| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155795 | A. Building<br>B. Wing | 06/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avalon Springs Health Campus | 2400 Silhavy Road<br>Valparaiso, IN 46383 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>20580<br><br>Based on record review and interview, the facility failed to follow up on a notification of a change of condition with a resident's physician, for 1 of 4 residents reviewed for physician notification. (Resident F)<br><br>Finding includes:<br><br>Resident F's record was reviewed on 6/12/24 at 10:36 a.m. The diagnoses included, but were not limited to, stroke and cellulitis.<br><br>A Nurse's Progress Note, dated 5/8/24 (Wednesday) at 3:57 p.m., indicated 2+ left lower leg edema and 1+ right lower leg edema. The resident had gained 2.5 pounds in two days. The resident stated he usually took an extra dose of Lasix (diuretic) when edema was present. The physician was faxed the assessment information and the resident and family were notified and would be updated when the physician responded to the notification.<br><br>There was no documentation that indicated the physician had responded to the fax sent to him on 5/8/24 at 3:57 p.m. and there was no follow up phone call with the condition changes.<br><br>A Nurse's Progress Note, dated 5/9/24 at 5:51 a.m., indicated the resident complained of wheezing. Wheezing was heard in the posterior bilateral lobes of the lung. He denied a cough, shortness of breath, or chest pain. There were no signs and symptoms of respiratory distress. His oxygen saturation was 97%. A fax was sent to the physician.<br><br>A Skilled Charting Progress Note, dated 5/9/24 at 9 p.m., indicated the resident had 4+ left lower leg edema and 3+ right lower leg edema. His breath sounds were clear.<br><br>There had been no documentation which indicated the physician had responded to the faxes sent to him on 5/8/24 and 5/9/24 and there was no follow up phone call with the condition changes.<br><br>A Nurse's Progress Note, dated 5/10/24 at 3:07 a.m., indicated there was no wheezing in the lungs and the edema of the right and left lower legs continued. The facility was still waiting on a response from the fax to the physician.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Physician's Progress Note, dated 5/10/24 at 8:54 p.m., indicated the Physician assessed the resident due to the edema that was secondary to congestive heart failure and was associated with the weeping of fluid from the legs. There was no acute distress and the lungs were clear. There was at least 3+ edema of the bilateral lower legs. The Lasix was increased to 80 mg (milligrams) daily for three days and potassium 40 milliequivalents daily was ordered for three days. The physician indicated the other medications the resident was possibly contributing to the edema.<br><br>During an interview on 6/12/24 at 3:37 p.m., the Director of Nursing indicated she was unable to find further information of when or if the physician responded to the faxed condition change notifications.<br><br>A provider notification policy, dated 9/12/17 and received as current from the RN Corporate Nurse, indicated during non-office hour times, the nurse was to notify the provider by phone if physician intervention was needed. The provider was to be notified by phone if there was an immediate need. If the provider was paged, a call back was expected to be within 15 minutes to one hour depending on the severity of the concern. If the facility was unable to reach the primary provider, the Medical Director was to be notified. If there had been no response to a fax by the provider within 12 hours, the nurse on duty was to call the physician.<br><br>3.1-5(a)(2) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>20580<br><br>Based on observation, record review, and interview, the facility failed to care for peripherally inserted central catheter (PICC line - long catheter inserted through a peripheral vein for intravenous treatments) in accordance with professional standards of practice, related to lack of measurement of the catheter length and arm circumference above the site, dressing changes to the sites, assessments of the site, and flushes of the catheters, for 3 of 3 residents with PICC lines. (Residents E, F, and C)<br><br>Findings include:<br><br>1. During an observation on 6/12/24 at 10:55 a.m., LPN 1 prepared and administered Resident E's antibiotic of piperacillan tazobactam 3.3555mg in 50 cc's (cubic centimeters) of 0.9% normal saline (NS). LPN 1 indicated she would use a 0.9% NS flush for the right upper arm PICC line lumen prior to the administration of the antibiotic. LPN 1 cleaned the PICC line's needleless connector with an alcohol prep pad, unclamped the PICC line lumen, and flushed the lumen with 10 cc's of 0.9% NS. She indicated she used 10 cc's of the NS for the flush. The IV (intravenous) antibiotic medication was then administered per the Physician's Orders.<br><br>During an observation on 6/12/24 at 11:37 a.m., LPN 1 indicated the IV antibiotic had been infused and she would be flushing the PICC line lumen with 5 cc's of heparin (blood thinner) and another 10 cc's of 0.9% NS. She then removed the IV tubing from the PICC line lumen and covered the end of the tubing with a cap. She then wiped the PICC line's needleless connector with an alcohol prep pad and administered the 5 cc's of heparin and then 10 cc's of 0.9% NS.<br><br>Resident E's record was reviewed on 6/13/24 at 10:39 a.m. The diagnoses included, but were not limited to, Right leg cellulitis.<br><br>A Nursing Admission Assessment Observation form, dated 6/6/24 at 6:17 p.m., indicated the resident had an intact cognitive status and there was no IV/central line present.<br><br>A Nurse's Progress Note, dated 6/6/24 at 6:29 p.m., indicated the resident arrived at the facility from the hospital with right leg cellulitis and had physician's orders for two IV antibiotics.<br><br>The Nursing Admission Assessment Observation and Admission Nurse's Progress Note, both dated 6/6/24, had not documentation the resident had a PICC line and there was no assessment of the PICC line insertion site, measurement of the PICC line catheter, and the right arm circumference.<br><br>A Nurse's Progress Note, dated 6/7/24 at 5:48 a.m., indicated the there was a double lumen PICC line present and both ports had been flushed with blood returned.<br><br>There was no assessment of the PICC line insertion site, measurement of the PICC Line Catheter, and the right arm circumference. The Nurse's Progress Note had not indicated where the double lumen PICC line was located.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The admission Physician's Orders, dated 6/6/24, indicated the PICC line site was to be monitored for signs and symptoms of infiltration every shift, and the PICC lumens were to be flushed with 5 cc's of normal saline before and after the antibiotic administration.<br><br>Physician's Orders, dated 6/12/24, indicated the PICC Line dressing change was to be completed every five days and the external catheter length was to be measured and documented. The right arm circumference was to be measured with the PICC line dressing change.<br><br>A Care Plan, dated 6/10/24 and revised on 6/12/24, indicated a right upper extremity IV was present for antibiotic therapy. The interventions indicated, complications from the IV would be assessed - infection, dislodgement, infiltration, phlebitis, fluid overload, dehydration, air embolus, electrolyte imbalance, IV insertion site care would be completed as ordered, the PICC site would be observed for swelling, redness, tenderness, and warmth, and the medication/flushes would be administered as ordered.<br><br>The Medication Administration Record, dated 6/2024, indicated the first measurement of the PICC line length and right arm circumference was completed on 6/12/24 on the day shift.<br><br>During an interview on 6/12/24 at 11 a.m., LPN 1 indicated she had flushed the PICC lumen with 10 cc's of NS and the ordered was for 5 cc's of NS.<br><br>During an interview on 6/13/24 at 11:22 a.m., the Director of Nursing (DON) indicated she was unable to locate an assessment of the PICC line insertion, dressing, catheter length, and arm circumference upon admission into the facility.<br><br>2. During an observation on 6/13/24 at 8:37 a.m., LPN 2 entered Resident F's room to provide care to the PICC line, located in the resident's right upper arm, after the administration of the IV antibiotic. She flushed the PICC line lumen with 5 cc's of 0.9% NS then 5 cc's of heparin, followed with 5 cc's of NS.<br><br>Resident F's record was reviewed on 6/12/24 at 10:36 a.m. The diagnoses included, but were not limited to, stroke and cellulitis.<br><br>An Admission MDS (Minimum Data Set) assessment, dated 5/2/24, indicated a moderately impaired cognitive status, no antibiotics, and no IV's or IV medication.<br><br>A Nurse's Progress Note, dated 5/28/24 at 4:33 p.m., indicated the resident had returned from a hospital leave of absence and had a PICC line in the right upper arm. He was diagnosed with cellulitis and was to receive vancomycin through the PICC line every 18 hours for four weeks.<br><br>A Care Plan, dated 5/29/24, indicated a PICC line was present. The interventions included, the Physician would be notified an any complication, complications from the IV would be assessed every shift and as needed for infection, electrolyte imbalance, air embolus, dislodgement, infiltration, phlebitis, fluid overload, and dehydration, PICC line site care would be completed as ordered, the PICC site would be assessed for swelling, redness, tenderness, and warmth, and the medication/flushes would be administered as ordered by the Physician.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | There was no documented assessment of the PICC site, length of the catheter, and arm circumference upon admission.<br><br>The Physician's Orders, dated 5/29/24, included the PICC dressing change was to be completed every five days and the external catheter length was to be measured with the dressing change.<br><br>The Medication Administration Record, dated 6/2024, indicated the PICC dressing had been changed on 6/2/24. There was no measurement of the catheter length. The dressing change and measurement of the catheter length on 6/7/24 had not been completed and was documented as not administered/not previously done for the reason the change had not occurred.<br><br>There were no measurements of the right arm circumference in the Nurses' Progress Notes and the Medication Administration Record from 5/29/24 through 6/12/24.<br><br>During an interview on 6/12/24 at 12:15 p.m., the DON was made aware of the concerns of the dressing changes not completed, assessments of the PICC catheter length and arm circumference not not assessed.<br><br>During an interview on 6/12/24 at 3:37 p.m., the DON indicated she was unable to find further information in regard to the concerns.<br><br>3. Resident C's closed record was reviewed on 6/12/24 at 1:42 p.m. The diagnoses included, but were not limited to, infection to a surgical site.<br><br>An Admission Observation and Assessment, dated 4/11/24 at 4 p.m., indicated a PICC line was present and the dressing was dry and intact.<br><br>A Nurse's Progress Note, dated 4/11/24 at 7:13 p.m., indicated the resident arrived at the facility by ambulance, was oriented to the room, call light, medications, and meal times.<br><br>There was no location of the PICC line, assessment of the site, measurement of the external catheter, or measurement of the arm circumference documented on the assessment or in the Admission Progress Notes.<br><br>A Physician's Order, dated 4/11/24, indicated the PICC line dressing change was to be completed every five days and as needed.<br><br>A Care Plan, dated 4/12/24, indicated IV medication was required. The interventions indicated the physician would be notified if there were complications, assessments every shift and as needed would be completed for complications of infection, electrolyte imbalance, air embolus, dislodgement, infiltration, phlebitis, fluid overload, and dehydration. The IV site care would be completed as ordered by the physician, the IV site would be assessed for swelling, redness, tenderness, and warmth, and the the medications and flushes would be administered as ordered.<br><br>An Admission MDS assessment, dated 4/14/24, indicated an intact cognitive status, received and antibiotic, had IV medications and an IV access.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The MAR, dated 4/2024, indicated the PICC dressing change was scheduled on 4/12/24, 4/17/24, 4/22/24, and 4/27/24. The MAR indicated the dressing was changed on on 4/12/24, 4/17/24, and 4/27/24. The length of the catheter was not measured on 4/17/24 and 4/27/24. The arm circumference was not measured on 4/12/24, 4/17/24, and 4/27/24. The MAR indicated the dressing had not been completed on 4/22/24 because it had been completed on 4/21/24. There was no documentation that indicated the dressing change had been completed or the external catheter and arm circumference was measured on 4/21/24 on the MAR dated 4/2024 and in the Nurses' Progress Notes, dated 4/21//24.<br><br>The MAR, dated 4/2024, indicated the PICC line site had not been assessed for swelling, redness, tenderness, and warmth from 4/11/14 through 4/27/24.<br><br>During an interview on 6/12/24 at 3:33 p.m., the DON indicated she was unable to locate any further information on the PICC line care and dressing change.<br><br>During the Exit Conference on 6/13/24 at 4:14 p.m., the DON indicated she was unable to find any further information on the PICC line care for Residents E, F, and C.<br><br>The facility policy for infusion therapy, dated 12/2015 and received as current from the Employee Experience Manager, indicated the upper arm circumference should be measured on admission and monitored for swelling possibly caused by infiltration. The external catheter length should be monitored on admission and with each dressing change for outward migration of the catheter.<br><br>This citation relates to Complaint IN00434520.<br><br>3.1-47(a)(2) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>20580<br><br>Based on observation, interview, and record review, the facility failed to ensure staff were aware of which residents were in Enhanced Barrier Precautions (EBP), failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 3 and LPN 2) when providing care to a resident who was in EBP, and failed to ensure staff removed soiled gloves and washed hands after touching contaminated surfaces, for 1 of 3 residents observed for infection control and EBP (Resident F) This had the potential to affect 2 residents with PICC lines (peripherally inserted central catheter - long catheter inserted through a peripheral vein for intravenous treatments). (Residents E and F).<br><br>Findings include:<br><br>1. During the initial tour of Hall 100 on 6/12/24 at 8:49 a.m., LPN 1 indicated Residents E and F had PICC lines in place. There were no signs on the entry doors to Resident E and F's rooms that indicated the residents were on EBP. There was no cart outside the rooms that indicated the resident's were on EBP.<br><br>During an interview on 6/12/24 at 9 a.m., Resident Care Associate 4 indicated she was not a CNA and could only make beds, pass ice waters, and other non-resident care duties. She stated she was trained by a CNA to wear gloves when changing the beds and only use gowns if the resident was in isolation. She was unsure about EBP precautions.<br><br>During an interview on 6/12/24 at 9:05 a.m., CNA 5, indicated if a resident was on EBP, there would be a sign on the door and an isolation cart outside the door. The sign on the door would tell staff to contact the nurse before entering.<br><br>During an interview and observation on 6/12/24 at 9:09 a.m., CNA 3 indicated if a resident was on EBP they would have a sign on their door. The staff were to don a gown and gloves for residents with IV's, catheters, and wounds. She indicated she had received education on EBP. CNA 3 then answered the Resident F's call light. Resident F was in the bathroom sitting on the toilet. CNA 3 donned gloves and stood next to the toilet to assist the resident. CNA 3 was stopped and asked about EBP and she indicated the resident had a PICC. She removed the gloves and went to the closet for a gown and indicated no one had restocked the gowns. She then left the room and brought a packet of gowns to the room and placed in the closet, donned the gown and gloves and assisted the resident with the care.<br><br>During an interview on 6/12/24 at 9:15 a.m., the LPN Infection Control Nurse indicated there were suppose to be signs on the resident's doors that indicated they were in EBP. The gowns, gloves, and masks were to be kept in the closet of each resident. She indicated there were no signs on Resident E and F's doors.<br><br>During an interview 6/12/24 at 9:45 a.m., the LPN Infection Control Nurse indicated she had not had an all staff education on EBP. She had completed education during, staff huddles (hallway meetings). She had not had staff sign their names to indicate the education had been completed.<br><br>a) During an observation on 6/12/24 at 11:37 a.m., Resident E was observed with a PICC line inserted into the right upper arm.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident E's record was reviewed on 6/13/24 at 10:39 a.m. The diagnoses included, but were not limited to, Right leg cellulitis.<br><br>A Nurse's Progress Note, dated 6/6/24 at 6:29 p.m., indicated the resident arrived at the facility from the hospital with right leg cellulitis and had physician's orders for two IV antibiotics.<br><br>A Care Plan, dated 6/10/24, indicated EBP was required related to a PICC line being present. The interventions included, hand hygiene would be performed before and after care. A gown and gloves were to be used during indwelling device care (PICC) and all high contact care.<br><br>b) During an observation on 6/12/24 at 10:33 a.m., Resident F was observed with a PICC line inserted in his right upper arm.<br><br>Resident F's record was reviewed on 6/12/24 at 10:36 a.m. The diagnoses included, but were not limited to, stroke and cellulitis.<br><br>A Nurses Progress Note, dated 5/28/24 at 4:33 p.m., indicated the resident had returned from a hospital leave of absence and had a PICC line in the right upper arm. He was diagnosed with cellulitis and was to receive vancomycin (antibiotic) through the PICC line every 18 hours for four weeks.<br><br>A Care Plan, dated 5/29/24, indicated EBP was required related to a PICC line was present. The interventions included, hand hygiene would be performed before and after care. A gown and gloves were to be used during indwelling device care (PICC) and all high contact care.<br><br>2. During an observation on 6/13/24 at 8:37 a.m., LPN 2 entered Resident's F's room to tend to the PICC line. The antibiotic administered through the PICC line had been completed, needed to be unhooked, and the PICC line flushed. There was a sign on the entry door that indicated the resident was on EBP.<br><br>LPN 2 washed her hands and donned gloves, prepared the normal saline and heparin flushes and started to initiate care and was stopped and she was asked about EBP. She indicated the resident was on EBP and stopped the PICC line care. She removed her gloves, washed her hands, donned a gown, mask, and new gloves. Prior to initiating the flushes, she picked up the trash can in the room, and pushed a gown that had been thrown away down into the the trash can, and moved the trash can next to her. She then started to pick up the normal saline flush syringe and was stopped prior to initiating the care. She acknowledged she should have changed gloves and washed her hands. LPN proceeded to remove gloves, washed her hands, and donned new gloves prior to the PICC care being initiated.<br><br>An enhanced barrier precautions policy, dated 4/1/24, and received from the LPN Infection Control Nurse as current, indicated PPE was to be used even if blood and body fluid exposure was not anticipated. Staff were to wear gloves and gowns during high-contact care activities. EBP was to be used for residents with central lines and any indwelling medical device.<br><br>A facility handwashing policy, dated 2/9/17, and received as current from the Corporate RN, indicated all health care workers were to utilize hand hygiene frequently and appropriately and were to complete hand hygiene after removing gloves and after resident equipment was touched.<br><br>This citation relates to Complaint IN00434520.<br><br>(continued on next page) |

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