STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  12/20/2023	
	PROVIDER OR SUPPLIEI SPRINGS HEALTI		STREET ADDRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
E 0000	REGULATORY OF	R LSC IDENTIFTING INFORMATION	IAG		DATE
Bldg					
		paredness Survey was ndiana Department of Health in CFR 483.73.	E 0000		
	Survey Date: 12/20/23				
	Facility Number: 0 Provider Number: AIM Number: 201	155795			
	Springs Health Car compliance with En Requirements for M	Preparedness survey, Avalon npus was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR			
	The facility has 61 the survey, the cens	certified beds. At the time of sus was 52.			
	Quality Review con	mpleted on 12/21/23			
E 0039 SS=F Bldg	441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), § 485.625(d)(2), § (2), §491.12(d)(2) *[For ASCs at §47]	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)			
		020, RHCs/FQHCs at			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE	TITLE	(X6) DATE

Crystal Wray **Executive Director** 01/05/2024

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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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155795 B. WING		UILDING	NSTRUCTION	(X3) DATE COMPL 12/20/	ETED	
	PROVIDER OR SUPPLIEF			2400 SII	DDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION RD Facilities at §494.62]:		TAG	BERGERCH		DATE
	(2) Testing. The [f exercises to test the annually. The [fact following:  (i) Participate in a community-based (A) When a community-based (B) If the [fact natural or man-matural or man-man-matural or man-matural or m	facility] must conduct the emergency plan fility] must do all of the  full-scale exercise that is levery 2 years; or munity-based exercise is muct a facility-based e every 2 years; or fility] experiences an actual ade emergency that requires mergency plan, the [facility] agaging in its next required for individual, facility-based e following the onset of the  ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) s conducted, that may limited to the following: scale exercise that is or individual, facility-based e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a					
	to challenge an er (iii) Analyze the [fa maintain documer exercises, and em	pared questions designed mergency plan. acility's] response to and ntation of all drills, tabletop mergency events, and revise ergency plan, as needed.					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED
		155795	B. W	ING		12/20/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			LHAVY ROAD		
Δ\/ΔΙ ΩΝ	SPRINGS HEALTI	H CAMPUS			RAISO, IN 46383		
		11 0, tivii 00		V/ (L1 / ()			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	*[For Hospices at						
	. , ,	spices that provide care in					
	the patient's home. The hospice must						
		s to test the emergency					
	1 '	ally. The hospice must do					
	the following:						
		a full-scale exercise that is					
	community based						
	1 ' '	nunity based exercise is not					
		exercise every 2 years; or					
		experiences a natural or					
	1 ' '	ency that requires activation					
	_	plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
	I	ctional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	1 ' '	e year the full-scale or					
		e under paragraph (d)(2)(i)					
		conducted, that may					
		limited to the following:					
	(A) A second full-	scale exercise that is					
	community-based	or a facility based					
	functional exercise	e; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er	mergency plan.					
	/a\ <b>-</b>						
	` '	spices that provide inpatient					
		hospice must conduct					
		he emergency plan twice					
	1 ' '	spice must do the following:					
	(I) Participate in a 	an annual full-scale exercise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795				ILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIP COD 2400 SILHAVY ROAD VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	EIATE	(X5) COMPLETION DATE
	that is community (A) When a commaccessible, condu- facility-based functional exercise emergency event (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercis (B) A mock disas (C) A tabletop ex facilitator that inclusing a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the hemaintain document exercises, and enthe hospice's emergency second the hospice's emergency plan. (iii) Analyze the hemaintain document exercises, and enthe hospice's emergency plan. (iii) Analyze the hemaintain document exercises, and enthe hospice's emergency plan. (iii) Analyze the hemaintain document exercises, and enthe hospice's emergency plan. (III) Analyze the hemaintain document exercises, and enthe hospice's emergency plan. (III) Analyze the hemaintain document exercises, and enthe hospice's emergency plan. (III) Analyze the hemaintain document exercises, and enthe hospice's emergency plan.  *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per year CAH] must do the	chased; or nunity-based exercise is not nunity-based exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the diditional annual exercise but is not limited to the escale exercise that is for a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem red messages, or prepared ed to challenge an espice's response to and nation of all drills, tabletop nergency events and revise ergency plan, as needed.  441.184(d), Hospitals at at \$485.625(d):] PRTF, Hospital, CAH] must at to test the emergency ar. The [PRTF, Hospital,					
	that is community (A) When a comm	-based; or nunity-based exercise is not					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155795	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIEF			2400 SI	ADDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	facility-based fund (B) If the [PRTF, Fan actual natural of that requires active plan, the [facility] is next required from individual, facility following the onsequence (ii) Conduct a exercise or and the limited to the following the onsequence (A) A second full-community-based facility-based fund (B) A monomorphism (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem start messages, or present to challenge an error (iii) Analyze the and maintain document to the facilitate (C) Testing. The Foundate exercises plan at least annuorganization must (i) Participate in a that is community.	rescale exercise that is or individual, a stional exercise; or lock disaster drill; or or exercise or workshop that for and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. The [facility's] response to sumentation of all drills, and emergency events cility's] emergency plan, as \$60.84(d):]  PACE organization must a to test the emergency ally. The PACE and annual full-scale exercise					

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accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the PACE experiences an actual natural

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED
		155795	B. WING		12/20/2023
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
				ILHAVY ROAD	
AVALON	SPRINGS HEALTI	H CAMPUS	VALPA	RAISO, IN 46383	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ergency that requires			
		mergency plan, the PACE			
	is exempt from engaging in its next required				
		nity based or individual,			
	I	ctional exercise following the			
	onset of the emer				
	l ' '	n additional exercise every			
		the year the full-scale or			
		e under paragraph (d)(2)(i)			
		conducted that may include,			
	but is not limited t				
	. ,	-scale exercise that is			
		l or individual, a facility			
	based functional e				
	(B) A mock disas				
	1 ' '	ercise or workshop that is			
	· ·	and includes a group			
	discussion, using				
	1	emergency scenario, and a			
	set of problem sta	pared questions designed			
	to challenge an e				
	_	PACE's response to and			
	1 ' '	ntation of all drills, tabletop			
		nergency events and revise			
		gency plan, as needed.			
	ine PACE Semen	gency pian, as needed.			
	*[For LTC Facilitie	es at §483.73(d):1			
	_	ity] must conduct exercises			
		ency plan at least twice per			
		announced staff drills using			
	1 -	ocedures. The [LTC facility,			
	ICF/IID] must do t				
	_	an annual full-scale exercise			
	that is community				
		nunity-based exercise is not			
	1 ' '	ıct an annual individual,			
	facility-based fund				
		cility] facility experiences an			

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actual natural or man-made emergency that

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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  12/20/2023	
	PROVIDER OR SUPPLIER			2400 SII	DDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	IOULD BE COMPLETION	
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		n of the emergency plan, the mpt from engaging its next					
		ile community-based or					
	l '	based functional exercise					
		et of the emergency event.					
	(ii) Conduct an a	dditional annual exercise					
		but is not limited to the					
	following:						
	` '	scale exercise that is					
		or an individual, facility					
	based functional (B) A mock disas	•					
	` '						
	(C) A tabletop exercise or workshop that is led by a facilitator includes a group						
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
	messages, or pre	pared questions designed					
	to challenge an er	mergency plan.					
		LTC facility] facility's					
	l '	naintain documentation of					
		exercises, and emergency					
		e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	· /-					
	, , <u> </u>	CF/IID must conduct					
		he emergency plan at least					
	following:	e ICF/IID must do the					
		n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ıct an annual individual,					
	I -	ctional exercise; or. experiences an actual					
	` '	experiences an actual ade emergency that requires					
		mergency plan, the ICF/IID					
		igaging in its next required					
		nity-based or individual,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	<del></del>	COMPL	ETED
		155795	B. W	ING		12/20/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			LHAVY ROAD		
۸\/۸۱	SPRINGS HEALTH	L CAMPUS					
AVALON	SPRINGS HEALTI	1 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 CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based fund	tional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct an additional annual exercise						
	that may include,	but is not limited to the					
	following:						
	(A) A second full-s	scale exercise that is					
	community-based						
	1	ctional exercise; or					
	(B) A mock disast						
	1 ' '	ercise or workshop that is					
		and includes a group					
	discussion, using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	1 ' '	CF/IID's response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the ICF/IID's emei	rgency plan, as needed.					
	*r= 1111A 1046	14.4001					
	*[For HHAs at §48	=					
		e HHA must conduct					
		he emergency plan at					
		e HHA must do the					
	following:	full cools avenues that is					
		full-scale exercise that is					
	community-based						
		ommunity-based exercise conduct an annual					
		based functional exercise					
	I	pased fullctional exercise					
	every 2 years; or.	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
		itional exercise following the					
	onset of the emer	_					
		ditional exercise every 2					
		ullional exercise every 2					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795				JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIEF		•	2400 SI	ADDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IATE	DATE
	years, opposite the functional exercises of this section is continued, but is not (A) A second community-based facility-based function (B) A mock describing the facility-based facility-based function (B) A mock describing the facility-based function (B) A mock describing the facility-based function (B) A mock describing the facility-based function (B) A tableton is led by a facilitate discussion, using clinically-relevant set of problem state messages, or present to challenge an erection (iii) Analyze the H maintain documere exercises, and entitle the HHA's emergen (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency plant actual natural or mergency discussion (PO) is exempt for required testing exemption of the emergency (ii) Analyze the Ol maintain documer	e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan.  HA's response to and nation of all drills, tabletop mergency events, and revise ency plan, as needed.  36.360]  a OPO must conduct the emergency plan. The following: er-based, tabletop exercise est annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of its, directed messages, or its designed to challenge and the OPO experiences and man-made emergency plan, the ome engaging in its next exercise following the onset					

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	LETED
		155795	B. W	NG		12/20	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R		2400 SILHAVY ROAD			
AVAI ON	SPRINGS HEALTI	-I CAMPUS		VALPARAISO, IN 46383			
	T				1		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	_	OPO's] emergency plan, as					
	needed.						
	*C DNOLU+ 0404	7.401					
	*[ RNCHIs at §403	=					
		e RNHCI must conduct					
		he emergency plan. The					
	RNHCI must do th	_					
		er-based, tabletop exercise					
	-	A tabletop exercise is a					
		led by a facilitator, using a					
		y-relevant emergency					
	· ·	et of problem statements,					
	_	s, or prepared questions					
	_	enge an emergency plan.					
		NHCI's response to and					
		ntation of all tabletop					
		nergency events, and revise					
		rgency plan, as needed.	I E O	20	Dranaration of avacution of thi	_	01/07/2024
		view and interview, the facility tercises to test the emergency	E 00	J39	Preparation of execution of thi	S	01/07/2024
	plan at least twice p				plan of correction does not	mont	
	-	drills using the emergency			constitute admission or agreer of provider of the truth of the fa		
		C facility must do the			alleged or conclusions set fort		
	following:	Claemty must do the			the Statement of Deficiencies.		
	_	annual full-scale exercise that			Plan of Correction is prepared		
	is community-based				executed solely because it is	and	
	_	ity-based exercise is not			required by the position of Fed	leral	
		an annual individual,			and State Law. The Plan of		
	facility-based funct				Correction is submitted in order	er to	
		y experiences an actual natural			respond to the allegation of		
		gency that requires activation			noncompliance cited during a	Life	
		lan, the LTC facility is exempt			Safety Code Recertification ar		
		ext required full-scale in a			State Licensure Emergency		
		or individual, facility-based			Preparedness Survey on		
	-	l exercise for 1 year following			12/20/2023. Please accept this	S	
	the onset of the actu	-			plan of correction as the provide		
	(ii) Conduct an add	itional exercise that may			credible allegation of complian		
		imited to the following:			Due to scope and severity of t		

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a. A second full-scale exercise that is

community-based or an individual, facility-based

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deficiencies, Avalon Springs

Health Campus is requesting

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

PRINTED: 01/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155795		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  12/20/2023	
	PROVIDER OR SUPPLIER		2400 S	ADDRESS, CITY, STATE, ZIP COD SILHAVY ROAD ARAISO, IN 46383	
AVALON  (X4) ID  PREFIX  TAG	SUMMARY SEACH DEFICIEN REGULATORY OR functional exercise. b. A mock disaster of c. A tabletop exercifacilitator that incluse a narrated, clinically and a set of problem messages, or preparchallenge an emerge (iii) Analyze the LT maintain documentate exercises, and emer LTC facility's emergaccordance with 42 deficient practice confirmed the Astoperations (ADPO) a.m. and 11:30 a.m. exercise and exercise the past year were in not show if the facil ensure the EPP poli interview at the time Director was only a what the events occ exercises, however after-action reports later confirmed the hazardous material disaster event, were	drill; or se or workshop that is led by a des a group discussion, using y-relevant emergency scenario, a statements, directed ed questions designed to ency plan. To facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This buld affect all occupants.  Wiew with the Executive sistant Director of Plant on 12/20/23 between 08:53, both the community-based se of choice conducted within encomplete. Both exercises did dity's response was analyzed to cries were effective. Based on e of observation, the Executive ble to produce emails detailing turred and details about the they agreed that no were produced or created. She two exercises, one of spill and another chemical the only exercises conducted			offect  Interest a steed a steed a with sing steed a steed a with sing steed a
K 0000	within the last year.  Findings were discurbing and ADPO	ussed with the Executive			

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	IT OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/20/2023	
	PROVIDER OR SUPPLIER			2400 SI	ADDRESS, CITY, STATE, ZIP COD LHAVY ROAD RAISO, IN 46383			
			I	ID			(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	3	(X5) COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	DATE	
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR		K 00	000				
	483.90(a).  Survey Date: 12/20	0/23						
	Facility Number: 0 Provider Number: AIM Number: 2010	155795						
	Health Campus was Requirements for Pa Medicare/Medicaid Life Safety from Fin National Fire Protec Life Safety Code (L	Code survey, Avalon Springs found not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2.						
	Type V (111) constr The facility has a fir detection in the corr corridors, and hard resident rooms. The consists of five wing the facility containe	ity was determined to be of ruction and fully sprinklered. The alarm system with smoke ridors, spaces open to the wired smoke detectors in all the Health Campus building the Health Campus building the 100, 200, and 300 wings. The apacity of 61 and had a census this visit.						
	were sprinklered an							

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		-
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01		COMPLETED		
		155795	B. WING		12/20	/2023	
			CTREET	ADDRESS, CITY, STATE, ZIP COD			_
NAME OF I	PROVIDER OR SUPPLIER	₹		SILHAVY ROAD			
AVALON	SPRINGS HEALTH	H CAMPUS		RAISO, IN 46383			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	ION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			DATE	_
K 0324	NFPA 101						
SS=E	Cooking Facilities						
Bldg. 01	Cooking Facilities						
	Cooking equipme	nt is protected in					
	accordance with N	NFPA 96, Standard for					
	Ventilation Contro	l and Fire Protection of					
	Commercial Cook	ing Operations, unless:					
	* residential cooki	ng equipment (i.e., small					
		is microwaves, hot plates,					
	1 ' '	I for food warming or limited					
	cooking in accord	ance with 18.3.2.5.2,					
	19.3.2.5.2						
	* cooking facilities	open to the corridor in					
	_	ents with 30 or fewer					
	•	rith the conditions under					
	18.3.2.5.3, 19.3.2						
	l '	in smoke compartments					
	_	atients comply with					
		18.3.2.5.4, 19.3.2.5.4.					
		protected according to					
		3 are not required to be					
		rdous areas, but shall not					
	be open to the cor						
	•	1 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
		on, record review and	K 0324	No residents were affected.		01/07/2024	
	interview, the facility failed to maintain 1 of 1			This deficient practice could at			
	kitchen commercial	cooking equipment in		approximately all kitchen staff			
	accordance with NI	FPA 96, Standard for		10 residents who use the adja			
	Ventilation Control	and Fire Protection of		dining room. The kitchen			
	Commercial Cookii	ng Operations (2011) as required		suppression system which was	S		
		Safety Code (2012), Section		due for a 12-year hydrostatic t			
	1 -	ection 10.2.6 states that		had the test completed on			
		guishing systems shall be		12/28/2023 with no issues not	ed.		
		nce with the terms of their		Executive Director/designee			
		cturer's instructions, and		inserviced Plant Operations or	า		
	NFPA 17A(09), Sta	andard for Wet Chemical		importance of reading the			
	Extinguishing Syste	ems where applicable. This		bi-annual Kitchen Suppression	1		

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Extinguishing Systems where applicable. This deficient practice could affect approximately all

kitchen staff and 10 residents who use the

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System Inspections, and following

up on any stated tests that may

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
		155795	B. WI	B. WING		12/20/2023	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				LHAVY ROAD		
AVALON SPRINGS HEALTH CAMPUS					RAISO, IN 46383		
AVALON SI KINGS FILALITI CAIVII 03				Ц	, 11 10000		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	
TAG		LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	adjacent dining room	n.			be due.		
	E' 1' ' 1 1				Director of Plant		
	Findings include:				Operations/Designee will bring	)	
	D 1 1	the state of the state of			these inspections to QAPI to		
		riew with the Assistant			review and make	0	
	-	perations (ADPO) on 12/20/23			recommendations as needed 2		
		and 11:33 a.m., The Kitchen			months or until 100% compliar	ice	
		n Inspection dated 09/21/23 en suppression system was			is achieved.		
		drostatic test. This was also					
		n Suppression System					
		20/23. An email was produced					
	•	company stating that the					
	_	s scheduled for next week at					
	-	nterview with the ADPO					
		w, he stated he was unaware if					
	-	occurred and was able to					
	contact the inspection company during the						
	survey. The inspection company stated that the						
		d they have not conducted it					
	_	on their schedule for next					
	week. The ADPO then confirmed and agreed that the hydrostatic testing has not been completed.  Findings were discussed with the ADPO and Executive Director at exit conference.  3.1-19(b)						
K 0353	NFPA 101						
SS=F	· ·	- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
	•	er and standpipe systems					
		ted, and maintained in					
		IFPA 25, Standard for the					
	Inspection, Testing, and Maintaining of						
		Protection Systems.					
	Records of system design, maintenance,						
	•	ting are maintained in a					
	secure location an	id readily available.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE :			TE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> CC		COMPI	COMPLETED	
		155795	B. W	B. WING		12/20/2023		
				CERTE	ADDRESS STEV STATE STR SOD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
AVALON ORDINGO LIFALTU CAMBUO					ILHAVY ROAD			
AVALON SPRINGS HEALTH CAMPUS				VALPA	RAISO, IN 46383			
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	a) Date sprinkler	system last checked						
	, .	•						
	b) Who provided	system test						
	, .	•						
	c) Water system	supply source						
	, ,	,						
	Provide in REMAI	RKS information on						
		non-required or partial						
	automatic sprinkle							
	9.7.5, 9.7.7, 9.7.8							
	Based on record review and interview, the facility		K 0	353	No residents were affected.		01/07/2024	
		ıll hydrostatic flush was			This deficient practice could a	ffect		
		automatic sprinkler piping			all residents, as well as staff a			
	•	nternally inspected as required			visitors in the facility. Paperwo			
	by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter				was received from Dustin Med			
					the VP of Fire and Sprinkler at			
					SafeCare which stated,"there			
		evention. Section 14.3.2			was not sufficient rust or debri			
		all be examined for internal			build up in the 3 fire sprinkler	•		
		conditions exist that could			systems to require a sprinkler			
		ping. Section 14.3.3, states if			flush", from the five-year intern	nal		
		stigation indicates the			pipe inspection completed on July			
		ent material to obstruct pipe or			27th, 2022.	· · · · ·		
	•	ete flushing program shall be			Executive Director/designee			
		fied personnel. Section 14.3.1			inserviced Plant Operations or	n		
		on has not been corrected or			importance of having follow up			
	the condition is one that could result in obstruction of piping despite any previous				documentation to any sprinkle			
					pipe inspection.	•		
		s that have been performed,			Plant Operations will bring any	,		
		examined internally for			new sprinkler pipe inspections			
		5 years. This deficient			completed to QAPI for review			
		et all residents, as well as staff			recommendations as needed			
	and visitors in the f				months or until 100% complian			
	and visitors in the r				is achieved.	100		
	Findings include:				lo dolliovod.			
	i manigo merade.							
	Based on record rev	view with the Assistant						
	Director of Plant Operations (ADPO) on 12/20/23 between 08:53 a.m. and 11:30 a.m., the Internal							
		ort titled "Sprinkler: Five Year						
	1 the makeding teh	on thick sprinkler. The real					İ	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED			
15		155795	B. WI	. WING		12/20/	12/20/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER	8			LHAVY ROAD			
AVALON	SPRINGS HEALTH	H CAMPUS		VALPAF	RAISO, IN 46383			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
		etion" dated 07/27/22 stated						
		"found some rust in the 2-1/2"						
		se clear of rust" and system #2						
		ıle rust in branch line,						
		ouring record review, the ADPO						
	_	eport results and was unaware						
		d to be done or already						
		aring the survey, the Director						
	of Plant Operations	(DPO) was able to be						
		as able to provide pictures and						
	a "work performed" document from the sprinkler							
	company. The DPO	continued to state that the						
	sprinkler company had originally stated that they							
	were to send a quot	e for a flush to be done on the						
	two systems. Howe	ver, the sprinkler company						
	decided that a flush	was not necessary.						
	Documentation from	n the DPO did not confirm or						
	state that a flush wa	s not necessary. Based on						
	interview, the DPO stated that the documentation							
	given to the survey is what he was able to obtain.							
	He further stated that he could not find anything							
	that said a flush was not required or the problem							
	has been resolved. Both the DPO and ADPO							
	confirmed that SafeCare indicated further work							
	was required.							
	This C. 1:	idid-db ADDOd						
	1	viewed with the ADPO and						
	Executive Director at the exit conference.							
	3-1.19(b)							
	I		1		I		ı	

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