PRINTED: 01/18/2024

	OF HEALTH AND HU						RM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 155236		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING			01/02/2024		
NAME OF P	PROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP COD		
AVON HE	EALTH & REHABIL	ITATION CENTER			IN 46123		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0000							
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/02/24 Facility Number: 000141 Provider Number: 155236 AIM Number: 100283860 At this Emergency Preparedness survey, Avon Health & Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid		E 00	We respectfully request consideration for paper compliance rather than a post-survey revisit. All necessary corrections have been completed by January 3, 2024. We allege compliance as of that date. We are committed to providing any supporting documentation deemed necessary to demonstrate our credible compliance with the deficiencies outlined in the CMS form 2567. Please be advised that the			
	The facility has 137 the survey, the cens	ders and Suppliers, 42 CFR Countries beds. At the time of us was 110. Inpleted on 01/05/24			submission of this Plan of Correction is not an admission agreement by the provider regarding the truth, effects, all deficiencies, or corrections stain the Statement of Deficiencie is prepared and submitted in accordance with state and fed law requirements.	eged ated es. It	
K 0000							
Bldg. 02	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0	000	We respectfully request consideration for paper compliance rather than a post-survey revisit. All necessary corrections have	e	

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

Survey Date: 01/02/24

Facility Number: 000141

Provider Number: 155236

AIM Number: 100283860

TITLE

providing any supporting

been completed by January 3, 2024. We allege compliance as of

that date. We are committed to

documentation deemed necessary

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
		155236	B. WING			01/02/2024	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
					OREST POINTE CIRCLE		
AVON HE	EALTH & REHABIL	ITATION CENTER		AVON,	IN 46123		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TC	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	16	DATE
					to demonstrate our credible		
	At this Life Safety (Code survey, Avon Health &			compliance with the deficienci	es	
		er was found not in compliance			outlined in the CMS form 2567		
	with Requirements	_			Please be advised that the		
	_	, 42 CFR Subpart 483.90(a),			submission of this Plan of		
		re and the 2012 edition of the			Correction is not an admission	ı or	
	I -	etion Association (NFPA) 101,			agreement by the provider	101	
		SC), Chapter 19, Existing			regarding the truth, effects, all	ened	
		ancies and 410 IAC 16.2.			deficiencies, or corrections sta	•	
	110uim cure occupe				in the Statement of Deficiencie		
	This one-story facil-	ity was determined to be of			is prepared and submitted in	, It	
		-			accordance with state and fed	eral	
	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				law requirements.	Ciai	
					law requirements.		
		-					
	the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 110 at the time of this visit.						
	and had a census of	110 at the time of this visit.					
	All areas where residents have customary access						
		he facility has one detached					
		ling storage which was not					
	sprinklered.	ing storage which was not					
	sprinklered.						
	Quality Review con	npleted on 01/05/24					
K 0351	NEDA 101						
SS=E	NFPA 101	Installation				ļ	
	Sprinkler System -						
Bldg. 02	Spinkler System -	Installation					
	2012 EXISTING	nd boonitale where required					
	_	nd hospitals where required					
	by construction typ						
	throughout by an approved automatic					ļ	
	sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler					ļ	
		ie iristaliation or sprinkler					
	Systems.	notruction alternative				ļ	
	1	nstruction, alternative					
	_ ·	es are permitted to be				ļ	
	1	inkler protection in specific					
	areas where state	or local regulations prohibit				ļ	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE	X3) DATE SURVEY		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER				COMPL	COMPLETED	
155236		B. WING 01/02/2024				/2024		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4171 FOREST POINTE CIRCLE					
	EALTH & REHABIL	ITATION CENTER		AVON,	IN 46123			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
TAG	sprinklers. In hospitals, sprinklers clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to maintain the corridors in accordate for the Installation of 2010 edition, Section escutcheons, or othe annular space around or shall be listed for deficient practice corresidents, 4 staff, and Findings include: Based on observation facility with the Ma at 12:36 p.m., the corresident room #101 Based on interview Maintenance Direct escutcheon and advanother one placed a soon as possible.	klers are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers t as required by NFPA 13, llation of Sprinkler (19.3.5.3, 19.3.5.4, 19.3.5.10, 19.7.1.1(1) on and interview, the facility ne ceiling construction in 1 of 7 ance with NFPA 13, Standard of Sprinkler Systems. NFPA 13, on 6.2.7.1 states plates, er devices used to cover the ad a sprinkler shall be metallic truse around a sprinkler. This bould affect as many as 20 and 2 visitors in the facility. The property of the control of the	K 0	351	Plan of Correction for K 351: 1.Corrective Actions for Affected Residents: No residents were negatively affected. The missi escutcheon on the sprinkler houtside of resident room #101 been promptly replaced. 2.Identification and Corrective Action for Other Residents: All residents have the potential to be affected. A comprehensive inspection of a other sprinkler heads in the fa has been conducted, ensuring properly placed escutcheons a in place. 3.Preventive Measures and Systemic Changes: The Maintenance Super or designee will conduct mont safety rounds to ensure compliance with Life Safety C Standards, including the proper	ng ead has all cility gare t	01/03/2024	
	Administrator during the exit conference on 01/02/24 at 2:20 p.m.				placement of escutcheons.			
	51. 02.2 . at 2.20 p.i.				4.Monitoring Corrective			
	3.1-19(b)				Actions:			
					·Monthly safety rounds w	/ill		
					be recorded in our TELS			

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155236	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/02/2024			
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 4171 FOREST POINTE CIRCLE AVON, IN 46123				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIET OF CROSS-		(X5) COMPLETION DATE		
					monitoring system. Results wi reported monthly to the Safety Committee and the Quality Assurance Improvement Committee.			
K 0374 SS=E Bldg. 02	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that in Nonrated protection are permitted. Door fixed fire window as are self-closing or require latching, as in the direction of provides a minimum for swinging or ho 19.3.7.6, 19.3.7.8 Based on observation failed to ensure 1 or restrict the movement minutes. LSC 19.3. barriers shall comple 8.5.4.1 requires door the opening leaving necessary for prope	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 20 residents, 4		374	Plan of Correction for K 374: 1.Corrective Actions for Affected Residents: No residents were negatively affected. The set of barrier doors in the corridor let to the Assisted Living area had been adjusted to close and se properly. 2.Identification and Corrective Action for Other Residents:	f ading s	01/03/2024	
		ons made during a tour of the intenance Director on 01/02/24			·All residents have the potential to be affected. A thorough inspection of all other	er		

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at 1:20 p.m., the set of barrier doors located in the

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barrier doors in the facility has

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/02/2024				
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CENTER			4171 F	STREET ADDRESS, CITY, STATE, ZIP COD 4171 FOREST POINTE CIRCLE AVON, IN 46123					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	REGULATORY OR LSC IDENTIFYING INFORMATION corridor leading to the Assisted Living area did not fully close leaving a one-inch gap when tested on three occasions. Based on interview during the time of observation, the Maintenance Director acknowledged these smoke barrier doors did not close and seal completely adding that he would have them looked at as soon as he had time to do so. This item was discussed with the facility Administrator during the exit conference on 01/02/24 at 2:20 p.m. 3.1-19(b)			been conducted, ensuring proclosure and sealing. 3.Preventive Measures and Systemic Changes: •The Maintenance Super or designee will conduct week safety rounds to ensure compliance with Life Safety C Standards, specifically focusir on barrier doors. 4.Monitoring Corrective Actions: •Weekly safety rounds w be recorded in our TELS monitoring system. Results wireported monthly to the Safety Committee and the Quality Assurance Improvement Committee.	visor kly ode ng ill				

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