DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE COMPI 01/10	LETED
	PROVIDER OR SUPPLIER SPRINGS HEALTH		,	2400 SI	ADDRESS, CITY, STATE, ZIP COD ILHAVY ROAD RAISO, IN 46383	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
E 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/10/23 Facility Number: 012766 Provider Number: 155795 AIM Number: 201051640 At this Emergency Preparedness survey, Avalon Springs Health Campus was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 61 and had a census of 53 at the time of this survey. Quality Review completed on 01/11/23		E 04	E 0000 Preparation of execution of plan of correction does not constitute admission or agree of provider of the truth of the alleged or conclusions set of the Statement of Deficiencies. The Plan of Correction is prepared by the position of Pland State Law. The Pland of Correction is submitted in or respond to the allegation of noncompliance cited during Safety Code Recertification Emergency Preparedness on 1/10/2023. Please acceed pland of correction as the precedible allegation of complements of the precedible allegation of complements. Available of the precedible allegation of complements of the precedible allegation of complements. Available of the precedible allegation of complements of the precedible allegation of complements. Available of the precedible allegation of complements of the precedible allegation of complements of the precedible allegation of complements. Available of the precedible allegation of complements of the precedible allegation of		ement facts rth on s. pared e it is ederal der to a Life and urvey t this rider's ance. the	
E 0004 SS=F Bldg	484.102(a), 485.6. 485.727(a), 485.9. 491.12(a), 494.62 Develop EP Plan, Annually §403.748(a), §416. §441.184(a), §460. §483.73(a), §483. §485.68(a), §485.	5(a), 483.475(a), 483.73(a), 25(a), 485.68(a), 20(a), 486.360(a),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Crystal Wray Executive Director 01/24/2023

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SU COMPLET 01/10/2		ETED			
	PROVIDER OR SUPPLIER			2400 SI	ADDRESS, CITY, STATE, ZIP COD ILHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The [facility] must Federal, State and preparedness requested that mee section. The emer program must include the following elem (a) Emergency Plated and updated at least system or CAH] must comprehensive er program that mee section, utilizing a "Efor LTC Facilitie Emergency Plandevelop and main preparedness plandevelop and min preparedness requested to the section, utilizing a "Efor LTC Facilitie Emergency Plandevelop and main preparedness plandevelop and main preparedness plandevelop and main preparedness plandevelop and main develop and main	comply with all applicable d local emergency uirements. The [facility] ablish and maintain a mergency preparedness ts the requirements of this regency preparedness ude, but not be limited to, ents: an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], in that must be [evaluated], in that must be [evaluated],					DATE
	Based on record rev	view and interview, the facility	E 00	004	No residents were affected by	the	01/26/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY PLETED 0/2023
	PROVIDER OR SUPPLIEF		2400 S	ADDRESS, CITY, STATE, ZIP CO SILHAVY ROAD ARAISO, IN 46383)D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
	failed to review and Preparedness Plan (accordance with 42 practice could affect Findings include: Based on records re Director and the Di 01/10/23 between 1 had a review date o be found to show the updated within the interview during re Plant Operations stareviewed within the This finding was re	Lupdate the Emergency EPP) at least annually in CFR 483.73(a). This deficient at all occupants. Eview with the Executive rector of Plant Operations on 1 a.m. and 1:15 p.m., the EPP f 2021, but no other date could the EPP was reviewed and last year. Based on an cords review, the Director of ated the EPP should have been		deficient practice. All health center resider the potential to be affect The Emergency Prepar Plan (EPP) was reviewed updated on 1/17/2023. Executive Director/Director/Director/Director/Designee on resort the LTC facility must and maintain an Emerge Preparedness Plan (EPmust be reviewed, and least annually. Plant Operations Director/Designee will as Emergency Preparednes (EPP) 1x monthly for conformation for six months, then quathereafter until 100% conists achieved. Plant Operations Director/Designee will paudits to QAPI for reviewed and precommendations as necessary prepared and precommendations as necessary prepared to the precious achieved.	eted. The edness ed and eter of edness ed and eter of edness ed and eter of edness education edu	
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/10/2023	
	PROVIDER OR SUPPLIEI SPRINGS HEALT		•	2400 SII	DDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§485.68(b), §485. §485.920(b), §486. §494.62(b).	.475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b),					
	develop and imple preparedness pol	rocedures. [Facilities] must ement emergency icies and procedures, based / plan set forth in paragraph					
	(a) of this section,	risk assessment at of this section, and the					
	communication pl section. The police	an at paragraph (c) of this cies and procedures must updated at least every 2					
	and procedures. develop and imple	- ·					
	on the emergency	icies and procedures, based / plan set forth in paragraph , risk assessment at					
	paragraph (a)(1)	of this section, and the an at paragraph (c) of this					
	section. The police	cies and procedures must updated at least annually.					
	*Additional Requi	rements for PACE and					
		60.84(b):] Policies and PACE organization must					
	preparedness pol on the emergency	icies and procedures, based / plan set forth in paragraph					
	1 ' '	risk assessment at of this section, and the					
	communication pl	an at paragraph (c) of this cies and procedures must					
	· ·	ment of medical and					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLET	ED
		155795	B. WING		01/10/20	023
			STRE	ET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	L.) SILHAVY ROAD		
AVALON	SPRINGS HEALTH	H CAMPUS		PARAISO, IN 46383		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE C	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TAG	DELICIENCE!		DATE
	1	gencies, including, but not uipment, power, or water				
		ed emergencies; and natural				
	disasters likely to threaten the health or					
	safety of the participants, staff, or the public.					
	The policies and procedures must be					
	reviewed and updated at least every 2 years.					
	*[For ESRD Facili	ties at §494.62(b):] Policies				
	1	The dialysis facility must				
	develop and imple					
	1 ' '	cies and procedures, based				
		plan set forth in paragraph				
	1 ' '	risk assessment at				
		of this section, and the an at paragraph (c) of this				
		sies and procedures must				
	1	updated at least every 2				
		rgencies include, but are				
	1 -	equipment or power				
		ed emergencies, water				
		n, and natural disasters				
		ne facility's geographic				
	area.					
		view and interview, the facility	E 0013	No residents were affected by	the (01/26/2023
		update the Emergency		deficient practice.		
	_	(EPP) Policies and Procedures				
	1	accordance with 42 CFR		All health center residents have		
		cient practice could affect all		the potential to be affected. The		
	occupants.			Emergency Preparedness Pla		
	Findings include:			(EPP) Policies and Procedure were reviewed and updated o		
	i maniga metude.			1/17/2023.	"	
	Based on records re	view with the Executive		1/11/2020.		
		or of Plant Operations on		Executive Director/Director of		
		1 a.m. and 1:15 p.m., the EPP		Nursing/Plant Operations hav		
	had a review date of 2021, but no other date could		been in-serviced by Plant			
		e EPP's Policies and		Operations Home Office		
	Procedures were rev	viewed and updated within the		Support/Designee on requirer	ment	
	last year. Based on	an interview during records		of the LTC facility must review	/ and	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155795	B. WI	NG		01/10/	/2023
				CTDEET A	ADDRESS SITV STATE ZIR COD		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD LHAVY ROAD		
A\/AI	SPRINGS HEALTH	L CAMPUS			RAISO, IN 46383		
AVALON	SPRINGS HEALTI	H CAIVIFUS		VALPAI	RAISO, IN 40363		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		r of Plant Operations stated the			update the Emergency		
		Procedures should have been			Preparedness Plan's (EPP)		
	reviewed or updated	d within the last year.			Policies and Procedures at lea	ıst	
					annually.		
	_	viewed with the Executive			Plant Operations		
		or of Plant Operations during			Director/Designee will audit		
	the exit conference.				Emergency Preparedness Pla		
					(EPP) Policies and Procedure		
				monthly for compliance for six			
					months, then quarterly thereaf	ter	
					until 100% compliance is		
					achieved.		
					Plant Operations		
					Director/Designee will present		
					audits to QAPI for review. QAI		
					make changes and/or		
					recommendations as needed.		
						ļ	
E 0029	403.748(c), 416.5	, ,					
SS=F	, ,	5(c), 483.475(c), 483.73(c),					
Bldg	484.102(c), 485.6						
	485.727(c), 485.9						
	491.12(c), 494.62	• •					
	•	Communication Plan					
		6.54(c), §418.113(c),					
	` ' ' -	0.84(c), §482.15(c),					
		475(c), §484.102(c),					
	- , , -	625(c), §485.727(c),					
	- , , -	6.360(c), §491.12(c),					
	§494.62(c).						
	(c) The [facilitv] m	ust develop and maintain					
		eparedness communication					
		s with Federal, State and					
		ist be reviewed and updated					
		ears [annually for LTC					
	facilities].	- •					
	Based on record rev	view and interview, the failed	E 00)29	No residents were affected by	the	01/26/2023
	to review and updat	te the Emergency			deficient practice.		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPI	
		155795	B. W	ING		01/10	/2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ILHAVY ROAD		
AVALON	SPRINGS HEALTI	H CAMPUS		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
	_	(EPP) Communication Plan at cordance with 42 CFR			All health center residents have	10	
	· ·	icient practice could affect all			the potential to be affected. The		
	occupants.	referit practice could affect an			Emergency Preparedness Pla		
	occupants.				(EPP) Communication Plan w		
	Findings include:				reviewed and updated on	as	
	g				1/17/2023.		
	Based on records re	eview with the Executive					
	Director and Direct	or of Plant Operations on			Executive Director/Director of		
		1 a.m. and 1:15 p.m., the EPP			Nursing/Plant Operations have	е	
		f 2021, but no other date could			been in-serviced by Plant		
		e EPP's Communication Plan			Operations Home Office		
		pdated within the last year.			Support/Designee on requiren		
		ew during records review, the			of the LTC facility must review	and and	
		perations stated the EPP's			update the Emergency		
		nn should have been reviewed			Preparedness Plan's (EPP)		
	or updated within the	ne last year.			Communication Plan at least		
	TE1 ' C' 1'				annually.		
	_	viewed with the Executive			Plant Operations		
	the exit conference.	or of Plant Operations during			Director/Designee will audit		
	the exit conference.				Emergency Preparedness Pla		
					(EPP) Communication Plan 13		
					monthly for compliance for six months, then quarterly thereal		
					until 100% compliance is	itei	
					achieved.		
					asinovou.		
					Plant Operations		
					Director/Designee will present	t	1
					audits to QAPI for review. QAI		
					make changes and/or		
					recommendations as needed.		
E 0036	402 740/4\ 440 5	4(d) 440 442(d)					
E 0036 SS=F	403.748(d), 416.5	, ,					
SS=F Bldg	441.184(d), 482.1 484.102(d), 485.6	5(d), 483.475(d), 483.73(d),					1
Diag	485.727(d), 485.9						
	491.12(d), 494.62	* *					
	EP Training and T						
	1	esting 3 54(d) 8418 113(d)					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 01/10/2023	
	PROVIDER OR SUPPLIER SPRINGS HEALTI			2400 SII	DDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	§483.73(d), §483. §485.68(d), §485.	0.84(d), §482.15(d), .475(d), §484.102(d), .625(d), §485.727(d), .6360(d), §491.12(d),					
	Hospice at §418.1 PACE at §460.84 HHAs at §484.102	§403.748, ASCs at §416.54, 113, PRTFs at §441.184, , Hospitals at §482.15, 2, CORFs at §485.68,					
	485.727, CMHCs §486.360, and RF Training and testi	5, "Organizations" under at §485.920, OPOs at HC/FHQs at §491.12:] (d) ng. The [facility] must Itain an emergency					
	that is based on the in paragraph (a) of	ning and testing program he emergency plan set forth of this section, risk ragraph (a)(1) of this					
	(b) of this section, plan at paragraph training and testin	and procedures at paragraph and the communication (c) of this section. The g program must be lated at least every 2 years.					
	*[For LTC facilities and testing. The	s at §483.73(d):] (d) Training LTC facility must develop emergency preparedness					
	the emergency placed of this section, ris	ng program that is based on an set forth in paragraph (a) k assessment at paragraph on, policies and procedures					
	communication pl section. The train	of this section, and the an at paragraph (c) of this ning and testing program and updated at least					
	annually.						
	-	§483.475(d):] Training and ID must develop and					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLE	ETED
		155795	B. WING		01/10/2	2023
NAME OF E	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	ROVIDER OR SUFFLIER		2400 S	ILHAVY ROAD		
AVALON	SPRINGS HEALTH	H CAMPUS	VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	+	DATE
		gency preparedness training Im that is based on the				
		et forth in paragraph (a) of				
		ssessment at paragraph				
	(a)(1) of this section, policies and procedures					
	. , , ,	of this section, and the				
	communication pla	an at paragraph (c) of this				
		ing and testing program				
		and updated at least every				
	2 years. The ICF/I					
	at §483.470(i).	evacuation drills and training				
	at 9400.470(i).					
	*[For ESRD Facili	ties at §494.62(d):]				
	-	and orientation. The				
	dialysis facility mu	st develop and maintain an				
		redness training, testing				
	-	ation program that is based				
		plan set forth in paragraph				
		risk assessment at				
		of this section, policies and agraph (b) of this section,				
		cation plan at paragraph (c)				
		ne training, testing and				
		m must be evaluated and				
	updated at every 2	2 years.				
		view and interview, the facility	E 0036	No residents were affected by	the	01/26/2023
		updated the Emergency		deficient practice.		
	-	(EPP) Training and Testing		All beauties and		
		ly in accordance with 42 CFR icient practice could affect all		All health center residents have the potential to be affected. The		
	occupants.	erent practice could affect all		Emergency Preparedness Pla		
	острана.			(EPP) Training and Testing Pl		
	Findings include:			was reviewed and updated on		
	Č			1/17/2023.		
	Based on records re	view with the Executive				
		or of Plant Operations on		Executive Director/Director of		
		1 a.m. and 1:15 p.m., the EPP		Nursing/Plant Operations have	e	
		f 2021, but no other date could		been in-serviced by Plant		
	be found to show th	e EPP's Training and Testing		Operations Home Office		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	<u></u>	COMPLE	TED
		155795	B. WING	j		01/10/2	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			LHAVY ROAD		
AVALON	SPRINGS HEALTH	H CAMPUS			RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME CORRECTION	T	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)	IE	DATE
	Plan was reviewed	and updated within the last			Support/Designee on requirem	nent	
	year. Based on an ir	nterview during records			of the LTC facility must review		
	review, the Director	r of Plant Operations stated the			update the Emergency		
	EPP's Training and	Testing Plan should have been			Preparedness Plan's (EPP)		
	reviewed within the				Training and Testing Plan at le	east	
					annually.		
	This finding was re-	viewed with the Executive			Plant Operations		
	Director and Director	or of Plant Operations during			Director/Designee will audit		
	the exit conference.				Emergency Preparedness Pla	n's	
					(EPP) Training and Testing Pla		
					1x monthly for compliance for	six	
					months, then quarterly thereaf	ter	
					until 100% compliance is		
					achieved.		
					Plant Operations		
					Director/Designee will present		
					audits to QAPI for review. QAF	PI to	
					make changes and/or		
					recommendations as needed.		
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 000	o I	Preparation of execution of thi	s	
	Licensure Survey w	as conducted by the Indiana			plan of correction does not		
	Department of Heal	th in accordance with 42 CFR			constitute admission or agreer	ment	
	483.90(a).				of provider of the truth of the fa	acts	
					alleged or conclusions set fort	h on	
	Survey Date: 01/10	0/23			the Statement of Deficiencies.		
					The Plan of Correction is prep	ared	
	Facility Number: 0				and executed solely because i		
	Provider Number:				required by the position of Fed	leral	
	AIM Number: 2010	051640			and State Law. The Plan of		
					Correction is submitted in order	er to	
	-	Code survey, Avalon Springs			respond to the allegation of		
	•	s found not in compliance with			noncompliance cited during a		
	Requirements for Pa	-			Safety Code Recertification ar		
		, 42 CFR Subpart 483.90(a),			Emergency Preparedness Sur	-	
	Life Safety from Fir	re and the 2012 edition of the			on 1/10/2023. Please accept	this	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155795		 UILDING	onstruction 01	(X3) DATE COMPL 01/10/	ETED	
	PROVIDER OR SUPPLIER		 2400 SI	ADDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	Life Safety Code (L. Health Care Occupation of this one story facility Type V (111) construction in the corresponding of the corridors, and hard resident rooms. The cosists of five wings. The healthcare porticipacity of 61 and hof this visit. All areas where resimined were sprinklered and services were sprinklered with a require be equipped with a require the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special locking arr CLINICAL NEEDS LOCKING where special locking arr cultical security neused, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times.	d means of egress shall not a latch or a lock that f a tool or key from the s using one of the following		plan of correction as the provicredible allegation of compliar Due to scope and severity of the deficiencies, Avalon Springs Health Campus is requesting Paper Compliance.	ice.	

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AND PLAN OF CORRECTION IDENT			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795		UILDING	nstruction <u>01</u>	(X3) DATE COMPL 01/10/	ETED
NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383					
	(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		safety needs of the the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkled space is protected detection system at an attended loc space); and both the systems are arrand upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRETARRANGEMENTS Approved, listed desystems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, superfection system of automatic sprinkled 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRANA Access-Controlled installed in accordate permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRANA Elevator lobby exit accordance with 7.2.1.2.2. ELEVATOR LOBE LOCKING ARRANA ELEVATOR LOBE LOBE LOCKING ARRANA ELEVATOR LOBE LOBE LOBE LOBE LOBE LOBE LOBE LOBE	king arrangements for the e patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised er system and the locked d by a complete smoke (or is constantly monitored action within the locked the sprinkler and detection aged to unlock the doors 2.2.5.2, TIA 12-4 SS LOCKING S lelayed-egress locking in accordance with permitted on door g low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies lance with 7.2.1.6.2 shall					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 01/10/2023
	PROVIDER OR SUPPLIER		2400 S	ADDRESS, CITY, STATE, ZIP COD SILHAVY ROAD ARAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	throughout by an a automatic fire dete approved, supervi system. 18.2.2.2.4, 19.2.2. Based on observation failed to ensure 1 of arrangements were LSC 7.2.1.6.1(3) why process shall release egress within 15 sea approved by the autupon application of required in 7.2.1.5.1 conditions: (a) The force shall recontinuously applied (c) The initiation of activate an audible adoor opening. (d) Once the lock has application of force relocking shall be be deficient practice of Walnut Grove hall are Findings include: Based on observation with the Director of between 1:16 p.m. as sitting area exit doos second delayed egret tested the irreversib was not initiated. Be observation, the Diractivate to activate to	approved, supervised action system and an sed automatic sprinkler 2.4 2.4 2.6 an and Interview, the facility of 6 delayed egress locking installed in accordance with nich states an irreversible of the lock in the direction of conds, or 30 seconds where thority having jurisdiction, a force to the release device of under all of the following that be required to exceed 15 lbf and be required to be do for more than 3 seconds. The release process shall signal in the vicinity of the to the released by the to the releasing device, y manual means only. This build affect 35 residents in the	K 0222	No residents were affected by deficient practice. All health center residents on 100 and 200 hallways have the potential to be affected. The Square sitting area exit door fixed and is now working properties of the exit door's irreversible process to releas lock needs to be initiated where testing the door. Plant Operations Director/Designee will audit the Town Square sitting area exit 1x weekly for compliance for months, then quarterly therea until 100% compliance is achieved. Plant Operations Director/Designee will preser audits to QAPI for review. QAPI make changes and/or recommendations as needed.	y the 01/26/2023 If the he Town was perly. Instead on the

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/10/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
K 0353 SS=E Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION The findings were reviewed with the Director of Plant Operations and the Executive Director during the exit conference. 3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing		K 0353	No residents were affected by deficient practice. No residents have the potentiable affected only staff. The two sprinkler heads in the dryer arwere cleaned by removing the dirt/lint accumulation. Plant Operations have been	al to o		
				in-serviced by Plant Operation Home Office Support/Designe			

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AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	ľ	JILDING	ONSTRUCTION <u>01</u>	(X3) DATE COMPL 01/10	ETED
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ILHAVY ROAD		
AVALON SPRINGS HEALTH CAMPUS			VALPARAISO, IN 46383				
(X4) ID	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by				requirement of the sprinkler he		
					being not loaded or covered w foreign material.	/IUN	
	the sprinkler manufacturer. This deficient practice could affect staff in the laundry room and mechanical rooms				Plant Operations		
					Director/Designee will audit th	0	
					two sprinkler heads in the drye		
	Findings include: Based on observation during a tour of the facility				area 1x weekly for compliance		
					six months, then quarterly	7 101	
					thereafter until 100% compliar	nce	
	with the Director of Plant Operations on 01/10/23				is achieved.		
		and 2:08 p.m. two sprinkler					
		rea were covered in dirt and			Plant Operations		
	lint. Based on interv	view at the time of observation,			Director/Designee will present		
	the Director of Plan	t Operations confirmed the			audits to QAPI for review. QAI	PI to	
	aforementioned spri	inkler heads showed dirt/lint			make changes and/or		
	accumulation and lo	oading.			recommendations as needed.		
		ussed with the Executive					
	Director and Director of Plant Operations at exit						
	conference.						
	3.1-19(b)						
K 0363	NFPA 101						
SS=D	Corridor - Doors						
Bldg. 01	Corridor - Doors						
		corridor openings in other					
	· ·	losures of vertical openings,					
		s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
	1	ng fire for at least 20					
		fully sprinklered smoke					
		e only required to resist the					
		e. Corridor doors and doors					
	to rooms containir	-					
		rials have positive latching atches are prohibited by					
		hese requirements do not					
	_	spaces that do not contain					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL		
		155795	B. WI	NG		01/10/	/2023
NAME OF DROVINER OR SURDI IED				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				2400 SI	LHAVY ROAD		
AVALON SPRINGS HEALTH CAMPUS				VALPAI	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DESCRIPTORY).			(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	flammable or com	bustible material. In bottom of door and floor					
	_	en bottom of door and floor ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
		device capable of keeping					
	l -	hen a force of 5 lbf is					
		no impediment to the					
		rs. Hold open devices that					
	_	door is pushed or pulled are					
		ed protective plates of					
	l •	re permitted. Dutch doors					
	meeting 19.3.6.3.6 are permitted. Door						
		beled and made of steel or					
	other materials in compliance with 8.3,						
	unless the smoke compartment is						
	sprinklered. Fixed fire window assemblies are						
	allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485						
	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.						
		on and interview, the facility	K 03	363	Resident in room 206 was not		01/26/2023
		f 17 resident room corridor			affected by the deficient practi	ce.	
		ing were provided with a			A II Is a side a said		
		keeping the door closed, had			All health center residents have	е	
	_	losing, latching and would			the potential to be affected. Resident door in room 206 wa	•	
		f smoke. This deficient at 1 resident in room 206.				-	
	practice could affect	t i resident in room 200.			fixed by Lazarro Companies Ir and it is now latching into the	ic.	
	Findings include:				frame.		
	Dagad - :: -1	on with the Director of DI			Dlant Onaretiere I		
		on with the Director of Plant			Plant Operations have been in-serviced by Plant Operations		
	_	0/23 between 1:16 p.m. and 2:08 oor to resident room 206 did					
	1 -				Home Office Support/Designee on		
	not latch into the frame when tested. Based on				requirement of the resident room		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/10/2023		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	REGULATORY OR LSC IDENTIFYING INFORMATION interview at the time of observation, the Director of Plant Operations agreed that the door would not latch into the frame and needed to be adjusted. The finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)			corridor doors on the health corprovide with a means suitable keeping the door closed, have impediment to closing, latching and would resist the passage of smoke. Plant Operations Director/Designee will audit for health center resident room corridor doors 1x weekly for compliance for six months, the quarterly thereafter until 100% compliance is achieved. Plant Operations Director/Designee will present audits to QAPI for review. QAF make changes and/or recommendations as needed.	for no g of ur		

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