

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  01/02/2014
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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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K020000	<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: 01/02/14</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 &amp; 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</p>	K020000	The Plan of Correction is prepared and executed because it is required by the Provisions of State and Federal Regulations. Avon Health and Rehab. maintains that each deficiency does not jeopardize the health and safety of our residents, not is it of such nature as to limit our capability to provide adequate care.	

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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K020029 SS=F	<p>corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 151 and had a census of 135 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 01/06/14.</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 Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 11 of 18 doors serving hazardous areas such as fuel fired heater rooms, soiled linen and trash</p>	K020029	Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The deficient will be corrected by	03/31/2014			

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	<p>collection rooms and storage rooms greater than fifty square feet in size and used to store combustible materials each had a 3/4 hour fire protection rating. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:05 p.m. on 01/02/14, the following areas each had a natural gas fired water heater in the room and the entry door had a 20 minute fire resistance rating label affixed to the door:</p> <ul style="list-style-type: none"> <li>a. corridor door to the mechanical room by the Director of Nursing Office.</li> <li>b. corridor door to the 100 Hall mechanical room.</li> <li>c. corridor door to the 200 Hall mechanical room.</li> <li>d. corridor door to the 200 Hall soiled linen room.</li> <li>e. corridor door to the 300 Hall soiled linen room.</li> <li>f. corridor door to the 400 Hall soiled linen room.</li> <li>g. corridor door to the 500 Hall mechanical room.</li> <li>h. corridor door to the 500 Hall soiled linen room.</li> <li>i. corridor door to the 100 Hall Laundry</li> </ul>		<p>replacing the doors with the minimum of 45 minutes fire resistance rating. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient. The Maintenance /Director will conduct inspection of all doors leading to corridors and utility to ensure that these doors meet fire resistance rating of 45 minutes. The deficient will be corrected by replacing the doors with 45 minutes fire resistance rating. What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur: The replacement of doors with 45 minutes of fire resistance rating will correct this deficient. How the corrective actions will be monitored to ensure the deficient practice will not recur: The Maintenance Director/Designee will conduct an inspection of doors being replaced to ensure that these doors meet the required fire resistance rating. The Maintenance Director/Designee will conduct inspections of all doors leading to corridor and utility to ensure that these doors meet fire resistance rating of 45 minutes and submit the reports to QA committee for review. By what date the systemic changes will be completed: 3/31/14 We are</p>		

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	<p>Services room.</p> <p>In addition, the Central Supply Room measured 150 square feet in total area, was used to store combustible boxes and supplies and the entry door had no fire resistance rating label affixed to the door. The 100 Hall Therapy Storage Room measured 80 square feet in total area, was used to store combustible boxes and supplies and had a 20 minute fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Maintenance Director stated no other documentation of the fire resistance rating of the aforementioned areas entry doors was available for review and acknowledged each of the aforementioned areas' entry doors did not have a fire resistance rating of at least 45 minutes.</p> <p>3.1-19(b)</p>		<p>requesting an extension due to the time and process involved in manufacturing the doors that would meet the facility standards including the Life Safety.</p>		

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K020039 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 Based on observation and interview, the facility failed to ensure 2 of 8 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 if 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 Director during a tour of the facility from 11:40 a.m. to 2:05 p.m. on 01/02/14, the 800 Hall and 900 Hall corridors each measured 85 inches in width. Based on interview at the time of the observations, the Maintenance Director stated the 800 Hall and 900 Hall corridors were constructed at the width of 85 inches and acknowledged the 800 Hall and 900 Hall corridors each do not have a clear and unobstructed width of at least 8 feet (96 inches).</p> <p>3.1-19(b)</p>	K020039	<p>K-039 Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Please see attached Annual waiver and FSES documentation and life safety plan pertaining to the above tag. See attached FSES conducted by RTM Consultants.</p>	01/16/2014			

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K020040 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 corridors 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 Hall 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 Hall and 900 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:05 p.m. on 01/02/14;</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>	K020040	<p>K-0040</p> <p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Please see attached waiver and FSES documentation and Life Safety Floor plan pertaining to above tag. Attached is the FSES documentation provided by RTM Consultants.</p>	01/16/2014			

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K020062 SS=C	<p>b. all resident room exit doors in the 800 Hall and 900 Hall measured 36 inches in width.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the north and south exit doors in the means of egress from the 800 Hall and 900 Hall and each resident room exit door in the 800 Hall and 900 Hall measured 36 inches in width.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 10 of 10 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be</p>	K020062	K-062  Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: All residents and visitors have the potential to be affected by this deficient. Facility has hired SafeCare Fire and Safety to perform Test and Inspection on all privately owned Fire Hydrants. How other residents having the potential to be affected by the same deficient practice will be identified and	03/31/2014			

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	<p>inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare "Fire Hydrants &amp; Water Supply Testing" documentation dated 09/07/12 with the Maintenance Director during record review from 9:40 a.m. to 11:40 a.m. on 01/02/14, documentation of annual fire hydrant testing for ten facility fire hydrants within the last twelve months was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:05 p.m. on 01/02/14, fire hydrants were located outside the facility near the parking lots and along the entrance road. Based on interview at the time of record review, the Maintenance Director stated the aforementioned fire hydrants were owned by the facility and acknowledged documentation of annual fire hydrant testing within the last twelve months was not available for review.</p> <p>3.1-19(b)</p>		<p>what corrective actions will be taken:All residents and visitors have the potential to be affected by this deficient. The test and inspection of Fire Hydrants by SafeCare Fire and Safety will correct this deficient.What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur:All privately owned Fire Hydrants will be on put on program for annual inspection with Safecare Fire and Safety. The Maintenance Director/Designee will view inspection report on monthly basis to ensure the annual inspection deadline is met and completed timely.How the corrective actions will be monitored to ensure the deficient practice will not recur:The Maintenance Director/Designee will audit the inspection report monthly to ensure annual inspection deadline is met and completed timely and will submit the reports to QA committee for review. By what date the systemic changes will be completed:3.31.14We are requesting the extension of completion date. As per Vendor this tests to be conducted in above freezing and mild temperatures. See attached letter from Safecare relates to this extension request.</p>				

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K020068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 8 mechanical rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 18.5.2.2. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the mechanical room by the Director of Nursing (DON) Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:40 a.m. to 2:05 p.m. on 01/02/14, the mechanical room by the DON Office contained one natural gas fired water heater and was not provided with intake combustion air from the outside. Based on interview at the time of observation, the Maintenance Director acknowledged there is no intake combustion air from the outside supplied to the mechanical room by the DON Office which contained one natural gas fired water heater.</p>	K020068	<p>K-068</p> <p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The DON office and the areas have a potential to be affected by this deficient. The facility has contacted the contractor to install the intake and return combustion air from the outside for the mechanical room. The work is being performed on 1/17/14 to correct this deficient. 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 areas surrounding the mechanical rooms with natural gas fired water heater requiring intake combustion air from outside would have the potential to be affected. What measures will be put into the place or what systemic changes will be made to ensure that the deficient practice does not recur: The installation of intake combustion air from outside in mechanical room would correct this deficient. The Maintenance Director /Designee will conduct a facility wide inspection of 1 mechanical rooms and boiler rooms with natural gas</p>	01/17/2014			

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	3.1-19(b)		fired water heater for intake combustion air vent.How the corrective actions will be monitored to ensure the deficient practice will not recur:The Maintenance Director/Designee will audit mechanical rooms with natural gas fired water heaters and boiler rooms on monthly basis for proper ventilation of outside air. The results of audit will be presented at QA meeting for review for 100% compliance. By what date the systemic changes will be completed:1/17/14		