STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155236	A. BUILDING -- B. WING	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN 46123

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/11/25 Facility Number: 000141 Provider Number: 155224 AIM Number: 100266780 At this Emergency Preparedness survey, Avon Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 137 certified beds. At the time of the survey, the census was 103. Quality Review completed on 02/12/25	E 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. the plan of correction ids provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	
K 0000 Bldg. 02	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: 02/11/25 Facility Number: 000141 Provider Number: 155236 AIM Number: 100283860 At this Life Safety Code survey, Avon Health &	K 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. the plan of correction ids provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brian P McKamie	Administrator	02/21/2025

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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	Rehabilitation Center 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, 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 corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 103 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached wooden shed providing storage which was not sprinklered. Quality Review completed on 02/12/25			
K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 3 riser rooms were maintained in a safe operating condition. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect as many as 16 residents, 4 staff, and 2 visitors. Findings include:	K 0511	**Plan of Correction (POC) for K511** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·The Director of Maintenance inspected the 500 Hall dry riser room and confirmed that the electrical conduit was not properly threaded into the valve body. ·The Maintenance Director made	02/19/2025

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	Based on observation with the Director of Maintenance during the tour of the facility on 02/11/25 at 12:49 p.m., there were exposed wires hanging from the junction box in the 500 Hall dry riser room. It looked as if the junction box had been struck with a linen cart that was stored therein. Based on an interview at the time of the observation, the Director of Maintenance stated that he was going to call his sprinkler system vendor and have them repair the junction box. This item was discussed with the facility Administrator, the Regional Maintenance Director, and the Director of Maintenance at the exit conference held on 02/11/25. 3.1-19(b)		the necessary repair on 02/12/25, securing the electrical conduit and ensuring proper installation. ·The repair was verified by the Executive Director to confirm compliance. **2. How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action(s) will be taken?** ·A facility-wide inspection of all riser rooms was conducted by the Director of Maintenance to ensure no other junction boxes or electrical components were damaged or improperly secured. ·No additional deficiencies were identified during this inspection. ·Staff were re-educated on the proper storage of linen carts and other equipment to prevent accidental damage to electrical and sprinkler system components. **3. What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** ·The facility will install a protective bar that will eliminate any forceful contact to the electrical conduit. Reducing the risk of it coming dislodged. ·Maintenance staff will conduct monthly preventative maintenance checks on all riser rooms to identify and address potential safety hazards.	

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			·Facility staff, including housekeeping and nursing, have been re-educated on the importance of keeping riser rooms clear of unauthorized storage. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place)?** ·The Director of Maintenance or designee will conduct weekly inspections of all riser rooms for 60 days to ensure compliance. ·After 60 days, inspections will continue monthly as part of the facility's Preventative Maintenance Program. ·Inspection findings will be documented and reviewed in monthly Quality Assurance and Performance Improvement (QAPI) meetings to ensure sustained compliance. ·Any non-compliance identified will result in immediate corrective action and additional staff education as needed.	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Based on record review and interview, the facility failed to ensure 10 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire	K 0712	**Plan of Correction (POC) for K712** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/19/2025

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	conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the document titled "Fire Drill Report" with the Director of Maintenance on 02/11/25 at 9:58 a.m., the documentation for the fire drills for ten of the past twelve months lacked verification of the transmission of the signal for drills. The documented fire drills for April of 2024 through January of 2025 all lacked the aforementioned verification of the transmission of the signal at the monitoring company. Based on interview at the time of record review, the Director of Maintenance stated that he was unaware of the requirement for the verification of the transmission of the fire alarm signal with the monitoring company in his records but added that he would begin to document this immediately. This item was discussed with the facility Administrator, the Regional Maintenance Director, and the Director of Maintenance at the exit conference held on 02/11/25. 3.1-19(b) 3.1-51(c)		**practice?** ·The Director of Maintenance and Maintenance Assistant were educated on 02/19/25 regarding the requirement to verify and document the transmission of the fire alarm signal to the facility's monitoring company (SafeCare) during fire drills. ·The February 2025 fire drill was conducted with proper verification and documentation of the alarm transmission to ensure immediate compliance. ·The Executive Director reviewed and verified the February drill documentation for accuracy. **2. How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action(s) will be taken?** ·Since fire safety procedures affect all residents, staff, and visitors, the facility reviewed past fire drill procedures to identify any gaps in compliance. ·The Director of Maintenance completed a full review of the facility's fire drill records for the past 12 months to confirm the issue was specific to missing verification documentation. ·Moving forward, all fire drills will include a documented verification from the monitoring company confirming receipt of the alarm signal. **3. What measures will be put**	

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			into place, and what systemic changes will be made to ensure that the deficient practice does not recur? ·The Fire Drill Report Form has been updated to include a specific field for documenting the monitoring company's verification of the alarm transmission. ·The Maintenance Director and Maintenance Assistant will receive ongoing training to ensure that this requirement is met for each monthly fire drill. ·The Executive Director will review all fire drill documentation within 24 hours of drill completion to ensure proper verification and compliance. **4. How will the corrective action(s) 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 verify and sign off on each monthly fire drill report to confirm that the monitoring company verification is properly documented. ·The Director of Maintenance will report fire drill compliance findings during the facility's monthly Quality Assurance and Performance Improvement (QAPI) meetings for the next six months. ·After six months of consistent compliance, fire drill documentation will continue to be monitored quarterly as part of the	

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			facility's ongoing life safety compliance program. ·Any identified deficiencies will result in immediate retraining and corrective action. **5. By what date will the systemic changes for each deficiency be completed?** ·02/19/25, with continued monitoring as outlined above.	