

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2015
--	---	---	---

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
K 0000 Bldg. 01	<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: 10/13/15</p> <p>Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540</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 resident rooms. The facility has a capacity of 128 and had a census of 114</p>	K 0000		

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 <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/13/2015
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	
K 0022 SS=E Bldg. 01	<p>at the time of this survey.</p> <p>All areas where resident have customary access were sprinklered except for the attic spaces above main health care, Edelweiss, and rehab. All areas providing facility services were sprinklered.</p> <p>Quality Review completed 10/15/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit from the assisted dining room was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect up to 10 residents in the assisted dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Facilities Management</p>	K 0022	- The door in the assisted dining room on Sonnenblum was observed as not being marked as an Exit or Not an Exit. This door is not used as an exit and has been labeled as; "Not an Exit" ; see Exhibit #1. - Labeling of this door will make clear to staff and residents that it is not used as an Exit. - Director of Maintenance will tour facility to assure that no other doors are not marked clearly as an; "Exit" or "Not an Exit". Completed as of 10/27/15.	10/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155707	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2015
--	---	---	---

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
K 0025 SS=E Bldg. 01	<p>Director and the Vice President of Operations on 10/13/15 at 10:30 a.m., the door leading to the outside from the assisted dining room lacked a sign that identified the door either as an exit or not an exit. Based on interview at the time of observation, the Facilities Management Director acknowledged the door was not identified either way.</p> <p>3.1-19(b)</p> <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 5 of 8 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</p>	K 0025	- Observations found penetrations in 6 of 9 smoke compartments had not been appropriately filled with caulk. This wiring was recently added for Wi-Fi services into the Healthcare facility and had not been filled. - Maintenance staff inspected and filled all penetrations with fire approved caulk on 10/13/2015. - All compartments have been inspected. No further wiring	10/13/2015

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 10/13/2015	
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>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 practice could affect up to 80 residents in 6 of 9 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Facilities Management Director on 10/13/15 from 12:00 p.m. to 12:35 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) above the ceiling tiles of the smoke barrier wall by room 358 there was an unsealed fourth of an inch penetration around a wire.</p> <p>b) above the ceiling tiles of the smoke barrier wall by room 360 there was an unsealed fourth of an inch penetration around a wire.</p> <p>c) above the ceiling tiles of the smoke barrier wall by room 374 there was an unsealed hole measuring three inches by five inches in size.</p> <p>d) above the ceiling tiles of the smoke barrier wall by room 337 there was an unsealed fourth of an inch penetration around a wire.</p> <p>e) above the ceiling tiles of the smoke</p>		planned in these areas.				

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 10/13/2015	
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			
K 0052 SS=C Bldg. 01	<p>barrier wall by room 385 there were two unsealed fourth of an inch penetration around a conduits.</p> <p>Based on interview at the time of observation, the Facilities Management Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all occupants.</p>	K 0052	- During record review, Facility was able to provide acknowledgment from Fire Alarm Testing company, but this paperwork did not provide, "a listing showing what devices were tested or hwat devices passed or failed." Since completion of survey, Facility was able to obtain the list requested and is submitted as Exhibit #2 with Plan of Correction. - Discussion with contractor regarding process of completing and providing appropriate paperwork indicating that proper assessment has occurred as designated under K 052. -We request that this deficiency be removed with the offering of the appropriate report.	10/27/2015			

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 10/13/2015	
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			
K 0062 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Facilities Management Director on 10/13/15 at 09:55 a.m., there was no paper work for review to show if the fire alarm systems received an annual test. Based on interview during records review, the Facilities Management Director called the service provider for the alarm system (Honeywell) and stated an email will be sent to surveyor showing the annual inspection. On 10/14/15 an email was received from the Facilities Management Director with a work order ticket from Honeywell stating "8-28-15 Completed fire test, some problems, mait.(maintenance) to replace batteries, be back to correct." On the work order ticket there was not a list showing what devices were tested or what devices passed or failed. The Facilities Management Director did state in email; "Can't get the completed printout until next week."</p> <p>3.1-19(b)</p> <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>						

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 10/13/2015	
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			
K 0075 SS=B Bldg. 01	<p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Facilities Management Director on 10/13/15 at 09:35 a.m., no internal pipe inspection documentation was available for review. Based on an interview at the time of record review, the Facilities Management Director could not find documentation to show if an internal pipe inspection was completed in the last five years. Also, the Facilities Management Director called the service provider for the sprinkler system (Shambaugh), and the Facilities Management Director stated Shambaugh did not have record of an internal pipe inspection.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in</p>	K 0062	- At the time of survey, Facility was unable to provide records of required inspection according to K 062. Communication with service provider, at that time, resulted in comment that no records could be found. Facility later contacted by Service Provider stating a mistake had been made. Report was discovered 10/19/15 and provided to the Facility. This report can be found as Exhibit #3. This report indicates that the 5 year inspection was completed in 2013. We request this deficiency be removed with the offering of the appropriate report.	10/19/2015			

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 10/13/2015
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>a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to properly maintain 1 of 1 unattended trash and soiled linen collection receptacles with a capacity of more than 32 gallons within a 64 square foot area. This deficient practice could affect up to 30 residents using the corridor outside the office suites.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Facilities Management Director and the Vice President of Operations on 10/13/15 at 11:18 a.m., there was a trash collection receptacle that contained paper to be shredded larger than 32 gallons in the medical records room which was open to the corridor. The Medical record office was only occupied during business hours and the room was not protected as a hazardous area. Based on interview at the time of observation, the Facilities Management Director acknowledged the capacity of the collection receptacle did exceed 32 gallons.</p>	K 0075	<p>- Observations found a trash collection type receptacle that contained paper to be shredded. This container is larger than 32 gallons and was being used by staff in an office that could be open to the corridor. This container is a shredder collection container provided by an outside contractor. It is being used temporarily in the medical records office while old medical records are being sorted, scanned and disposed.- This container has been moved to Medical Record storage. This room is closed and locked at all times. Records in this process will be transported daily via cart to this room and container. This has been completed as of 10/14/2015.- Director of Maintenance toured facility to assure no other containers of this capacity are being used in this manner. Medical Record Staff educated on proper storage of container and transporting of finished documents.</p>	10/14/2015	

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 10/13/2015
--	---	--	---

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
K 0130 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the</p>	K 0130	- Observations found an unsealed fourth of an inch penetration around a wire in the fire wall that separates Rehabilitation and Residential Living. This penetration will be filled around the wire with approved fire caulk to protect from the potential passing of fire through the fire wall. - Fire walls inspected and penetrations filled as of 10/14/15. Wires recently installed for Wi-Fi in Rehabilitation area. No plans of further installation of wiring.	10/14/2015

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 10/13/2015
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>following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect up to 20 residents in the rehabilitation unit.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Facilities Management Director on 10/13/15 at 12:30 p.m., there was an unsealed fourth of an inch penetration around a wire in the fire wall that separates rehabilitation from residential living. Based on interview at the time of observation, the Facilities Management Director confirmed the wall was a fire barrier and provided measurements of the penetration.</p> <p>3.1-19(b)</p>				