

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2013
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/26/13</p> <p>Facility Number: 012766 Provider Number: 155795 AIM Number: 201051640</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Avalon Springs Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>The facility consists of two separate buildings: the Health Campus and the Legacy buildings which are both one story, Type V (111) construction and fully sprinklered. Each building has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and</p>	K010000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies sited during the Life Safety survey which was conducted on August 26, 2013. 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 September 9, 2013. Considering the volume, scope and severity of the alleged deficient practice noted in the CMS-2567, Avalon Springs Health Campus respectfully requests a desk review for this survey. If approved, we would be willing to provide all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as part of this Plan of Correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>hard wired smoke detectors in all resident sleeping rooms. The Health Campus building has five wings: the 100, 200 and 300 wings which are certified and the 400 and 500 wings which are licensed residential. The Legacy building is licensed residential. The facility is licensed for 136 beds, with 61 certified beds and 75 residential beds and had a total census of 122 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 10 of 10 exit doors with electromagnetic locks unlocked while the fire alarm system was activated. LSC 7.2.1.6.2(e) requires doors with special locking arrangements such as electromagnetic locks shall automatically unlock upon actuation of an approved fire alarm system and remain unlock until the system is manually reset. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 08/26/13 during a fire alarm test at 2:47 p.m. with the Maintenance Supervisor, the electromagnetic locks on all ten exits doors would unlock when the fire alarm was activated, but would lock down when approached with a wander guard band. Based on interview on 08/26/13 concurrent with the observations, it was acknowledged by the Maintenance Supervisor all exit doors would not remain unlocked when tested with a wander guard band.</p> <p>3.1-19(b)</p>	K010038	<p>K038 1. The doors with the maglocks have been assessed and any door that did not release was serviced by Vanguard on 8/29/13. 2. All other doors with maglock were assessed and serviced by Vanguard on 8/29/13. 3. Director of Plant Ops (DPO) was re-inserviced on 9/6/13 by Home Office Support operations concerning ensuring the mag locks release whe fire alarm activates. The DPO/Designee will audit system monthly with fire drills to include all 3 shifts checking all doors to ensure the mag locks unlock. The DPO/Designee will report findings monthly to the QAA. 4. Audits will be reviewed by QAA monthly for 6 months and then quarterly thereafter until 100% compliance is obtained. 5. Compliance obtained for K038: 9/10/13</p>	09/10/2013			

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