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	11/26/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00446368. This visit included a State Residential Licensure Survey and the Investigation of Residential Complaint IN00444549. Complaint IN00446368 - No deficiencies related to the allegations are cited. Complaint IN00444549 - No deficiencies related to the allegations are cited. Survey dates: November 21, 22, 25, and 26, 2024 Facility number: 012766 Provider number: 155795 AIM number: 201051640 Census Bed Type: SNF/NF: 17 SNF: 40 Residential: 48 Total: 105 Census Payor Type: Medicare: 26 Medicaid: 10 Other: 21 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/2/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Sheets	Director of Health Services	12/12/2024

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.

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure a resident had Physician's Order to self-administer their own medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 38) Finding includes: During random observations on 11/21/24 at 10:20 a.m. and 2:04 p.m., and on 11/22/24 at 8:30 a.m., 10:21 a.m., and 1:24 p.m., Resident 38 was observed in bed. At those times, there was a bottle of nasal saline spray on her overbed table. On 11/22/24 at 2:45 p.m., LPN 1 was observed in the resident's room. At that time, she was made aware of the nasal saline spray on the overbed table. The record for Resident 38 was reviewed on 11/22/24 at 11:20 a.m. Diagnoses included, but were not limited to, heart disease, congestive heart failure, acute pulmonary edema, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident had an unplanned significant weight loss and received a therapeutic diet. The resident received oxygen therapy while at the facility. There was no Care Plan to self-administer medications. Physician's Orders, dated, 8/26/24, indicated	F 0554	Resident 38 had no negative outcome related to deficiency. Nasal spray was placed in medication cart for storage. All residents have the potential to be affected by this deficiency. Other residents were audited for medications at bedside with no concerns identified. Nurses and QMAs will receive education regarding medication storage and self-administration assessments for residents. DHS/Designee will audit three residents weekly covering all shifts for medication left at bedside/self-administration assessment for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	12/23/2024

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	Saline Nasal Spray 0.65%, 1 spray to each nare for dryness twice a day as needed. There was no order for the resident to self-administer the nasal spray. During an interview on 11/22/24 at 2:46 p.m., LPN 1 indicated the resident did not have any orders to leave the nasal spray in her room or to self-administer the nasal spray. During an interview on 11/25/24 at 2:00 p.m., the Director of Nursing had no additional information to provide. 3.1-11(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure a physician was notified of abnormal vital signs for 1 of 5 residents reviewed for unnecessary medications. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 11/22/24 at 2:17 p.m. The resident was admitted to the facility on 10/7/24. Diagnoses included, but were not limited to, heart failure, hypertensive heart disease and diabetes mellitus. The Admission MDS assessment, dated 10/11/24, indicated the resident was cognitively intact and was dependent on staff for toileting and transfers. A Physician's Order, dated 10/8/24, indicated to give carvedilol (medication used to treat hypertension) 25 milligrams (mg) twice daily for hypertension. There were no blood pressure or	F 0580	Resident 5 had no negative outcome related to deficiency. All residents have the potential to be affected by this deficiency. Other residents were audited for abnormal vital signs with physician notification as indicated. Nurses and QMAs will receive education regarding notifying the physician of abnormal vital signs. DHS/Designee will audit three residents weekly for physician notification of abnormal vital signs for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	12/23/2024

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	heart rate parameters in place indicating when to hold the medication. The October 2024 Medication Administration Record (MAR) indicated the medication had been given twice daily from 10/8/24 through 10/15/24. The resident was sent to the hospital on 10/16/24, and returned on 10/24/24. The October and November 2024 MAR indicated he received the medication twice daily from 10/24/24 through 11/11/24. It was not given once on the evening of 11/4/24, the MAR note indicated he was unavailable. A Progress Note, dated 11/12/24, indicated the Physician had assessed the resident and there was a new order to decrease the carvedilol to 12.5 mg twice daily due to low heart rate. A Physician's Order, dated 11/12/24, indicated to give carvedilol, 12.5 mg, twice daily for hypertension. There were no blood pressure or heart rate parameters in place indicating when to hold the medication. The November 2024 MAR indicated the resident received the new dose of carvedilol once on 11/12/24. He was again sent to the hospital on 11/12/24 and returned on 11/16/24. The resident received the medication twice daily from 11/17/24 through 11/24/24. It was not given once in the evening of 11/21/24, the MAR note indicated the medication was unavailable. During October and November 2024, the resident's heart rate was documented below 55 beats per minute (bpm) on the following dates: 10/11- 50 bpm 10/12- 52 bpm 10/27- 53 bpm			

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	10/31- 53 bpm 11/1- 49 bpm 11/2- 48 bpm 11/3- 52 bpm 11/5- 53 bpm 11/10- 50 bpm 11/11- 46 bpm 11/12- 40 bpm 11/13- 49 bpm There were no additional vital signs for review on the November MAR after 11/17/24. There was no documentation the physician had been notified of the heart rates below 55 beats per minute. During an interview on 11/25/24 at 11:30 a.m., the Director of Nursing was made aware of the the lack of Physician notification of the abnormal heart rates. No additional information was provided. The guidelines for carvedilol were retrieved from the David Drug Guide website at www.drugguide.com/ddo/view/Davis-Drug Guide/51134/all/carvedilol on 11/25/24, and indicated, "...Monitor BP and pulse frequently during dose adjustment period and periodically during therapy. Assess for orthostatic hypotension when assisting patient up from supine position. If heart rate decreases below 55 bpm, decrease dose ... Implementation-PO [by mouth] Take apical pulse before administering. If < [less than] 50 bpm or if arrhythmia occurs, withhold medication and notify health care professional...." The policy, "Physician-Provider Notification Guidelines", dated 12/17/23, indicated, "...Purpose			

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	to ensure the resident's physician or practitioner (may include NP, PA or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...." 3.1-5(a)(2)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation and interview, the facility failed to ensure a resident's privacy was maintained related to the electronic medication record (EMR) left open and unlocked in the hallway during medication pass for 1 of 8 residents observed during medication pass. (Resident 363) Finding includes: On 11/21/24 at 12:21 p.m., RN 1 was observed disconnecting an intravenous medication for Resident 363. She had the electronic medication record open on the computer as she gathered her supplies from the 300 Hall cart and then walked towards the resident's room to disconnect the medication and flush the line. The computer screen was left open and on, leaving the residents medications and personal information available to view. At 12:28 p.m., RN 1 was observed returning to the 300 Unit Nurses' Station where she sat down. The 300 Hall cart computer was still open and could be viewed in the hallway. During an interview on 11/21/24 at 12:28 p.m., RN 1 indicated she did not realize she had left the	F 0583	Resident 363 is no longer in the facility. All residents have the potential to be affected by this deficiency. Nurses/QMAs will receive education regarding resident privacy including electronic records. DHS/Designee will audit nurses' stations, including med carts weekly covering all shifts for resident privacy of electronic records for six months then quarterly thereafter until 100% compliance is achieved.	12/23/2024

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	screen open, but the screen should always be locked when not in use. She proceeded to close the computer so that the record could no longer be seen in the hallway. During an interview on 11/25/24 at 2:57 p.m., the Director of Nursing indicated the computer screen should have been locked when the nurse walked away from the computer. 3.1-3(p)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure residents were involved in decisions about their care related to new medications and ensuring a resident attended and participated in care planning conferences for 2 of 2 residents reviewed for participation in care planning. (Residents 38 and 49) Findings include: 1. During an interview on 11/21/24 at 10:18 a.m., Resident 38 indicated she was not always informed of new medications, laboratory tests or treatments. The record for Resident 38 was reviewed on 11/22/24 at 11:20 a.m. Diagnoses included, but were not limited to, heart disease, congestive heart failure, acute pulmonary edema, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making.	F 0657	Residents 38 had no negative outcome related to deficiency. Resident 41 is no longer in the facility. All residents have the potential to be affected by this deficiency. Nurses will receive education regarding informing residents of medication/treatment changes, and labs. Social services will receive education regarding inviting residents to Care Plan Conferences. DHS/Designee will audit three residents weekly regarding notification of changes in plan of care, and invitation to Care Plan Conferences for six months then quarterly thereafter until 100% compliance is achieved.	12/23/2024

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A Physician's Order, dated 11/14/24, indicated Remeron (an antidepressant medication) 15 milligrams (mg), give 1/2 tablet at bedtime.

A Nurse's Note, dated 8/26/24 at 10:09 a.m., indicated the resident's daughter was made aware of the new order for Remeron.

Physician's Orders, dated 10/1/24, indicated Complete Blood Count (CBC) and Complete Metabolic Panel (CMP) and Magnesium levels to be drawn.

A Nurse's Note, dated 10/1/24 at 2:36 p.m., indicated the resident's daughter was notified of the new orders for the labs of CBC, CMP and Magnesium levels to be drawn.

There was no documentation the resident was made aware of the new medications and lab draws.

During an interview on 11/25/24 at 2:30 p.m., the Director of Nursing indicated the resident should have been notified of the change in medication and of the labs to be drawn.

2. During an interview on 11/21/24 at 2:27 p.m., Resident 49 indicated he had not attended or been invited to a care plan conference and was not always kept informed of medication changes.

The record for Resident 49 was reviewed on 11/22/24 at 10:54 a.m. Diagnoses included, but were not limited to, right knee replacement, acute kidney failure, hypertensive chronic kidney disease, type 2 diabetes, heart disease, falls, bradycardia, and anemia.

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	The 9/29/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The Scheduled 5 day MDS assessment, dated 10/29/24, indicated the resident was moderately impaired for daily decision making. The 9/30/24 Care Plan, indicated the resident demonstrated moderate cognitive impairment which was anticipated to progress due to the intrinsic nature of the disease process. The approaches were to encourage the resident to participate in familiar activities and daily tasks. A Physician's Order, dated 11/1/24, indicated Protonix 40 milligrams (mg) give 1 tablet two times a day. A Nurse's Note, dated 11/1/24 at 5:31 p.m., indicated the resident's wife was made aware of the new order for Protonix and draw the resident's blood on Monday. A Physician's Order, dated 11/20/24, indicated Doxycycline 100 mg twice a day. A Nurse's Note, dated 11/20/24 at 3:09 p.m., indicated the resident's wife was notified of the new order for the antibiotic of Doxycycline. Care Plan conference documentation, dated 11/11/24 at 1:00 p.m., indicated the resident's spouse and daughter were in attendance and plans were discussed regarding discharge. There was no documentation the resident was notified of the new medications or the lab draws. There was also no documentation if the resident was invited or attended the care conference.			

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	During an interview on 11/25/24 at 2:00 p.m., the Director of Nursing had no additional information to provide. During an interview on 11/26/24 at 8:55 a.m., the Administrator indicated the resident was invited to the care plan conference, however, the family did not want the resident there. They did not hold a separate conference with only the resident. 3.1-35(d)(2)(B)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure blood pressure medication was administered as ordered according to parameters for 1 of 1 resident reviewed for blood pressure parameters and for 1 of 5 residents reviewed for unnecessary medications. (Residents 38 and 5) Findings include: 1. The record for Resident 38 was reviewed on 11/22/24 at 11:20 a.m. Diagnoses included, but were not limited to, heart disease, congestive heart failure, acute pulmonary edema, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident received oxygen therapy while at the facility. Physician's Orders, dated 12/22/22, indicated Hydralazine (a medication used to lower the blood	F 0684	Resident 38 had no negative outcome related to deficiency. Other residents with blood pressure parameters for medications were audited with no concerns identified. Nurses/QMAs will receive education regarding following physician's orders including parameters to hold medications. DHS/Designee will audit three residents weekly for compliance with parameters for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed	12/23/2024

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	pressure) 25 milligrams (mg) twice a day and to hold if systolic blood pressure was less than 110 and the heart rate was less than 60. Metoprolol succinate (a medication used to lower the blood pressure and heart rate) extended release 25 mg once a day and hold if systolic blood pressure was less than 110 and/or the heart rate was less than 60. The 9/2024 Medication Administration Record (MAR) indicated the Hydralazine was administered on following dates: 11:00 a.m.-1:30 p.m.: - 9/12/24 and the blood pressure was 108/61. - 9/20/24 and the blood pressure was 109/69. - 9/25/24 and the blood pressure was 109/64. 6:30 p.m.-10:30 p.m. - 9/1/24 and the blood pressure was 99/59. - 9/5/24 and the blood pressure was 89/44. - 9/7/24 and the blood pressure was 99/54. - 9/10/24 and the blood pressure was 98/58. - 9/18/24 and the blood pressure was 102/70. The 9/2024 MAR indicated the Metoprolol was administered on following dates at 11:00 a.m.-1:30 p.m.: - 9/2/24 and the heart rate was 57. - 9/8/24 and the heart rate was 59. - 9/12/24 and the blood pressure was 108/61. - 9/15/24 and the blood pressure was 102/68. - 9/20/24 and the blood pressure was 106/69. - 9/24/24 and the blood pressure was 97/57 and the heart rate was 59. - 9/25/24 and the blood pressure was 109/64. The 10/2024 MAR indicated the Hydralazine was administered on the following dates: 11:00 a.m.-1:30 p.m. - 10/10/24 and the blood pressure was 100/54.			

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	- 10/30/24 and the blood pressure was 107/61. 6:30 p.m.-10:30 p.m. -10/8/24 and the blood pressure was 106/65. The 10/2024 MAR indicated the Metoprolol was administered on the following dates at 11:00 a.m. -1:30 p.m. -10/10/24 and the blood pressure was 100/54. -10/30/24 and the blood pressure was 107/61. The 11/2024 MAR indicated the Hydralazine was administered on the following dates at 11:00 a.m. -1:30 p.m.: - 11/6/24 and the blood pressure was 84/56. - 11/14/24 and the blood pressure was 97/51. - 11/16/24 and the blood pressure was 104/63. - 11/19/24 and the blood pressure was 104/62. - 11/22/24 and the blood pressure was 106/62. The 11/2024 MAR indicated the Metoprolol was administered on the following dates at 11:00 a.m. -1:30 p.m.: - 11/6/24 and the blood pressure was 84/56. - 11/14/24 and the blood pressure was 97/51. - 11/16/24 and the blood pressure was 104/63. - 11/19/24 and the blood pressure was 104/62. - 11/20/24 and the blood pressure was 95/64. - 11/22/24 and the blood pressure was 106/62. During an interview on 11/22/24 at 2:46 p.m., LPN 1 indicated a QMA had passed the medications on her unit. She was told by the QMA that she held the Metoprolol for the resident and did not administer it. She indicated the medication was to be administered according to the parameters. During an interview on 11/25/24 at 2:30 p.m., the Director of Nursing indicated the medication			

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	should have been administered as ordered by the Physician.2. The record for Resident 5 was reviewed on 11/22/24 at 2:17 p.m. The resident was admitted to the facility on 10/7/24. Diagnoses included, but were not limited to, heart failure, hypertensive heart disease and diabetes mellitus. The Admission MDS assessment, dated 10/11/24, indicated the resident was cognitively intact and was dependent on staff for toileting and transfers. A Physician's Order, dated 10/8/24, indicated to give carvedilol (medication used to treat hypertension) 25 milligrams (mg) twice daily for hypertension. There were no blood pressure or heart rate parameters in place indicating when to hold the medication. The October 2024 Medication Administration Record (MAR) indicated the medication had been given twice daily from 10/8/24 through 10/15/24. The resident was sent to the hospital on 10/16/24, and returned on 10/24/24. The October and November 2024 MAR indicated he received the medication twice daily from 10/24/24 through 11/11/24. It was not given once on the evening of 11/4/24, the MAR note indicated he was unavailable. A Progress Note, dated 11/12/24, indicated the Physician had assessed the resident and there was a new order to decrease the carvedilol to 12.5 mg twice daily due to low heart rate. A Physician's Order, dated 11/12/24, indicated to give carvedilol, 12.5 mg, twice daily for hypertension. There were no blood pressure or heart rate parameters in place when to hold the medication.			

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	155795	A. BUILDING 00 B. WING	11/26/2024

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	The November 2024 MAR indicated the resident received the new dose of carvedilol once on 11/12/24. He was again sent to the hospital on 11/12/24 and returned on 11/16/24. He received the medication twice daily from 11/17/24 through 11/24/24. It was not given once in the evening of 11/21/24, the MAR note indicated the medication was unavailable. During October and November 2024, the resident's heart rate was documented below 55 beats per minute (bpm) on the following dates: 10/11- 50 bpm 10/12- 52 bpm 10/27- 53 bpm 10/31- 53 bpm 11/1- 49 bpm 11/2- 48 bpm 11/3- 52 bpm 11/5- 53 bpm 11/10- 50 bpm 11/11- 46 bpm 11/12- 40 bpm 11/13- 49 bpm There were no additional vital signs for review in the November MAR after 11/17/24. During an interview on 11/25/24 at 11:10 a.m., the Director of Nursing indicated holding the medications would depend on the patient, if a heart rate was in the 40's it should probably be held. A policy was requested but not provided. The guidelines for carvedilol was was retrieved from the David Drug Guide website at www.drugguide.com/ddo/view/Davis-Drug Guide/51134/all/carvedilol, on 11/25/24, indicated,			

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	"...Monitor BP and pulse frequently during dose adjustment period and periodically during therapy. Assess for orthostatic hypotension when assisting patient up from supine position. If heart rate decreases below 55 beats/min, decrease dose ... Implementation-PO Take apical pulse before administering. If < [less than] 50 bpm or if arrhythmia occurs, withhold medication and notify health care professional...." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure urinary output was documented as ordered and an indwelling Foley (urinary) catheter collection bag was off of the floor for a resident with a history of infection for 3 of 3 residents reviewed for urinary catheters. (Residents 6, 216, and 13) Findings include: 1. Record review for Resident 6 was completed on 11/25/24 at 9:57 a.m. Diagnoses included, but were not limited to, neurogenic bladder, end stage renal disease, Alzheimer's, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/22/24, indicated the resident was cognitively impaired. The resident required maximum assistance for toileting. The resident had an indwelling urinary catheter. A Care Plan, dated 10/10/22 and revised 11/11/24, indicated the resident used a Foley catheter. The resident was at risk for complications, including a urinary tract infection. An intervention included	F 0690	Residents 6, 216, and 13 had no negative outcome related to this deficiency. No other residents with Foley catheters had a negative outcome related to this deficiency. Nursing staff will receive education regarding documenting urine output every shift, and ensuring catheter collection bags do not touch floor. DHS/Designee will audit three residents weekly for documentation of urine output and proper placement of catheter collection bags, covering all shifts for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	12/23/2024

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	to record the resident's urinary output. The November 2024 Physician's Order Summary (POS) indicated an order to monitor urinary output every shift. The November 2024 Medication Administration Record (MAR) had the urinary output signed off as completed each shift, but lacked the amount of output. The Urinary output section of the Vital Signs had urine output documented only on day shifts for the past 30 days on the following dates: -10/26, 10/27, 10/28, 10/29, 11/2, 11/3, 11/4, 11/5, 11/8, 11/9, 11/10, 11/12, 11/14, 11/16, 11/21, 11/22, 11/23, 11/24, and 11/25/24. There was a lack of documentation to indicate the urinary output was documented on any other shift other than the day shift. During an interview on 11/26/24 at 9:26 a.m., the Director of Nursing (DON) indicated the nurses worked 12 hour shifts. There should be documentation of the urine output every shift. 2. On 11/21/24 at 10:39 a.m., Resident 216 was observed seated in her wheelchair in the lounge area near the 100 Hall Nurse's Station. The urinary catheter bag was hanging from the bottom of her wheelchair and resting on the floor. On 11/21/24 at 2:34 p.m., Resident 216 was observed seated in her wheelchair in her room. The urinary catheter bag was hanging from the bottom of her wheelchair and resting on the floor. On 11/22/24 at 11:02 a.m., Resident 216 was seated in her wheelchair in her room. No urinary catheter bag was visible. Resident 216 pulled up her pant			

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	leg and a urinary catheter leg bag was observed. Resident 216's record was reviewed on 11/22/24 at 10:38 a.m. Diagnoses included, but were not limited to, chronic kidney disease, type 2 diabetes mellitus, and dementia. The Admission Minimum Data Set assessment, dated 11/12/24, indicated the resident was cognitively impaired and had an indwelling urinary catheter. The Physician's Order Summary, dated 11/2024, indicated to monitor urine output every shift. There were no orders related to the use of a urinary catheter leg bag. A care plan, updated 11/20/24, indicated the resident required a urinary catheter for neurogenic bladder. The interventions included, record urinary output. There were no interventions related to the use of a urinary catheter leg bag. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 11/2024, indicated the urinary output had been signed off as monitored every shift (12 hour shifts) but no amounts had been recorded. The resident had received cefdinir (an antibiotic) 300 mg (milligrams) every 12 hours from 11/8/24 through 11/11/24 for acute cystitis (inflammation of the bladder) with hematuria (blood in the urine). The vital signs urine output documentation, dated 11/8/24 through 11/22/24, indicated the urine output had only been recorded once a day on the following dates: 11/10/24 at 1:16 p.m. 11/13/24 at 1:45 p.m. 11/16/24 at 12:38 p.m.			

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	11/17/24 at 10:56 a.m. 11/18/24 at 12:12 p.m. During an interview on 11/22/24 at 2:26 p.m., the Director of Nursing was made aware of the resident's urinary catheter bag resting on the floor. She indicated the urinary output should have been documented on each shift and there were two shifts per day. There was no specific policy related to urine output documentation, or the type of urinary catheter bag used. A policy was requested related to urinary catheter bag placement. No further information was provided.3. The record for Resident 13 was reviewed on 11/22/24 at 1:42 p.m. Diagnoses included, but were not limited to, sepsis, urinary tract infection, pneumonia, hemiplegia (paralysis on one side of the body) due to a stroke, and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment, dated 11/1/24, indicated the resident was cognitively intact and had an indwelling urinary catheter. A Care Plan, updated 6/27/23, indicated the resident had an indwelling urinary catheter. An intervention indicated to monitor and document urinary output. A Physician's Order, dated 1/30/24, indicated the urinary output was to be monitored every shift, three times per day, at the following times: 7:00 a.m. - 2:00 p.m., 3:00 p.m. - 10:00 p.m., 11:00 p.m. - 7:00 a.m. The resident's record indicated urinary outputs were measured once per day on 11/14/24, 11/18/24, 11/19/24, 11/21/24, 11/22/24, 11/23/24, and 11/24/24. Urinary output was documented twice			

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	per day on 11/15/24, 11/16/24, and 11/17/24. During an interview on 11/25/24 at 10:28 a.m., CNA 1 indicated she emptied the urine bag three times per shift and documented the amount in the resident's record. During an interview on 11/25/24 at 11:13 a.m., the DON indicated the CNAs should be documenting a urine output every shift and offered no further information. 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to monitor weekly weights and nutritional intake for meals and supplements as ordered for a resident with significant weight loss for 1 of 2 residents reviewed for nutrition. (Resident 38) Finding includes: The record for Resident 38 was reviewed on 11/22/24 at 11:20 a.m. Diagnoses included, but were not limited to, heart disease, congestive heart failure, acute pulmonary edema, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and weighed 78 pounds. The resident had an unplanned significant weight loss and received a therapeutic diet.	F 0692	Resident 38 had no negative outcome related to this deficiency. All residents have the potential to be affected by this deficiency. Nursing staff will receive education regarding documenting meal and supplement intake; and obtaining weights as recommended. DHS/Designee will audit three residents weekly for meal consumption and weights covering all shifts for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	12/23/2024

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	The revised Care Plan, dated 11/12/24, indicated the resident was malnourished/ at risk for malnutrition related to inadequate nutrient/ energy intakes, and/or metabolic demands. The approaches were to provide diet, supplements, medications, and adaptive equipment as ordered. A Physician's Order, dated 3/3/23 and on the current Physician Order Statement dated 11/2024, indicated point of care tasks: check breakfast, lunch and dinner. A Physician's Order, dated 5/14/24, indicated regular fortified foods with meals. A Physician's Order, dated 8/16/24, indicated med pass (nutritional supplement) 90 milliliters (ml) daily. The resident's weight was 77 pounds on 7/11/24 and on 8/2/24 she weighed 70 pounds. The resident's current weight on 11/14/24 was 78 pounds. A Registered Dietitian (RD) Note, dated 8/15/24 at 11:46 a.m., indicated the resident had a significant weight loss of 8.2% in the last 30 days. The RD suggested adding med pass supplement of 90 ml daily and obtaining weekly weights times four weeks. There was no documentation the weekly weights were completed for 4 weeks. The consumption of the of the med pass supplement was not documented as being administered on 10/6, 10/7, 10/10, 10/11, 10/15, 10/17, 11/9, 11/14, 11/15, and 11/21/24. The meal consumption log indicated there was no			

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	documentation for the breakfast meal on 9/2, 10/11, 11/1, 11/3, 11/5, 11/7, 11/12, and 11/19/24 The meal consumptions indicated there was no documentation for the lunch meal on 9/2, 10/11, 11/1, 11/3, 11/5, 11/19, and 11/21/24. The meal consumptions indicated there was no documentation for dinner meal on 9/2, 9/5, 9/9, 9/14, 9/18, 9/22, 10/1, 10/5, 10/9, 10/11, 10/14, 10/18, 10/21, 10/23, 10/26, 11/1, 11/5, 11/8, 11/10, 11/14, 11/17, 11/18, and 11/19/24. During an interview on 11/25/24 at 2:20 p.m., the Director of Nursing indicated the meal and supplement consumptions were incomplete. During an interview on 11/26/24 at 9:10 a.m., the Director of Nursing indicated the weekly weights were not completed. 3.1-46(a)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review, and interview, the facility failed to ensure a peripherally inserted central catheter (PICC) line was maintained related to bandage changes for 1 of 1 resident reviewed for infections. (Resident 363) Finding includes: During an interview on 11/21/24 at 11:15 a.m., Resident 363 indicated he had received intravenous (IV) antibiotics for a wound infection in his foot. The PICC line bandage had not been changed since he had been at the facility and one	F 0694	Resident 363 is no longer in the facility. No other residents have PICC lines. Nurses will receive education regarding completing PICC dressing changes as ordered. DHS/Designee will audit residents with PICC line for dressing changes weekly for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as	12/23/2024

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	of the ports did not work. The white split gauze sponge under the clear tegaderm was observed with brown dried blood. There was no date on the bandage of the PICC line. On 11/21/24 at 3:20 p.m., the resident was sitting up in his wheelchair inside his room. The PICC line bandage remained the same as above. During an interview on 11/22/24 at 8:25 a.m., the resident indicated the nurse had changed his PICC line bandage that morning. The record for Resident 363 was reviewed on 11/22/24 at 10:27 a.m. Diagnoses included, but were not limited to, absence of the right foot, osteomyelitis, abscess of the right foot, type 2 diabetes, arteriosclerosis, peripheral vascular disease, heart disease, heart failure, depression, and anxiety. The resident was admitted to the facility on 11/7/24. The 11/13/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making, received an antibiotic, and had an IV. The Care Plan, dated 11/8/24, indicated the resident required IV medication. The approaches were IV site care as ordered. Physician's Orders, dated 11/7/24, indicated change PICC dressing every 5 days and measure external catheter length. The Treatment Administration Record (TAR) for the month of 11/2024, indicated the PICC line dressing change was not signed out as being completed on 11/12 and 11/17/24. The first time it was signed out as being completed was on		needed.	

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	11/22/24. There was no documentation on 11/12 or 11/17/24 the PICC line bandage was changed. During an interview on 11/25/24 at 2:00 p.m., the Director of Nursing had no additional information to provide. The current and revised 12/2015 "Catheter Insertion and Care" policy, provided by the Assisted Living Director as current on 11/25/24 at 3:15 p.m., indicated the midline catheter dressing was to be changed at specified intervals or when needed to prevent catheter-related infections. The midline catheter was to be changed every five to seven days, or if it was wet, dirty, not intact, or compromised in any way. 3.1-47(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen concentrators were set at the correct flow rate for 1 of 2 residents reviewed for oxygen therapy. (Resident 38) Finding includes: During random observations on 11/21/24 at 10:20 a.m. and 2:04 p.m., and on 11/22/24 at 8:30 a.m., 10:21 a.m., and 1:24 p.m., Resident 38 was observed in bed. At those times, she was wearing oxygen via nasal cannula and the oxygen concentrator was set at 2.5 liters per minute. On 11/22/24 at 2:45 p.m., LPN 1 was observed in	F 0695	Resident 38 had no negative outcome related to deficiency. Other residents' oxygen concentrators were audited for correct flow rate with no concerns identified. Nurses will receive education regarding ensuring residents' oxygen concentrators are set at the correct flow rate. DHS/Designee will audit three residents weekly, covering all shifts for correct oxygen liter flow for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make	12/23/2024

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	the resident's room. At that time, she was made of the oxygen setting and immediately changed the rate to 3 liters. The record for Resident 38 was reviewed on 11/22/24 at 11:20 a.m. Diagnoses included, but were not limited to, heart disease, congestive heart failure, acute pulmonary edema, chronic obstructive pulmonary disease (COPD), and acute respiratory failure. The 9/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making. The resident received oxygen therapy while at the facility. The Care Plan, revised on 11/11/24, indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory disease. The approach was to provide oxygen. Physician's Orders, dated 9/15/24, indicated set oxygen at 3 liters nasal cannula continuously During an interview on 11/22/24 at 2:46 p.m., LPN 1 indicated the oxygen should be on as ordered by the physician. During an interview on 11/25/24 at 2:00 p.m., the Director of Nursing was informed of the oxygen and had no additional information to provide. 3.1-47(a)(6)		changes and/or recommendations as needed.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, record review and interview, the facility failed to ensure a resident's	F 0697	Resident 157 had no negative outcome related to deficiency.	12/23/2024

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	pain was managed and monitored for 1 of 2 residents reviewed for pain. (Resident 157) Finding includes: On 11/21/24 at 3:18 p.m., Resident 157 was observed sitting in his wheelchair in his room. He was grimacing, shifting in his chair, and complaining of back pain rated 7 out of 10 for severity. The resident indicated his back pain was not well controlled and he felt like he needed new or changed pain medications. On 11/25/24 at 9:26 a.m., the resident was observed fidgeting and attempting to reposition himself in bed. He indicated he was having back pain and the Fentanyl (an opioid pain medication) patch and Norco (an opioid pain pill) he had received were not controlling his pain. The resident's record was reviewed on 11/25/24 at 10:32 a.m. Medical diagnoses included, but were not limited to, cellulitis of the legs, heart failure, chronic kidney disease, atrial fibrillation, depression, spinal stenosis, and opioid use. The Admission Observation and Data Collection, dated 11/17/24, indicated the resident had moderate cognitive impairment, and was able to make needs known. The current Pain Care Plan indicated a goal that the resident's pain would be at a tolerable level with interventions. Interventions included, but were not limited to, observe for and record verbal and non-verbal signs of pain, administer medications as ordered, and attempt non-pharmacological interventions. The November 2024 Medication Administration		All residents have the potential to be affected by this deficiency. Other residents were audited for effective pain management with no concerns identified. Nurses will receive education regarding assessment and treatment of residents' pain. DHS/Designee will audit three residents weekly covering all shifts for pain/treatment for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	

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	Record (MAR) indicated the resident could receive diclofenac gel (a topical anti-inflammatory) as needed for pain, but he had not received it. There was no indication any non-pharmacological interventions had been attempted to manage the resident's pain. During an interview on 11/25/24 at 2:00 p.m., RN 2 indicated the non-pharmacological interventions for pain were rest and repositioning, and the resident did that himself. The resident was never given the diclofenac gel because he did not ask for it, but she did not know if he knew he could have it. QMA 1 then got the diclofenac gel from the medication cart, and went into the resident's room. On 11/25/24 at 2:15 p.m., the resident indicated he was glad the QMA applied the diclofenac to his back as he had not tried it before, and did not know it was available to him. During an interview on 11/26/24 at 10:35 a.m., the Director of Nursing was informed of the pain concerns and no further information was received. A facility policy, titled, "Guidelines for Pain Observation and Management", received from the Administrator as current, indicated, "... Procedures ... 5. Educate the resident / family / caregivers on the pain management interventions ... 6. Implement the care plan approaches to assist with pain management. 7. Evaluate the effectiveness of pain management interventions and modify as indicated." 3.1-37(a)			
F 0842 SS=D	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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Bldg. 00	Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented, related to the correct medication administration route for 1 of 1 resident reviewed for tube feeding. (Resident 41) Finding includes: During an interview on 11/21/24 2:15 p.m., Resident 41's daughter indicated the resident received her medications "sometimes through the tube and sometimes she got them by mouth." The record for Resident 41 was reviewed on 11/25/24 at 9:05 a.m. Diagnoses included, but were not limited to, colitis, dehydration, congestive heart failure, dementia, Alzheimer's disease, heart disease, Parkinson's disease, dysphagia (difficulty swallowing), peg tube (a tube inserted directly into the stomach for nutrition) . The 10/21/24 Significant Change Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had a peg tube through which she received 25% or less of nutrition. Physician's Orders, listed on the current Physician Order Summary dated 11/2024, indicated the medications of Carbidopa-Levodopa 25-250 milligrams (mg) give 1 tablet orally four times a day, and Pepcid 20 mg, give 1 tablet orally at night time. There was no order to administer the medications through the peg tube. During an interview on 11/25/24 at 11:23 a.m., RN 3	F 0842	Resident 41 is no longer in the facility. All residents have the potential to be affected by this deficiency. Nurses/QMAs will receive education regarding medication administration including correct route. DHS/Designee will observe one nurse weekly covering all shifts for medication administration for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	12/23/2024

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	indicated she had administered the resident's medications through the peg tube, however, there was no physician's order to administer the medications through the peg tube. During an interview on 11/25/24 at 2:30 p.m., the Director of Nursing indicated the resident had received her medications orally and not through the peg tube, but since her decline, she received the medications through the peg tube. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to enhanced barrier precautions (EBP) not in use for a resident with pressure ulcers during a wound treatment and for a resident with a peripherally inserted central catheter (PICC) line during medication pass. The facility also failed to change gloves in between pressure ulcer treatments and perform hand hygiene after glove removal during medication pass for 1 of 2 residents observed during a pressure ulcer treatment and for 1 of 8 residents observed during medication administration. (Residents 41 and 363) (Hospice CNA 1, Hospice RN 1, and RN 1) Findings include: 1. During an observation on 11/25/24 at 10:33 a.m., Hospice CNA 1 and Hospice RN 1 were observed in Resident's 41 room. At that time, Hospice CNA 1 indicated she was going to give the resident a complete bed bath and Hospice RN 1 was going to change the resident's bandages for	F 0880	Residents 41 and 363 are no longer in the facility. The hospice provider was contacted regarding deficiency. All residents have the potential to be affected by this deficiency. Nursing staff will receive education regarding Enhanced Barrier Precautions, hand hygiene, and glove changes. DHS/Designee will audit three residents weekly covering all shifts for infection control guidelines including following Enhanced Barrier Precautions, hand hygiene, and glove changes for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	12/23/2024

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	her pressure ulcers. The CNA and RN both had performed hand hygiene and donned a pair of clean gloves to both hands and proceeded to give the resident a bed bath. Neither one of them donned a gown to provide care and give the bath. They turned the resident over on her right side and there were 5 foam bandages on the residents back side. The hospice nurse removed her gloves and washed her hands with soap and water. She donned a clean pair of gloves to both hands and removed the bandage to the sacrum. The pressure ulcer on sacrum had thick black necrotic tissue and a large amount of drainage. The RN cleaned the wound with normal saline wearing the same pair of gloves to both hands, and patted it dry. With the same gloves, she squeezed a moderate amount of Cal Zinc cream on her gloved hands and proceeded to spread the cream around the wound. She then placed a clean foam bandage over the wound. During an interview at that time, Hospice RN 1 indicated the pressure sore was much worse and she thought it was now a Kennedy ulcer (a dark, irregularly shaped sore that develops rapidly in the final stages of life) and the focus would be to prevent further breakdown, as the ulcer would need debridement. Using the same pair of gloves, she removed the bandage on the left ischium and cleaned the wound with normal saline. She patted the wound dry and squeezed a small amount of the Cal Zinc cream into the same pair of gloves and proceeded to spread the cream over the pressure ulcer on the ischium. She then placed a foam bandage over the wound. After she had finished completing the treatments, she removed her gloves and washed her hands with soap and water. At that time, there was a sign on the outside of the resident's door that indicated the resident was in EBP and a gown and gloves were needed if			

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	coming in contact with the resident. During an interview at that time, Hospice CNA 1 and Hospice RN 1 both indicated they were not aware the resident was in EBP. During an interview on 11/25/24 at 2:30 p.m., the Director of Nursing indicated the resident was in EBP and a gown was required while providing wound treatments, bathing, and turning and repositioning the resident. The current 12/31/23 "Dressing Changes" policy, provided by the Director of Nursing on 11/26/24 at 10:40 a.m., indicated the pressure ulcer procedure was to wash hands with soap and water and put on the first pair of gloves. Remove the soiled dressing, discard in a plastic bag or trash can and dispose of the gloves. Wash hands with soap and water and put on a second pair of disposable gloves. Follow the doctor's recommendations for treatments, apply a dressing and secure with tape. After completing the treatment, remove the gloves, discard, and wash hands with soap and water. 2. During a medication pass observation on 11/21/24 at 11:31 a.m., RN 1 was observed checking Resident 363's blood sugar and administering ampicillin (antibiotic medication) via a peripheral intravenous central catheter (PICC). Upon entering the resident's room, a sign on the door indicated the resident was in Enhanced Barrier Precautions (EBP), which required staff to wear a gown and gloves while performing any high contact care with the resident. RN 1 entered the room and donned clean gloves. She did not wash her hands prior to putting on the gloves. She checked the resident's blood sugar, removed her gloves, and then donned a new pair of gloves without performing hand hygiene between glove use. She had mixed a 3 gram ampicillin vial with a			

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	50 cc bag of 0.9% normal saline solution and then primed intravenous (IV) tubing with the medication. She placed a cap over the end of the IV tubing once it was primed. While attaching the IV tubing to the PICC line, the IV tubing was observed touching the floor. She continued to administer the medication, then removed her gloves and performed hand hygiene. During an interview on 11/21/24 at 12:14 p.m., RN 1 indicated she should have washed her hands in between glove changes each time. She was unaware the tubing had touched the floor, but she had tried to keep it off of the floor while moving the tubing around. The resident was in Enhanced Barrier Precautions (EBP), but it was only required while caring for his wound or catheter. A gown was not required for the PICC line medication administration, but "it would not have hurt" to have it on during care. During an interview on 11/25/24 at 2:57 p.m., the Director of Nursing indicated she had no further information to provide. A policy titled, "Enhanced Barrier Precautions (EBP) Standard Operating Procedure," noted as current, indicated "...1. Enhanced Barrier Precautions (EBP) will be in place during high-contact care activities for residents with the following conditions: a. Residents at an increased risk of MDRO acquisition which include: i. All residents with chronic wounds, including but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. ii. All Residents with indwelling medical devices 1. Includes but not limited to: catheters, central lines, feeding tubes, tracheostomy tubes...2. Personal protective equipment (PPE) should be used even if blood and body fluid			

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	exposure is not anticipated. a. At minimum, staff shall wear gloves and gowns during high-contact care activities...3. High-contact care activities include but are not limited to: morning and evening ADL care, toileting, and showers.: A policy titled, "Guideline for Handwashing/Hand Hygiene," noted as current, indicated "...1. All health care workers (HCW) shall utilize hand hygiene frequently and appropriately...3. HCW shall use hand hygiene at times such as: ...c. Before/after having direct physical contact with residents. d. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc..." 3.1-18(b)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey and the Investigation of Residential Complaint IN00444549. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00446368. Complaint IN00444549 - No deficiencies related to the allegations are cited. Complaint IN00446368 - No deficiencies related to the allegations are cited. Survey dates: November 21, 22, 25, and 26, 2024. Facility number: 012766	R 0000		

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	Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 12/2/24.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure a Service Plan was developed for 2 of 9 sampled residents. (Residents 2 and 4) Findings include: 1. The record for Resident 2 was reviewed on 11/21/24 at 2:00 p.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, dementia with behavior disturbance, sleep disorder, and inappropriate sexual behaviors. The Nurse's Notes for the months of October 2024 and November 2024, indicated the resident had multiple falls, behaviors, and she was receiving an as needed (PRN) anti-anxiety medication. A Service Plan was not available for review. During an interview, on 11/26/24 at 10:40 a.m., the Assisted Living Director indicated the resident did not have a current service plan. 2. The record for Resident 4 was reviewed on 11/21/24 at 3:14 p.m. Diagnoses included, but were not limited to, type 2 diabetes, dementia with behavioral disturbance, altered mental status, anxiety, sleep disorders, and major depressive disorder.	R 0217	Preparation of this plan of correction does not constitute admission or agreement of provider of the truth of 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. The plan of correction is submitted to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey on 11/26/2024. Please accept this plan of correction as the provider's credible allegation of compliance. Due to the scope and severity of the deficiencies, Avalon Springs Health Campus is requesting Paper Compliance. Service Plans were completed for residents 2 and 4. Other residents were audited for completion of Service Plans. Nurses will receive education regarding completing Service Plans. DHS/DAL/LND will audit two	12/23/2024

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	The Nurse's Notes for the months of September 2024, October 2024, and November 2024, indicated the resident had multiple falls, behaviors, and he was receiving insulin and antidepressant medications. A Service Plan was not available for review. During an interview, on 11/26/24 at 10:40 a.m., the Assisted Living Director indicated the resident did not have a current service plan.		residents monthly for completion of Service Plans for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes/recommendations as needed.	