STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155286	A. BUILDING -- B. WING	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(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. This visit was in conjunction with the Life Safety Code Complaint Survey that exited on 11/25/24. Survey Date: 11/25/24 Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210 At this Emergency Preparedness survey, Avalon Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 67 certified beds. At the time of the survey, the census was 51. Quality Review completed on 11/27/24	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **REQUESTING DESK REVIEW**	
K 0000 Bldg. 01	A Life Safety Code Recertification (LSC) and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). This visit was in conjunction with the Life Safety Code Complaint Survey that exited on 11/25/24. Survey Date: 11/25/24	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **REQUESTING DESK REVIEW**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Slone	Executive Director	12/10/2024

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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	Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210 At this LSC survey, Avalon Village 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-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 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 building is fully protected by a 275kW diesel-powered generator. The facility has a capacity of 67 and had a census of 51 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/27/24			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 1 of 4 pendent type sprinkler heads in the 200-hall spa were not damaged in accordance with LSC 9.7.5. NFPA 13, 2010 Edition, Section 3.6.2.3 definces a pendent sprinkler as a sprinkler designed to be installed in such a way that the water stream is directed downward against the deflector. NFPA 25, 2011 edition, at	K 0353	REQUESTING DESK REVIEW K 353 Sprinkler System - Maintenance and Testing **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/10/2024

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	5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 11/25/24 at 11:40 a.m., the back left pendent type sprinkler head in the 200-hall spa was damaged due to the deflector on the sprinkler head being bent up and not flat. This condition would spray the water up to the ceiling instead of spreading evenly to the floor. Based on interview at the time of observation, the Maintenance Director agreed the back left pendent type sprinkler head in the 200-hall spa was damaged and bent. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**practice:** The back left pendent type sprinkler head in the 200 hall spa was replaced **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. All other sprinkler heads were assessed to ensure compliance **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been educated that all sprinkler heads must be in compliance and free from damage. The QAPI and PM calendar was updated for the Maintenance Director to check that all sprinkler heads are in compliance and free from damage. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all sprinkler heads are in compliance and free from damage. The Executive Director will review the preventative	

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			maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **5. By what date the systemic changes will be completed: 12/10/24**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 11/25/24 at 1:00 p.m., above the drop ceiling of the 200-hall smoke wall there was an	K 0372	REQUESTING DESK REVIEW **K 372 Subdivision of building spaces- Smoke barrier construction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Repair was made to the one inch gap that was located around a pipe in the 200 hall smoke wall. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. All of the remaining smoke barrier walls were inspected, and is in compliance. **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff has been educated on K372	12/10/2024

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	unsealed one-inch gap around a pipe. Based on interview at the time of observation, the Maintenance Director agreed there was an unsealed hole in the 200-hall smoke barrier. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		requiring that all smoke barrier walls remain maintained in accordance with K 372 The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review that all smoke barrier walls are inspected for unsealed penetrations and are in compliance with K 372. Upon completion of any new construction or repair will be inspected by Maintenance Director to ensure there are no unsealed gaps or holes **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all smoke barrier structures are in good repair and compliant with K 372. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **By what date the systemic changes will be completed: 12/10/24**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility	K 0374	REQUESTING DESK REVIEW	12/10/2024

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	failed to ensure 1 of 3 cross corridor smoke doors would restrict the movement of smoke for at least 20 minutes in accordance with LSC Chapter 8. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 11/25/24 between 11:30 a.m. and 1:00 p.m., the 200-hall smoke doors had a ¾ inch gap between the doors when closed. Based on an interview at the time of observation, the Maintenance Director agreed there was a gap larger than 1/8 inch between the 200-hall smoke doors when closed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**K374 Subdivision of building spaces- Smoke Barrier Doors** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The 200 Hall smoke door was assessed and repaired to ensure the opening leaves the minimum necessary for proper operations as defined in K 374. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. All other smoke doors in the building were assessed and in compliance with K 374 **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur:** Staff was educated on K 374 and ensuring smoke door gaps are at a minimum necessary for operations as defined by 1/8 inch per K 374. The QAPI and PM calendar was updated for the Maintenance Director to review compliance with K 374. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place: The Executive Director will round with the maintenance director prior to the compliance date to ensure all smoke doors are at a minimum necessary for operations as defined by 1/8 inch per K 374. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. **5. By what date the systemic changes will be completed: 12/10/24**	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation and interview, the facility failed to ensure 1 of 3 smoke barrier doors were routinely inspected and repaired as part of the facility maintenance program. NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives, 2010 edition at Section 5.1.4.3 states when holes are left in a door or frame due to changes or removal of hardware or plant-ons, the holes shall be repaired by either of the following methods: (1) Installation of steel fasteners that completely fill the holes (2) Filling of the screw or bolt holes with the same material as the door or frame This deficient practice could affect 25 residents in two smoke compartments. Findings include:	K 0761	REQUESTING DESK REVIEW **K761-Maintenance, Inspection & Testing-Doors** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The 300 Hall smoke door was assessed and repaired. The screw holes were filled with fire caulk and the repair of the astragal has been completed. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be**	12/10/2024

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	Based on observation with the Maintenance Director on 11/25/24 at 12:30 p.m., the 300-hall smoke doors were damaged and had 8 screw holes that went halfway through the door. Based on an interview at the time of observation, the Maintenance Director stated an astragal was removed and the holes were not repaired. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**taken:** All residents have the potential to be affected. All other smoke doors in the building were assessed and in compliance with K 761 **3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur:** Staff was educated on K 761 and ensuring smoke doors are repaired as part of the facility maintenance program. The QAPI and PM calendar was updated for the Maintenance Director to review compliance with K 761. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director will round with the maintenance director prior to the compliance date to ensure all smoke doors are compliant per K 761 and all astragals are in place. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. 5. **By what date the systemic changes will be completed: 12/10/24**	