STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155814	A. BUILDING -- B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKE KNOLL VILLAGE	1108 KINGWOOD DRIVE 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: 11/17/22 Facility Number: 012901 Provider Number: 155814 AIM Number: 201215100 At this Emergency Preparedness survey, Brooke Knoll Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 117 certified beds. At the time of the survey, the census was 74. Quality Review completed on 11/22/22	E 0000	Submission o f this plan of correction does not constitute an admission or an agreement of the truth of the facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted in accordance with the requirements under state and federal law. Please accept this plan of correction as our credible allegations of compliance as of November 18th, 2022.	
K 0000 Bldg. 01	A Life Safety Code and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/17/22 Facility Number: 012901 Provider Number: 155814 AIM Number: 201215100 At this Life Safety Code survey, Brooke Knoll Village was found not in compliance with Requirements for Participation	K 0000	Submission o f this plan of correction does not constitute an admission or an agreement of the truth of the facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted in accordance with the requirements under state and federal law. Please accept this plan of correction as our credible	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Davison, HFA	Administrator	12/02/2022

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	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 also has piped in oxygen and suction in all resident rooms. The facility has a capacity of 117 and had a census of 74 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 11/22/22		allegations of compliance as of November 18th, 2022.	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 1 of 1 door from the kitchen to the service hall was provided with door latches that required only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing	K 0200	Submission o f this plan of correction does not constitute an admission or an agreement of the truth of the facts alleged or correction set forth on the statement of deficiencies. The	11/18/2022

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	mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect as many as five staff working in the kitchen. Findings include: Based on observation during a tour of the facility with Director of Corporate Maintenance and the facility Administrator on 11/17/22 at 1:22 p.m., the kitchen door leading out into the service hall door was equipped with an independent dead bolt in addition to a vertical door lever mechanism. Based on interview at the time of observation, The Director of Corporate Maintenance acknowledged the kitchen door as having an independent dead bolt as well as a vertical door lever mechanism with latching hardware and stated that he would have the door lever replaced as soon as he was able as the facility Maintenance Director was out on vacation. This finding was reviewed with the Administrator and the Director of Corporate Maintenance during the exit conference on 11/17/22 at 2:30 p.m. 3.1-19(b)		plan of correction is prepared and submitted in accordance with the requirements under state and federal law. Please accept this plan of correction as our credible allegations of compliance as of November 18th, 2022. 1. Upon notification of this alleged deficiency, the facility immediately removed the secondary operating mechanism from the aforementioned kitchen door. 2. The facility conducted audits of all kitchen doors to ensure no similar conditions existed. No further concerns were notified. 3. As a means to ensure ongoing compliance, the Director of Maintenance shall inspect all kitchen doors on a monthly basis for a minimum of six months per the preventative maintenance program to confirm no secondary operating mechanisms have been affixed. 4. The results of the monthly audit and any corrective actions 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 compliance.	

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K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 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.) Based on observation and interview, the facility failed to install exit signage in 1 of 1 kitchen in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect as many as five staff working in the kitchen area. Findings include: Based on observation during a tour of the facility with Director of Corporate Maintenance and the facility Administrator on 11/17/22 at 1:25 p.m., the kitchen had no exit signage located within it. There were a total of four doors located within the kitchen, but none of these were identified as facility exits to the public way necessary for evacuation in the case of an emergency. Based on interview at the time of observation, the Director of Corporate Maintenance acknowledged the aforementioned condition and confirmed that the path of egress to the nearest facility exit was not	K 0293	Submission o f this plan of correction does not constitute an admission or an agreement of the truth of the facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted in accordance with the requirements under state and federal law. Please accept this plan of correction as our credible allegations of compliance as of November 18th, 2022. 1. An approved EXIT sign has been affixed to two designated kitchen exit doors in the kitchen to designate the path of egress to the nearest facility exit. 2. All other doors throughout the kitchen were inspected with no other doors identified as exits and in need of a sign to indicate the path of egress to the nearest facility exit. 3. As a means to ensure	11/18/2022

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	obvious. This finding was reviewed with the Administrator and the Director of Corporate Maintenance during the exit conference on 11/17/22 at 2:30 p.m. 3.1-19(b)		ongoing compliance, the Director of Maintenance shall inspect all kitchen exit doors on a monthly basis to for a minimum of six months per the preventative maintenance program to confirm that any door that is marked as an exit maintains appropriate signage that reads EXIT to ensure the door designates the path of egress to the nearest facility exit. Should a sign be observed to be missing / misplaced, immediate corrective action shall be taken. 4. The results of the monthly 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 indicated, on the basis of compliance.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4	K 0712	Submission o f this plan of correction does not constitute an	11/18/2022

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	quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the facility Administrator and the Director of Corporate Maintenance on 11/17/22 at 12:04 p.m., no documentation could be provided regarding a fire drill for the first quarter (January, February, and March) of 2022. Based on interview at the time of record review, the Director of Corporate Maintenance acknowledged that there was no additional available fire drill documentation available for review at the time of this survey. This finding was reviewed with the Administrator and the Director of Corporate Maintenance during the exit conference on 11/17/22 at 2:30 p.m. 3.1-19(b) 3.1-51(c)		admission or an agreement of the truth of the facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted in accordance with the requirements under state and federal law. Please accept this plan of correction as our credible allegations of compliance as of November 18th, 2022. 1. Upon notification of this alleged deficiency, the facility initiated education to the Maintenance Director related to the fire drill policy. Education conducted to ensure fire drills are completed monthly on alternating shifts so that each shift will experience a fire drill each quarter. 2. The fire drill records for previous months were reviewed with no concerns identified 3. As a means to ensure ongoing compliance, the monthly fire drill records will be audited monthly for a minimum period of 6 months by the administrator or designee. 4. The results of the monthly audit and any corrective actions 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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			compliance.	