STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155236	A. BUILDING -- B. WING	01/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON HEALTH & REHABILITATION CENTER	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 APPROPRIATE 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 Participating Providers and Suppliers, 42 CFR 483.73 The facility has 137 certified beds. At the time of the survey, the census was 110. Quality Review completed on 01/05/24	E 0000	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 submission of this Plan of Correction is not an admission or agreement by the provider regarding the truth, effects, alleged deficiencies, or corrections stated in the Statement of Deficiencies. It is prepared and submitted in accordance with state and federal law requirements.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/02/24 Facility Number: 000141 Provider Number: 155236 AIM Number: 100283860	K 0000	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	155236	A. BUILDING 02 B. WING	01/02/2024

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	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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 resident sleeping rooms. The facility has a capacity of 137 and had a census of 110 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached wooden shed providing storage which was not sprinklered. Quality Review completed on 01/05/24		to demonstrate our credible compliance with the deficiencies outlined in the CMS form 2567. Please be advised that the submission of this Plan of Correction is not an admission or agreement by the provider regarding the truth, effects, alleged deficiencies, or corrections stated in the Statement of Deficiencies. It is prepared and submitted in accordance with state and federal law requirements.	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit			

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	sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 7 corridors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect as many as 20 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 01/02/24 at 12:36 p.m., the corridor sprinkler head outside resident room #101 had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director acknowledged the missing escutcheon and advised that he would have another one placed around the sprinkler head as soon as possible. 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)	K 0351	**Plan of Correction for K 351:** **1.Corrective Actions for Affected Residents:** ·No residents were negatively affected. The missing escutcheon on the sprinkler head outside of resident room #101 has been promptly replaced. **2.Identification and Corrective Action for Other Residents:** ·All residents have the potential to be affected. A comprehensive inspection of all other sprinkler heads in the facility has been conducted, ensuring properly placed escutcheons are in place. **3.Preventive Measures and Systemic Changes:** ·The Maintenance Supervisor or designee will conduct monthly safety rounds to ensure compliance with Life Safety Code Standards, including the proper placement of escutcheons. **4.Monitoring Corrective Actions:** ·Monthly safety rounds will be recorded in our TELS	01/03/2024

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			monitoring system. Results will be reported monthly to the Safety Committee and the Quality Assurance Improvement Committee.	
K 0374 SS=E Bldg. 02	NFPA 101 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 staff, and 2 visitors within the facility. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 01/02/24 at 1:20 p.m., the set of barrier doors located in the	K 0374	**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 leading to the Assisted Living area has been adjusted to close and seal properly. **2.Identification and Corrective Action for Other Residents:** ·All residents have the potential to be affected. A thorough inspection of all other barrier doors in the facility has	01/03/2024

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	155236	A. BUILDING 02 B. WING	01/02/2024

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	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 proper closure and sealing. **3.Preventive Measures and Systemic Changes:** ·The Maintenance Supervisor or designee will conduct weekly safety rounds to ensure compliance with Life Safety Code Standards, specifically focusing on barrier doors. **4.Monitoring Corrective Actions:** ·Weekly safety rounds will be recorded in our TELS monitoring system. Results will be reported monthly to the Safety Committee and the Quality Assurance Improvement Committee.	