

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/14/14</p> <p>Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Swiss Village Inc. 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 with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the</p>	K010000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014	
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010011 SS=D	<p>resident rooms. The facility has a capacity of 128 and had a census of 110 at the time of this survey.</p> <p>All areas where resident have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Westenfeld fire barriers to nonconforming buildings was protected by a two hour fire wall. This deficient practice could affect 1 of 2 smoke compartments in the Westenfeld hall.</p>	K010011	<p>TAG K 011_SS=D Based on the findings and interview, the facility failed to ensure that 1 of 1 Westenfeld fire barrier to the nonconforming building was protected by a two hour fire wall. This deficient practice could affect 1 of 2 smoke compartments in the</p>	01/29/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>Based on observation with the Plant Operations Manager on 10/14/14 at 1:10 p.m., he acknowledged the firewall which separates the Westenfeld hall from the main kitchen/entrance area had a set of 30 minute fire rated double doors that lacked latching hardware and failed to latch into the frame.</p> <p>3.1-19(b)</p>		<p><i>Westenfeld hall. The deficiency is not in compliance to NFPA 101 Life Safety Standard 19.1.1.4.1, 19.1.1.4.2 and 19.1.2.1.</i></p> <p><i>Finding include: Based on the observation with Plant Operations Manager on 10/14/14 at 1:10pm, he acknowledged the firewall which separates the Westenfeld hall from the main kitchen/entrance area had a set of 30 minute fire rated double doors that lacked latching hardware and failed to latch into the frame. POC</i></p> <p>1.The set of double doors entering the Westenfeld Place were identified by the surveyor as not creating a fire barrier from the adjacent corridor. The doors were rated 1 hour but need to be rated as 2 hour fire rated doors to be in compliance to NFPA 101 Life Safety Standard 19.2.2.5, 7.2.4, 7.2.4.3.1, 8.2.3.2, 7.2.1.8, 7.2.1.5.4, and 8.2.3.2.3.1</p> <p>1.The Westenfeld double doors will be replaced with 2 hour rated fire doors and will have hardware that will latch into the door frame as well as latching into adjoining door. This will meet NFPA 101 Life Safety Standard 19.2.2.5, 7.2.4, 7.2.4.3.1, 8.2.3.2, 7.2.1.8, 7.2.1.5.4, and 8.2.3.2.3.1.</p> <p>1.Plant Operation and Maintenance Supervisor will manage the installation, inspection and operation of the Westenfeld pair of fire doors to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K010021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure that once the fire alarm system is activated 1 of 1 horizontal exit door sets entering healthcare would remain self closing until the fire alarm system is returned to normal operations. This deficient practice could affect 1 of 9 smoke compartments.</p>	K010021	<p>assure that doors operate and latch providing a fire separation from the corridor.</p> <p>1.This inspection will be documented and reported to The Quality Assessment & Assurance Committee quarterly. Discussion with Provider of this service, between order, ship and installation an estimated completion time of approximately three months.</p> <p>TAG K 021_SS=D <i>Based on the observation and interview, the facility failed to ensure that once the fire alarm system is activated 1 of 1 horizontal exit door set entering healthcare would remain self closing until the fire alarm system returned to normal operations. This deficient practice could affect 1 of 9 smoke compartments.</i></p>	11/13/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Findings include:</p> <p>Based on observation with the Plant Operations Manager on 10/14/14 at 3:15 p.m., after the activation and subsequent silencing of the fire alarm system the magnetic hold open devices at the set of fire doors entering the Healthcare area engaged holding the fire doors in the open position. The Plant Operations Manager agreed the fire doors must remain self closing until the fire alarm system has been reset and returned to normal operation.</p> <p>3.1-19(b)</p>		<p><i>Findings include:</i></p> <p><i>Based on observation with the Plant Operations Manager on 10/14/14 at 3:15p.m., after the activation and subsequent silencing of the fire alarm systems the magnetic hold open device at the set of fire doors entering the Healthcare area engaged holding the fire doors in the open position. The Plant Operation Manger agrees the fire doors must remain self closing until the fire alarm system has been reset and returned to normal operation.</i></p> <p>POC</p> <p>1. The set of fire doors entering the Healthcare were indentified by the surveyor as remaining engaged after activation and subsequent silencing of the fire alarm system. Upon investigation it was found that the fire alarm control relay, for the fire doors in question, failed to release magnetic hold open device when fire alarm was activated and then silenced. Fire alarm control relay was replaced and then tested by activating and silencing the fire alarm system.</p> <p>2. All fire doors were tested by activating the fire alarm system and silencing the alarms. It was found that upon activation all fire doors released allowing the doors to function as designed.</p> <p>3. Plant Operation Manager will manage the operation and activation of the fire alarm system to assure that the system functions as required and that fire</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014	
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 4 of 9 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient</p>	K010025	<p>doors release as designed. 4. This inspection will be documented and reported on each quarterly "Fire Alarm Report." Exhibit #4</p> <p>TAG K 025_SS=D Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/ or conduit through 4 of 9 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC 8.3.6.1 requires the passage of building services such as pipes, cables or wires be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose.</p>	11/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014	
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>practice could affect 6 of 10 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Plant Operations Manager on 10/14/14 from 12:10 p.m. to 12:45 p.m., the following was noted:</p> <p>a) at the attic smoke barrier wall near resident room 335 there was an unsealed penetration measuring two inches around. At the same smoke barrier wall above the ceiling tile there was an unsealed penetration measuring one inch around an Internet cable</p> <p>b) at the attic smoke barrier wall near resident room 385 there was an unsealed penetration measuring one inch around wiring</p> <p>c) at the attic smoke barrier will entering Edelweiss west there was a one inch unsealed penetration and another unsealed penetration measuring one half inch</p> <p>d) above the ceiling tile at the Sonnenblum smoke barrier wall near resident room 358 there was an unsealed penetration measuring one fourth inch around a data cable</p> <p>Measurements were provided by the Plant Operations Manager at the time of observations.</p>		<p><i>This deficient practice could affect 6 of 10 smoke compartment. Findings include: Based on observation with Plant Operation Manager on 10/14/14 from 12:00 pm to 12:45 pm the following was noted:</i></p> <p><i>1. At the attic smoke barrier wall near resident room 335 there was an unsealed penetration measure 2 inches around. At the same smoke barrier wall above the ceiling tile there was an unsealed penetration measuring one inch around an internet cable.</i></p> <p><i>2. At attic smoke barrier wall near resident room 385 there was an unsealed penetration measuring inch around wiring.</i></p> <p><i>3. At the attic smoke barrier while entering Edelweiss west there was a one inch unsealed penetration and another unsealed penetration measuring one half inch.</i></p> <p><i>4. Above the ceiling tile in Sonnablum smoke barrier wall near resident room 358 there was an unsealed penetration measuring one forth inch around data cable.</i></p> <p><i>Measurements were provided by the Plant Operation Manager at the time of observations. 3.1-19 (b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke Osmoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect staff.</i></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014	
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observations with the Plant Operations Manager on 10/14/14 from 12:14 p.m. to 1:50 p.m., the following was noted:</p> <p>a) in the Lavendale laundry room and adjacent janitor's closet there were unsealed ceiling penetrations ranging in size from a two inch by 12 inch hole around the electrical lines above the breaker box to one fourth inch around a single electrical line.</p> <p>b) above the ceiling tile at the smoke barrier wall near resident room 335 there were unsealed penetrations around water lines measuring from two inches to one fourth inch.</p> <p>Measurements were provided by the Plant Operations Manager at the time of observation.</p>		<p><i>Findings includes: Based on an observations with the Plant Operations Manager on 10/14/14 from 1 2:14 p.m. to 1:50 p.m. the following was noted:</i></p> <p><i>1.In Lavendel laundry room and adjacent janitor's closet there were unsealed ceiling penetrations ranging in size from two inch by 12 inch hole around electrical lines above the breaker box to one forth inch around a single electrical line.</i></p> <p><i>2.Above the ceiling tile at the smoke barrier wall near resident room 335 there were unsealed penetrations around water lines measuring from two inches to one forth inch.</i></p> <p>POC</p> <p>1.The penetrations identified during the survey were sealed with an approved fire caulk to meet the LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC 8.3.6.1 requires the passage of building services such as pipes, cables or wires be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. The list of penetration corrected and their locations are:</p> <p>1.At the attic smoke barrier wall near resident room 335 there was an unsealed penetration</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	3.1-19(b)		<p>measure 2 inches around. At the same smoke barrier wall above the ceiling tile there was an unsealed penetration measuring one inch around an internet cable.</p> <p>2.At attic smoke barrier wall near resident room 385 there was an unsealed penetration measuring inch around wiring.</p> <p>3.At the attic smoke barrier while entering Edelweiss west there was a one inch unsealed penetration and another unsealed penetration measuring one half inch.</p> <p>4.Above the ceiling tile in Sonnablum smoke barrier wall near resident room 358 there was an unsealed penetration measuring one forth inch around data cable.</p> <p>5.In Lavendel laundry room and adjacent janitor's closet there were unsealed ceiling penetrations ranging in size from two inch by 12 inch hole around electrical lines above the breaker box to one forth inch around a single electrical line.</p> <p>6.Above the ceiling tile at the smoke barrier wall near resident room 335 there were unsealed penetrations around water lines measuring from two inches to one forth inch.</p> <p>2.A visual inspection was conducted to assure that all fire walls and smoke barriers are sealed and meet the LSC Section 19.3.7.3.</p> <p>3.Plant Operation Manager will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K010038 SS=D	<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 1 stairways exit doors was readily accessible at all times. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect residents in the Alpenrose Place memory unit evacuated through the stairway in the event of an emergency.</p>	K010038	<p>manage the inspection of all fire and smoke barriers quarterly to assure that all fire and smoke barriers meet the LSC Section 19.3.7.3 code.</p> <p>4.This inspection will be documented and reported to The Quality Assessment & Assurance Committee quarterly for the next year. Exhibit #5</p> <p>TAG K 038 <i>Based on observation and interview, the facility failed to ensure 1 of 1 stairways exit doors was readily accessible at all times. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No 1 requires door locking arrangements without delay egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measure for their safety, provided staff can unlock doors at all times. This deficient practice could affect residents in the Alpenrose Place memory unit evacuated through the stairways in the event of an emergency. Findings include:</i></p>	11/13/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Findings include:</p> <p>Based on observation and interview with the Plant Operations Manager on 10/14/14 at 1:15 p.m., he confirmed the exit door leading to the stairway from Alpenrose Place was equipped with a magnetic lock that released only upon activation of the fire alarm system.</p> <p>3.1-19(b)</p>		<p><i>Based observation and interview with the Plant Operations Manager on 10/14/14 at 1:15 p.m., he confirmed the exit door leading to the stairway from Alpenrose Place was equipped with a magnetic lock that released only upon activation of the fire alarm. POC</i></p> <p>1.The exit door leading to the stairway from Alpenrose Place was equipped with a magnetic lock that released only upon activation of the fire alarm. This was a violation of LSC 18.2.2.2.4 which requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No 1 requires door locking arrangements without delay egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measure for their safety, provided staff can unlock doors at all times. A keypad was installed adjacent to the door area to allowing the stair door to release allowing exiting of the building.</p> <p>2.An inspection of the building was made to assure all exiting door conformed to LSC 18.2.2.2.4.</p> <p>3.Plant Operation Manager will manage inspection and operational integrity of all exiting door to assure compliance to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
			<p>LSC 18.2.2.2.4.</p> <p>4.Plant Operation Manager will manage future construction to assure all fire doors meet LSC 18.2.2.2.4.</p> <p>TAG K 050_SS=C Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affect all occupants. Findings include: Based on record review of the "Fire Drill Report" from the Plant Operation Manager on 10/14/14 at 11:04 a.m., all second shift fire drill took place between 3:00 p.m. and 4:15 p.m. for four of the last four quarters. This was confirmed by the Plant Operations Manager at the time of record review. POC</p> <p>1.Based on record review of the "Fire Drill Report" the facility failed to conduct second shift fire drills, four of the last four quarters, at unexpected time as all drill took place between 3:00 p.m. and 4:15 p.m. This is a deficient practice in violation of NFPA 101 Section 19.7.1.2.</p> <p>2.Although the dates and fire drill situation were different during each drill, the time of each drill was held between the time of 3:00 p.m. and 4:15 p.m.</p> <p>3.Plant Operations Manager will manage drills for each shift on a quarterly basis to fall on different times, situations, and different days of the month.</p> <p>4.The fire drills will be documented and reported to the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014	
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" forms with the Plant Operations Manager on 10/14/14 at 11:04 a.m., all second shift fire drills took place between 3:00 p.m. and 4:15 p.m. for four of the last four quarters. This was confirmed by the Plant Operations Manager at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>Quality Assessment & Assurance Committee quarterly for the next year.</p> <p>TAG K 050_SS=C Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affect all occupants. Findings include: Based on record review of the "Fire Drill Report" from the Plant Operation Manager on 10/14/14 at 11:04 a.m., all second shift fire drill took place between 3:00 p.m. and 4:15 p.m. for four of the last four quarters. This was confirmed by the Plant Operations Manager at the time of record review. POC 1. Based on record review of the "Fire Drill Report" the facility failed to conduct second shift fire drills, four of the last four quarters, at unexpected time as all drill took place between 3:00 p.m. and 4:15 p.m. This is a deficient practice in violation of NFPA 101 Section</p>	11/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014	
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 1 of 4 quarters. LSC 9.7.5 refers to NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice affects all occupants.</p> <p>Findings include:</p>	K010062	<p>19.7.1.2. 2. Although the dates and fire drill situation were different during each drill, the time of each drill was held between the time of 3:00 p.m. and 4:15 p.m. 3. Plant Operations Manager will manage drills for each shift on a quarterly basis to fall on different times, situations, and different days of the month. 4. The fire drills will be documented and reported to the Quality Assessment & Assurance Committee quarterly for the next year.</p> <p>TAG 062_SS=C <i>Based on the findings, improper documentation of the sprinkler inspection that occurred in June/July, 2014 was not discovered until mid October, 2014. NFPA 25, the Standard for Inspection, Testing, and maintenance of Water-based Fire Protection System defines defines inspection, testing, and Maintenance service program provided by qualified contractor or owner's representative in which all components unique to the property's systems are inspected and tested at the required times</i></p>	11/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2014
NAME OF PROVIDER OR SUPPLIER SWISS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 W MAIN ST BERNE, IN 46711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	Based on record review of the "Sprinkler Alarm Testing Report" documentation from Shambaugh & Sons with the Plant Operations Manager on 10/14/14 at 11:35 a.m., the facility lacked documentation of a sprinkler inspection where the waterflow alarms were tested for the second quarter of 2014. After placing a phone call to Shambaugh & Sons at the time of record review, he confirmed there was no sprinkler inspection for the second quarter of 2014. 3.1-19(b)		<i>and necessary maintenance is provided./ This includes logging and retention of relevant records.</i> POC (1) Sprinkler inspection for the second quarter was dated as completed on July 2nd, 2014 when actual completion of inspection was June 30th. This is a record keeping error, so facility had no inspection record dated for the second quarter. (2) Plant Operation and Maintenance Supervisor will manage the scheduling of all future sprinkler inspection to assure that inspection fall with-in time frame to meet the NFPA 25 Standards. (3) Sprinkler inspection will be documented and reported to The Quality Assessment & Assurance Committee quarterly for the next year.		