PRINTED: 12/28/2023

|  | EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES |  |                      |                         |  |  |      |
|--|--|--|----------------------|-------------------------|--|--|------|
| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795 |  | (X2) MULTII<br>A. BUILDII<br>B. WING                                 |                      | nstruction<br><u>00</u> | (X3) DATE SURVEY COMPLETED 12/04/2023  |  |      |
| NAME OF I  | PROVIDER OR SUPPLIE  | ER   |                      |                         | DDRESS, CITY, STATE, ZIP COD<br>LHAVY ROAD   |  |      |
| AVALON   | I SPRINGS HEALT  | TH CAMPUS  | VALPARAISO, IN 46383 |                         |  |  |      |
| (X4) ID  | SUMMARY  | Y STATEMENT OF DEFICIENCIE   | ID                   |                         | PROVIDER'S PLAN OF CORRECTION  |  | (X5) |
| PREFIX   |  | NCY MUST BE PRECEDED BY FULL   | PREF                 |                         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |  |      |
| TAG<br>F 0000  | REGULATORY C   | DR LSC IDENTIFYING INFORMATION                                       | TAG DEFICIENCY)      |                         | DEFICIENCY   |  | DATE |
| 0000   |  |  |                      |                         |  |  |      |
| Bldg. 00   |  | a Recertification and State This visit included a State sure Survey. | F 0000               |                         | /b>  |  |      |
|  | Survey dates: No<br>December 1, 4, 20  | vember 27, 28, 29, 30 and 23.  |                      |                         |  |  |      |
|  | Facility number: 0<br>Provider number:<br>AIM number: 201                      | 155795   |                      |                         |  |  |      |
|  | Census Bed Type:<br>SNF/NF: 19<br>SNF: 32<br>Residential: 52<br>Total: 103     |  |                      |                         |  |  |      |
|  | Census Payor Typ<br>Medicare: 22<br>Medicaid: 11<br>Other: 18<br>Total: 51     | e:   |                      |                         |  |  |      |
|  | These deficiencies accordance with 4   | s reflect State Findings cited in 10 IAC 16.2-3.1.                   |                      |                         |  |  |      |
|  | Quality review con   | mpleted on 12/7/23.  |                      |                         |  |  |      |
| F 0623<br>SS=D<br>Bldg. 00   |  | ents Before  |                      |                         |  |  |      |

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

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in

resident, the facility must-

(X6) DATE

TITLE

Kim Sheets Director of Health Services 12/20/2023

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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795 |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING   | ONSTRUCTION  00 | COM  | (X3) DATE SURVEY COMPLETED 12/04/2023 |                    |
|--|---|--|-----------------|--|---------------------------------------|--------------------|
|  | PROVIDER OR SUPPLIEI<br>I SPRINGS HEALT   |  | 2400 SI         | ADDRESS, CITY, STATE, ZIP CO<br>ILHAVY ROAD<br>RAISO, IN 46383                             | )D                                    |                    |
| (X4) ID<br>PREFIX  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL   | ID<br>PREFIX    | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY) |                                       | (X5)<br>COMPLETION |
| TAG  | a language and m facility must send representative of Long-Term Care (ii) Record the readischarge in the maccordance with p section; and (iii) Include in the in paragraph (c)(§ §483.15(c)(4) Tim (i) Except as speciand (c)(8) of this stransfer or dischasection must be m 30 days before the discharged. (ii) Notice must be practicable before (A) The safety of would be endange (i)(C) of this section (B) The health of would be endange (i)(D) of this section (C) The resident's to allow a more in discharge, under section; (D) An immediate required by the reneeds, under parasection; or (E) A resident has for 30 days. | asons for the transfer or esident's medical record in paragraph (c)(2) of this notice the items described 5) of this section.  Ining of the notice.  Cified in paragraphs (c)(4)(ii) section, the notice of rge required under this nade by the facility at least e resident is transferred or e made as soon as a transfer or discharge when-individuals in the facility ered under paragraph (c)(1) on; individuals in the facility ered, under paragraph (c)(1) | TAG             |  |                                       | DATE               |

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this section must include the following:

Event ID:

XTC711

Facility ID: 012766

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) M                        | ULTIPLE CO | NSTRUCTION            | (X3) DATE SURVEY  |        |            |
|--|-----------------------|-------------------------------|------------|-----------------------|---|--------|------------|
| AND PLAN   | OF CORRECTION         | IDENTIFICATION NUMBER         | A. BU      | A. BUILDING <u>00</u> |   |        | ETED       |
|  |                       | 155795                        | B. W       | ING                   |   | 12/04/ | /2023      |
|  |                       |                               |            | STDEET A              | ADDRESS, CITY, STATE, ZIP COD   |        |            |
| NAME OF P  | ROVIDER OR SUPPLIER   | 2                             |            |                       | LHAVY ROAD  |        |            |
| Δ\/ΔΙ ΩΝ   | SPRINGS HEALTH        | H CAMPUS                      |            |                       | RAISO, IN 46383   |        |            |
| AVALON   | OF KINGS FILALTI      | T CAIVII 00                   |            | VALIA                 | (AISO, IN 40303   |        |            |
| (X4) ID  | SUMMARY               | STATEMENT OF DEFICIENCIE      |            | ID                    | PROVIDER'S PLAN OF CORRECTION   |        | (X5)       |
| PREFIX   | (EACH DEFICIEN        | ICY MUST BE PRECEDED BY FULL  |            | PREFIX                | REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |        | COMPLETION |
| TAG  | REGULATORY OR         | R LSC IDENTIFYING INFORMATION |            | TAG                   | DEFICIENCY)   |        | DATE       |
|  | (i) The reason for    | transfer or discharge;        |            |                       |   |        |            |
|  | (ii) The effective d  | ate of transfer or discharge; |            |                       |   |        |            |
|  | (iii) The location to | which the resident is         |            |                       |   |        |            |
|  | transferred or disc   | charged;                      |            |                       |   |        |            |
|  | (iv) A statement of   | f the resident's appeal       |            |                       |   |        |            |
|  | rights, including th  | ne name, address (mailing     |            |                       |   |        |            |
|  | and email), and te    | elephone number of the        |            |                       |   |        |            |
|  | entity which receive  | ves such requests; and        |            |                       |   |        |            |
|  | information on how    | w to obtain an appeal form    |            |                       |   |        |            |
|  | and assistance in     | completing the form and       |            |                       |   |        |            |
|  | submitting the app    | peal hearing request;         |            |                       |   |        |            |
|  | (v) The name, add     | dress (mailing and email)     |            |                       |   |        |            |
|  | and telephone nur     | mber of the Office of the     |            |                       |   |        |            |
|  | State Long-Term       | Care Ombudsman;               |            |                       |   |        |            |
|  | (vi) For nursing fa   | cility residents with         |            |                       |   |        |            |
|  | intellectual and de   | evelopmental disabilities or  |            |                       |   |        |            |
|  | related disabilities  | , the mailing and email       |            |                       |   |        |            |
|  | address and telep     | hone number of the agency     |            |                       |   |        |            |
|  | responsible for the   | e protection and advocacy     |            |                       |   |        |            |
|  | of individuals with   | developmental disabilities    |            |                       |   |        |            |
|  | established under     | Part C of the                 |            |                       |   |        |            |
|  | •                     | sabilities Assistance and     |            |                       |   |        |            |
|  | Bill of Rights Act of | of 2000 (Pub. L. 106-402,     |            |                       |   |        |            |
|  | codified at 42 U.S    | .C. 15001 et seq.); and       |            |                       |   |        |            |
|  | (vii) For nursing fa  | acility residents with a      |            |                       |   |        |            |
|  | mental disorder or    | r related disabilities, the   |            |                       |   |        |            |
|  |                       | address and telephone         |            |                       |   |        |            |
|  | number of the age     | ency responsible for the      |            |                       |   |        |            |
|  | protection and adv    | vocacy of individuals with a  |            |                       |   |        |            |
|  | mental disorder es    | stablished under the          |            |                       |   |        |            |
|  | Protection and Ad     | vocacy for Mentally III       |            |                       |   |        |            |
|  | Individuals Act.      |                               |            |                       |   |        |            |
|  |                       |                               |            |                       |   |        |            |
|  | - ' ' ' '             | anges to the notice.          |            |                       |   |        |            |
|  |                       | in the notice changes prior   |            |                       |   |        |            |
|  | to effecting the tra  | insfer or discharge, the      |            |                       |   |        |            |
|  |                       | te the recipients of the      |            |                       |   |        |            |
|  | notice as soon as     | practicable once the          |            |                       |   |        |            |
|  | updated information   | on becomes available.         |            |                       |   |        |            |
|  |                       |                               |            |                       |   |        |            |

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155795 B. WING 12/04/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2400 SILHAVY ROAD **AVALON SPRINGS HEALTH CAMPUS** VALPARAISO, IN 46383 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(I). Based on record review and interview, the facility F 0623 ="" span=""> 12/29/2023 failed to ensure a resident and/or their Resident 45 is no longer in the Responsible Party were notified in writing related facility. to a transfer to the hospital for 1 of 1 residents Other discharged residents were reviewed for hospitalization. (Resident 45) audited for written notice of discharge. The closed record for Resident 45 was reviewed Nurses will receive in-service on 11/30/23 at 10:40 a.m. Diagnoses included, but regarding providing and were not limited to, chronic kidney disease and documenting written notice of congestive heart failure. discharge when discharging residents. The Quarterly Minimum Data Set (MDS) DHS/Designee will audit assessment, dated 9/22/23, indicated the resident discharges weekly for written was cognitively intact. notice of discharge for six months, then quarterly thereafter until A Progress Note, dated 10/10/23, indicated the 100% compliance is achieved. resident was lethargic, her heart rate was 44, and QAPI to make changes and/or her oxygen saturation was 60%. The resident's recommendations as needed. blood pressure was not able to be assessed. The resident was put on a rebreather mask. The Nurse Practitioner checked on the resident. The family and Physician were notified and the resident was sent to the hospital. There was a lack of documentation any hospital transfer form had been completed or the State transfer form had been provided in writing to the resident or her responsible party.

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|                            | CPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES  |   |   |   |                                     |                                 |  |  |  |
|----------------------------|---|---|---|---|-------------------------------------|---------------------------------|--|--|--|
|                            | NT OF DEFICIENCIES OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155795   | (X2) MULTIPLI<br>A. BUILDING<br>B. WING | E CONSTRUCTION  G 00  | COM                                 | TE SURVEY<br>MPLETED<br>04/2023 |  |  |  |
| NAME OF                    | PROVIDER OR SUPPLIE   | R   |   | ET ADDRESS, CITY, STATE,<br>O SILHAVY ROAD                                | ZIP COD                             |                                 |  |  |  |
| AVALON                     | I SPRINGS HEALT   | H CAMPUS  | VAL                                     | PARAISO, IN 46383   |                                     |                                 |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>O THE APPROPRIATE | (X5) COMPLETION DATE            |  |  |  |
|                            | 12/04/23 at 1:33 p.:<br>transfer/discharge p  | Director of Nursing (DON) on m., indicated there was no paperwork in the system. She ide any further documentation.   |   |   |                                     |                                 |  |  |  |
| F 0655<br>SS=D<br>Bldg. 00 | 483.21(a)(1)-(3) Baseline Care Pla §483.21 Compreh Care Planning §483.21(a) Baseli §483.21(a) Baseli §483.21(a)(1) The implement a base resident that inclu to provide effectiv of the resident tha standards of qual plan must- (i) Be developed or resident's admiss (ii) Include the min information neces resident including (A) Initial goals ba (B) Physician ord (C) Dietary orders (D) Therapy servi (E) Social service (F) PASARR reco | an nensive Person-Centered ine Care Plans e facility must develop and eline care plan for each ides the instructions needed re and person-centered care at meet professional ity care. The baseline care within 48 hours of a ion.  Inimum healthcare is sary to properly care for a put not limited to-essed on admission orders.  Bessel on admission orders. |   |   |                                     |                                 |  |  |  |
|                            | comprehensive ca  | e facility may develop a<br>are plan in place of the<br>n if the comprehensive care   |   |   |                                     |                                 |  |  |  |

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(i) Is developed within 48 hours of the

(ii) Meets the requirements set forth in

resident's admission.

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| STATEMENT OF DEPICICEUS AND PLAN OF CORRECTION DESTRIPCATION NUMBER 155795  NAME OF PROVIDER OR SUPPLIER  AVALON SPRINGS HEALTH CAMPUS  SIMPLAY NO AD VALPARAISO, IN 46383  VALPARAISO, IN 46383  VALPARAISO, IN 46383  VALPARAISO, IN 46383  AND PRETX TAG  SETRET ADDRESS, CITY, STATE, ZIP CD 2400 SILHAVY ROAD VALPARAISO, IN 46383  VALPARAISO, IN 46383  WALPARAISO, IN 46383  DESTRIPCATOR OF CORRECTION CONFIDENCE AND SPRINGS HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEPICIANY OR LSC IDENTIFYING INFORMATION)  PRETX TAG  PRETX TAG  PRETX TAG  S483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the residents medications and dielary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility railed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the residents Baseline Care Plans. The Assistive Povice section indicated the resident.  | CENTERS FOR MEDICARE & MEDICAID SERVICES |   |                                  |        |            |   | OM        | IB NO. 0938-039 |  |
|--|--|---|----------------------------------|--------|------------|---|-----------|-----------------|--|
| NAME OF PROVIDER OR SUPPLIER  AVALON SPRINGS HEALTH CAMPUS  VALPARAISO, IN 46383  (X4) ID  REGULATORY OR LSC IDENTIFYING INFORMATION  PREFIX TAG  PREFIX PROGRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383  (X5)  REGULATORY OR LSC IDENTIFYING INFORMATION  PREFIX TAG  PREFIX PROGRESS, LOG CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION  FAG REGULATORY OR LSC IDENTIFYING INFORMATION  PREFIX PROGRESS AND PROGRESS AND CONCRECTION COMPLETION  PREFIX PROGRESS AND CONCRECTION COMPLETION  PREFIX PROGRESS AND CONCRECTION COMPLETION  AND A summary of the baseline care plan that includes but is not limited to:  (i) A summary of the resident's medications and dietary instructions.  (iii) Any services and treatments to be administered by the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The   | STATEMEN                                 | NT OF DEFICIENCIES                      | X1) PROVIDER/SUPPLIER/CLIA       | (X2) M | ULTIPLE CO | ONSTRUCTION                             | (X3) DATE | SURVEY          |  |
| AVALON SPRINGS HEALTH CAMPUS  AVALON SPRINGS HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FILL. TAG  paragraph (b) (2)(i) of this section (excepting paragraph (b) (2)(i) of this sect | AND PLAN                                 | OF CORRECTION                           | IDENTIFICATION NUMBER            | A. BU  | JILDING    | 00                                      | COMPI     | LETED           |  |
| AVALON SPRINGS HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGILATORY OR LSC IDENTIFYING INFORMATION TAG Paragraph (b) of this section (excepting paragraph (b)(2)(1) of this section (excepting paragraph |  |   | 155795                           | B. W   | ING        |   | 12/04     | /2023           |  |
| AVALON SPRINGS HEALTH CAMPUS  (X4]ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION paragraph (b) (2)(i) of this section (excepting paragraph (b) (2)(i) of this section).  §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the residents medications and dietary instructions. (iii) As unmary of the baseline care plan that includes but is not limited to: (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The   | NAME OF I                                | DROVIDED OD GUDDI IEI                   |                                  | •      | STREET .   | ADDRESS, CITY, STATE, ZIP COD           |           |                 |  |
| SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION  PROBLEM TAG Paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).  \$483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the residents medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The  | NAME OF I                                | PROVIDER OR SUPPLIER                    | C                                |        |            |   |           |                 |  |
| PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  paragraph (b) of this section (excepting paragraph (b) of this section (continued paragraph (b) of the section (continued paragraph (b) of this section (continued paragraph (b) of this section (continued paragraph (b) of this se | AVALON                                   | SPRINGS HEALTI                          | H CAMPUS                         |        | VALPA      | RAISO, IN 46383                         |           |                 |  |
| TAG REQUIATORY OR LSC IDENTIFYING INFORMATION  paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).  §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:  (i) The initial goals of the residents medications and dietary instructions.  (iii) Any services and treatments to be administered by the facility, and personnel acting on behalf of the facility, and personnel acting on behalf of the facility and personnel acting on behalf of the facility and personnel acting on behalf of the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The   | (X4) ID                                  | SUMMARY                                 | STATEMENT OF DEFICIENCIE         |        | ID         |   |           | (X5)            |  |
| paragraph (b)(2)(i) of this section).  §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:  (i) The initial goals of the resident.  (ii) A summary of the residents medications and dietary instructions.  (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.  (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  DHS/Designee will audit baseline care plans werely for assistive devices. DHS/Designee will audit baseline care plans weekly for assistive devices. DHS/Designee will audit baseline care plans weekly for assistive devices. DHS/Designee will audit baseline care plans weekly for assistive devices. DHS/Designee will audit baseline care plans weekly for assistive devices of six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.  | PREFIX                                   | (EACH DEFICIEN                          | CY MUST BE PRECEDED BY FULL      |        | PREFIX     | CROSS-REFERENCED TO THE APPROPRIA       | TE        | COMPLETION      |  |
| paragraph (b)(2)(i) of this section).  §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:  (i) The initial goals of the resident.  (ii) A summary of the resident's medications and dietary instructions.  (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.  (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Plans. (Resident 97)  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The  | TAG                                      |   |                                  |        | TAG        | DEFICIENCY)                             |           | DATE            |  |
| \$483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:  (i) The initial goals of the resident.  (ii) A summary of the resident's medications and dietary instructions.  (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.  (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The  |  |   | ,                                |        |            |   |           |                 |  |
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| acting on behalf of the facility.  (iv) Any updated information based on the details of the comprehensive care plan, as necessary.  Based on observation, record review, and interview, the facility failed to ensure a baseline care plan was developed and implemented that included an assistive device within 48 hours of admission for 1 of 19 residents reviewed for care plans. (Resident 97)  Finding includes:  On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Plans (Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23, included the resident's Baseline Care Plans. The  |  | (iii) Any services                      | and treatments to be             |        |            |   |           |                 |  |
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| regarding implementing baseline care plans for assistive devices.  DHS/Designee will audit baseline care plans weekly for assistive devices of six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The  |  |   |                                  |        |            |   |           |                 |  |
| Finding includes:  Care plans for assistive devices.  DHS/Designee will audit baseline care plans weekly for assistive devices for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The   |  | printer (resident)                      | ,                                |        |            |   | ine       |                 |  |
| On 11/27/23 at 11:37 a.m. and 11/28/23 at 1:00 p.m., Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The  |  | Finding includes:                       |                                  |        |            | care plans for assistive device         | s.        |                 |  |
| Resident 97 was observed wearing a back brace.  Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The   |  | On 11/27/23 at 11-3                     | 37 a m. and 11/28/23 at 1:00 n m |        |            | _                                       |           |                 |  |
| Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The   |  |   | -                                |        |            | •                                       | ,         |                 |  |
| Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The   |  | 1 | a maning a such state.           |        |            | l ·                                     | )         |                 |  |
| 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The  |  | Record review for I                     | Resident 97 was completed on     |        |            | 1 .                                     |           |                 |  |
| the facility on 11/20/23.  An Admission Observation Form, dated 11/20/23, included the resident's Baseline Care Plans. The   |  |   | -                                |        |            | 1 · · · · · · · · · · · · · · · · · · · |           |                 |  |
| included the resident's Baseline Care Plans. The   |  | the facility on 11/20                   | 0/23.                            |        |            | _                                       |           |                 |  |
| included the resident's Baseline Care Plans. The   |  |   |                                  |        |            |   |           |                 |  |
|  |  |   |                                  |        |            |   |           |                 |  |
| L Aggistiza Daviga gaption in diagtad the maidant  |  |   |                                  |        |            |   |           |                 |  |
|  |  |   |                                  |        |            |   |           |                 |  |
| did not have a brace or a splint. There was not a  |  |   |                                  |        |            |   |           |                 |  |
| baseline care plan put into place related to the resident's back brace.  |  |   |                                  |        |            |   |           |                 |  |

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Interview with LPN 1 on 11/28/23 at 1:16 p.m.,

Event ID:

XTC711 Facility ID: 012766

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | onstruction<br><u>00</u> | (X3) DATE SURVEY COMPLETED 12/04/2023  |                      |
|--|--|---|--------------------------|--|----------------------|
|  | PROVIDER OR SUPPLIER<br>SPRINGS HEALTH   |   | 2400 S                   | ADDRESS, CITY, STATE, ZIP COD<br>SILHAVY ROAD<br>ARAISO, IN 46383  |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   | (X5) COMPLETION DATE |
| F 0684<br>SS=D<br>Bldg. 00   | with the back brace documentation to in the back brace was 3.1-30(a)  483.25 Quality of Care § 483.25 Quality of Quality of care is a applies to all treat facility residents. Ecomprehensive as facility must ensur treatment and care professional stand comprehensive peand the residents' Based on observation interview, the facil received the necessarelated to the lack of for a wound treatmer reviewed for non-proper a back brace for 1 opositioning and lim (Residents 102 and Findings include:  1. On 11/27/23 at 1 observed sitting in a room. The resident elbow. There was was not legible.  On 11/28/23 at 11:0 observed sitting in a served sitting | of care a fundamental principle that ment and care provided to Based on the Basessment of a resident, the re that residents receive re in accordance with Bards of practice, the reson-centered care plan, choices. The provided to ensure residents resure treatment and services of Physician's Orders in place rest for 1 of 2 residents ressure skin conditions and for of 3 residents reviewed for ited range of motion. | F 0684                   | Residents 97 and 102 are no longer in the facility. Other residents were audited for treatment orders for non-pression conditions, and braces with no concerns identified. Nurses will receive in-service regarding obtaining orders for non-pressure skin conditions, abraces. DHS/Designee will audit three residents weekly for treatment orders for non-pressure skin conditions, and braces for six months, then quarterly thereaf until 100% compliance is achieved. QAPI to make changand/or recommendations as needed. | and                  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION      |       |                       | (X3) DATE SURVEY   |       |            |
|--|--|---------------------------------|-------|-----------------------|--|-------|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER           | A. BU | A. BUILDING <u>00</u> |  |       | ETED       |
|  |  | 155795                          | B. W  | ING                   |  | 12/04 | /2023      |
|  |  |                                 |       |                       |  |       |            |
| NAME OF I  | PROVIDER OR SUPPLIEF   | ₹                               |       |                       | ADDRESS, CITY, STATE, ZIP COD  |       |            |
| 43 (44 64  | 00000000000  | L CAMPUS                        |       |                       | LHAVY ROAD   |       |            |
| AVALON   | SPRINGS HEALTI   | H CAMPUS                        |       | VALPAI                | RAISO, IN 46383  |       |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | TC    | COMPLETION |
| TAG  | REGULATORY OF  | R LSC IDENTIFYING INFORMATION   |       | TAG                   | DEFICIENCY)  | 16    | DATE       |
|  | dated 11/27/23. He indicated he had fallen a while   |                                 |       |                       |  |       |            |
|  | ago and had been w   | vearing a bandage to his elbow  |       |                       |  |       |            |
|  | since then. The nurses changed the bandage   |                                 |       |                       |  |       |            |
|  | "once in a while."   |                                 |       |                       |  |       |            |
|  |  |                                 |       |                       |  |       |            |
|  | Record review for Resident 102 was completed on  |                                 |       |                       |  |       |            |
|  | 11/28/23 at 11:03 a  | .m.                             |       |                       |  |       |            |
|  |  |                                 |       |                       |  |       |            |
|  |  | ervation Form, dated 11/17/23,  |       |                       |  |       |            |
|  |  | ent had no skin issues noted to |       |                       |  |       |            |
|  | the right elbow.   |                                 |       |                       |  |       |            |
|  |  |                                 |       |                       |  |       |            |
|  |  | f documentation to indicate     |       |                       |  |       |            |
|  |  | tion was or what caused it.     |       |                       |  |       |            |
|  | · ·  | ysician's Order in place for a  |       |                       |  |       |            |
|  | _  | ht elbow that included how      |       |                       |  |       |            |
|  | often the bandage v  | vas to be changed.              |       |                       |  |       |            |
|  | 1  | 11 11/20/22 4 11 00             |       |                       |  |       |            |
|  |  | V 1 on 11/28/23 at 11:08 a.m.,  |       |                       |  |       |            |
|  |  | ent had a scabbed area to his   |       |                       |  |       |            |
|  | _  | ous fall. She had changed the   |       |                       |  |       |            |
|  |  | yesterday. The bandage had      |       |                       |  |       |            |
|  |  | ultiple days prior to changing  |       |                       |  |       |            |
|  |  | current Physician's Order for a |       |                       |  |       |            |
|  | treatment to the are   | a to his elbow.                 |       |                       |  |       |            |
|  | 2 On 11/27/22 of 1   | 11:37 a.m., Resident 97 was     |       |                       |  |       |            |
|  |  | a wheelchair in the Therapy     |       |                       |  |       |            |
|  | _  | esident had a back brace in     |       |                       |  |       |            |
|  | place.   | esident had a back brace in     |       |                       |  |       |            |
|  | piace.   |                                 |       |                       |  |       |            |
|  | On 11/28/23 at 1:00  | 0 p.m., Resident 97 was         |       |                       |  |       |            |
|  |  | a wheelchair in her room. The   |       |                       |  |       |            |
|  | _  | ng a back brace. The back       |       |                       |  |       |            |
|  |  | -                               |       |                       |  |       |            |
|  | brace was wrapped around her waist and had straps that came over her shoulders. The straps |                                 |       |                       |  |       |            |
|  | _  | were not buckled to the waist.  |       |                       |  |       |            |
|  |  | ted she had fallen and          |       |                       |  |       |            |
|  |  | and now had to wear the back    |       |                       |  |       |            |
|  |  | She indicated she needed help   |       |                       |  |       |            |
|  | orace an the time.   | one mateated she heeded help    | 1     |                       |  |       | 1          |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795 |   | A. BU   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |              |   | (X3) DATE SURVEY COMPLETED 12/04/2023 |                    |
|--|---|---|--|--------------|---|---------------------------------------|--------------------|
|  | PROVIDER OR SUPPLIEF  |   |  | 2400 SII     | DDRESS, CITY, STATE, ZIP COD<br>LHAVY ROAD<br>RAISO, IN 46383                                     |                                       |                    |
| (X4) ID<br>PREFIX  |   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE                                    | (X5)<br>COMPLETION |
| TAG  |   | R LSC IDENTIFYING INFORMATION   |  | TAG          | DEFICIENCY)   |                                       | DATE               |
|  |   | cing it off. Sometimes the staff it on and take it off.   |  |              |   |                                       |                    |
|  | Record review for Resident 97 was completed on 11/28/23 at 1:03 p.m. The resident was admitted to the facility on 11/20/23. |   |  |              |   |                                       |                    |
|  | indicated the reside<br>for rehab after a T6<br>resident had a TLS0   | dated 11/24/23 at 7:43 a.m., nt was admitted to the facility compression fracture. The O Sacral-Orthosis)brace.   |  |              |   |                                       |                    |
|  |   | herapy Note, dated 11/24/23,<br>nt was to have the TLSO brace   |  |              |   |                                       |                    |
|  | Physician's Order w<br>that included when   | documentation to indicate a vas in place for the back brace, the resident was supposed to needed assistance to apply it   |  |              |   |                                       |                    |
|  | indicated the reside<br>with the back brace<br>to wear the brace at<br>The resident needed<br>taking it off. She w          | If 1 on 11/28/23 at 1:16 p.m., nt was admitted to the facility. The resident was supposed by time she was out of bed. If assistance putting it on and was unaware there was not a place for the back brace and een one. |  |              |   |                                       |                    |
|  | 3.1-37(a)   |   |  |              |   |                                       |                    |
| F 0692<br>SS=D<br>Bldg. 00   | §483.25(g) Assist<br>(Includes naso-ga<br>tubes, both percu   | n Status Maintenance<br>ed nutrition and hydration.<br>estric and gastrostomy<br>taneous endoscopic<br>percutaneous endoscopic  |  |              |   |                                       |                    |

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| STATEMEN  | T OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA                                 | (X2) M | ULTIPLE CO | ONSTRUCTION   | (X3) DATE SURVEY |            |
|-----------|----------------------|--|--------|------------|---|------------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER                                      | A. BU  | JILDING    | 00  | COMPL            | LETED      |
|           |                      | 155795   | B. W   | ING _      |   | 12/04            | /2023      |
|           |                      |  |        | STREET     | ADDRESS, CITY, STATE, ZIP COD                                       | <u> </u>         |            |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹  |        |            | ILHAVY ROAD   |                  |            |
| Δ\/ΔΙ ΩΝ  | SPRINGS HEALTI       | H CAMPUS   |        |            | RAISO, IN 46383   |                  |            |
| AVALON    | OF KINGO FIEAETI     | TI OAWII 00  |        | VALIA      |   |                  |            |
| (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 | ATE              | COMPLETION |
| TAG       | REGULATORY OF        | R LSC IDENTIFYING INFORMATION                              |        | TAG        | DEFICIENCY)   |                  | DATE       |
|           |                      | enteral fluids). Based on a                                |        |            |   |                  |            |
|           | · ·                  | hensive assessment, the                                    |        |            |   |                  |            |
|           | facility must ensur  | re that a resident-  |        |            |   |                  |            |
|           |                      |  |        |            |   |                  |            |
|           |                      | intains acceptable   |        |            |   |                  |            |
|           | •                    | ritional status, such as                                   |        |            |   |                  |            |
|           | , ,                  | t or desirable body weight                                 |        |            |   |                  |            |
|           |                      | lyte balance, unless the                                   |        |            |   |                  |            |
|           |                      | condition demonstrates                                     |        |            |   |                  |            |
|           | that this is not pos |  |        |            |   |                  |            |
|           | preferences indica   | ate otherwise;   |        |            |   |                  |            |
|           | \$400.05(m)(0) la a  | fformal cufficient fluid intoles                           |        |            |   |                  |            |
|           |                      | offered sufficient fluid intake<br>r hydration and health; |        |            |   |                  |            |
|           | to maintain prope    | i flydrauoff and fleatiff,                                 |        |            |   |                  |            |
|           | 8483 25(a)(3) ls o   | offered a therapeutic diet                                 |        |            |   |                  |            |
|           |                      | utritional problem and the                                 |        |            |   |                  |            |
|           |                      | ler orders a therapeutic diet.                             |        |            |   |                  |            |
|           |                      | view and interview, the facility                           | F 0    | 692        | Resident 42 weight loss was   |                  | 12/29/2023 |
|           |                      | d consumption logs were                                    |        | 0,2        | related to edema/diuretic use.                                      |                  | 12/29/2025 |
|           |                      | ents with a history of weight                              |        |            | No other residents had a nega                                       |                  |            |
|           |                      | ents reviewed for nutrition.                               |        |            | outcome related to this deficie                                     |                  |            |
|           | (Resident 42)        |  |        |            | Staff will receive in-service                                       | ,                |            |
|           |                      |  |        |            | regarding documenting meal  |                  |            |
|           | Finding includes:    |  |        |            | consumption accurately and  |                  |            |
|           |                      |  |        |            | consistently.   |                  |            |
|           |                      | dent 42 was reviewed on                                    |        |            | DHS/Designee will audit three                                       | <del>;</del>     |            |
|           |                      | m. Diagnoses included, but were                            |        |            | residents twice weekly for me                                       | al               |            |
|           | not limited to, cong | estive heart failure and atrial                            |        |            | consumption covering all mea  | ls for           |            |
|           | fibrillation.        |  |        |            | six months, then quarterly  |                  |            |
|           |                      |  |        |            | thereafter until 100% complian                                      | nce              |            |
|           |                      | nimum Data Set (MDS)                                       |        |            | is achieved. QAPI to make   |                  |            |
|           |                      | 0/23/23, indicated the resident                            |        |            | changes and/or recommenda   | tions            |            |
|           |                      | paired and required supervision                            |        |            | as needed.  |                  |            |
|           | with eating.         |  |        |            |   |                  |            |
|           | The model 1          | ad 200 manuada am 10/26/22 1                               |        |            |   |                  |            |
|           | _                    | ed 200 pounds on 10/26/23 and                              |        |            |   |                  |            |
|           | 183 pounds on 11/2   | 20/23.   |        |            |   |                  |            |
|           | A Registered Dietic  | cian Note, dated 11/21/23,                                 |        |            |   |                  |            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | onstruction 00      | (X3) DATE SURVEY COMPLETED 12/04/2023   |   |
|--|--|---|---------------------|---|---|
|  | PROVIDER OR SUPPLIER   |   | 2400 S              | ADDRESS, CITY, STATE, ZIP COD<br>SILHAVY ROAD<br>ARAISO, IN 46383   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | (X5) COMPLETION DATE                        |
| IAU  |  | nt had a significant weight   | TAU                 |   | DATE  |
|  | lacked documentation - Breakfast on 11/2/11/20/23 Lunch on 11/2/23, and 11/24/23 Dinner on 11/2/23 11/8/23, 11/9/23, 11/21/23, 11/24/23, 11/27/23.  Interview with the Eat 10:09 a.m., indicate were incomplete. The with their electronic incomplete.   | on of the following meals: 723, 11/9/23, 11/11/23, and 711/9/23, 11/11/23, 11/20/23, 11/5/23, 11/6/23, 11/7/23, 11/10/23, 11/12/23, 11/12/23, 11/25/23, 11/26/23, and Evening Supervisor on 12/1/23 ated the food consumption logs there had been some trouble a charting program recording mes. She was unable to documentation. |                     |   |   |
| F 9999   |  |   |                     |   |   |
| Bldg. 00   | including alcoholic concentrates, and the as ordered by the shall be supervised follows:  (8) Per required nee administered only ulicensed nurse or phnurse or physician response to the concentration of the concentration | ion of drugs and treatments, beverages, nutrition terapeutic supplements, shall attending physician and by a licensed nurse as and (PRN) medications may be upon authorization of a mysician. All contacts with a mot on the premises for minister PRNs shall be  | F 9999              | Resident 4 had no negative outcome related to this deficier No other residents had a negatioutcome related to this deficier QMAs and nurses will receive in-service regarding obtaining a documenting prior authorization QMAs to administer PRN medications.  DHS/Designee will audit 3 receive weekly for nurse authorization QMA to administer PRN medications for six months, the | tive<br>ncy.<br>and<br>n for<br>ords<br>for |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795 |   | A. BU  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |              |   | (X3) DATE SURVEY COMPLETED 12/04/2023 |                    |
|--|---|--|--|--------------|---|---------------------------------------|--------------------|
|  | PROVIDER OR SUPPLIEI  |  |  | 2400 SI      | ADDRESS, CITY, STATE, ZIP COD<br>ILHAVY ROAD<br>RAISO, IN 46383   |                                       |                    |
| (X4) ID<br>PREFIX  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                                    | (X5)<br>COMPLETION |
| TAG  | documented in the   | R LSC IDENTIFYING INFORMATION nursing notes indicating the   |  | TAG          | quarterly thereafter until 100%   |                                       | DATE               |
|  | time and date of the contact.  This State rule was not met as evidenced by:   |  |  |              | compliance is achieved. QAPI make changes and/or recommendations as needed.                             | το                                    |                    |
|  | failed to ensure a Q<br>Aide) received prio<br>nurse before admin<br>medication to a res  | wiew and interview, the facility MA (Qualified Medication or authorization from a licensed istering a PRN (as needed) ident for 1 of 5 residents essary medications. (Resident   |  |              |   |                                       |                    |
|  | Finding includes:   |  |  |              |   |                                       |                    |
|  |   | was reviewed on 11/30/23 at es included, but were not limited d anxiety disorder.  |  |              |   |                                       |                    |
|  | indicated an order to hydrocodone-aceta   | der Summary, dated 11/2023,<br>For<br>minophen (a narcotic pain<br>5 mg (milligrams) every 6 hours   |  |              |   |                                       |                    |
|  | dated 11/2023, indi<br>hydrocodone-aceta<br>p.m. by QMA 5, 11<br>and 11/6/23 at 8:34<br>EMAR (electronic<br>record) notes or do<br>Nurse had assessed | Iministration Record (MAR), cated the resident was given minophen on 11/4/23 at 8:38 at 7:09 p.m. by QMA 5, a.m. by QMA 6. There were no medication administration cumentation to indicate a the resident or given minister the PRN medications. |  |              |   |                                       |                    |
|  | at 10:09 a.m., indic<br>to get authorization<br>medications and co  | Evening Supervisor on 12/1/23 ated the QMAs were supposed from the Nurse for any PRN mplete an observation in the urse to cosign. She was unable   |  |              |   |                                       |                    |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155795   | X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   |   | (X3) DATE SURVEY  COMPLETED  12/04/2023 |                            |
|--------------------------|--|---|---|---|---|---|----------------------------|
|                          | ROVIDER OR SUPPLIER  |   |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>2400 SILHAVY ROAD<br>VALPARAISO, IN 46383 |   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION er documentation.  |   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                              | TE                                      | (X5)<br>COMPLETION<br>DATE |
| R 0000<br>Bldg. 00       | Survey. This visit in<br>State Licensure Sur<br>Survey dates: Nove<br>December 1, 4, 202<br>Facility number: 01<br>Residential Census:   | ember 27, 28, 29, 30 and 3.  12766  52  | R 00  | 000   | /b>   |   |                            |
| R 0246<br>Bldg. 00       | Quality review com  410 IAC 16.2-5-4( Health Services - (6) PRN medication a qualified medical authorization by a physician. The QN authorization for e PRN medication. Aphysician not on the authorization to act documented in the time and date Based on record revialled to ensure qual (QMAs) received an nurse or physician process. | pleted on 12/7/23.  e)(6) Deficiency ons may be administered by tion aide (QMA) only upon licensed nurse or MA must receive appropriate ach administration of a All contacts with a nurse or the premises for dminister PRNs shall be en ursing notes indicating of the contact. Friew and interview, the facility lified medication aides athorization from a licensed orior to giving as needed (prn) for records reviewed. | R 02  | 246   | ="" b=""> ="" span=""> Preparation of execution of thi plan of correction does not constitute admission or agree of provider of the truth of the fa | ment                                    | 12/29/2023                 |

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|   | AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795   |  | A. Bl   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING   |  | (X3) DATE SURVEY COMPLETED 12/04/2023 |                    |
|---|---|--|---|--|--|---------------------------------------|--------------------|
| NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS |   |  | STREET ADDRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383 |  |  |                                       |                    |
| (X4) ID<br>PREFIX   | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |   | IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | λΤΕ.                                  | (X5)<br>COMPLETION |
| TAG   | Findings include:  1. Record review for Resident 2 was completed on 12/1/22 at 10/21 a.m. Diagnosce included but  |  |   | TAG  | alleged or conclusions set for                 | DATE                                  |                    |
|   |   |  |   | the Statement of Deficiencies. The Plan of Correction is prepared a executed solely because it is                          |  |                                       |                    |
|   |   |  |   |  |  | -ll                                   |                    |
|   | 12/1/23 at 10:31 a.m. Diagnoses included, but were not limited to, pain and anemia.   |  |   | required by the position of Feder<br>and State Law. The Plan of<br>Correction is submitted in order                        |  |                                       |                    |
|   |   |  |   |  |  |                                       |                    |
|   | The November 2023 Physician's Order Summary   |  |   |  | respond to the allegation of                   |                                       |                    |
|   | (POS) indicated an order for acetaminophen  |  |   |  | noncompliance cited during a                   |                                       |                    |
|   | (pain/fever reducer) 650 mg (milligrams) every 4  |  |   |  | Recertification and State                      |                                       |                    |
|   | hours prn.  |  |   |  | Licensure Survey on 12/4/2023.                 |                                       |                    |
|   |   |  |   |  | Please accept this plan of                     |                                       |                    |
|   | The November 2023 Medication Administration   |  |   |  | correction as the provider's                   |                                       |                    |
|   | Record (MAR) indicated the prn acetaminophen  |  |   |  | credible allegation of complian                |                                       |                    |
|   | was administered by a QMA on the following date   |  |   |  | Due to scope and severity of the               |                                       |                    |
|   | and time:   |  |   |  | deficiencies, Avalon Springs                   |                                       |                    |
|   | - 11/16/23 at 3:48 a.m., for back pain. Administered  |  |   |  | Health Campus is requesting  Paper Compliance. |                                       |                    |
|   | by QMA 4.   |  |   |  | Residents 2, 4, and 8 had no                   |                                       |                    |
|   | There was a lack of documentation to indicate the   |  |   |  | negative outcome related to the                | nis                                   |                    |
|   |   | authorization from a licensed            |   |  | deficiency.                                    |                                       |                    |
|   | nurse or physician prior to administering the medication.   |  |   |  | No other residents had a nega                  | ative                                 |                    |
|   |   |  |   |  | outcome related to this                        |                                       |                    |
|   |   |  |   |  | deficiency.                                    |                                       |                    |
|   | Interview with the Director of Nursing (DON) on 12/1/23 at 1:55 p.m., indicated she could not provide any documentation the QMA had received prior authorization before administering the resident the prn acetaminophen.  2. Record review for Resident 8 was completed on 12/1/23 at 1:12 p.m. Diagnoses included, but were |  |   |  | QMAs and nurses will receive                   |                                       |                    |
|   |   |  |   |  | in-service regarding obtaining                 |                                       |                    |
|   |   |  |   |  | documenting prior authorization                | on for                                |                    |
|   |   |  |   |  | QMAs to administer PRN                         |                                       |                    |
|   |   |  |   |  | medications.  DHS/Designee will audit 3 rec    | ords                                  |                    |
|   |   |  |   |  | weekly for nurse authorization                 | for                                   |                    |
|   |   |  |   |  | QMA to administer PRN                          |                                       |                    |
|   | not limited to, lung cancer and osteoarthritis.   |  |   | medications for six months, then quarterly thereafter until 100%   |  |                                       |                    |
|   | The October 2023 POS indicated an order for oxycodone-aceteminophen (narcotic pain  |  |   |  | compliance is achieved. QAP                    |                                       |                    |
|   |   |  |   |  | make changes and/or                            |                                       |                    |
|   | medication) 7.5-325 mg every 6 hours prn.   |  |   |  | recommendations as needed.                     |                                       |                    |
|   | The October 2023 I<br>Record (MAR) indi   | Medication Administration icated the prn |   |  |  |                                       |                    |

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|   |   | IDENTIFICATION NUMBER  155795  |   | JILDING             |                                     |  | COMPLETED 12/04/2023       |  |
|---|---|--|---|---------------------|-------------------------------------|--|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS |   |  | STREET ADDRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383 |                     |                                     |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  |  |   | ID<br>PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIATE |  | (X5)<br>COMPLETION<br>DATE |  |
|   | QMA on the follow - 10/27/23 at 5:05 p - 10/27/23 at 5:05 p - 10/28/23 at 5:21 a - 10/28/23 at 7:17 a QMA 1 11/30/23 at 1:46 a - 11/31/23 at 7:25 a  The November 202: - lorazepam (for any (prefilled syringe) e - lorazepam 2 mg/m prn - morphine (narcotive give 10 mg every 2  The November 202: Record (MAR) indiverse and - 11/2/23 at 2:37 a.m - 11/2/23 at 1:03 p.m mg by QMA 1 11/2/23 at 1:13 p 4 11/3/23 at 11:13 p 4 11/3/23 at 11:13 p - 11/4/23 at 11:13 a - 11/4/23 at 11:13 a - 11/4/23 at 11:29 p - 11/5/23 at 9:54 a.m  There was a lack of QMAs had received | p.m., by QMA 2m., by QMA 2. a.m., and 6:00 p.m., by QMA 1m., 1:30 p.m., and 7:20 p.m., by .m., by QMA 2m., by QMA 2m., by QMA 3. 3 POS indicated orders for: xiety) 0.25 ml (milliliters) PFS very 2 hours prn al, administer 1 mg every 1 hour c pain medication) 100 mg/5 ml; hours prn 3 Medication Administration cated the prn lorazepam and dministered by QMAs on the |   |                     |                                     |  |                            |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795    | r í                                       | ultiple construction<br>jilding <u>00</u><br>ing |   | (X3) DATE SURVEY  COMPLETED  12/04/2023 |            |
|--|--|--|---|--|---|---|------------|
| NAME OF PROVIDER OR SUPPLIER                     |  |  |   |  | ADDRESS, CITY, STATE, ZIP COD   |   |            |
| AVALON SPRINGS HEALTH CAMPUS                     |  |  | 2400 SILHAVY ROAD<br>VALPARAISO, IN 46383 |  |   |   |            |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL                         |  | ID  |  | PROVIDER'S PLAN OF CORRECTION   | (X5)                                    |            |
| PREFIX   |  |  |   | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE                                      | COMPLETION |
| TAG  |  | REGULATORY OR LSC IDENTIFYING INFORMATION                  |   | TAG  | DEFICIENC!  |   | DATE       |
|  | Interview with the Evening Supervisor on 12/1/23 at 2:38 p.m., indicated she could not provide any |  |   |  |   |   |            |
|  |  | QMAs had received prior                                    |   |  |   |   |            |
|  | authorization before administering the resident the  |  |   |  |   |   |            |
|  | PRN medications.   |  |   |  |   |   |            |
|  | 3. Resident 4's record was reviewed on 12/4/23 at  |  |   |  |   |   |            |
|  | _  | s included, but were not limited                           |   |  |   |   |            |
|  | to, hypertension and mood disorder.  |  |   |  |   |   |            |
|  | The Physician's Order Summary, dated 11/2023,  |  |   |  |   |   |            |
|  | indicated orders for   | hydrocodone-acetaminophen                                  |   |  |   |   |            |
|  |  | dication) 5-325 mg (milligrams)                            |   |  |   |   |            |
|  | 1  | (as needed), morphine (a                                   |   |  |   |   |            |
|  | _  | eation) 20 mg/ml (milliliter) 5 mg                         |   |  |   |   |            |
|  | 1  | , and lorazepam (an anti-anxiety                           |   |  |   |   |            |
|  | medication) 2 mg/n   | nl 0.5 mg every 2 hours PRN.                               |   |  |   |   |            |
|  | The Medication Ad  | ministration Record (MAR),                                 |   |  |   |   |            |
|  |  | cated the resident was given                               |   |  |   |   |            |
|  | hydrocodone-acetai   | minophen on 11/17/23 at 12:03                              |   |  |   |   |            |
|  | p.m. by QMA 3. Sl  | he received the lorazepam on                               |   |  |   |   |            |
|  | _  | n. by QMA 5 and 11/23/23 at                                |   |  |   |   |            |
|  |  | 5. She was given the morphine                              |   |  |   |   |            |
|  |  | p.m. by QMA 7, 11/10/23 at 5:39                            |   |  |   |   |            |
|  |  | /15/23 at 9:18 p.m. by QMA 7, m. by QMA 5, and 11/23/23 at |   |  |   |   |            |
|  | _  | 5. There were no EMAR                                      |   |  |   |   |            |
|  |  | ion administration record)                                 |   |  |   |   |            |
|  |  | tion to indicate a Nurse had                               |   |  |   |   |            |
|  | assessed the resider   | nt or given authorization to                               |   |  |   |   |            |
|  | administer the PRN   | medications.   |   |  |   |   |            |
|  | Interview with the l   | Evening Supervisor on 12/1/23                              |   |  |   |   |            |
|  |  | ated the QMAs were supposed                                |   |  |   |   |            |
|  | _  | from the Nurse for any PRN                                 |   |  |   |   |            |
|  |  | mplete an observation in the                               |   |  |   |   |            |
|  | computer for the Nurse to cosign. She was unable   |  |   |  |   |   |            |
|  | to provide any further documentation.  |  |   |  |   |   |            |

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