

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 06/09/2015
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NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00173196.</p> <p>Complaint IN00173196-Substantiated. Federal/State deficiencies related to the allegation are cited at F225, and F226.</p> <p>Unrelated deficiency is cited.</p> <p>Survey date: June 9, 2015</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Census bed type: SNF: 35 SNF/NF: 20 Residential: 57 Total: 112</p> <p>Census payor type: Medicare: 29 Medicaid: 12 Other: 71 Total: 112</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000	<p>This plan of correction is submitted by Avalon Springs Health Campus in order to respond to the alleged deficiencies cited during the Complaint IN00173196 survey which was conducted on June 9, 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 June 22, 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.

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F 0225 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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 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</p>						

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	<p>verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to notify the State Agency of an allegation abuse/neglect for 1 of 3 residents reviewed for abuse/neglect in the sample of 5. (Resident #B)</p> <p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 6/9/15 at 10:00 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, glaucoma, right and left knee replacements.</p> <p>Upon admission to the facility on 3/10/15, the resident was assessed by the therapy department to use a Sara Lift (a sit to stand lift to aid residents with transfers) for all transfers until they determined her weight bearing ability.</p> <p>The Admission Minimum Data Set assessment, dated 3/17/15, indicated the resident was alert and oriented. The resident needed extensive assist with 2 person physical assist for transfers and toilet use.</p> <p>A hand written statement provided by the Director of the Therapy Department was</p>	F 0225	<ul style="list-style-type: none"> · Resident B is no longer in facility. · Concern Forms for the last 30 days pertaining to current LTC residents were audited for allegations of abuse. No allegations of abuse were identified. · DHS/Designee in-serviced staff regarding the Concern Form process, and reporting allegations of abuse to Executive Director immediately. · Clinical Support in-serviced Executive Director, and nursing administration regarding investigating and reporting allegations of abuse to ISDH. · DHS/Designee will audit Concern Forms two times weekly for allegations of abuse for 6 months or until QAA states otherwise. · Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. · Date of compliance 6-22-15 	06/22/2015

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	<p>reviewed. The statement was dated 3/13/15 at 2:30 p.m., and indicated "To the Administrator; This writer was working with resident (name) in room (number). Resident expressed that last night when she wanted to use toilet for bowel movement, she approached nursing aid to help. Nursing aid responded to her saying you are not supposed to go to toilet and the nursing aid transferred resident to bed and turned off the lights. Resident couldn't find call light and she slept with urge to void."</p> <p>A Social Service Progress Note, dated 3/13/15, indicated "Social Services met with (resident name). She stated that she cannot stand to use the toilet. They tried to use a lift on her and she stated she got shaky. The nurse then shut the bathroom door and told her not to open the door. She then said that they put her to bed (did not use a lift) and she never got to use the restroom. Resident was unable to name the staff but said she is working now. She thinks she was wearing a light blue shirt and had glasses. She stated she was tall and average built. She was unable to point out the staff member to writer. Writer returned ten minutes later and she stated it was the lady that was sitting at the desk when I took her to the nurses station."</p>			

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F 0226 SS=D Bldg. 00	<p>Interview with the Administrator, on 6/9/15 at 2:10 p.m., indicated she recalled the incident. She indicated she had interviewed staff, however, did not write anything down. No staff were suspended pending the investigation. She further indicated she did not interview the resident at all. The Administrator indicated she did not report the allegation of abuse/neglect to the State Agency and had no explanation of why the incident was not reported.</p> <p>This Federal Tag relates to Complaint IN00173196.</p> <p>3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their policy regarding the notification of the State Agency for an allegation abuse/neglect for 1 of 3 residents reviewed for abuse/neglect in the sample of 5. (Resident #B)</p>	F 0226	<p>· Resident B is no longer in facility. · Concern Forms for the last 30 days pertaining to current LTC residents were audited for allegations of abuse. No allegations of abuse were identified. · DHS/Designee in-serviced staff regarding the Concern Form process, and</p>	06/22/2015

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	<p>Finding includes:</p> <p>The closed record for Resident #B was reviewed on 6/9/15 at 10:00 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, glaucoma, right and left knee replacements.</p> <p>Upon admission to the facility on 3/10/15, the resident was assessed by the therapy department to use a Sara Lift (a sit to stand lift to aide residents with transfers) for all transfers until they determined her weight bearing ability.</p> <p>The Admission Minimum Data Set assessment, dated 3/17/15, indicated the resident was alert and oriented. The resident needed extensive assist with 2 person physical assist for transfers and toilet use.</p> <p>A hand written statement provided by the Director of the Therapy Department was reviewed. The statement was dated 3/13/15 at 2:30 p.m., and indicated "To the Administrator; This writer was working with resident (name) in room (number). Resident expressed that last night when she wanted to use toilet for bowel movement, she approached nursing aid to help. Nursing aid</p>		<p>reporting allegations of abuse to Executive Director immediately. · Clinical Support in-serviced Executive Director, and nursing administration regarding investigating and reporting allegations of abuse to ISDH. · DHS/Designee will audit Concern Forms two times weekly for allegations of abuse for 6 months or until QAA states otherwise. · Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. · Date of compliance 6-22-15</p>	

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	<p>responded to her saying you are not supposed to go to toilet and the nursing aid transferred resident to bed and turned off the lights. Resident couldn't find call light and she slept with urge to void."</p> <p>A Social Service Progress Note, dated 3/13/15, indicated "Social Services met with (resident name). She stated that she cannot stand to use the toilet. They tried to use a lift on her and she stated she got shaky. The nurse then shut the bathroom door and told her not to open the door. She then said that they put her to bed (did not use a lift) and she never got to use the restroom. Resident was unable to name the staff but said she is working now. She thinks she was wearing a light blue shirt and had glasses. She stated she was tall and average built. She was unable to point out the staff member to writer. Writer returned ten minutes later and she stated it was the lady that was sitting at the desk when I took her to the nurses station."</p> <p>The current, 9/16/11, Abuse and Neglect Procedure Guidelines provided by the Director of Health Services was reviewed. The policy indicated "Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The Executive Director is accountable for</p>			

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F 0323 SS=D Bldg. 00	<p>investigating and reporting. The Executive Director is responsible for notification to the State Department of Health...."</p> <p>Interview with the Administrator, on 6/9/15 at 2:10 p.m., indicated she recalled the incident. She indicated she had interviewed staff, however, did not write anything down. No staff were suspended pending the investigation. She further indicated she did not interview the resident at all. The Administrator indicated she did not report the allegation of abuse/neglect to the State Agency and had no explanation of why the incident was not reported.</p> <p>This Federal Tag relates to Complaint IN00173196.</p> <p>3.1-28(e)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a</p>	F 0323	<p>· Resident F is no longer in facility. · All exit door locks and Wanderguard system were</p>	06/22/2015			

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	<p>resident was supervised regarding a resident who exited the facility and was brought back to the facility by the police for 1 of 1 resident reviewed for elopement in a sample of 5. (Resident #F)</p> <p>Finding includes:</p> <p>Resident #F was observed on 6/9/15 at 11:43 a.m. in therapy working with a therapist. There was a wanderguard bracelet around her right wrist.</p> <p>The resident's record was reviewed on 6/9/15 at 11:21 a.m. The resident's diagnoses included, but were not limited to, dementia and anxiety.</p> <p>Review of the Physician Order Statement for 6/2015 indicated the resident was to have a wanderguard in place.</p> <p>Review of the Resident First Conference Notes, dated 5/27/15, indicated in the safety section the resident had a physical device used: wanderguard. The reason was due to wandering. The resident was at risk for wandering and was an elopement risk. The resident had a bracelet in place and had been included in the "wandering book" (a book with resident's pictures who have the potential to elope). The section for mood/behavior</p>		<p>audited for function, and both were fully functional. · Other residents with Wanderguards were audited for placement and function of wanderguard, no issues were found. · Updated annunciator panel was installed for the Wanderguard Alarm System 6/5/15. · DHS/Designee in-serviced staff regarding responding to door alarms, and elopement procedure. DHS/Designee in-serviced licensed nursing staff regarding writing wanderguard orders. · Social Services will audit/interview 5 staff members weekly regarding residents with wanderguards, response to door alarms and elopement books for 6 months or until QAA states otherwise. · DHS/Designee will conduct door alarm/elopement drills one time monthly rotating shifts to ensure all shifts are covered for 6 months or until QAA states otherwise. · Maintenance Director/Designee will check function of door locks/Wanderguard System weekly for 6 months or until QAA states otherwise. · Audits will be reviewed in QAA monthly for 6 months then quarterly thereafter until 100% compliance is achieved. QAA will make recommendations and changes as appropriate. Date of Compliance 6-22-15.</p>	

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	<p>indicated one of the resident's behaviors as wandering.</p> <p>A Nursing note, dated 5/29/15 at 2:45 a.m., indicated the resident was wandering in/out of other resident's rooms, picking up water cups at bedside and proceeding to empty water into the sink or trash cans.</p> <p>A Nursing note, dated 6/3/15 at 8:00 p.m., indicated "The resident exited the building around 7:44 tonight. The (city) police found the resident on (name of road). The facility was called to determine if she was a resident. The staff indicated yes and the resident was brought back to the facility." The Physician was informed of the situation. The resident's wanderguard was on her right wrist. The resident was placed on 5 minute checks.</p> <p>An incident report indicated an incident dated of 6/3/15 at 7:40 p.m. involved Resident #F. A description of the incident indicated LPN #1 received a phone call from the police dispatcher around 7:40 p.m. on 6/3/15 asking if the facility had a resident named (Resident #F's name). According to the dispatch the resident was currently with the police officer in the subdivision directly across the street from the facility. Staff went</p>			

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	<p>and got the resident and walked her back into the facility. No physical injuries were noted. The Executive Director, Physician, and family were all notified. A head count was immediately taken and the investigation was started. Resident #F was placed on 5 minutes checks. The staff were interviewed. The wanderguard system was checked and fully functioning. All doors were checked and fully functioning. The resident's wanderguard was checked and fully functioning. The resident's wanderguard was replaced. The staff was in-serviced on elopement and ensuring they check outside before resetting alarms. Preventive Measures Taken: The resident was immediately assessed with no noted injuries. The Executive Director, Physician, and family were notified. A head count was taken and investigation started. The resident was placed on 5 minute checks. Staff were interviewed and the wanderguard system checked and fully functioning. The resident's wanderguard was replaced. Staff was in-serviced on elopement and ensuring they check outside before resetting alarms.</p> <p>A written statement from LPN #2 indicated she heard the alarms and looked at the panel and the whole right side was lit up. The nurse went to the sun room</p>			

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	<p>first and hit the code for the alarm and it did not stop. The nurse looked outside in both directions and did not see anyone then went to the main entrance and entered the code and turned off the alarm. The nurse indicated she did not look outside. She was not sure what time the event happened but thought it was around 7:30 p.m. She indicated she did not see Resident #F. She only saw Resident #F when the resident came back.</p> <p>A written statement from RN #1 indicated she went on break at 7:42 p.m. and Resident #F was wandering around Town Square area listening to the piano player. She came back from her break around 8:00 p.m. and Resident #F was in her room.</p> <p>A written statement from LPN #3 indicated she had last seen Resident #F around 7:00 p.m. The resident was wandering down to the 100 unit looking for her suitcase. The resident was escorted back to the 300 unit. The resident wandered down to the 100 unit 3 or 4 more times after dinner. LPN #3 indicated she did not hear any alarms and the resident was getting more and more agitated.</p> <p>A written statement from CRCA (Certified Resident Care Aide) #1</p>			

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	<p>indicated, Resident #F was by the clock tower listening to the the piano player about 7:15 p.m. Her wanderguard was on her right wrist. She did not hear any alarms. She was told the police were on the phone about 7:45 p.m. She went to the front door and saw Resident #F in the car with the police officer. The resident was asking the police officer to take her to her home (name of town).</p> <p>A written statement from CRCA #2 indicated, she last saw Resident #F in the dining room at the diner. She heard the alarms. She looked at the panel and more than one door was lit up. She started walking down towards the sun room area to try to figure out which door it was. Then saw LPN #2 coming back from the front and she indicated she did not see anyone.</p> <p>A written statement from LPN #1 indicated, he heard the alarms when he was near the clock tower. He looked in the sun room and living room. He went down to the end of the 200 unit to make sure it was not the door down there. By the time he got to the door, the alarm was no longer sounding. It was about 7:40 p.m. when he received the call from the police dispatcher. The dispatcher indicated the police had a resident that needed to be identified. He notified the</p>			
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	<p>Director of Health Services. A head count of all residents was completed and all residents were present.</p> <p>The Procedure Guide for Missing Residents was provided by the Director of Health Services on 6/9/15 at 3:00 p.m. The Director of Health Services indicated the policy was current. The policy indicated the purpose was to establish guidelines to report and investigate all reports of missing persons. The procedure included, but was not limited to: "Facilities that have a sounding alarmed door: staff should respond promptly to sounding door alarm, a facility head count to be completed to determine who was missing, two staff should exit the alarming doorway and go in opposite directions around the building perimeter, and the alarm should be disabled only at the direction of the Executive Director or facility supervisor."</p> <p>An interview with the Executive Director (ED), the Director of Health Services (DHS), and the Nurse Consultant, on 6/9/15 at 2:23 p.m., indicated the following: per the DHS, Resident #F got out the front door. The alarm went off and the panel on the 200 unit wall indicated all 4 exit doors were open. There was someone playing the piano so</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 06/09/2015
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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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	<p>it was hard to hear the alarms when they sounded. She further indicated when the alarms were triggered all the door lights on the panel lit up. She also indicated that even residents with wanderguards could get the exit doors open if they pushed on the door for 15 seconds. The DHS also indicated staff did not go outside when the alarm sounded and it was the policy of the facility to go outside when the alarms were triggered. She further indicated Resident #F never crossed the street. The resident was last seen in the facility at 7:15 p.m. and the facility received a call from the police at 7:39 p.m.</p> <p>3.1-45(a)(2)</p>			