STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155811	A. BUILDING -- B. WING	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF AVON	10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234

(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: 12/08/22 Facility Number: 013085 Provider Number: 155811 AIM Number: 201279600 At this Emergency Preparedness survey, Wellbrooke of Avon was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 70 certified beds. At the time of the survey, the census was 49. Quality Review completed on 12/14/22	E 0000		
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: 12/08/22 Facility Number: 013085 Provider Number: 155811 AIM Number: 201279600 At this Life Safety Code survey, Wellbrooke of Avon was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Dent	Executive Director	12/23/2022

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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	Requirements for Participation 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 has a capacity of 70 and had a census of 49 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 12/14/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 5 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following	K 0211	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The	12/14/2022

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	155811	A. BUILDING 01 B. WING	12/08/2022

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	conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Director of Plant Operations (D.P.O.) on 12/08/22 at 12:50 p.m. during a tour the facility, there was a PVC cart approximately 60 inches wide by 28 inches deep by 60 inches high cart sitting in the corridor identified as "Ren 1" by Therapy. Staff referred to this as the lost-and-found cart. This cart had five pairs of slacks, seven shirts, and other miscellaneous items stored in it. Based on interview with the Director of Plant Operations at the time of the observation, he acknowledged the item was not in use, medical emergency equipment, or patient lift or transport equipment and was being stored in the corridor. This item was discussed at the exit conference with the facility Administrator and the D.P.O. on 12/08/22 at 1:30 p.m. 3.1-19(b)		Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on December 8, 2022 **K211 – Means of egress** **Immediate Intervention** The wheeled cart that was being stored in the hallway was immediately removed to a location in the campus as not to impede the path of egress in the hallway. Which could affect approximately 16 residents, 4 Staff and 2 visitors to meet deficiency K211. **Exhibit A – Photo** **Exhibit B – Photo** **Compliance Date 12- 14-22** The Director of Plant Operations was educated by regional support on NFPA 101 Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11 and 18.2.1,19.2.1, 7.1.10.1 and in accordance with 19.2.3.4(4) **Exhibit C – Inservice Documentation**	

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			The Director of Plant Operations will audit hallways for means of egress Daily for 6 weeks then weekly for 6 weeks **Exhibit D – Audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	