

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/15/14</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) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the</p>	K010000	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.

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 09/15/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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>resident rooms. The facility has a capacity of 80 and had a census of 32 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had an unsprinklered shed with storage of maintenance equipment and activity supplies.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/18/14.</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 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 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating.</p>	K010025	<p>1. No residents were affected by this alleged negative practice. All ceiling penetrations were filled and covered on 10-4-2014</p> <p>2. No residents were affected by</p>	10/15/2014			

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 09/15/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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			
K010029 SS=D	<p>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 observations with the Director of Maintenance on 09/15/14 from 1:53 p.m. to 2:20 p.m., the following ceiling penetrations were noted</p> <p>a) there was a one fourth inch gap alongside the escutcheon of the ceiling sprinkler head in the biohazard room</p> <p>b) there was a one half inch gap in the ceiling of the Social Services office</p> <p>c) there were two ceiling penetrations measuring from one fourth inch to one half inch around TV cables in the radio room.</p> <p>Measurements were provided by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p> <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</p>		<p>this alleged negative practice. All ceiling penetrations were filled and covered on 10-4-2014</p> <p>3. In an effort to ensure ongoing compliance with ceiling penetrations, the Director of Maintenance was educated and in-serviced over the importance of filling the ceiling penetrations in a timely manner. The Director of Maintenance and/or designee will monitor ceiling penetrations 1x a week for 4 weeks, then monthly thereafter to ensure there are no findings of ceiling penetrations. Any negative findings will be forwarded to the Administrator immediately and corrected.</p> <p>4. The Director of Maintenance and/or designee will report findings and corrective action of any ceiling penetrations to the Q.A. committee monthly x 3 months, then quarterly thereafter and the plan will be adjusted accordingly.</p>				

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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=E	<p>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 1 of 1 conference rooms with combustibles, measuring over 50 square feet in size, was provided with a self closing device. This deficient practice could affect residents in the conference room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/15/14 at 3:27 p.m., the corridor door to the conference room with combustible storage, measuring over 50 square feet in size, lacked a self closing device. The closet in the conference room contained at least 50 cardboard boxes of facility records. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <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>	K010029	<ol style="list-style-type: none"> No residents were affected by this alleged negative practice. The corridor doors to the closet in the conference room had door closures added to them on 10-4-2014. No residents were affected by this alleged negative practice. The corridor doors to the closet in the conference room had door closures added to them on 10-4-2014. In an effort to ensure ongoing compliance with door closures for rooms with storage, the Director of Maintenance will check all rooms with storage to ensure they have a door closure if needed on a monthly basis for 3 months and quarterly thereafter. Any negative findings will be forwarded to the Administrator immediately and corrected. The Director of Maintenance and/or designee will report findings and corrective action on any issues with rooms that need to have door closures to the Q.A. committee monthly x3 months, then quarterly thereafter and the plan will be adjusted accordingly. 	10/15/2014

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 09/15/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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>Based on observation and interview, the facility failed to ensure 2 of 8 exit doors were 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 any residents evacuated through the service hall from the main dining room in the event of an emergency. This deficient practice could affect 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 09/15/14 at 1:15 p.m. and then again at 1:24 p.m., the north dining room west exit door and the northwest exit door were equipped with electromagnetic locks. When the Director of Maintenance applied force to the doors for at least 15 seconds no alarm sounded and the doors failed to release. A sign on each of the doors indicated it would release in 15 seconds. Additionally, magnetic lock on the northwest exit door did not release when the code was entered. Both doors released upon activation of the fire alarm system. At the time of observations, the Director of Maintenance stated he had</p>	K010038	<ol style="list-style-type: none"> No residents were affected by this alleged negative practice. The north dining room west exit door and the northwest exit door were fixed immediately to ensure the alarms sounded and the doors released in 15 seconds. No residents were affected by this alleged negative practice. The north dining room west exit door and the northwest exit door were fixed immediately to ensure the alarms sounded and the doors released in 15 seconds. In an effort to ensure ongoing compliance with exit doors that need to alarm and release in 15 seconds, the director of maintenance and/or designee will monitor all exit doors 5 days a week for 4 weeks, then weekly x4 weeks, then monthly thereafter. Any negative findings will be forwarded to the Administrator immediately and corrected. The Director of Maintenance and/or designee will report findings and corrective action of any issues to the Q.A. committee monthly x3 months, then quarterly thereafter and the plan will be adjusted accordingly. 	10/15/2014			

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 09/15/2014
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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=F	<p>problems with the magnetic locking system on these doors and would need to order parts but had not yet done so.</p> <p>3.1-19(b)</p> <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 ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly Fire Drill Report" with the Director of Maintenance on 09/15/14 at 12:46 p.m., there was no record of a third shift fire drill for the first quarter of 2014 and the third quarter of 2013. Based on an interview with the Director of Maintenance at the time of record review, he was not employed with the facility at</p>	K010050	<ol style="list-style-type: none"> No residents were affected by this alleged negative practice. A fire drill was conducted on 3rd shift on 9-15-2014. No residents were affected by this alleged negative practice. A fire drill was conducted on 3rd shift on 9-15-2014. In an effort to ensure ongoing compliance with fire drills, the Director of Maintenance was re-educated over the importance of conducting fire drills on various shifts a various times. The Administrator will monitor all fire drills that are completed to ensure they are completed on a timely basis and follow state regulation monthly x6 months, then quarterly thereafter. Any negative findings will be corrected immediately. 	10/15/2014	

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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
K010052 SS=E	<p>that time and there was no other documentation available for review.</p> <p>3.1-19(b) 3.1-51(c)</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 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 any number of occupants.</p> <p>Findings include: Based on record review with the Director</p>	K010052	<p>4. The Director of Maintenance and/or designee will report findings and corrective action in regards to fire drills to the Q.A. committee monthly x3 months, then quarterly thereafter and the plan adjusted accordingly.</p> <p>1. No residents were affected by this alleged negative practice. Elwood Fire Equipment was called on 9-15-2014 to determine where all 10 heat detectors in the facility are located and these were added to the preventative maintenance list to be checked annually.</p> <p>2. No residents were affected by this alleged negative practice. Elwood Fire Equipment was called on 9-15-2014 to determine where all 10 heat detectors in the facility are located and these were added to the preventive maintenance list to be checked annually.</p> <p>3. In an effort to ensure ongoing compliance with annual alarm inspections the heat detectors were added to the preventative maintenance list and the Maintenance Director and/or designee will monitor these monthly</p>	10/15/2014

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 09/15/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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			
K010074 SS=D	<p>of Maintenance on 09/15/14 at 12:13 p.m., the Elwood Fire Equipment fire alarm inspection titled "Fire Alarm Report" dated 04/29/14, listed a total of 10 heat detectors in the facility. Review of the function test documentation listed only seven heat detectors received an annual function test. This was confirmed by the Director of Maintenance at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window coverings in 2 of 30 resident rooms were flame retardant. This deficient practice</p>	K010074	<p>x3 months, then quarterly x3, and then annually. Any negative findings will be forwarded to the Administrator immediately and corrected.</p> <p>4. The Director of Maintenance and/or designee will report findings of any issues to Q.A. committee monthly x3 months, then quarterly x3, then annually thereafter and the plan adjusted accordingly.</p> <p>1. Residents in room 303 and 211 were not affected by this alleged negative practice. The blanket in room 303 was removed. Curtains for room 303 and 211 were</p>	10/15/2014			

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 09/15/2014	
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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			
K010130 SS=F	<p>could affect 3 residents.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 09/15/14 at 1:50 p.m., there was a blanket covering the window in resident room 303 and at 2:02 p.m., there were curtains at the window in resident room 211. Based on an interview with the Director of Maintenance at the time of observation, the window coverings in the aforementioned resident rooms lacked attached documentation confirming they were inherently flame retardant and he was unable to provide documentation regarding the flame retardancy for each window covering.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls were 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,</p>	K010130	<p>ordered.</p> <p>2. No other residents were affected by this alleged negative practice. The blanket in room 303 was removed. Curtains for room 303 and 211 were ordered.</p> <p>3. In an effort to ensure ongoing compliance the Maintenance Director has reviewed his documentation of fire ratings for window coverings in the facility. Any negative findings were forwarded to the Administrator and corrected.</p> <p>4. All fire rating documentation will be kept in a binder and will be reviewed monthly by the Q.A committee. This monitoring will be ongoing.</p> <p>1. No residents were affected by this alleged negative practice. A closure was added to the door in the attic. The grey substance was removed from the penetrations in the 3 fire walls and was sealed with fire resistant caulk.</p> <p>2. No residents were affected by this alleged negative practice. A closure was added to the door in the attic. The grey substance was</p>	10/15/2014			

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 09/15/2014
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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>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 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 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Maintenance on 09/15/14 at 4:10 p.m., in the attic at the fire barrier wall near the nurses' station a large hole</p>		<p>removed from the penetrations in the 3 fire walls and was sealed with fire resistant caulk.</p> <p>3. In an effort to ensure ongoing compliance the Maintenance Director and/or designee will monitor the closure on the door in the attic and the caulking of the penetrations in the fire walls weekly for four weeks, then monthly x3, and then quarterly thereafter. Any negative findings will be forwarded to the Administrator immediately and corrected.</p> <p>4. The Director of Maintenance will report findings and corrective action to the Q.A committee monthly x3, then quarterly thereafter and the plan adjusted accordingly.</p>		

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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
K010144 SS=F	<p>was cut into the wall to allow access to the other side. The hole in the wall was protected with a sliding door constructed of two layers of five eights inch drywall. The opposite side of the wall had a door constructed of two layers of five eights inch drywall. Neither door was designed to self close and latch into the door frame.</p> <p>b. Based on observations with the Director of Maintenance on 09/15/14 from 1:15 p.m. to 4:11 p.m., the penetrations in all 3 fire walls were sealed with a gray substance. Based on an interview with the Director of Maintenance at the time of observations, he was unable to confirm the gray substance was fire resistant.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in</p>	K010144	<p>1. No residents were affected by this alleged negative practice. An audit of the generator weekly and monthly logs were completed with no negative findings.</p> <p>2. No residents were affected by this alleged negative practice. An audit of the generator weekly and monthly logs were completed with</p>	10/15/2014

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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>accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log "Emergency Generator Monthly Test Log" with the Director of Maintenance on 09/15/14 at 12:05 p.m., there was no documentation of a monthly load test in May 2014. Based on an interview with the Director of Maintenance at the time of record review, he was not employed with the facility at that time and there was no other documentation available for review.</p> <p>3.1-19(b)</p>		<p>no negative findings.</p> <p>3. To ensure ongoing compliance the Maintenance Director was educated in regards to the importance of maintaining the generator inspection log on a weekly basis and ensuring a 30 minute load test is performed monthly. Administrator and/or designee will monitor the generator logs monthly x3, then quarterly thereafter. Any negative findings will be corrected immediately and will result in further education and/or disciplinary action.</p> <p>4. The Maintenance Director and/or designee will report findings and corrective action to the Q.A committee monthly x3, then quarterly thereafter and the plan will be adjusted accordingly.</p>	

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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>2. Based on record review and interview, the facility failed to provide the complete documentation for the weekly visual inspection of 1 of 1 emergency generators providing power to the emergency systems. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the generator log "Emergency Generator Weekly Inspection Checklist" with the Director of Maintenance on 09/15/14 at 12:11 p.m., there was no documentation of a weekly inspection for the month of May 2013. Based on an interview with the Director of Maintenance at the time of record review, he was not employed with the facility at that time and there was no other documentation available for review.</p>			

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 09/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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
K020027 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 2 of 5 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation with the Director of Maintenance on 09/15/14 at 1:34 p.m., the west door of the north dining room set of smoke barrier doors remained in the open position upon activation of the fire alarm. This was confirmed by the</p>	K020027	<ol style="list-style-type: none"> No residents were affected by this alleged negative practice. The west smoke barrier doors in the north dining room was fixed immediately to ensure they close automatically when the fire alarm activates. No residents were affected by this alleged negative practice. All other smoke barrier doors were checked to ensure they all close properly and timely when fire alarm is activated. In an effort to ensure ongoing compliance with smoke barrier doors, the director of maintenance will check all smoke barrier doors 1x week for 4 weeks and monthly thereafter. Any negative findings will be forwarded to the Administrator immediately and corrected. The director of maintenance and/or designee will report findings and corrective action of any issues with the smoke barrier doors to the 	10/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155473	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 09/15/2014
NAME OF PROVIDER OR SUPPLIER CHALET VILLAGE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1065 PARKWAY 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	
	Director of Maintenance at the time of observation, when he released the smoke barrier door from the magnetic device and the door self closed and the magnetic lock did not re-energize. 3.1-19(b)		Q.A. committee monthly x3 months and quarterly thereafter and the plan will be adjusted accordingly.		