STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155795	A. BUILDING 00 B. WING	02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00449145. Complaint IN00449145 - Federal/State deficiencies related to the allegations are cited at F689. Survey date: February 27, 2025 Facility number: 012766 Provider number: 155795 AIM number: 201051640 Census Bed Type: SNF/NF: 19 SNF: 37 Residential: 51 Total: 107 Census Payor Type: Medicare: 31 Medicaid: 13 Other: 12 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/3/25.	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place to prevent injury for a resident with multiple falls for 1 of 3 residents reviewed for accidents. (Resident C)	F 0689	Preparation of execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on	03/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Sheets	Director of Health Services	03/14/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING 00 B. WING	02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Finding includes: On 2/27/25 at 10:06 a.m., Resident C was observed in bed asleep. The resident's bed was against the wall, he had bed rails, and there was a trapeze bar above the bed. The room was clean and clutter free and the call light was within reach. There were no bolsters observed on the resident's bed. On 2/27/25 at 10:25 a.m., and 1:10 p.m., the resident was observed sitting on the side of the bed. There were no bolsters on the bed. Record review for Resident C was completed on 2/27/25 at 10:36 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), stroke, chronic obstructive pulmonary disease (COPD), depression, and diabetes. The Significant Change in Status Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the resident was cognitively impaired. The resident required substantial/maximum assistance with shower/bathing, toileting, lower body dressing, and putting on footwear. The resident was on hospice services. The resident had impairment on one side of upper and lower extremities, used a wheelchair, and required hospice services. A Care Plan, last reviewed on 1/9/25, indicated the resident was at risk for falls related to weakness and impaired physical functioning. Approaches were to provide a trapeze to assist resident with positioning, place bed against the wall, have hospice review medications, and have hospice provide bolsters to the resident's bed.		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. The plan of correction is submitted to respond to the allegation of noncompliance cited during a Complaint survey on 02/27/2025. Please accept this plan of correction as the provider's credible allegation of compliance. Due to the scope and severity of the deficiency, Avalon Springs Health Campus is requesting paper compliance. Fall interventions were reviewed and updated for Resident C. Fall interventions were reviewed and updated as needed for other residents. Nursing Staff/MDS will receive education regarding ensuring fall interventions are in place. DHS/Designee will audit three residents weekly for fall interventions for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING 00 B. WING	02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The last two months were reviewed and the resident had four falls on the following dates: 1/6/25 2/9/25 2/11/25 2/26/25 A Nurses's Progress Note, dated 2/26/25 at 9:04 p.m., indicated the writer entered the room to respond to the call light, the resident was lying on the floor. The resident claimed he was trying to reposition himself in bed using the trapeze bar when he slipped and fell out of bed. A Nurses's Progress Note, dated 2/11/25 at 11:18 a.m., indicated the resident was found kneeling on the floor next to his bed. The resident claimed he was attempting to sit up in bed and began to slide out. A Nurses's Progress Note, dated 2/09/25 at 7:00 a.m., indicated the resident was found kneeling next to his bed. The resident was assessed with no signs and symptoms noted. A Nurses's Progress Note, dated 1/06/25 at 7:01 a.m., indicated the resident had turned on the call light and upon entering the room, the resident was observed sitting on the floor with his back against the bed. The resident indicated he was lying there and was not reaching for anything. The resident was assisted back to bed via Hoyer (mechanical) lift. During an interview on 2/27/25 at 1:18 p.m., RN 1 indicated the resident does not have bolsters on his bed or in his room. She could not recall the resident ever having bolsters on his bed. During an interview on 2/27/25 at 1:44 p.m., the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING 00 B. WING	02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Director of Nursing (DON) acknowledged the care plan had bolsters as an approach and she would go observe the resident. During an interview on 2/27/25 at 2:36 p.m., the DON indicated the resident did not have bolsters on his bed and she had no additional information to provide. This citation relates to Complaint IN00449145. 3.1-45(a)(2)			