Designee will in-service Social Services regarding timely invitation to care plan meetings as well as follow up after meetings as needed. Social Services/Designee will audit for timely Care Plan Meeting invitation and needed follow up weekly for 2 months; then monthly thereafter 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 7.30.14</p>	07/30/2014

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>provided with follow up after the meeting about what was discussed.</p> <p>The record for Resident #46 was reviewed on 6/24/14 at 4:11 p.m. The resident's diagnosed included, but were not limited to, diabetes mellitus, hypertension, and congestive heart failure.</p> <p>The resident had an Admission Minimum Data Set (MDS) Assessment completed on 5/20/14.</p> <p>A "Resident First Conference Notes" form, undated, indicated "when [Resident #46's name] gets back from Washington he'll have to d/c and Medicare wont' pay, it'll go back to Private Pay. Have to go over it with Dr. (doctor)." The form indicated the resident/responsible party was notified of the meeting but did not attend. The form indicated if family "unable to attend, follow up with phone call or mail conference notes."</p> <p>During an interview on 6/26/14 at 1:15 p.m., the Social Service Director indicated Social Services was responsible for inviting the family/responsible party to care plan meetings. She indicated "We haven't been on it, I'll admit that." She further indicated if family can't attend they will try to reschedule the meeting at</p>			

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000282	<p>a time that works best for the family. She indicated if a family/responsible party is unable to attend they usually follow up with a phone call. She indicated she was not present at Resident #46's meeting but would speak to the Social Service Aide who had been there.</p> <p>During an interview on 6/26/14 at 1:44 p.m., the Social Service Aide indicated she had made a phone call to the resident's responsible party and left a message for them regarding the care plan meeting. She indicated the care plan meeting took place about a week before the resident's honor flight. The resident left for his honor flight on 5/28/14. She further indicated she had not received any call back from the family and no family showed up to the care plan meeting. She indicated the first time she followed up with the family was when Resident #46's son came to pick up the resident for his honor flight on 5/27/14. She indicated Resident #46's family should have received more timely notice of the care plan meeting and should have received follow up after the meeting.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii)</p>						

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
SS=D	<p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to follow the care plan related to monitoring bruises for residents who were at risk for bruising for 2 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non pressure related skin conditions. The facility also failed to follow physician orders and the care plan for monitoring pulse prior to medication administration for 1 of 5 residents reviewed for unnecessary medications. (Resident's #94, #113, and #100).</p> <p>Findings include:</p> <p>1. During an observation on 6/23/14 at 2:40 p.m., Resident #94 was laying in bed. The resident was observed to have a dark brown discoloration noted to her right hand thumb area and three red discolorations noted to the top of her right hand. The resident was unable to say how she received the discolorations.</p> <p>During an observation on 6/24/14 at</p>	F000282	<p>1. Skin impairment documentation, family notification, and care plan update completed 6/24/14 for bruises identified on residents #94 and #113. Heart rate parameters for resident #100 had been discontinued at the time of survey.2. Skin sweep completed 6/24/14 with documentation , notification, and care plan updates as needed for any concerns identified. Director of Nursing in-serviced nursing staff regarding skin impairment documentation 6/24/14. Other residents with heart rate parameters were audited and MD notified of concerns. 3. Director of Nursing/Designee will in-service nursing staff regarding completing thorough weekly skin assessments, skin impairment documentation, and care plan updates. Director of Nursing/Designee to complete skin checks on 3 residents weekly for 2 months; then one resident weekly thereafter until QAA states otherwise. Director of Nursing/Designee will in-service licensed nursing staff regarding following physician's orders including HR monitoring. Director of Nursing/Designee to audit MAR for heart rates 3 times</p>	07/30/2014			

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>3:15 p.m., Resident # 94 was sitting in her wheelchair in her room. The resident was noted to have a dark brown discoloration and three red discolorations to her right hand that was observed the day before.</p> <p>A record review for Resident #94 was completed on 6/24/14 at 1:38 p.m. The resident's diagnoses included, but were not limited to, hypertension, congestive heart failure, dementia with behavioral symptoms, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed on 3/17/14, indicated Resident #94 was cognitively impaired. The resident was an extensive 2+ person assist for bed mobility and transfers. The MDS Assessment indicated the resident had a functional limitation in Range Of Motion (ROM) to both of her upper and lower limbs. The resident was receiving an anticoagulant (blood thinning medication) 7 x in the 7 day assessment period.</p> <p>Resident #94 had a care plan for Risk For Bleeding related to anti-coagulant use Aspirin. The nursing interventions included to assess for negative outcomes of anticoagulant drug use, in example of</p>		<p>weekly for 2 months, then weekly thereafter until QAA states otherwise. 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 7.30.14</p>		

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>discolorations.</p> <p>The June 2014 Medication Administration Record (MAR) indicated the resident was administered Aspirin 325 milligrams (mg) daily and a weekly skin assessment was completed on 6/6/14, 6/13/14, and 6/20/14. With each skin assessment a 0 was marked indicating no new areas of impairment.</p> <p>A skin impairment circumstance, assessment and intervention form was completed on 6/24/14 at 4:00 p.m. The form indicated bruises to the top of the right hand and right thumb. A multiple bruise monitoring sheet was completed on 6/24/14 for bruises to the top of Resident #94's right hand. The bruises were as follows:</p> <ul style="list-style-type: none"> -Bruise A: between right 1st/2nd knuckle, color is red and measured 1 centimeters (cm) x 1 cm -Bruise B: right 2nd knuckle, color is red and measured 0.4 cm x 0.3 cm -Bruise C: right index finder, color is red and measured 0.6 cm x 0.3 cm <p>A skin impairment assessment was completed on 6/24/14 for the bruise to the right top of the thumb. The color was brown and measured 5 cm</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>x 2 cm.</p> <p>The resident's record lacked documentation the discolorations to the right hand had been addressed or assessed until brought to the facilities attention of the discolorations to Resident #94's right hand.</p> <p>During an interview with LPN #2 on 6/24/14 at 3:34 p.m., indicated she was unaware of the discolorations to Resident #94's right hand and thumb area.</p> <p>During an interview with the Staff Development LPN on 6/24/14 at 3:40 p.m., indicated nurses do weekly skin assessments and the CNA's visually check residents skin with care. She further indicated staff should have noticed the discoloration to the residents hand since yesterday before bringing it to their attention.</p> <p>During and interview with the Director of Health Services (DHS) on 6/25/14 at 2:47 p.m., indicated staff should have noticed the discoloration and addressed and assessed it before bringing it to their attention. She further indicated the CNA's dress the resident every morning therefore should of noticed the bruises and</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>reported them.</p> <p>During an interview with CNA #2 on 6/26/14 at 1:55 p.m., indicated the CNA's observe residents skin during care. She further indicated she would tell the nurse immediately if a resident had any skin tears, bruising, or redness to their skin.</p> <p>2. On 6/23/14 at 2:40 p.m., a bruise was observed to the back of Resident #113's left (L) hand. Geri sleeves were present on both arms.</p> <p>On 6/25/14 at 10:12 a.m., Resident #113 was observed sitting in his wheelchair in the hallway by the nurses' station. A nickel-sized purplish bruise was noted to the back of his hand on his left index finger. The resident indicated he "fell and hit it on the cement" the other day. Geri sleeves were present to both arms and had been observed being adjusted about 5 minutes prior by the AIT (Administrator in Training). There was no mention of the bruise to his left hand.</p> <p>The record for Resident #113 was reviewed on 6/25/14 at 8:35 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, history of stroke with R (right) hemiplegia (partial paralysis), vascular dementia with depressed anxiety state, dementia with</p>			
--	--	--	--	--

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>behavior disturbances - violent outbursts, pacemaker, and history of falls.</p> <p>Review of the Physician Order Summary (POS) for June 2014, indicated:</p> <ul style="list-style-type: none"> - weekly skin assessment on Thursday 7-3 shift - geri sleeves to bilateral upper extremities at all times, may remove for bathing - Aspirin (medication with blood thinning properties) 81 mg (milligrams) give 1 tablet orally once daily for CVA (stroke) <p>Review of the MAR (Medication Administration Record) for June 2014 indicated the resident had been receiving his Aspirin daily as ordered and his geri-sleeves were documented as on every shift.</p> <p>Skin impairment investigation forms were completed for the following dates:</p> <ul style="list-style-type: none"> 1/14/14 - skin tears R forearm 2/10/14 - skin tears R hand 2/20/14 - skin tear L hand 2/20/14 - skin tear R forearm 2/24/14 - red area/ bruise lower back (fall) 4/3/14 - skin tear L hand 4/5/14 - skin tear 5/15/14 - intact scabs top of head - resident scratched 5/18/14 - skin tears & bruises R upper 						

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>arm</p> <p>5/21/14 - skin tear R upper forearm</p> <p>There was no Skin Impairment Form for a new bruise to the L(left) hand as of 6/25/14 8:35 a.m.</p> <p>A Fall Circumstance Investigation form dated 6/22/14 indicated a fall in the resident's room with no injury. The form included a three day follow up charting assessment from 6/22/13 3-11 shift through 6/25/14 7-3 shift. All charting indicated no injury evident.</p> <p>Review of care plans indicated a current care plan for skin conditions. Interventions included, but were not limited to, ".... Assess/ record changes in skin status, ... administer/ monitor effectiveness of/ response to preventative treatment as ordered" A care plan for "at risk for bleeding R/T (related to) ASA (Aspirin) therapy included the intervention "assess for S/S (Signs/ Symptoms) of bleeding."</p> <p>The ADHS (Assistant Director of Health Services) was asked about the bruise to Resident #113's left hand on 6/25/14 at 10:15 a.m. She was unaware of the area and indicated if staff nurses were aware, a Skin Impairment Form would have been initiated, including notification of the Physician and responsible party.</p>						

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>A Multiple Bruise Monitoring Sheet dated 6/24/14 was produced by the SDC on 6/25/14 at 10:30 a.m. indicating a bruise to top L index finger as well as R (right)4th finger, R middle finger, R index finger and R side of neck. A notation also indicated "recent fall noted." At this time, she indicated there was no Skin Impairment Sheet for the L hand bruise and, if related to a fall, should be documented on the Fall Circumstance Investigation form.</p> <p>Interview with the DHS (Director of Health Services) on 6/25/14 at 10:35 a.m. regarding the bruise on Resident #113's left hand, indicated a Bruise Monitoring Sheet was just initiated yesterday (6/24/14) and not earlier, "We did a skin sweep last night."</p> <p>Follow up interview with the DHS on 6/25/14 at 2:40 p.m., indicated, "Yes, a staff member should have seen the bruise earlier since residents are dressed every morning & given care throughout the day."</p> <p>Interview on 6/26/14 at 2:00 p.m. with CNA #7, indicated the aides assess skin condition of all residents during daily care. If anything unusual is noticed such as bruises, skin tears, new discoloration</p>			
--	--	--	--	--

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>or anything abnormal, aides should report to the nurse.</p> <p>A policy was provided by the DHS on 6/25/14 at 11:06 a.m., titled "Weekly Skin Assessment Guideline", and deemed as current. The policy indicated: "Purpose: To monitor the effectiveness of interventions for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/ or treatment measures as indicated. Procedure: 1. A full body assessment shall be completed weekly by the licensed nurse... 5. Initiate applicable wound form if a new area of impairment is identified. (Pressure/ stasis/ arterial/ diabetic/ or other). 6. In addition to the Weekly Assessment by the licensed nurse the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified."</p> <p>3. The record for Resident #100 was reviewed on 6/25/14 at 11:20 a.m. The resident's diagnoses included, but were not limited to high blood pressure and atrial fibrillation.</p> <p>Review of the Physician Order Summary</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>(POS) for June 2014, indicated Metoprolol (a blood pressure medication) 25 milligrams (mg) 1/2 tab BID (twice daily) - hold if Systolic Blood Pressure (SBP) less than 100 or Heart Rate (HR) less than 60.</p> <p>Review of the Medication Administration Record (MAR) for April, May and June 2014 indicated there was no evidence of heart rates documented before administration of the Metoprolol medication for the following dates: April: 7 a.m.: 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, and 30. 7 p.m.: 13 and 18 May: 7 a.m.: 20. 7 p.m.: 11, 20, and 21 June: 7 a.m.: 2, 4, 5, 6, 9, 10, 11, and 12. 7 p.m.: 6, 7, and 8</p> <p>Review of the resident's care plans included, but were not limited to, hypertension (HTN) and cardiac. Interventions for the resident's HTN care plan included, " Administer meds as ordered and monitor for side effects and effectiveness (see physician order and MAR)" The cardiac care plan indicated, "Resident is at risk for decreased cardiac output R/T (Related to): Atrial Fib and Hypertension. Interventions included, "Administer meds per order"</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000309 SS=D	<p>Interview with the DHS on 6/26/14 at 11:10 a.m., indicated the heart rates should have been completed and documented on the MAR prior to administration. At this time, she also indicated she had found documentation of heart rates for some of the missing dates in the daily charting (April 5, 7, 8, 9, 10, 11, 14, 15, 16, 17, 23, 24, and 29; May 21; June 4 and 9) but couldn't be sure they were for the same time the medication was given.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 2 of 3 residents reviewed for non pressure related skin conditions of the 3 residents who met the criteria for non pressure related skin conditions. (Resident's #94 and #113).</p>	F000309	<p>1. Skin impairment documentation, family notification, and care plan update completed 6/24/14 for bruises identified on residents #94 and #113. 2. Skin sweep completed 6/24/14 with documentation, notification, and care plan updates as needed for any concerns identified. Director of Nursing in-serviced nursing staff regarding skin impairment documentation 6/24/14. 3. Director of Nursing/Designee will</p>	07/30/2014

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Findings include:</p> <p>1. During an observation on 6/23/14 at 2:40 p.m., Resident #94 was laying in bed. The resident was observed to have a dark brown discoloration noted to her right hand thumb area and three red discolorations noted to the top of her right hand. The resident was unable to say how she received the discolorations.</p> <p>During an observation on 6/24/14 at 3:15 p.m., Resident # 94 was sitting in her wheelchair in her room. The resident was noted to have a dark brown discoloration and three red discolorations to her right hand that was observed the day before.</p> <p>A record review for Resident #94 was completed on 6/24/14 at 1:38 p.m. The resident's diagnoses included, but were not limited to, hypertension, congestive heart failure, dementia with behavioral symptoms, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed on 3/17/14, indicated Resident #94 was cognitively impaired. The resident was an extensive 2+ person assist for bed mobility and transfers. The MDS</p>		<p>re-in-service nursing staff regarding completing thorough weekly skin assessments, skin impairment documentation, and care plan updates. Director of Nursing/Designee to complete skin checks on 3 residents weekly for 2 months; then one resident weekly thereafter 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 7.30.14</p>				

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Assessment indicated the resident had a functional limitation in Range Of Motion (ROM) to both of her upper and lower limbs. The resident was receiving an anticoagulant (blood thinning medication) 7 x in the 7 day assessment period.</p> <p>The June 2014 Medication Administration Record (MAR) indicated the resident was administered Aspirin 325 milligrams (mg) daily and a weekly skin assessment was completed on 6/6/14, 6/13/14, and 6/20/14. With each skin assessment a 0 was marked indicating no new areas of impairment.</p> <p>A skin impairment circumstance, assessment and intervention form was completed on 6/24/14 at 4:00 p.m. The form indicated bruises to the top of the right hand and right thumb. A multiple bruise monitoring sheet was completed on 6/24/14 for bruises to the top of Resident #94's right hand. The bruises were as follows: -Bruise A: between right 1st/2nd knuckle, color is red and measured 1 centimeters (cm) x 1 cm -Bruise B: right 2nd knuckle, color is red and measured 0.4 cm x 0.3 cm -Bruise C: right index finger, color is</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>red and measured 0.6 cm x 0.3 cm</p> <p>A skin impairment assessment was completed on 6/24/14 for the bruise to the right top of the thumb. The color was brown and measured 5 cm x 2 cm.</p> <p>The resident's record lacked documentation the discolorations to the right hand had been addressed or assessed until brought to the facilities attention of the discolorations to Resident #94's right hand.</p> <p>During an interview with LPN #2 on 6/24/14 at 3:34 p.m., indicated she was unaware of the discolorations to Resident #94's right hand and thumb area.</p> <p>During an interview with the Staff Development LPN on 6/24/14 at 3:40 p.m., indicated nurses do weekly skin assessments and the CNA's visually check residents skin with care. She further indicated staff should of noticed the discoloration to the residents hand since yesterday before bringing it to their attention.</p> <p>During and interview with the Director of Health Services (DHS) on 6/25/14 at 2:47 p.m., indicated staff should</p>			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>have noticed the discoloration and addressed and assessed it before bringing it to their attention. She further indicated the CNA's dress the resident every morning therefore should of noticed the bruises and reported them.</p> <p>During an interview with CNA #2 on 6/26/14 at 1:55 p.m., indicated the CNA's observe residents skin during care. She further indicated she would tell the nurse immediately if a resident had any skin tears, bruising, or redness to their skin.</p> <p>2. On 6/23/14 at 2:40 p.m., a bruise was observed to the back of Resident #113's left (L) hand. Geri sleeves were present on both arms.</p> <p>On 6/25/14 at 10:12 a.m., Resident #113 was observed sitting in his wheelchair in the hallway by the nurses' station. A nickel-sized purplish bruise was noted to the back of his hand on his left index finger. The resident indicated he "fell and hit it on the cement" the other day. Geri sleeves were present to both arms and had been observed being adjusted about 5 minutes prior by the AIT (Administrator in Training). There was no mention of the bruise to his left hand.</p> <p>The record for Resident #113 was</p>			
--	--	--	--	--

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>reviewed on 6/25/14 at 8:35 a.m.</p> <p>Diagnoses included, but were not limited to, atrial fibrillation, history of stroke with R (right) hemiplegia (partial paralysis), vascular dementia with depressed anxiety state, dementia with behavior disturbances - violent outbursts, pacemaker, and history of falls.</p> <p>Review of the Physician Order Summary (POS) for June 2014, indicated:</p> <ul style="list-style-type: none"> - weekly skin assessment on Thursday 7-3 shift - geri sleeves to bilateral upper extremities at all times, may remove for bathing - Aspirin (medication with blood thinning properties) 81 mg (milligrams) give 1 tablet orally once daily for CVA (stroke) <p>Review of the MAR (Medication Administration Record) for June 2014 indicated the resident had been receiving his Aspirin daily as ordered and his geri-sleeves were documented as on every shift.</p> <p>Skin impairment investigation forms were completed for the following dates:</p> <ul style="list-style-type: none"> 1/14/14 - skin tears R forearm 2/10/14 - skin tears R hand 2/20/14 - skin tear L hand 2/20/14 - skin tear R forearm 2/24/14 - red area/ bruise lower back 			

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>(fall) 4/3/14 - skin tear L hand 4/5/14 - skin tear 5/15/14 - intact scabs top of head - resident scratched 5/18/14 - skin tears & bruises R upper arm 5/21/14 - skin tear R upper forearm There was no Skin Impairment Form for a new bruise to the L hand as of 6/25/14 8:35 a.m.</p> <p>A Fall Circumstance Investigation form dated 6/22/14 indicated a fall in the resident's room with no injury. The form included a three day follow up charting assessment from 6/22/13 3-11 shift through 6/25/14 7-3 shift. All charting indicated no injury evident.</p> <p>Review of care plans indicated a current care plan for skin conditions. Interventions included, but were not limited to, ".... Assess/ record changes in skin status, ... administer/ monitor effectiveness of/ response to preventative treatment as ordered" A care plan for "at risk for bleeding R/T (related to) ASA (Aspirin) therapy included the intervention "assess for S/S (Signs/ Symptoms) of bleeding."</p> <p>The ADHS (Assitant Director of Health Services) was asked about the bruise to</p>				

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Resident #113's left hand on 6/25/14 at 10:15 a.m. She was unaware of the area and indicated if a staff nurse were aware, a Skin Impairment Form would have been initiated, including notification of the Physician and responsible party.</p> <p>A Multiple Bruise Monitoring Sheet dated 6/24/14 was produced by the SDC on 6/25/14 at 10:30 a.m. indicating a bruise to top L index finger as well as R 4th finger, R middle finger, R index finger and R (right) side of neck. A notation also indicated "recent fall noted." At this time, she indicated there was no Skin Impairment Sheet for the L hand bruise and, if related to a fall, should be documented on the Fall Circumstance Investigation form.</p> <p>A Physician's Order dated 6/25/14 at 5 p.m. indicated "Monitor bruises to R side of neck, R fingers and top L pointer finger for S/S swelling/ pain daily until healed."</p> <p>Interview with the DHS (Director of Health) on 6/25/14 at 10:35 a.m. regarding the bruise on Resident #113's left hand, indicated a Bruise Monitoring Sheet was just initiated yesterday (6/24/14) and not earlier, "We did a skin sweep last night."</p>			

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000329 SS=D	<p>Follow up interview with the DHS on 6/25/14 at 2:40 p.m., indicated, "Yes, a staff member should have seen the bruise earlier since residents are dressed every morning & given care throughout the day."</p> <p>Interview on 6/26/14 at 2:00 p.m. with CNA #7, indicated the aides assess skin condition of all residents during daily care. If anything unusual is noticed such as bruises, skin tears, new discoloration or anything abnormal, aides should report to the nurse.</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and</p>						

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medications related to monitoring heart rate before administration of high blood pressure medications 1 of 5 residents reviewed for unnecessary medications. (Resident #100)</p> <p>Findings include:</p> <p>The record for Resident #100 was reviewed on 6/25/14 at 11:20 a.m. The resident's diagnoses included, but were not limited to high blood pressure and atrial fibrillation.</p> <p>Review of the Physician Order Summary (POS) for June 2014, indicated Metoprolol (a blood pressure medication) 25 milligrams (mg) 1/2 tab BID (twice daily) - hold if Systolic Blood Pressure (SBP) less than 100 or Heart Rate (HR) less than 60.</p> <p>Review of the Medication Administration Record (MAR) for April, May and June 2014 indicated there was no evidence of heart rates documented before</p>	F000329	<p>1. Heart rate parameters for resident #100 had been discontinued at the time of survey. 2. Other residents with heart rate parameters were audited and MD notified of concerns. 3. Director of Nursing/Designee will in-service licensed nursing staff regarding following physician's orders including HR monitoring. Director of Nursing/Designee to audit MAR for heart rates 3 times weekly for 2 months, then weekly thereafter until QAA states otherwise. 4. Audits to be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. 5. Date of compliance 7.30.14</p>	07/30/2014

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F000441 SS=D	<p>administration of the Metoprolol medication for the following dates: April: 7 a.m.: 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, and 30. 7 p.m.: 13 and 18 May: 7 a.m.: 20. 7 p.m.: 11, 20, and 21 June: 7 a.m.: 2, 4, 5, 6, 9, 10, 11, and 12. 7 p.m.: 6, 7, and 8</p> <p>Interview with the DHS (Director of Health Services) on 6/26/14 at 11:10 a.m., indicated the heart rates should have been completed and documented on the MAR prior to administration. At this time, she also indicated she had found documentation of heart rates for some of the missing dates in the daily charting (April 5, 7, 8, 9, 10, 11, 14, 15, 16, 17, 23, 24, and 29; May 21; June 4 and 9) but couldn't be sure they were for the same time the medication was given.</p> <p>3.1-48(a)(3)</p> <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</p>						

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to maintain proper infection control related to the storage and cleaning of residents' bedpans and urinals for 2 of 30 residents whose rooms were observed. (Residents #60 and #108)</p> <p>Findings include:</p> <p>1. During a room observation on 6/23/14</p>	F000441	<p>1. Bedpan in room 202 and urinal in room 201 were replaced and stored in plastic bag per policy. 2. Audit of all bathrooms was completed and any areas of concern were corrected immediately. Staff was in-serviced immediately regarding proper storage of bedpans/urinals</p> <p>3. Director of Nursing/Designee to re-in-service nursing staff regarding proper storage of bedpans/urinals. Director of</p>	07/30/2014			

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>at 10:45 a.m., a bedpan soiled with a dark yellow dried substance was sitting uncovered directly on the bathroom floor of room 202.</p> <p>On 6/26/14 at 3:20 p.m., the bedpan remained soiled and uncovered on the bathroom floor in room 202.</p> <p>On 6/26/14 at 3:30 p.m., during a brief tour with the AIT (Administrator in Training), the soiled bedpan was still observed uncovered on the bathroom floor of room 202.</p> <p>At the time of the brief tour, the AIT indicated the bedpan should have been cleaned and then placed in the plastic storage bag which was already tied to the railing in the bathroom of room 202. He further indicated he would have to refer to</p> <p>2. During a room observation on 6/24/14 at 9:07 a.m., an uncovered urinal was hanging on the handrail in the bathroom of room 201.</p> <p>On 6/26/14 at 3:20 p.m., the urinal remained hanging uncovered on the handrail in room 201.</p> <p>On 6/26/14 at 3:30 p.m., during a brief tour with the AIT (Administrator in</p>		<p>Nursing/Designee to complete infection control rounds related to proper storage and cleaning of bed pans/urinals in 5 bathrooms 3 times weekly for 2 months, then weekly thereafter 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 7.30.14</p>	

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000000	<p>Training), the urinal was still hanging uncovered on the handrail in the bathroom of room 201.</p> <p>At the time of the brief tour, the AIT indicated he would have to refer to the policy for the proper handling of the uncovered urinal.</p> <p>A policy titled Guidelines for Use of Bedpans and Urinals dated 3/10/14 was provided by the AIT on 6/26/14 at 4:00 p.m. At that time, the AIT indicated the facility would begin appropriate staff inservicing. The policy indicated, " clean the bedpan or urinal. Wipe dry with a clean paper towel. Discard paper towel into designated container. Store the bedpan or urinal in a plastic bag with residents name"</p> <p>3.1-18(a)</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p>	R000000	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 30, 2014. Preparation or execution of this plan of correction does not constitute admission or	

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 06/30/2014
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
R000092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals		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 July 30, 2014. 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.		

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to conduct or invite the local fire department at least every 6 months to a fire drill.</p> <p>Findings include:</p> <p>The fire drill records were reviewed on 06/23/14 at 9:30 a.m. There was lack of documentation the local fire department attended or was invited to fire drills that were conducted June 2013 through May 2014.</p> <p>During an interview with the Director of Plant Services on 06/23/14 at 10:05 a.m., he indicated he had not invited the fire department in over a year.</p>	R000092	<p>1. Fire department has been invited to attend fire drill. 2. Executive Director/Designee will in-service Maintenance Director regarding inviting fire department to attend fire drills at least every 6 months. 3. Fire department will be invited to attend fire drills at least every 6 months by Maintenance/DesigneeExecutive Director/Designee will audit fire drill records monthly for six months to ensure fire department is invited to attend fire drill. 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 7.30.14</p>	07/30/2014

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed, related to monthly weights not completed as ordered for 1 of 7 residents reviewed for physicians' orders in a total sample of 9 (Resident #4)</p> <p>Findings include:</p> <p>The record for Resident #4 was reviewed on 6/30/14 at 9:05 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, and hypothyroidism.</p> <p>The Physician's Order Summary, dated 6/2014, indicated an order for "monthly weight on the 7th of each month, " originally ordered on 1/8/13.</p> <p>There was lack of documentation in the</p>	R000241	<p>1. MD/family were notified of missing weights in February and March for resident #4. No significant weight changes were noted over past 12 months .Order for monthly weight was discontinued. 2. No other residents have orders for monthly weights. 3. Director of Nursing/Designee will in-service licensed nursing staff regarding following physician's orders; new tracking log initiated for weight tracking. Director of Nursing/Designee will audit physician's orders related to monthly weights 3 times weekly to ensure proper follow up for 2 months; then monthly thereafter 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 7.30.14</p>	07/30/2014

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000243	<p>record to indicate the monthly weights had been completed as ordered for February and March 2014.</p> <p>During an interview on 6/30/14 at 3:55 p.m., the Director of Health Services (DHS) indicated the weights had not been completed as ordered.</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment.</p> <p>Based on record review and interview, the facility failed to document blood sugar results and insulin administration for 1 of 7 residents whose records were reviewed for medications in a sample of 9. (Resident #2)</p> <p>Findings included:</p> <p>The record for Resident #2 was reviewed on 6/30/14 at 8:45 a.m. The resident's diagnoses included, but were not limited to, type 2 Diabetes Mellitus,</p>	R000243	<p>1. MD was notified of missing documentation of insulin administration and blood glucose checks for resident #2. 2. Other residents with orders for insulin/blood glucose checks audited for documentation of administration. 3. Director of Nursing/Designee will in-service licensed nursing staff regarding documenting blood glucose results and insulin administration. Director of Nursing/Designee to audit MAR for documentation of blood glucose results and insulin administration 3 times weekly for</p>	07/30/2014

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>hypertension, coronary artery disease, hypothyroidism, anemia, and depression.</p> <p>Review of the June 2014 POS (Physician's Order Summary) included the following orders related to diabetes management:</p> <ul style="list-style-type: none"> - Lantus (long-acting insulin) give 35 units SQ (subcutaneously, under the skin) BID (twice daily) - Accuchecks (test for blood sugar (BS) level) QID (four times daily) with Novolog (short-acting insulin) sliding scale (SS): <p>BS < 150 = 0 BS 150-200 = 2 units BS 201-250 = 4 units BS 251-300 = 8 units BS 301-350 = 10 units BS 351-400 = 12 units BS 401-450 = 14 units BS > 450, give 14 units and call physician</p> <p>Review of the MARs (Medication Administration Records) for May and June 2014 indicated the following dates lacking documentation:</p> <ul style="list-style-type: none"> - No BS result for 5/24 bedtime, 5/29 lunch, and 6/29 lunch. - No SS insulin administration for 5/10 dinner, 5/13 bedtime, 5/24 lunch, 5/24 bedtime, 5/29 lunch, 6/2 breakfast and 6/29 lunch. 		<p>2 months, then weekly thereafter 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 7.30.14</p>	

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R000301	<p>- No scheduled lantus insulin administration for 5/19 morning, 5/22 bedtime, 5/28 bedtime, 6/5 morning and 6/16 bedtime.</p> <p>During an interview with the DHS on 6/30/14, she indicated the nursing staff should have documented BS results and insulin administration on the MARs.</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation, record review and interview the facility failed to label open dates on medications for a nebulizer breathing treatment, an inhaler and a nasal spray on 2 of 4 medication carts.</p> <p>Findings include:</p>	R000301	<p>1. Medication in Legacy carts were replaced/dated. 2. Other medication carts were audited for labeling of unit dose medications with no concerns identified. 3. Director of Nursing/Designee will in-service licensed nurses regarding labeling unit dose medication when opened and recommended expiration</p>	07/30/2014

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 06/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>1. During an observation on 06/30/14 at 11:30 a.m. with LPN #2, in the 700 Hallway medication cart on the Legacy Unit, the medication budesonide (Pulmicort) 0.5 mg(milligrams)/2 ml(milliliters)(a breathing treatment medication used to treat lung conditions) vial was in an open foil package lacking an open date. The instructions on the box indicated "...once foil envelope is opened, use the vials within 2 weeks...."</p> <p>The "RECOMMENDED EXPIRATION DATES" from the pharmacy indicated the recommended discard date for "...Pulmicort 2 weeks from removal of foil pouch...."</p> <p>During interview with LPN #2 at the time of the observation, she indicated there should have been an open date on the open package.</p> <p>2. On 06/30/14 at 11:35 a.m. during an observation with LPN #2 in the medication cart number 1 or the other cart on the Legacy Unit, the inhaler Advair 115 mcg(micrograms)/21 mcg (an inhaled treatment used for the lungs) and the nasal spray calcitonin-salmon(a hormone medication) 200 IU (International Unit) lacked the documentation of an open date.</p>		<p>dates. Director of Nursing/Designee to audit medication carts for proper labeling of unit dose medications weekly for 2 months; then monthly thereafter 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 7.30.14</p>	

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 06/30/2014	
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>During interview with LPN #2 at the time of the observation, she indicated there should have been an open date on the nasal spray and the inhaler.</p> <p>The The "RECOMMENDED EXPIRATION DATES" from the pharmacy indicated the recommended discard date for "...Advair Inhaler 30 days form removal of foil pouch...Calcitonin Nasal Spray 30 days from date opened/store upright...."</p> <p>An interview with the DHS on 06/30/14 at 4:00 p.m., she indicated there was not a policy on medication labeling, just the recommendations from the pharmacy on expiration dates.</p>						