STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155795	A. BUILDING -- B. WING	12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/18/24 Facility Number: 012766 Provider Number: 155795 AIM Number: 201051640 At this Emergency Preparedness survey, Avalon Springs Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 61 certified beds. At the time of the survey, the census was 53. Quality Review completed on 12/19/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/18/24 Facility Number: 012766 Provider Number: 155795 AIM Number: 201051640 At this Life Safety Code survey, Avalon Springs Health Campus was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Crystal Wray	Executive Director	12/31/2024

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The Health Campus building consists of five wings. The healthcare portion of the facility contained the 100, 200, and 300 wings. The facility has a capacity of 61 and had a census of 53 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinkled except for one garage which was not sprinklered. Quality Review completed on 12/19/24			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put	K 0921	Preparation of execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on 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	01/16/2025

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	into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. The findings include: Based on records review and interview with the Director of Plant Operations (DPO) on 12/18/24 at 2:40 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The DPO stated that PCREE such as air mattresses, oxygen concentrators and other electrical medical equipment was present and in use at the facility. The DPO stated he was not aware of the testing requirement of PCREE and no inspection documentation was available at the time of the survey. This finding was reviewed with the Executive Director and Director of Plant Operations at the		cited during a Life Safety Code Recertification and State Licensure Emergency Preparedness Survey on 12/18/2024. Please accept this plan of correction as the provider's credible allegation of compliance. Due to scope and severity of the deficiency, Avalon Springs Health Campus is requesting Paper Compliance. All residents were affected with no noted harm or injury, and all have the potential to be affected by the same deficient practice. Director of Plant Operations has inspected, tested and documented the physical integrity, resistance, leakage current test for fixed and portable patient-care related electrical equipment (PCREE). The Director of Plant Operation was educated by the Facilities Management Support on: K921 - Equipment - Testing and Maintenance Requirements, NFPA 101, 2012 Edition, All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are	

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	exit conference. 3.1-19(b)		considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. The Director of Plant Operations/Designee will complete a one-time inspection of all PCREE devices in the facility. Following the Director of Plant Operations/Designee will complete a monthly audit for two months on all PCREE devices, then all new devices prior to use and annually thereafter. Results of this inspection and audits will be presented by the Director of Plant Operations/Designee to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. Date of compliance: 1/16/2025	

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