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 _____	C 01/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00424684 and IN00425412. Complaint IN00424684 - No deficiencies related to the allegations are cited. Complaint IN00425412 - Federal/state deficiencies related to the allegations are cited at F760. Survey date: January 11, 2024 Facility number: 012766 Provider number: 155 AIM number: 201051640 Census Bed Type: SNF/NF: 19 SNF: 33 Residential: 53 Total: 105 Census Payor Type: Medicare: 18 Medicaid: 12 Other: 22 Total: 52 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/17/24.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant	F 760		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were given as ordered to prevent significant medication errors for 1 of 3 residents reviewed for medication errors. (Resident B) The deficient practice was corrected by 1/3/24, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the medication error. The facility's plan of action included staff education related to counseling and education on medication administration and dosage calculations. Medication administration competencies were completed for nurses and QMAs. Audits began for as needed (PRN) injectable medications. Finding includes: Resident B's record was reviewed on 1/11/24 at 9:35 a.m. Diagnoses included, but were not limited to, encephalopathy, diabetes mellitus, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 12/18/23, indicated the resident was moderately cognitively impaired for daily decision making. A Progress Note, dated 12/30/23 at 6:09 a.m., indicated the resident was awake yelling for help. The resident was demonstrating confusion and was re-oriented. A Progress Note, dated 1/1/24 at 12:45 a.m., indicated the resident was yelling for help and	F 760	Past noncompliance: no plan of correction required.	

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F 760	Continued From page 2	F 760		

was found on her knees with her upper half of body still in bed. A neurological assessment was completed and she was at her baseline with continued confusion. Redirection was provided at this time and appropriate parties were notified.

A Progress Note, dated 1/1/24 at 1:00 a.m., indicated a new order for molnupiravir (an antiviral medication) 800 mg twice daily for five days for COVID-19.

A Progress Note, dated 1/1/24 at 4:48 a.m., indicated the resident was screaming out "help, help." Redirection was provided, but was ineffective. Staff sitting with resident in her room was also not effective.

A Progress Note, dated 1/1/24 at 5:05 a.m., indicated the resident continued to scream out, yelling eve with staff inn the room. The Physician was called and new orders were given for Haldol (an antipsychotic medication) 1 milligram (mg) intramuscular (IM) injection one time now.

A Progress Note, dated 1/1/24 at 6:16 a.m., indicated 1 mg Haldol was ordered by the Physician, 5 mg of IM Haldol was administered. There were no adverse reactions noted. The Physician was notified and no new orders were given. The family was updated. The resident's vital signs were stable, she continued to rest in bed talking to herself. Her neurological assessment remained at baseline.

A Progress Note, dated 1/1/24 at 11:57 a.m., indicated the Physician was in the facility and was informed of the resident's status change, prior testing, and family requests for more testing.

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F 760	Continued From page 3	F 760		

A Progress Note, dated 1/1/24 at 4:42 p.m., indicated during the last neurological check, the resident was noted to remain lethargic and unresponsive to touch or speech. Her vital signs remained stable, slight twitches to hands and arms, and her fingers were purple and cold to the touch. The family requested the resident be sent to the emergency department for evaluation. 911 arrived and transported the resident to the hospital.

During a phone interview on 1/11/24 at 11:28 a.m., the Physician indicated the resident was out of control with her behaviors on the morning of 1/1/24, so he gave the order for Haldol due to the resident becoming combative and physically aggressive with the staff, for her safety and the safety of the staff. The nurse administered the incorrect dose of the medication. The resident went to the hospital later that afternoon due to lethargy. Haldol has a very short half-life. Someone who is taking Haldol as a scheduled medication or for recurring behaviors would have to take it anywhere from two to three times a day. He had never seen Haldol affect anyone to that degree in his practice and it would be unlikely that it would cause death two days later due to the half-life of the medication.

During a phone interview on 1/11/24 at 12:09 p.m., the Consultant Pharmacist indicated the half-life of the medication is around 20 hours. Side effects of the amount given would be increased sedation and possible hypotension, but that was rare. It would not have had any affect on her blood sugar besides the sedation causing poor intake. A good portion of the medication would have been out of her system from time of administration until 1/3/24 when she passed.

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F 760	Continued From page 4 During an interview on 1/11/24 at 9:59 a.m., the Director of Nursing (DON) indicated RN 1 received an order for one time dose of Haldol 1 mg IM on 1/1/24 around 5:30 a.m. RN 1 mistakenly gave 1 milliliter, which was equivalent to 5 milligrams of Haldol. RN 1 called the doctor immediately after she realized the error and the doctor did not give any new orders. The resident had just had a fall recently, was still in isolation due to having COVID-19, and was having new behaviors. RN 1 had an aide sit in the room with the resident because she was so anxious and restless. She was becoming combative with the staff. After RN 1 administered the medication, the resident slept a lot. The resident's family became concerned and requested that she go to the hospital. The resident was admitted at the hospital and the next day (1/2/24) the resident was arousable, sitting up, and eating. On 1/3/24, she coded in the hospital and died. After the incident occurred, the DON provided education to all of the nurses on medication pass procedures and error prevention, dosage calculations, performed medication pass observations, blood sugar monitoring, and injectable medication audits were started weekly. This citation relates to Complaint IN00425412. 3.1-48(c)(2)	F 760		