

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  03/29/2012
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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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(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
K0000	<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: 03/29/12</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. The resident rooms are without smoke detection at this time. The facility has a capacity of 80 and had a census of 29 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/04/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0015 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure the interior finish for 1 of 1 main dining rooms has a flame spread rating of Class A, Class B or Class C finish. This deficient practice could affect any resident in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 03/29/12 at 1:30 p.m., all four walls in the main dining room were covered with carpet. Based on an interview with the Maintenance Supervisor at the time of observation, he stated there was no documentation available to demonstrate the carpet provides a flame spread</p>	K0015	<p>K0015 Corrective Action for Residents affected: No residents were affected by this alleged negative practice. Carpet removed from the main dining room wall on 4/16/12. Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. Carpet was removed from the main dining room wall on 4/16/12. Measures to ensure this practice does not recur: Maintenance Director has reviewed his documentation of fire ratings for all wall coverings in the facility. All wall coverings in facility</p>	04/16/2012			

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	rating of a Class A, Class B or Class C finish.  3.1-19(b)		currently provide a flame spread rating of a Class A, Class B, or Class C finish. The corrective action will be monitored by: All fire ratings documentation is kept in a binder and will be reviewed monthly at the Quality Assurance meeting to ensure continued compliance. This monitoring will be ongoing. Date of completion: 4/16/12		

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K0017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Physical Therapy rooms was provide with corridor walls separating the therapy room from the corridor. This deficient practice could affect any number of residents in the therapy room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 03/29/12 at 3:40 p.m., the rooms on both sides of the east hall corridor near the exit lacked walls separating the rooms from the corridor. Each room contained</p>	K0017	<p>K0017 Corrective Action for Residents affected: No residents were affected by this alleged negative practice. The therapy department and equipment was moved to an enclosed room on 4/16/12. Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. The therapy department and equipment was moved to an enclosed room of 4/16/12. Measures to ensure this practice does not recur:</p>	04/16/2012			

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	therapy equipment such as: exercise balls, a set of steps, a therapy bed and weights. Based on an interview with the Administrator and the Maintenance Supervisor at the time of observation, the entire area was used for resident physical therapy.  3.1-19(b)		Administrator has assessed all corridors to ensure no care is being given in corridors. The Administrator will monitor weekly and document findings on Attachment #1 and will be reviewed monthly in Quality Assurance meeting. The corrective action will be monitored by: The Administrator will monitor weekly and document findings on Attachment #1. Any negative finding will be immediately corrected. Date of completion: 4/16/12		

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 3 of 4 storage rooms with combustibles, measuring over 50 square feet in size, were provided with a self closing device. This deficient practice could affect any of the 10 residents on the west hall and 3 residents on the north hall.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Supervisor on 03/29/12 from 4:05 p.m. to 4:35 p.m., the corridor door to the following rooms with combustible storage, measuring over 50 square feet in size, lacked a self closing device:</p>	K0029	<p>K0029 Corrective Action for Residents affected: No residents were affected by this alleged negative practice.</p> <ol style="list-style-type: none"> <li>Self closing device was installed on west hall nursing supply room by Maintenance Director on 4/20/12.</li> <li>Self closing device was installed on north hall activity storage room by Maintenance Director on 4/20/12.</li> <li>Self closing device was installed on housekeeping office by Maintenance Director on 4/20/12.</li> </ol> <p>Other residents having the potential to be affected and</p>	04/20/2012			

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	<p>a) the west hall nursing supply room measuring one hundred and forty four square feet containing cardboard boxes of briefs,</p> <p>b) the north hall Activity storage room measuring one hundred and ninety four square feet containing seventeen plastic totes full of craft supplies and stuffed animals,</p> <p>c) the north hall housekeeping office measuring two hundred and eight square feet containing cardboard boxes of pillows, paper towels and supplies.</p> <p>This was confirmed by the Maintenance Supervisor at the time of observations.</p> <p>Measurements were provided by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>corrected action: No other residents were affected by this alleged negative practice.</p> <ol style="list-style-type: none"> <li>Self closing device was installed on west hall nursing supply room by Maintenance Director on 4/20/12.</li> <li>Self closing device was installed on north hall activity storage room by Maintenance Director on 4/20/12.</li> <li>Self closing device was installed on housekeeping office by Maintenance Director on 4/20/12.</li> </ol> <p>Measures to ensure this practice does not recur: Director of Maintenance has assessed all storage rooms and offices with no other findings of noncompliance. Maintenance Director will monitor storage rooms and offices monthly and document findings on attachment #2 to ensure self closing devices are installed on proper rooms. The corrective action will be monitored by: Storage</p>		

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			room and office monitoring will be reviewed monthly at Quality Assurance meeting for continued compliance. Any negative findings will be corrected immediately. This monitoring will be ongoing. Date of completion: 4/20/12		

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K0050 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 "Monthly Fire Drill Record" forms with the Administrator and the Maintenance Supervisor on 03/29/12 at 1:40 a.m., all second shift fire drills took place between 3:00 p.m. and 4:20 p.m. for four of the last four quarters and all third shift fire drills took place between 11:00 p.m. and 12:45 a.m. for four of the last four quarters. This was acknowledged by the Maintenance Supervisor at the time of record review.</p>	K0050	<p>K0050 Corrective Action for Residents affected: No residents were affected by this alleged negative practice. The Maintenance Director was re-educated by the Administrator for the need of fire drills to be conducted at unexpected, staggering times for each shift. Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. The Maintenance Director was re-educated by the Administrator for the need of fire drills to be conducted at unexpected, staggering times for each shift.</p>	04/16/2012

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	3.1-19(b) 3.1-51(c)		Measures to ensure this practice does not recur: The Maintenance Director was re-educated by the Administrator for the need of fire drills to be conducted at unexpected, staggering times for each shift. The corrective action will be monitored by: The Administrator will review fire drill documentation monthly during Quality Assurance meetings to ensure continued compliance. Any negative findings will be immediately corrected and will result in re-education and/or disciplinary action. This monitoring will be ongoing. Date of completion: 4/16/12		

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K0056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 2 building overhangs in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice was not in a resident care area but could affect any of the staff.</p> <p>Findings include:</p>	K0056	<p>K0056</p> <p>Corrective Action for Residents affected: No residents were affected by this alleged negative practice.</p> <p>1. Sprinkler will be installed to the overhang area by Elwood Fire Company on 4/27/12.</p> <p>2. Sprinkler in medical records room will be relocated four inches from the wall by Elwood Fire Company on 4/27/12.</p> <p>3. Sprinkler heads in west hall soiled utility rooms will be separated by at least 6 feet by Elwood Fire Company on 4/27/12.</p> <p>Other residents having the</p>	04/27/2012	

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	<p>Based on an observation the Administrator and the Maintenance Supervisor on 03/29/12 at 3:10 p.m., there was an unsprinklered combustible overhang extending seven and one half feet from the building at the service hall exit. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads installed in the medical record closet was at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 03/29/12 at 4:10 p.m., the</p>		<p>potential to be affected and corrected action: No other residents were affected by this alleged negative practice.</p> <ol style="list-style-type: none"> <li>1. Sprinkler will be installed to the overhang area by Elwood Fire Company on 4/27/12.</li> <li>2. Sprinkler in medical records room will be relocated four inches from the wall by Elwood Fire Company on 4/27/12.</li> <li>3. Sprinkler heads in west hall soiled utility rooms will be separated by at least 6 feet by Elwood Fire Company on 4/27/12.</li> </ol> <p>Measures to ensure this practice does not recur: Director of Maintenance has assessed each sprinkler for correct positioning and placement with no other sprinklers being found out of compliance.</p> <p>The corrective action will be monitored by: Maintenance Director will monitor monthly the location of sprinkler heads on Attachment #4.</p> <p>Documentation of sprinkler</p>		

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	<p>sprinkler head in the medical records closet was mounted two inches from the wall. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler heads in the west hall soiled utility room were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any of the 10 residents in the west hall in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 03/29/12 at 4:15 p.m., the west hall soiled utility room had three sprinkler heads. The center sprinkler head was located four and one half feet from the west</p>		<p>inspection will be reviewed monthly at Quality Assurance meeting to ensure continued compliance. This monitoring will be ongoing. Date of completion: 4/27/12</p>	

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	<p>sprinkler head and the three and one half feet from the east sprinkler head. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>			

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(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
K0064 SS=E	<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 main dining room extinguishers was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect any resident in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 03/29/12 at 2:50 p.m., a fire extinguisher is located behind the right side smoke barrier door entering the main dining room. The door was held open with a magnet that releases with the fire alarm. This was acknowledged by the Maintenance Supervisor at the time of observation.</p>	K0064	<p>K0064 Corrective Action for Residents affected: No residents were affected by this alleged negative practice. The fire extinguisher was relocated to ensure it is readily accessible by Maintenance Director on 4/20/12. Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. The fire extinguisher was relocated to ensure it is readily accessible by Maintenance Director on 4/20/12. Measures to ensure this practice does not recur: All fire extinguishers are inspected monthly and will be monitored by the Maintenance Director to ensure all are readily accessible. The corrective action will be monitored by: Facility floor plan with fire extinguisher</p>	04/20/2012

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  03/29/2012
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	3.1-19(b)		locations will be reviewed at monthly Quality Assurance meeting to ensure continued compliance. This monitoring will be ongoing. Date of completion: 4/20/12		

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K0076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 6 of 17 oxygen "E" cylinders were properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any staff in or near the oxygen room.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Supervisor on 03/29/12 at 3:05 p.m., there were six unsupported "E" cylinders of compressed oxygen in the oxygen storage room. This was</p>	K0076	<p>K0076 Corrective Action for Residents affected: No residents were affected by this alleged negative practice. The oxygen E cylinders were properly restrained on 3/29/12. Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. The oxygen E cylinders were properly restrained on 3/29/12. Measures to ensure this practice does not recur: Maintenance Director will monitor oxygen storage room weekly and document findings on Attachment #3 to ensure oxygen E cylinders are restrained.</p>	04/20/2012			

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	acknowledged by the Maintenance Supervisor at the time of observation.  3.1-19(b)		The corrective action will be monitored by: Oxygen storage room monitoring will be reviewed monthly at Quality Assurance meeting for continued compliance. Any negative findings will be corrected immediately. This monitoring will be ongoing. Date of completion: 4/16/12		