

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  06/22/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000  Bldg. 01	<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: 06/22/15</p> <p>Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210</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 facility has a capacity of 67 and had a census of 45 at the time of this survey.</p>	K 0000	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. 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. Requesting Desk Review	

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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K 0025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</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 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 18 residents in one of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Executive Director and the Maintenance Supervisor on 06/22/15 from 10:45 a.m. to 11:15 a.m.,</p>	K 0025	<p>Requesting Desk Review K0251. There were no residents affected by this practice. The penetrations in rooms 209, 205, and 211 were all sealed with escutcheons. 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. 3. The Maintenance Director was educated by the Executive Director on 6-22-15 related to unsealed ceiling penetrations. The Maintenance Director and the Executive Director did rounds to ensure that all ceiling penetrations have been sealed. Any ceiling penetrations will be inspected by the</p>	06/26/2015

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	<p>penetrations were noted measuring a half of an inch to one fourth of an inch around the following sprinkler heads:</p> <p>a.) two in room 209 b.) one in the bathroom of 209 c.) one in the bathroom of 205 d.) one in the bathroom of 211</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>		<p>Maintenance Director following the service of vendors to ensure the ceiling smoke barriers are sealed.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. 5. Completion Date 6/26/15</p>		