PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155814		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/17/2022			
NAME OF PROVIDER OR SUPPLIER  BROOKE KNOLL VILLAGE				STREET ADDRESS, CITY, STATE, ZIP COD 1108 KINGWOOD DRIVE AVON, IN 46123					
(VA) ID	CIRALANY	OT A TEMENT OF DEFICIENCIE	<u> </u>		1		0/5)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	DATE		
E 0000									
Bldg	conducted by the In accordance with 42 Survey Date: 11/17 Facility Number: 0 Provider Number: 201 At this Emergency Knoll Village was f Emergency Prepare Medicare and Medi and Suppliers, 42 C The facility has 117 the survey, the cens	27/22 212901 2155814 215100  Preparedness survey, Brooke found in compliance with dness Requirements for caid Participating Providers 2FR 483.73  2 certified beds. At the time of	E 00	000	Submission of this plan of correction does not constitute admission or an agreement of truth of the facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared submitted in accordance with requirements under state and federal law.  Please accept this plan of correction as our credible allegations of compliance as of November 18th, 2022.	f the e and the			
K 0000									
Bldg. 01	was conducted by the Health in accordance Survey Date: 11/17 Facility Number: 0 Provider Number: AIM Number: 201 At this Life Safety (	12901 155814 215100 Code survey, Brooke Knoll	K 0	000	Submission of this plan of correction does not constitute admission or an agreement of truth of the facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared submitted in accordance with requirements under state and federal law.	f the e and the			
	Village was found i	not in compliance with	1		Please accept this plan of				

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

Requirements for Participation

correction as our credible

TITLE

Megan Davison, HFA Administrator 12/02/2022

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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(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155814		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  11/17/2022							
NAME OF PROVIDER OR SUPPLIER BROOKE KNOLL VILLAGE			1108 K	STREET ADDRESS, CITY, STATE, ZIP COD 1108 KINGWOOD DRIVE AVON, IN 46123					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112				
	Life Safety From Fi National Fire Protec Life Safety Code (I Health Care Occupa	, 42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, .SC), Chapter 19, Existing ancies and 410 IAC 16.2.		allegations of compliance as of November 18th, 2022.	of				
	Type V (111) const The facility has a findetection in the corridor. The far wired to the fire alaresident sleeping ropiped in oxygen and	ruction and fully sprinklered. re alarm system with smoke ridor and in all areas open to cility has smoke detectors hard rm system installed in all oms. The facility also has d suction in all resident rooms. upacity of 117 and had a							
	access were sprinkle facility services were	residents have customary ered. All areas providing re sprinklered.							
K 0200 SS=E Bldg. 01	Means of Egress List in the REMAR Section 18.2 and requirements that provided K-tags, b information, along Safety Code or NF	Requirements - Other Requirements - Other RKS section any LSC 19.2 Means of Egress are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.							
	Based on observation failed to ensure 1 of service hall was progrequired only one of states doors comply	on and interview, the facility full door from the kitchen to the evided with door latches that peration to open. LSC 19.2.2.1 ing with 7.2.1 shall be 0.2 requires the releasing	K 0200	Submission of this plan of correction does not constitute admission or an agreement of truth of the facts alleged or correction set forth on the statement of deficiencies. Th	f the				

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	COMPLETED	
155814		B. WING 11/17/2022			/2022			
				STREET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				INGWOOD DRIVE			
BROOKE	KNOLL VILLAGE				IN 46123			
			1				ı	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE	
		en the door leaf with not more			plan of correction is prepared			
		operation. This deficient			submitted in accordance with	the		
	l -	t as many as five staff working			requirements under state and			
	in the kitchen.				federal law.			
	Eindings in sluder				Diagon account this wise of			
	Findings include:				Please accept this plan of			
	Dagad on abassur-4:	on during a tour of the facility			correction as our credible	.f		
		on during a tour of the facility rporate Maintenance and the			allegations of compliance as o	Л		
		or on 11/17/22 at 1:22 p.m., the			November 18th, 2022.			
	1	g out into the service hall door			1. Upon notification of this			
	1	an independent dead bolt in			- 1			
		l door lever mechanism. Based			alleged deficiency, the facility immediately removed the			
		time of observation, The			secondary operating mechanis	000		
		te Maintenance acknowledged			from the aforementioned kitch			
	_	having an independent dead				en		
		tical door lever mechanism			door. 2. The facility conducted			
		are and stated that he would			2. The facility conducted audits of all kitchen doors to			
	_	replaced as soon as he was			ensure no similar conditions			
	able as the facility Maintenance Director was out on vacation.				existed. No further concerns value notified.	were		
	on vacation.				3. As a means to ensure			
	This finding was reviewed with the Administrator				ongoing compliance, the Direct	etor		
	_	Corporate Maintenance during			of Maintenance shall inspect a			
		on 11/17/22 at 2:30 p.m.			kitchen doors on a monthly ba			
	the exit conference	on 11/1//22 at 2.30 p.m.			for a minimum of six months p			
	3.1-19(b)				the preventative maintenance			
	J.1-17(U)				program to confirm no second			
					operating mechanisms have b			
					affixed.	CCII		
					4. The results of the month	nlv		
					audit and any corrective action	-		
					will be reported to the Quality	ı		
					Assurance Committee during	the		
					monthly quality assurance	u IC		
					meeting with the frequency of			
					inspection to be revised, as			
					indicated, on the basis of			
					compliance			
	ī		1				•	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM			COMPL	ETED	
		155814	B. WI	B. WING 11/		11/17/	11/17/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				INGWOOD DRIVE			
BROOKE KNOLL VILLAGE				AVON, IN 46123				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0293	NFPA 101							
SS=E	Exit Signage							
Bldg. 01	Exit Signage							
	2012 EXISTING							
	Exit and directional signs are displayed in							
		.10 with continuous						
	illumination also served by the emergency lighting system.							
	19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants							
	where the line of exit travel is obvious.)		K 0293					
	Based on observation and interview, the facility				Submission of this plan of		11/18/2022	
	failed to install exit signage in 1 of 1 kitchen in the				correction does not constitute			
	-	ce with LSC 7.10. LSC 7.10.1.2.1			admission or an agreement of	the		
		in exterior exit doors that			truth of the facts alleged or			
	•	ly are identifiable as exits,			correction set forth on the			
	•	an approved sign that is			statement of deficiencies. The			
	-	any direction of exit access.			plan of correction is prepared			
		es horizontal components of the nexit enclosure shall be			submitted in accordance with t	.ne		
		d exit or directional exit signs			requirements under state and federal law.			
		ion of the egress path is not			l lederal law.			
		ent practice could affect as			Please accept this plan of			
		orking in the kitchen area.			correction as our credible			
	many as nive starr w	orking in the kitchen trea.			allegations of compliance as o	f		
	Findings include:				November 18th, 2022.	'		
	8				110101111011111111111111111111111111111			
	Based on observation	on during a tour of the facility			1. An approved EXIT sign	has		
		rporate Maintenance and the			been affixed to two designated			
		or on 11/17/22 at 1:25 p.m., the			kitchen exit doors in the kitche			
		signage located within it.			designate the path of egress to	o		
		f four doors located within the			the nearest facility exit.			
	kitchen, but none of	these were identified as			2. All other doors througho	out		
	facility exits to the	public way necessary for			the kitchen were inspected wit			
		se of an emergency. Based on			other doors identified as exits			
	interview at the time	e of observation, the Director			in need of a sign to indicate th	е		
	of Corporate Mainte	enance acknowledged the			path of egress to the nearest			
	aforementioned con	dition and confirmed that the			facility exit.			
	path of egress to the nearest facility exit was not				3. As a means to ensure			

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155814		A. BUILDING B. WING	01	COMPLETED  11/17/2022					
NAME OF PROVIDER OR SUPPLIER  BROOKE KNOLL VILLAGE			1108 K	STREET ADDRESS, CITY, STATE, ZIP COD 1108 KINGWOOD DRIVE AVON, IN 46123					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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				
	and the Director of	viewed with the Administrator Corporate Maintenance during on 11/17/22 at 2:30 p.m.		ongoing compliance, the Direct of Maintenance shall inspect a kitchen exit doors on a month basis to for a minimum of six months per the preventative maintenance program to confit that any door that is marked a exit maintains appropriate sign that reads EXIT to ensure the designates the path of egress the nearest facility exit. Shou sign be observed to be missin misplaced, immediate correct action shall be taken.  4. The results of the mont inspection and any corrective action will be reported to the Quality Assurance Committee during monthly quality assurance meetings with the frequency of inspection revised, as indicate on the basis of compliance.	all ly  irm us an nage door to ld a ug / ive hly				
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dri and unexpected tir conditions, at leas: The staff is familia aware that drills ar routine. Where dri 9:00 PM and 6:00 announcement ma audible alarms. 19.7.1.4 through 1 Based on record rev	t quarterly on each shift.  r with procedures and is re part of established  ills are conducted between  AM, a coded  ay be used instead of	K 0712	Submission o f this plan of correction does not constitute	11/18/2022				

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		X1) PROVIDER/SUPPLIER/CLIA	1 1	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER							COMPLETED	
155814		B. WING 11/17/2022				2022		
NAME OF PROVIDER OR SUPPLIER BROOKE KNOLL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 1108 KINGWOOD DRIVE AVON, IN 46123					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIC DI AN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	<sub></sub>	COMPLETION	
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	quarters. LSC 19.7.	1.6 requires drills to be			admission or an agreement of	the		
	conducted quarterly	on each shift under varied			truth of the facts alleged or			
	conditions. This def	ficient practice affects all staff			correction set forth on the			
	and residents.				statement of deficiencies. The	e		
					plan of correction is prepared	and		
	Findings include:				submitted in accordance with	the		
					requirements under state and			
		view with the facility			federal law.			
		he Director of Corporate						
		17/22 at 12:04 p.m., no			Please accept this plan of			
		d be provided regarding a fire			correction as our credible			
	_	arter (January, February, and			allegations of compliance as o	of		
	March) of 2022. Based on interview at the time of				November 18th, 2022.			
		Director of Corporate			Upon notification of this	3		
		wledged that there was no			alleged deficiency, the facility			
		fire drill documentation			initiated education to the			
	available for review	at the time of this survey.			Maintenance Director related	to		
	7E1 ' C' 1'	. 1 24 4 4 1 2 4			the fire drill policy. Education			
		viewed with the Administrator			conducted to ensure fire drills			
		Corporate Maintenance during			completed monthly on alterna	ling		
	the exit conference	on 11/17/22 at 2:30 p.m.			shifts so that each shift will			
	3.1-19(b)				experience a fire drill each			
	3.1-19(b) 3.1-51(c)				quarter.  2. The fire drill records fo	,		
	J.1-J1(c)				previous months were reviewe			
					with no concerns identified	,		
					3. As a means to ensure			
					ongoing compliance, the month	thly		
					fire drill records will be audited			
					monthly for a minimum period			
					months by the administrator o			
					designee.			
					4. The results of the month	nly		
					audit and any corrective action	-		
					will be reported to the Quality			
					Assurance Committee during	the		
					monthly quality assurance			
					meeting with the frequency of			
					inspection to be revised, as			
				indicated, on the basis of				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155814	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/17/2022		
NAME OF PROVIDER OR SUPPLIER BROOKE KNOLL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 1108 KINGWOOD DRIVE AVON, IN 46123				
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION					DATE
					compliance.		

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