STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Springs Health Campus	2400 Silhavy Road 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review and interview, the facility failed to ensure infection control measures were in place and implemented related to appropriate signage posted during a respiratory outbreak, lack of monitoring for a resident that was COVID-19 positive and lack of COVID-19 testing for a symptomatic resident for 2 of 3 residents reviewed for infection control and random infection control observations. (Residents 19 and 44)Findings include:1.On 1/8/26 at 8:35 a.m., the entrance to the facility was observed. There was no signage posted that indicated there was currently a respiratory outbreak in the facility and listed current precautions such as masking was optional or available. During the initial tour of the facility, there were resident rooms observed to have droplet precautions signs and PPE (personal protective equipment) bins outside the rooms. The staff indicated the residents on precautions had tested positive for COVID-19. The positive residents resided on the 100 and 300 halls. There was no signage that indicated those halls had a respiratory outbreak. During an interview on 1/9/26 at 2:22 p.m., the Director of Nursing indicated current infection control precautions were to make masks available, but not required, to visitors and residents. There were signs on the COVID + rooms that instructed visitors to see the nurse before entering. She indicated they did not have signs up advising visitors there was an outbreak in the facility. During an interview on 1/9/26 at 2:27 p.m., the Nurse Consultant indicated there was a sign at the entrance that indicated if visitors had signs or symptoms of the flu, they should wear a mask or defer visiting. She indicated the flu and COVID had similar respiratory symptoms. The Executive Director indicated there were signs on the COVID + rooms that instructed visitors to see the nurse before entering and posting anything elsewhere wasn't required. The facility policy, COVID-19 Identification and Management, approved date 1/7/26, indicated, .General Campus Operating Procedures. The campus will post visual alerts at the entrance and in strategic places throughout the campus. Alerts will provide information on current IPC (infection prevention control) recommendations CDC (Center for Disease Control) guidelines were retrieved on 1/9/26 from https://www.cdc.gov/covid/hcp/infection-control/index.html and indicated, .Establish a Process to Identify and Manage Individuals with Suspected or Confirmed SARS-CoV Infection. Ensure everyone is aware of recommended IPC practices in the facility. Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations 2. Resident 19's record was reviewed on 1/12/26 at 9:47 a.m. Diagnoses included, but were not (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	limited to, hypertension, congestive heart failure, and atrial fibrillation. A Progress Note, dated 1/7/26 at 4:38 p.m., indicated the resident was re-admitted from the hospital and had tested positive for COVID-19 while in the hospital. A Physician's Order, dated 1/8/26, indicated the resident was on contact and droplet precautions due to being COVID positive. The Medication Administration Record and Treatment Administration Record, dated 1/2026, lacked any documentation of assessment and monitoring of COVID symptoms or vital signs. The Vital Signs tab indicated the resident's vital signs had been recorded only on 1/7/26 at 5:14 p.m. and 1/11/26 at 8:02 p.m. During an interview on 1/12/26 at 11:25 a.m., the Infection Preventionist indicated COVID positive residents should be assessed once per shift/twice a day. There should have been an order in place for monitoring symptoms and checking vital signs twice a day. 3. Resident 44's record was reviewed on 1/14/26 at 9:45 a.m. Diagnoses included, but were not limited to, dementia and stroke. The admission Minimum Data Set (MDS) assessment, dated 12/13/25, indicated the resident was moderately cognitively impaired. A Physician's Order, dated 12/10/25, indicated COVID testing per current state and federal requirements, may test as needed (PRN) if resident has symptoms. A Physician's Order, dated 1/1/26, indicated the resident was in contact precautions. A Progress Note, dated 1/1/26 at 7:24 p.m., indicated the resident had rhonchi to the lung bases and a slight expiratory wheeze, no shortness of breath. The resident did not appear to be in distress. The resident stated that he had coughed up white mucous. The resident remained in contact isolation for Clostridium difficile (gastrointestinal infection, also known as c.diff). The daughter was at the bedside. The Nurse Practitioner was updated, and new orders were received for a complete blood count (CBC) and basic metabolic panel (BMP), chest x-ray in the morning, and DuoNeb nebulizer treatments every 4 hours as needed for shortness of breath and wheezing. A Point of Care (POC) Antigen COVID-19 test was completed on 1/1/26 with negative results. A Point of Care (POC) Influenza test was completed on 1/1/26 with negative results. A Progress Note, dated 1/2/26 at 6:56 a.m., indicated the resident had rhonchi, a tight congested cough and diminished breath sounds. A Progress Note, dated 1/3/26 at 4:30 p.m., indicated the resident's daughter voiced concerns about sleepiness and possible pneumonia/sepsis. The resident had coarse lung sounds with expiratory wheezes, worse on the right side. New orders were placed for doxycycline (antibiotic) 100 milligrams twice daily for 7 days and 1 liter 0.45% normal saline at 60 milliliters per hour. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The chest x-ray was completed on 1/3/26 and was positive for pneumonia. A Nurse Practitioner Progress Note, dated 1/8/26 at 4:19 p.m., indicated the resident was seen for a follow-up with active c.diff infection and pneumonia. The resident had upper rhonchi lung sounds. A Progress Note, dated 1/10/26 at 3:58 p.m., indicated the resident had a non-productive cough and the lung sounds remained diminished/clear. He continued to be in contact isolation for c.diff infection. A Progress Note, dated 1/12/26 at 6:05 p.m., indicated the resident's family member called and indicated she had tested positive for COVID-19 and had been visiting with the resident recently. The resident was tested for COVID-19 and was positive with no symptoms at the time. New orders were received for Lagevrio (antiviral drug) and droplet precautions. During an interview on 1/14/26 at 12:27 p.m., the Infection Prevention (IP) Nurse Manager indicated they would normally test the resident again for COVID-19 in 48 hours if they had symptoms, however since he was being treated for pneumonia, they did not do another test because he was already on precautions. She indicated that he was only on contact precautions because he was positive for c.diff and was not on droplet precautions. The resident was symptomatic when he tested positive for COVID-19 on 1/12/26 and he had only been tested because his family who had recently visited called and indicated the family member had tested positive for COVID-19. The IP Nurse Manager indicated it was protocol to test again in 48 hours only if symptomatic. The resident was symptomatic and should have been tested again after the initial negative COVID test. A Facility Policy, revised on 6/5/23 and titled, COVID-19 Identification and Management, indicated, .Symptomatic Residents Being Evaluated for COVID-19 Infection.If using a POC (antigen test), a negative result should be confirmed by either a negative PCR test or second negative POC test taken 48 hours after the first negative test. Resident should remain in TBP until second negative test is confirmed. 3.1-18(b)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to ensure complete and accurate information was included in Indiana Department of Health (IDOH) Reportable Incidents related to abuse allegations for 2 of 3 IDOH Reportable Incidents reviewed. (Residents 11 and 42)Findings include:1.During an interview on 1/9/26 at 11:07 a.m., Resident 11 indicated a staff member had been rude and mean to her. She indicated she did not recall who the staff member was but that she had reported it to another staff member. The resident's record was reviewed on 1/9/26 at 1:20 p.m. Diagnoses included, but were not limited to, hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following a cerebral infarction and dysphagia. The Significant Change Minimum Data Set assessment, dated 1/3/26, indicated the resident had moderate cognitive impairment. An IDOH Reportable Incident, dated 9/26/25, indicated the resident's family had reported a concern with care. The resident was assessed and no injury was noted. An investigation was initiated. Other residents who resided on the same hall were interviewed by Social Services and reported feeling safe and denied concerns with care. The Follow Up report indicated the resident continued with her usual routine, there were no concerns of psychosocial changes. A urine analysis had been completed, and the resident was found to have a urinary tract infection and currently on antibiotic therapy. Abuse could not be substantiated. There was no indication in the Reportable Incident what the concern with care had been and did not identify an abuse allegation was made. During an interview on 1/13/26 at 11:31 a.m., the Director of Nursing (DON) indicated the resident had reported someone had kicked her in the leg. The resident was unable to say if it was a staff member or another resident. She had been assessed for injury, and none was noted. The DON indicated they had been instructed to keep Reportable Incidents generic. She indicated she understood the need to accurately document the details of future IDOH Reportable Incidents. 2. On 1/9/26 at 1:22 p.m. a list of facility reportable incidents, received from the Administrator, indicated Resident 42 had reported a care concern on 7/24/25. An Indiana Department of Health (IDOH) Reportable Incident, dated 7/24/25 at 11:01 a.m., indicated Resident 42 had voiced concerns related to care. A head-to-toe assessment of the resident had been completed, and bruises had been found on her left forearm and right elbow. A CNA had been suspended pending investigation. The follow up report indicated the resident's bruises were determined to be from bumping her arms on her wheelchair while reaching for items. Other residents on the same hall had been interviewed and had no concerns. The resident had no further concerns with care. There was lack of any documentation to indicate what the resident's care concerns were or if there was any allegation of abuse. During an interview on 1/13/26 at 11:38 a.m., the Director of Nursing indicated the resident had made an allegation that the CNA was rough with care during a transfer. The actual allegation was not described in the IDOH reportable. They had worded it as a care concern as a general description of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation instead of documenting the exact allegation. A facility policy, titled Abuse and Neglect Procedural Guidelines, indicated, .f. Investigation .vi. Providing complete & thorough documentation of the investigation . 3.1-28(c)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview, the facility failed to ensure fall interventions were in place for a resident with a history of falls for 1 of 1 residents reviewed for accidents. (Resident 6)Finding includes:On 1/9//26 at 9:40 a.m., Resident 6's room was observed. There was a standard size bed placed in the middle of the room with the headboard against the wall. On the right side of the bed, there was an oxygen concentrator between the bed and the wall. The resident was seated in a Broda chair near the nurse's station.The resident's record was reviewed on 1/9/26 at 9:26 a.m. Diagnoses included, but were not limited to, traumatic subdural hematoma, acute and chronic respiratory failure and Alzheimer's dementia.The Significant Change Minimum Data Set assessment, dated 12/15/25, indicated the resident had severe cognitive deficits and was dependent for transfers and toileting.An Indiana Department of Health Reportable Incident, dated 11/3/25, indicated the resident had sustained a fall on 10/31/25 and had been sent to the hospital for evaluation. He sustained a traumatic subdural hematoma to his head. The follow up indicated his care plan would be updated.An IDT (Interdisciplinary team) Note, dated 11/4/25 indicated the root cause of the fall was the resident rolled out of bed. The intervention was to place the bed against the wall.The Fall Care Plan, dated 4/18/23, indicated the resident was at risk for falls related to weakness and impaired physical functioning. Interventions included, but were not limit to, larger bed to allow for larger surface area. On 11/5/25, the intervention had been added to put the bed against the wall. During an interview on 1/13/26 at 8:40 a.m. in the resident's room, CNA 1 indicated the bed was standard size and was always in the current position, it was not pushed against the wall. During an interview on 1/13/26 at 9:30 a.m., the Director of Nursing indicated the resident's care plan had been updated the previous day, 1/12/26, and some interventions had been closed. She was made aware interventions were not in place on 1/9/26. No additional information was provided. 3.1-45(a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on record review and interview, the facility failed to ensure a peripherally inserted central catheter (PICC) intravenous (IV) access site was assessed and monitored accurately as ordered for 1 of 3 residents reviewed for parenteral/IV fluids. (Resident 41)Finding includes: Resident 41's record was reviewed on 1/14/26 at 12:36 a.m. Diagnoses included, but were not limited to, osteomyelitis (infection of the bone) and cellulitis of the right and left lower limbs (skin infection). The admission Minimum Data Set (MDS) assessment, dated 12/17/25, indicated the resident was moderately cognitively impaired. He required intermittent oxygen therapy, received intravenous (IV) antibiotic medications, and had a central IV access site. A Care Plan, dated 12/15/25, indicated the resident required IV medications related to osteomyelitis. Interventions included, but were not limited to, assess for complications of the IV every shift such as infection or dislodgment, and IV site care as ordered. A Physician's Order, dated 12/12/25, indicated PICC line dressing change every 5 days; measure external catheter length. The December 2025 and January 2026 Medication and Treatment Administration Record indicated the PICC line dressing change was completed on the following dates with external catheter measurements: -12/12/25, 25 centimeters (cm)-12/17/25, 3 cm -12/22/25, 26 cm-12/27/25, 12 cm-1/1/26, 11 cm -1/6/26, 17 cm-1/11/26, 3.5 cmDuring an interview on 1/14/26 at 2:35 p.m., the Assistant Director of Nursing indicated the resident had not had any problems with the PICC line, the staff were not all measuring the external catheter the same way so there were varying measurements documented. During an interview on 1/14/26 at 2:44 p.m., the Director of Nursing indicated she had no further information to provide and she had no policies related to PICC line care/measurements. 3.1-47(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interview, the facility failed to document care for a PICC line (peripherally inserted central catheter, intravenous catheter placed into the peripheral veins of the upper arm) in accordance with professional standards of practice, related to flushing the PICC line for 2 of 3 residents reviewed for intravenous care. (Residents 14 and 59)Findings include:1. On 1/9/26 at 10:16 a.m. Resident 14 was observed with a PICC line to her right upper arm. She indicated she was receiving IV (intravenous) antibiotics.Resident 14's record was reviewed on 1/12/26 at 3:44 p.m. Diagnoses included, but were not limited to, bacteremia and type two diabetes mellitus.The admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated the resident was cognitively intact.A Physician's Order, dated 12/16/25, indicated piperacillin-tazobactam (an antibiotic medication) 4.5 grams intravenous every eight hours at 8:00 a.m., 4:00 p.m., and 12:00 a.m.A Physician's Order, dated 1/7/26, indicated daptomycin (an antibiotic medication) 350 mg intravenous every 48 hours at 2:00 p.m.A Physician's Order, dated 12/16/25, indicated Flush PICC with 10 cc (cubic centimeters) normal saline before and after medication twice a day, 6:00 a.m. - 10:00 a.m. and 6:00 p.m. - 10:00 p.m.The Medication Administration Record (MAR), dated 12/2025 and 1/2026, indicated there was no PICC flush documented as given before and after the administration of the 4:00 p.m. and 12:00 a.m. doses of piperacillin-tazobactam or the 2:00 p.m. dose of daptomycin.During an interview on 1/13/26 at 10:12 a.m., the Director of Nursing indicated the flush orders were put in the computer as twice a day/once per shift, but the nurses knew to flush the PICC before and after every dose of the antibiotic medication. She was unable to find any facility policy related to intravenous antibiotic medication administration. 2. On 1/9/26 at 9:17 a.m. Resident 59 was observed with a PICC line to her right upper arm. She indicated she recently had foot surgery and was receiving IV (intravenous) antibiotics.Resident 59's record was reviewed on 1/9/26 at 3:08 p.m. Diagnoses included, but were not limited to, osteomyelitis and atrial fibrillation.The admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated the resident was cognitively intact.A Physician's Order, dated 12/23/25, indicated piperacillin-tazobactam (an antibiotic medication) 3.375 grams intravenous every eight hours at 6:00 a.m., 2:00 p.m., and 10:00 p.m.A Physician's Order, dated 12/23/25, indicated daptomycin (an antibiotic medication) 483 mg (milligrams) intravenous once a day every other day 6:30 a.m.-10:30 a.m.A Physician's Order, dated 12/22/25, indicated Flush PICC with 10 cc (cubic centimeters) normal saline before and after medication twice a day, 6:00 a.m. - 10:00 a.m. and 6:00 p.m. - 10:00 p.m.The Medication Administration Record (MAR), dated 12/2025 and 1/2026, indicated there was no PICC flush documented as given before and after the administration of the 2:00 p.m. dose of piperacillin-tazobactam.During an interview on 1/13/26 at 10:12 a.m., the Director of Nursing indicated the flush orders were put in the computer as twice a day/once per shift, but the nurses knew to flush the PICC before and after every dose of the antibiotic medication. She was unable to find any facility policy related to intravenous antibiotic medication administration.3.1-50(a)