

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155286	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2014
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NAME OF PROVIDER OR SUPPLIER AVALON VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 KINGSTON CIR LIGONIER, IN 46767
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K010000	<p>A Life Safety Code Recertification and State Licensure was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/23/14</p> <p>Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Avalon Village 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridors. Battery operated smoke detectors have been installed in the resident rooms. The</p>	K010000	<p>Requesting Desk Review</p> <p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
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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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K010025 SS=E	<p>facility has a capacity of 67 and had a census of 52 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for a small detached building housing the generator.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide</p>	K010025	Requesting Desk Review 1. There were no residents affected by this practice. The	10/02/2014

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	<p>a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect three of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 09/23/14 from 12:42 p.m. at 2:05 p.m., the following areas had unsealed ceiling penetrations:</p> <p>a) In the mechanical room at the nurses' station there was a one fourth inch unsealed penetration around a cable line, a penetration sealed with a gray substance and a one fourth unsealed penetration covered with duct tape</p> <p>b) In the mechanical room located in the conference room there was an unsealed gap measuring three fourths inch by three inches alongside a light fixture</p> <p>c) Above the ceiling tile at the fire doors entering the 100 hall there were two unsealed penetration both measuring one fourth inch.</p> <p>d) At the 200 hall ceiling all 7 sprinkler lines for the sprinkler heads in the corridor had unsealed penetrations measuring three fourths inch. Measurements were provided by the Maintenance Supervisor at the time of</p>		<p>penetrations in the mechanical room at the nurses' station, the mechanical room located in the conference room, the ceiling tile at the fire doors entering the 100 hall, and the sprinklers at the 200 hall ceiling were all sealed with fire caulk.</p> <p>2. All residents have the potential to be affected by this practice. A house wide audit was completed by the Maintenance Director to ensure all ceiling penetrations were sealed.</p> <p>3. The Maintenance Director was educated by the Executive Director on 9-24-14 related to unsealed ceiling penetrations. The Maintenance Director and the Executive Director did rounds to ensure that all ceiling penetrations have been sealed. Any new construction or remodeling will be inspected by the Maintenance Director to ensure the ceiling smoke barriers are sealed.</p> <p>4. The Maintenance Director/Designee will complete rounds to ensure all ceiling penetrations are sealed with fire caulk daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The Executive Director will monitor that rounds are completed and that all ceiling penetrations are sealed daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months. The results of the monitoring will be forwarded to the CQI committee.</p>		

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K010038 SS=D	<p>observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 kitchen exit doors between the main dining room and the kitchen was readily accessible at all times. This deficient practice was not in a resident care area but could affect kitchen staff in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Executive Director and the Maintenance Supervisor on 09/23/14 at 1:30 p.m., the door exiting the kitchen from the dish machine area lacked the hardware required to open the door in the event of a fire emergency. Based on an interview with the Executive Director at the time of observation, the kitchen staff use this door to enter the kitchen from the main dining room and the door could not be opened from the kitchen side.</p> <p>3.1-19(b)</p>	K010038	<p>5. Completion Date 10/2/14</p> <p>Requesting Desk Review</p> <ol style="list-style-type: none"> There were no residents affected by this practice. . Hardware has been placed on the kitchen door to allow for compliance of K038. All residents have the potential to be affected by this practice. All other doors were examined by the Maintenance Director to ensure compliance with K038. The Maintenance Director was educated on K038 pm 9-24-14 by the Executive Director. All other doors were examined by the Maintenance Director to ensure compliance with K038. The Maintenance Director/Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure that all exits are readily accessible at all times. The results of the monitoring will be forwarded to the CQI committee. Completion date: 10/17/14 	10/17/2014	

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K010062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to maintain sprinkler heads in 2 of 33 resident rooms. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 4 of 52 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 09/23/14 from 12:20 p.m. to 12:35 p.m., the escutcheon was missing from the sprinkler head in resident room 303 and the sprinkler head in the restroom of resident room 308 was loaded with paint. The Maintenance Supervisor acknowledged there was paint on the sprinkler head in restroom of resident room 308 and was unable to locate the</p>	K010062	<p>Requesting Desk Review</p> <ol style="list-style-type: none"> There were no residents affected by this practice. Sprinkler heads in rooms 303 and 308 were replaced. All residents have the potential to be affected by this practice. Inspection of all sprinkler heads and escutcheons were completed by the Maintenance Director to ensure all escutcheons were present and the integrity of the sprinkler heads were maintained. The Maintenance Director was educated by the Executive Director on 9-24-14 related to K062 to ensure all automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. Any new construction or remodeling will be inspected by the Maintenance Director to ensure escutcheons are present and sprinkler heads are in good repair. The Maintenance Director/ Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to 	10/02/2014

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K010064 SS=D	<p>escutcheon missing from the sprinkler head in resident room 303.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 employee break room fire extinguishers was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/23/14 at 1:05 p.m., the fire extinguisher mounted on the wall in the employee's break room measured five foot nine inches from the floor to the top of the fire extinguisher.</p>	K010064	<p>ensure all sprinkler sprinkler systems are continuously maintained in reliable operating condition. The results of the monitoring will be forwarded to the CQI committee.</p> <p>5. Completion Date: 10/2/14</p> <p>Requesting Desk Review</p> <ol style="list-style-type: none"> There were no residents affected by this practice. The fire extinguisher in the employee break room was placed so that the top of the extinguisher was no more than five feet above the floor. All residents have the potential to be affected by this practice. A house wide audit was completed to ensure all fire extinguishers are in compliance with K064 and are no more than 5 feet above the floor. The Maintenance Director was educated on 9-24-14 by the Executive Director on K064 to ensure all fire extinguishers are no more than five feet above the floor. A house wide audit was completed to ensure all fire extinguishers are in compliance with K064 and are no more than 5 feet above the floor. The Maintenance Director/ Designee will make rounds daily x 4 	10/02/2014

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K010066 SS=E	<p>Measurements were provided by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on record review and interview, the facility failed to regulate smoking practices for unsafe smokers in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.7.4 and 19.7.4 (2). This deficient</p>	K010066	<p>weeks then weekly x 4 weeks then monthly for at least 6 months to ensure all fire extinguishers are in compliance with K064 and no more than five feet above the floor. The results of the monitoring will be forwarded to the CQI committee.</p> <p>5. Completion Date: 10/2/14</p> <p>Requesting Desk Review</p> <p>1. There were no residents affected by this practice. The small basket located in the Social Service office containing cigarette packs have been removed. All smoking material is contained behind a</p>	10/02/2014

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K010144 SS=D	<p>practice could affect any number of residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 09/23/14 at 11:35 p.m., a small basket containing several cigarette packs and lighters was accessible and stored on a shelving unit in the Social Service's office. The office was unoccupied and the corridor door was open. Based on an interview with the Executive Director at 3:30 during the exit conference, the smoking material belonged to residents who were no longer at the facility and should have been stored in a locked area.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA</p>	K010144	<p>locked door.</p> <p>2. All residents have the potential to be affected by this practice. The Executive Director reviewed the location of all sm oking materials to ensure materials are in kept in a locked area.</p> <p>3. The Social Service Director and nursing staff has been educated by the Executive Director on 9-24-14 regarding K066 to ensure that all smoking materials are stored in a locked area.</p> <p>4. The Executive Director/Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure all smoking material is stored in a locked area. The results of the monitoring will be forwarded to the CQI committee.</p> <p>5. Completion Date: 10/2/14</p> <p>Requesting Desk Review</p> <p>1. There were no residents affected by this practice. All storage was removed from the generator room.</p> <p>2. All residents have the potential to be affected by this practice. All storage was removed from the generator room.</p> <p>3. The Maintenance Director</p>	10/02/2014

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	<p>110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-11.1 states the room in which the EPS (Emergency Power Supply) equipment is located shall not be used for storage purposes. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/23/14 at 1:18 p.m., there was a large air compressor and a maintenance cart stored near the generator limiting access to the generator in the event of a generator emergency. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>was educated on 9-24-14 by the Executive Director on 9-24-14 regarding K144 to ensure the generator room stays free from storage.</p> <p>4. The Executive Director/Designee will make rounds daily x 4 weeks then weekly x 4 weeks then monthly for at least 6 months to ensure the generator room remains free from storage. The results of the monitoring will be forwarded to the CQI committee.</p> <p>5. Completion Date: 10/2/14</p>	