

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 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/15/15</p> <p>Facility Number: 012766 Provider Number: 155795 AIM Number: 201051640</p> <p>At this Life Safety Code survey, Avalon Springs Health Campus was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with automatic smoke detection in the corridors, in spaces open to the corridors and in all resident sleeping rooms. The Health Campus building has five wings: the 100, 200 and</p>	K 0000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies cited during the Life Safety Code survey which was conducted on June 15, 2015. 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 15, 2015. 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 <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
K 0011 SS=E Bldg. 01	<p>300 wings which are certified and the 400 and 500 wings which are licensed residential. The facility has a certified capacity of 61 and had a certified census of 55 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire door sets in the common wall with a nonconforming building was arranged to automatically close and latch. This deficient practice affects one of three smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation on 06/15/15 at 12:52 p.m., the two hour fire rated fire doors in the common wall between Healthcare and Assisted Living were manually released but stayed propped in</p>	K 0011	-No residents were directly involved -The two hour fire rated fire doors in the common wall between Healthcare and Assisted living were fixed and now properly self close and latch when released. -Executive Director/ Designee will inservice Maintenance Department on importance of fire doors self closing and latching when released. -Executive Director/Designee will audit fire doors 1x monthly to ensure proper self closing and latching when released on the Health Center. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100%	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
K 0029 SS=E Bldg. 01	<p>the open position by a raised area in the floor. Based on an interview at the time of observation, the Director of Plant operations confirmed the fire doors failed to self close and latch stating flooring was recently replaced.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 hazardous cooking areas was separated from the corridor by smoke resistive partitions or doors. This deficient practice could affect residents in the Crusaders cafe and the corridor near the Crusader cafe.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 06/15/15 at 3:05 p.m., an individual was filling bags with popcorn from the hot oil popcorn machine in the Crusader cafe. The Crusader cafe lacked corridor door and was therefore open to the corridor. Based on an interview with the Life Enrichment</p>	K 0029	<p>compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p> <p>-No residents were directly involved -Activities Staff were immediately instructed to no longer make popcorn in the crusader cafe. -Executive Director/designee will inservice Activities Department on importance of only cooking popcorn in appropriate designated area that meets Life Safety Code. -Activities Director/Designee will audit popcorn social weekly to ensure popcorn is being prepared in appropriate areas.-Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p>	07/15/2015

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 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
K 0038 SS=E Bldg. 01	<p>Assistant who was the individual filling the bags of popcorn at the time of observation, she had cooked the popcorn in the Crusaders cafe prior to filling the bags of popcorn.</p> <p>3.1-19(b)</p> <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 1 of 1 exit discharge paths from the Administrative hall was readily accessible at all times. This deficient practice could affect all residents evacuated through the Administrative hall exit in the event of an emergency.</p> <p>Finding include:</p> <p>Based on observation with the Director of Plant Operations on 06/15/15 at 2:40 p.m., the exit discharge path from the Administrative hall was obstructed by two plant stands and three large bags of potting soil. Additionally, the gate was equipped with a magnetic lock requiring a code on the inside and an additional latch type lock on the outside which had to be unlocked by reaching through the opening in the fence. Based on an</p>	K 0038	<p>-No residents were directly involved -The latch on the gate was immediately removed. The two plant stands and three bags of potting soil were immediately removed from the path of egress on the patio from the Administrative Hall. -Executive Director/designee will inservice Activities staff and Maintenance staff regarding importance of keeping the path of egress clear on the patio. -Maintenance Director/Designee will audit 1x weekly for path of egress is clear on the patio. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p>	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
K 0046 SS=C Bldg. 01	<p>interview at the time of observation, the Director of Plant Operations acknowledged and moved the plant stands and potting soil and confirmed two separate operations were required to open the gate in the path of egress.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p>	K 0046	<p>-No residents were directly involved.-Maintenance Director conducted a 90 minute annual test on the battery operated emergency light in the generator enclosure.-Executive Director/Designee will inservice Maintenance staff of importance of conducting a 90 minute annual test on the battery operated emergency light in the generator enclosure.-Maintenance Director/Designee will audit 2x yearly for the conducting of a 90 minute annual test on the battery operated emergency light in the generator enclosure.-Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p>	07/15/2015

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 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
K 0050 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation and interview on 06/10/13 at 3:15 p.m., the Director of Plant Operation confirmed he did not conduct a 90 minute annual test on the battery operated emergency light in the generator enclosure.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Record of</p>	K 0050	-No residents were directly involved -Maintenance Director completed a midnight fire drill per life safety standards. -Executive Director/Designee will inservice Maintenance staff on importance of conducting fire drills at least quarterly on all shifts per life safety standands. -Executive Director/Designee will inservice Maintenance staff on firedrill/fire alarm procedures.	07/15/2015

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 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>Drills" with the Director of Plant Operations on 06/15/15 at 12:09 p.m., there was no record of a third shift fire drill for the fourth quarter of 2014 and the third shift fire drills conducted on 09/15/14 and 01/15/15 were not actual fire drills but training sessions that did not include all elements of a fire drill. Based on an interview at the time of record review, the Director of Plant Operations acknowledged the aforementioned fire drill issues.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview of 6 of the last 12 months of fire drills, the facility failed to ensure the staff was familiar with procedures in case of fire. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings included:</p> <p>Based on record review of the "Record of Drills" with the Director of Plant Operations on 06/15/15 at 12:09 p.m., for the last six months revealed none of the drills conducted provided documentation of signatures to show which staff participated in the fire drill. Based on</p>		<p>-Maintenance/designee will inservice staff in the other departments on fire drill/fire alarm procedures. -Executive Director/Designee will audit fire drills 1x quarterly to ensure all shifts were conducted per life safety standards.</p> <p>-Maintenance/designee will audit 2 employees for following proper fire drill/alarm procedures during fire drills monthly. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p>	

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 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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
K 0062 SS=E Bldg. 01	<p>interview at the time of review, this deficient practice was confirmed by the Director of Plant Operations.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace the corroded sprinkler head in 1 of 1 Healthcare entrances canopies. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not in a resident care area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 06/15/15 at 2:30</p>	K 0062	<p>-No residents were directly involved. -Maintenance Director has the corroded sprinkler head in the health center entrance canopy scheduled to be replaced. All the other sprinkler heads under the canopy were checked for corrosion with no issues noted. -Executive Director/Designee will inservice Maintenance Department on importance of replacing sprinkler heads which are corroded and do not meet life safety code. -Maintenance Director/Designee will audit outside sprinkler heads 1x monthly for needed replacement due to being corroded and not meeting life safety code. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes</p>	07/15/2015

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 06/15/2015
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	
K 0143 SS=E Bldg. 01	<p>p.m., one of six sprinkler heads in the Healthcare entrance canopy was corroded with a green substance. This was acknowledged by the Director of Plant Operations at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 2 oxygen storage/transfer locations was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any of the 26 residents in McCullum Court.</p>	K 0143	<p>as appropriate. -Date of compliance 7-15-15</p> <p>-No residents in Mc Cullen Court had any negative outcome.-The large cylinder of liquid oxygen in resident room 214 was removed immediately and placed in the designated oxygen room. No other rooms contain liquid oxygen tanks.-DHS/designee will inservice nursing staff on importance of only transfilling oxygen from the designated oxygen room.-DHS/designee will audit 1x monthly for proper</p>	07/15/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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
K 0147 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 06/15/15 at 2:01 p.m., there was a large cylinder of liquid oxygen in resident room 214. Based on an interview with the Director of Plant Operations, after questioning the hall nurse, the staff were transfilling the resident's small portable units from the liquid oxygen cylinder located in resident room 214.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords such as extension cords, 4 of 4 power strips and 3 of 3 multiplug adapters were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient</p>	K 0147	<p>transfilling of oxygen in designated oxygen room.-Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p> <p>-No residents had negative outcomes -The extension cord providing power to camera system monitor in 200 hall was removed. The power strip plugged into another power strip in room 210 was removed. The extension cord in room 213 was removed and the power strip was moved away from the bed. The power strip in 212 was moved away from the bed. The multiplug adapter in room 215 and 106 were removed. The extension cord and lava lamp in room 109 were removed. All other rooms on health center</p>	07/15/2015

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 06/15/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>practice could affect 10 of 55 residents.</p> <p>Findings include:</p> <p>Based on observation and interview, the Director of Plant Operations acknowledged the following:</p> <p>a) at 1:45 p.m., an extension cord was plugged in and providing power to the camera system monitor in the 200 hall nurses' station medication room</p> <p>b) at 1:50 p.m., a power strip was plugged into another power strip providing power to computer equipment in resident room 210</p> <p>c) at 1:52 p.m., a power strip was plugged into the wall at the head of the bed in resident room 213. Additionally in resident room 213, an extension cord was plugged in and providing power to a phone</p> <p>d) at 2:00 p.m., a power strip was plugged in and providing power to a lamp at the head of the bed in resident room 212</p> <p>e) at 2:02 p.m., a multiplug adapter was plugged in and providing power to a light and radio and another multiplug adapter was plugged in and providing power to a TV in resident room 215</p> <p>f) at 2:15 p.m., a multiplug adapter was plugged in and providing power to a life share box in resident room 106</p> <p>g) at 2:17 p.m., an extension cord was</p>		<p>were checked and are in compliance. -Executive Director/Designee will inservice staff on importance of no extension cords, or multiplug adaptors used in rooms, and no power strip plugged into another power strip, and no power stips used around residents beds.</p> <p>-Maintenance Director/designee will audit 5 rooms 1x weekly for proper utilization of power strips, and no extension cords or multiplug adaptors. -Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. -Date of compliance 7-15-15</p>	

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 06/15/2015
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	
	plugged in and providing power to a lava lamp in resident room 109 3.1-19(b)				