

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2012
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NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY ST BERNE, IN 46711
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/24/12</p> <p>Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Chalet Village Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111)</p>	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detections have been install in the resident rooms. The facility has a capacity of 80 and had a census of 35 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except an unsprinklered shed used for storage of maintenance equipment and activity supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/02/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exit doors was accessible. Health care occupancies permit delayed egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect 4 residents in the South hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Administrator on 09/24/12 at 1:00 p.m., according to the signage on the main entrance/exit door, the door was equipped with electromagnetic locks which released after pushing the door for 15 seconds. When tested by the Maintenance Supervisor at the time of observation, the door released after 30 seconds. This</p>	K0038	<p>Corrective Action for Residents affected: Maintenance Director reprogrammed door to release in 15 seconds. This was completed on 9/24/12.</p> <p>Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. Maintenance Director reprogrammed door to release in 15 seconds. This was completed on 9/24/12.</p> <p>Measures to ensure this practice does not recur: Maintenance Director has assessed all doors to ensure they all release in 15 seconds. The Maintenance Director will monitor weekly x 4 weeks, then monthly thereafter and document findings on Attachment #1 and will be reviewed monthly in Quality Assurance meeting.</p> <p>The corrective action will be monitored by: The Maintenance Director will monitor weekly x 4 weeks, then monthly thereafter and document findings on Attachment #1. Any negative finding will be immediately corrected.</p>	09/24/2012

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	was acknowledged by the Administrator at the time of observation and test. 3.1-19(b)				

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K0064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire extinguishers on the South hall was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice could affect 4 residents in the South hall.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 09/24/12 at 11:50 a.m., the gauge on the portable fire extinguisher located near the South hall lounge indicated the extinguisher needed to be recharged. This was acknowledged by the Maintenance</p>	K0064	<p>Corrective Action for Residents affected: Maintenance Director replaced uncharged fire extinguisher with new, charged extinguisher on 9/24/12.</p> <p>Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice.</p> <p>Maintenance Director replaced uncharged fire extinguisher with new, charged extinguisher on 9/24/12.</p> <p>Measures to ensure this practice does not recur: Director of Maintenance has assessed all fire extinguishers with no other findings of noncompliance. Maintenance Director will monitor fire extinguishers weekly x 4 weeks, then monthly thereafter and document findings on attachment #2 to ensure fire extinguishers are charged.</p> <p>The corrective action will be monitored by: Fire Extinguisher monitoring will be reviewed monthly at Quality Assurance meeting for continued compliance. Any negative findings will be corrected immediately. This monitoring will be ongoing.</p>	09/24/2012

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	Supervisor at the time of observation. 3.1-19(b)			