

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2012
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NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR AVON, IN 46123
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/28/12</p> <p>Facility Number: 000141 Provider Number: 155236 AIM Number: 100283860</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Avon Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all</p>	K0000	<p>This plan of correction is prepared and executed because it is required by the Provisions of State and Federal Regulations. Avon Health and Rehabilitation maintains that each deficiency does not jeopardize the health and safety of the residents, not is it of such nature as to limit our capability to provide adequate care.</p>	

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

TITLE

(X6) DATE

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

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	<p>resident sleeping rooms. The facility has a capacity of 151 and had a census of 138 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached wood shed providing storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/02/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0039 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 exit access corridors had a clear and unobstructed exit width of at least 8 feet (96 inches). This deficient practice could affect 28 residents, staff and visitors needing to exit the facility from the 800 and 900 Hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:30 p.m. on 09/28/12, the 800 and 900 Hall corridors measured 85 inches in width. Based on interview at the time of the observations, the Maintenance Supervisor stated the 800 and 900 Hall corridors were constructed at the width of 85 inches and acknowledged the 800 and 900 Hall each do not have a clear an unobstructed width of at least 8 feet (96 inches).</p> <p>3.1-19(b)</p>	K0039	Please see attached waiver and FSES documentation pertaining to the above Tag. See attached REVISED FSES and Life Safety Floor Plan..	10/28/2012	

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K0040 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 exit doors in the means of egress from the corridor in the 800 and 900 Hall had a minimum clear width of 41.5 inches, and 26 of 26 resident room exit doors in the 800 and 900 Hall had a minimum clear width of 41.5 inches. This deficient practice could affect 28 residents, staff and visitors needing to exit any resident room in the 800 and 900 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:05 a.m. to 1:30 p.m. on 09/28/12:</p> <p>a) the north exit door in the means of egress from the 800 Hall and the south exit door in the means of egress from the 900 Hall each measured 36 inches in width.</p> <p>b) all resident room exit doors in the 800 and 900 Hall measured 36 inches in width.</p> <p>Based on interview at the time of the</p>	K0040	Please see attached waiver and FSES documentation pertaining to the above Tag. Please see attached REVISED FSES documentations and Life Safety Floor Plan.	10/28/2012			

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	<p>observations, the Maintenance Supervisor acknowledged the north and south exit doors in the means of egress from the 800 and 900 Hall and each resident room exit door in the 800 and 900 Hall measured 36 inches in width.</p> <p>3.1-19(b)</p>			

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K0048 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 18.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Emergency Preparedness Manual: Fire Policy and Procedure" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 11:05 a.m. on 09/28/12, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire</p>	K0048	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: A written policy and procedure has been included in the facility fire safety plan including Emergency Preparedness Manual addressing the use of ABC and K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The policy addresses that in event of a fire, the hood extinguishing system must be activated before the use of the portable fire extinguishers. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The dietary staff and visitors in the vicinity of the kitchen have the potential to be affected. The Maintenance Director/Designee will conduct in-service with the kitchen staff on the use of K-class fire extinguisher in relationship with the use of the kitchen overhead extinguishing system and will review the facility policy with the kitchen staff by 10/28/12. The policy has been included in the fire safety manual including Emergency Preparedness</p>	10/28/2012	

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>Manuals. What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur: In-service on the use of K-class fire extinguishers in relationship to Overhead system will be included in orientation of new kitchen employees. How the corrective actions will be monitored to ensure the deficient practice will not recur: Maintenance Director/Designee will submit the in-service, policy and procedure and lists of all staff educated on this procedure to the Administrator during monthly QA meeting for its compliance. By what date the systemic changes will be completed: Completion date: 10/28/12</p>	