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	12/14/2023

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: 12/14/23 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 49. Quality Review completed on 12/18/23	E 0000	**REQUESTING DESK REVIEW** 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	
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). Survey Date: 12/14/23 Facility Number: 000184 Provider Number: 155286 AIM Number: 100267210 At this LSC survey, Avalon Village was found not in compliance with Requirements for Participation	K 0000	**REQUESTING DESK REVIEW** 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessica Slone	Executive Director	12/28/2023

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	155286	A. BUILDING 01 B. WING	12/14/2023

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	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 49 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 12/18/23			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered			

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	Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type of V (111) by ensuring the one hour rated ceiling was kept in good repair and was not open to the attic. This deficient practice affects 25 residents in one smoke compartment. Findings include: Based on observation with the Regional Maintenance Director and the Administrator on 12/14/23 at 11:53 a.m., above the ceiling tiles by the 200-hall smoke wall there was a three-foot by two-foot section of the double layer of drywall that collapsed and was laying on the suspended ceiling. Based on interview at the time of	K 0161	REQUESTING DESK REVIEW **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Repair was made and the ceiling by the 200 hall smoke doors now complies with K 161. **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:**	12/31/2023

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	observation, the Regional Maintenance Director agreed the one hour rated ceiling was not properly maintained due to the damage of the ceiling. This finding was reviewed with the Regional Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		All residents have the potential to be affected. All of the remaining ceiling structure was 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 K161 requiring that all ceiling structures remain maintained in accordance with K 161. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review that all ceiling structures are inspected for damage and are in compliance with K 161. **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 ceiling structures are in good repair and compliant with K 161. 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:** **12/31/23**	

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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. 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 1 of 6 hazardous mechanical rooms which contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20	K 0321	REQUESTING DESK REVIEW **1. What corrective action(s) will be accomplished for those residents found to have been**	12/31/2023

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	residents in one smoke compartment. Findings include: Based on observation with the Regional Maintenance Director and the Administrator on 12/14/23 at 10:53 a.m., in the administrator office mechanical room which contained fuel fired hot water heaters had two unsealed one-inch gaps around duct work in the ceiling. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed penetrations in the mechanical room which contained fuel fired equipment. This finding was reviewed with the Regional Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		**affected by the deficient practice:** The penetrations in the mechanical room were repaired and sealed. **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 mechanical rooms were assessed and there were no penetrations found. **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 was educated that that all mechanical rooms are to be free of penetrations and all duct work is to be sealed and in compliance. The QAPI and PM calendar was updated for the Maintenance Director to check that all mechanical rooms are free of penetrations are in compliance with K321. **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 mechanical rooms are free of	

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			penetrations. 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: 12/31/23**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or			

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	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure only hold open devices that release when the door is pushed or pulled was used for 1 of 1 maintenance doors. This deficient practice could affect staff in the service hall. Findings include: Based on observation with the Regional Maintenance Director and the Administrator on 12/14/23 at 11:13 a.m., the maintenance office door was held open with a rope which was tied to a doorknob from a hook on the wall, and the door would not close by just pulling or pushing the door. Based on interview at the time of observation, the Administrator agreed the door was held open with a rope and could not close the door unless the rope was removed. This finding was reviewed with the Regional Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0363	REQUESTING DESK REVIEW **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Maintenance Door was assessed immediately and is able to open and close by pulling or pushing on the door. **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 areas in the building were assessed and in compliance with K 363 **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 363 and	12/31/2023

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			ensuring doors are not obstructed or held open by devices. The QAPI and PM calendar was updated for the Maintenance Director to review compliance with K 363. **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 rooms are unobstructed and doors open and close when being pushed or pulled shut. 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: 12/31/23**	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent			

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	to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observations, records review, and interview, the facility failed to ensure 2 of 2 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814, Standard Test Method for Fire-Tests of Through-Penetration Fire Stops. This deficient practice affects all residents in three smoke compartments. Findings include: Based on observation with the Regional Maintenance Director and the Administrator on 12/14/23 at 11:58 a.m., the 200 and 300 smoke barrier walls contained three penetrations sealed with white silicone. Based on records review with the Regional Maintenance Director and the Administrator at 12:05 p.m., there was no documentation to show if the white silicone meets ASTM 814. Based on interview at the time of observation, the Regional Maintenance Director stated the listing of the caulk is unknown. This finding was reviewed with the Regional Maintenance Director and the Administrator	K 0372	REQUESTING DESK REVIEW **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The silicone around the penetrations in 200 and 300 hall were removed and the walls were repaired and fire caulk applied. **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 ceiling structures were inspected by the smoke doors to ensure penetrations were filled with fire caulk and not silicone. **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 proper filling of penetrations with approved fire caulk. The QAPI and PM calendar was updated for the Maintenance Director to check all ceilings structures to ensure appropriate approved fire caulk is used in penetrations.	12/31/2023

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	during the exit conference. 3.1-19(b)		**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 penetrations have approved fire caulk. 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: 12/31/23**	