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	02/02/2023

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. Survey Date: 02/02/2023 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 a capacity of 67 and had a census of 51 at the time of this survey. Qaulity Review competed on 02/08/23	E 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance Requesting Desk Review	
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: 02/02/2023 Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210 At this Life Safety Code 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	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance Requesting Desk Review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Slone	Executive Director	02/17/2023

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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	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. 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. Qaulity Review competed on 02/08/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.			

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	19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 housekeeping supply rooms which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff in the service hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/02/23 at 2:35 p.m., the housekeeping storage room, a hazardous storage room that was greater than 50 square feet, was equipped with a self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the room was used as storage, was larger than 50 square feet, and stated the door to the housekeeping supply room did not latch into the frame. This finding was reviewed with the Administrator	K 0321	**Requesting Desk Review** **K 321 Hazardous Areas - Enclosure** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Repair was made and the door to the housekeeping storage room now latches into the frame. **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 doors were inspected, and all doors are in compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	02/17/2023

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	and Maintenance Director at the exit conference. 3.1-19(b)		Maintenance Director has been educated on K321 requiring that doors latch into the frame. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review that all doors latch properly into their frames. **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 doors latch into their frames. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks were completed. Completion Date: 2/17/23	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/02/23 at 1:45 p.m, in the spare sprinkler cabinet in the riser room there were 12 spare sprinkler heads, 2 of which were not in their own protected slot, being stored in the spare sprinkler cabinet. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabinet had 2 spare sprinklers not in protected slots.	K 0353	Requesting Desk Review K 353 Sprinkler System - Maintenance and Testing **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** the spare sprinkler heads were placed in their own protected slot. **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 and in their own protected slot **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director educated that the spare sprinkler heads must be placed in their own protected slot. The QAPI and PM calendar was updated for the Maintenance Director to check that all spare sprinkler heads are placed in their own protected slots.	02/17/2023

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**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 spare sprinkler heads are placed in their own protective slot. 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: 2/17/23**	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 nursing station with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same	K 0361	Requesting Desk Review K 361 Corridors - Areas Open to Corridor **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The nurses station is now	02/17/2023

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	smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 10 residents in one smoke compartments. Findings include: Based on observation with the Maintenance Director on 02/02/23 at 2:20 p.m., the nurses station had a pass-through window that had an opening of 864 square inches and was not protected by an electrically supervised automatic smoke detection. Based on interview at the time of observation, the Maintenance Director agreed the window was greater than 20 square inches and the office did not contain electrically supervised automatic smoke detection. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		protected by a smoke detector. **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 areas in the building were assessed and in compliance with K 361 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur:** Maintenance Director was educated on K 361 and providing a smoke detector to the nursing station with a pass-through window greater than 20 square inches. The QAPI and PM calendar was updated for the Maintenance Director to review compliance with K 361. **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 rooms with a pass-through window greater than 20 square inches has a smoke detector. The Executive Director will review the preventative maintenance checks performed by the	

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			maintenance director monthly and sign off that the checks were completed. **By what date the systemic changes will be completed: 2/17/23**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in resident room 303 contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 2 residents in resident room 303. Findings include: Based on observation with the Maintenance Director on 02/02/23 at 2:10 p.m., in resident room 303 there was an electrical outlet with a broken cover plate. Based on interview at the time of observation, the Maintenance Director agreed the outlet had a broken cover plate.	K 0511	Requesting Desk Review K 511 Utilities - Gas and Electric **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The electrical outlet in resident room 303 was repaired. The light switch in the kitchen walk-in refrigerator was repaired. **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 outlets and light switches were assessed immediately. All outlets and switches are in compliance. **What measures will be put into**	02/17/2023

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	This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical light switch outlet for the walk-in refrigerator in the kitchen was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 4 employees in the kitchen. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/02/23 at 2:40 p.m., the light switch in the kitchen walk-in refrigerator was broken and falling apart. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not reoccur:** Maintenance Director was educated to check all outlets and light switches to ensure compliance with K 511. The QAPI and PM calendar was updated for the Maintenance Director to check outlets and light switches for compliance. **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 outlets and light switches are free from damage. 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:** **2/17/23**	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only			

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	used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents. Findings include: Based on observation with the Maintenance Director on 02/02/23 at 1:55 p.m., resident room 203 contained a multi-plug adaptor powering personal equipment. Based on interview at the time of observation, the Maintenance Director	K 0920	Requesting Desk Review K 920 Electrical Equipment - Power Cords and Extens **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** multi-plug adaptor powering personal equipment was removed from resident room 203 **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 rooms were	02/17/2023

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	agreed a mulit-plug adaptor was in use in resident room 203. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		checked for multi-plug adaptors/extension cords. There were none found. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director will be educated on not using multi-plug adaptors as a substitute for fixed wiring . The QAPI and PM calendar was updated for the Maintenance Director to check for multi plug adaptors/extension cords to ensure compliance. **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:** /p> **By what date the systemic changes will be completed:** **2/17/23**	