STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155811	A. BUILDING -- B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 E COUNTY RD 100 N, INDIANAPOLIS, IN 46234

(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: 03/07/24 Facility Number: 013085 Provider Number: 155811 AIM Number: 201279600 At this Emergency Preparedness survey, Wellbrooke of Avon was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 70 certified beds. At the time of the survey, the census was 46. Quality Review completed on 03/11/24	E 0000		
K 0000 Bldg. 01	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: 03/07/24 Facility Number: 013085 Provider Number: 155811 AIM Number: 201279600 At this Life Safety Code survey, Wellbrooke of Avon was found not in compliance with	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danielle Minito	Executive Director	03/18/2024

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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	Requirements for Participation 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 corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 46 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/11/24		the allegation of noncompliance cited during the survey visit with exit on March 7th, 2024.	
K 0374 SS=E Bldg. 01	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.			

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	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 smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect as many as 24 residents, as well as 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility on 03/07/24 at 11:36 a.m. with the visiting Director of Plant Operations (DPO) and the Facilities Management Support person (FMS), the set of smoke barrier doors leading to the Suites #101 through #135 failed to fully close leaving a 36 inch / 3-foot gap along the center where the doors came together in the closed position. Based on an interview at the time of the observation, it was stated that the carpet in this hall had recently been replaced and the bottom of the door was rubbing on the carpet, not allowing the doors to fully close and seal smoke tight. Based on further interview, the visiting DPO stated that he would adjust the doors as soon as possible. This item was again discussed at the exit conference on 03/07/24 with both the DPO and the FMS. 3.1-19(b)	K 0374	**Immediate intervention** Adjusted the speed of the closure for the opening providing the necessary latching for proper operation that could affect 24 residents and 4 staff and 2 visitors in two compartments to meet deficiency K374. **Compliance date** **3-8-24** The Director of Plant Operations was educated by Regional Support on K374 smoke barrier doors would restrict the movement of smoke for at least 20 minutes as it pertains to NFPA 101 2012 19.3.7.6, 19.3.7.8, 19.3.7.9 in Compliance with LSC Section 8.5.4, LSC 8.5.4.1 **Exhibit A – Inservice** The Director of plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit B – Audit tool**	03/08/2024

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			Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	