

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 08/12/2013
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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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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: 08/12/13</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	<p>K0000</p> <p>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.</p>	

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>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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010029 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 doors to 1 of 1 biohazard storage rooms and 1 of 1 laundry rooms, both hazardous areas, were provided with a self closing device and would latch into the door frame. This deficient practice could affect 2 residents in the 300 hall and 5 residents on the 100 hall.</p> <p>Findings include:</p> <p>a. Based on observation with the Administrator and the Maintenance Supervisor on 08/12/13 from 12:00 p.m. to 12:41 p.m., a self closing device was not provided on the corridor door to the biohazard room on the 300 hall or for the corridor door to the services hall entrance into the laundry room. Based on an interview with the Maintenance Supervisor at the time of observations,</p>	K010029	<p>K 029</p> <p>Corrective Actions for Residents affected: The Maintenance Director installed new door closure devices on the biohazard room door and the laundry room door through the service hall on 08-28-13.</p> <p>Other residents having the potential to be affected and corrected action: No other residents were affected by the alleged negative practice. Maintenance Director installed new door closure devices on the biohazard room door and the laundry room door through the service hall on 08-28-13.</p> <p>Measures to ensure this practice does not recur: Maintenance Director checked all doors that are mandatory to have a door closure on them to ensure that they do and assessed them</p>	08/28/2013			

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	<p>each door had been equipped with a self closing device at one time but it had been removed.</p> <p>b. Based on observation with the Administrator and the Maintenance Supervisor on 08/12/13 at 1:05 p.m., the corridor door to the soiled linen entrance of the laundry room did self close, but it failed to latch into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>to make sure they work properly. The Maintenance Director will monitor monthly to ensure that all doors that need a mandatory door closure have a door closure and that it works properly. Findings will be documented and reviewed in the Quality Assurance meetings.</p> <p>The corrective action will be monitored by: The Maintenance Director will monitor monthly to ensure that all doors that need a mandatory door closure have a door closure and that it works properly. Any negative findings will be immediately corrected. Findings will be documented and reviewed in the Quality Assurance meetings.</p> <p>Date Corrected: 08-28-2013</p>		

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K010062 SS=D	<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 observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads was unobstructed in the closet of resident room 205. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 1 resident in resident room 205.</p> <p>Findings include:</p> <p>Based on observation and interview with the Administrator and the Maintenance Supervisor on 08/12/13 at 12:30 p.m., it was acknowledged the spray pattern for the sprinkler head in closet of resident room 205 was obstructed by the resident's personal belongings stacked to the ceiling on the top shelf of the closet.</p> <p>3.1-19(b)</p>	K010062	<p>K 062</p> <p>Corrective Actions for Residents affected: AIT and DON immediately helped the resident in room 205 to clean out her closet to ensure that the spray pattern for the sprinkler head was not obstructed. This was completed on 8/12/2013.</p> <p>Other Residents having to potential to be affected and corrected action: AIT spoke to resident and educated resident about the danger of having personal items stacked in closet to avoid obstructing the spray pattern of the sprinkler head. AIT and DON helped the resident in cleaning out her closet. This was completed on 8/12/2013. Maintenance Director checked all resident's room closets to ensure that their were no obstructions to the spray pattern of the sprinkler heads.</p> <p>Measures to ensure this practice does not recur: Maintenance Director will monitor monthly all resident's room closets to ensure their belongings are not obstructing the spray pattern of the sprinkler heads and</p>	08/28/2013			

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			<p>document findings. This will be reviewed monthly in Quality Assurance meeting.</p> <p>This corrective action will be monitored by: The Maintenance director will monitor monthly all resident's room closets to ensure their belongings are not obstructing the spray pattern of the sprinkler heads and document findings. Any negative findings will be immediately corrected. This will be reviewed monthly in Quality Assurance meeting.</p> <p>Date Corrected: 08-28-2013</p>		

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K010064 SS=B	<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 1 Therapy room portable fire extinguishers was mounted so the top of the extinguisher was no more than five feet (60 inches) above the floor. NFPA 10, Section 1-6.10 requires fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so the top of the fire extinguisher is not more than 5 feet (60 inches) above the floor. This deficient practice could affect possibly 6 residents at a time in the Therapy room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 08/12/13 at 12:10 p.m., the fire extinguisher mounted on the wall in the Therapy room measured five feet seven inches from the floor to the top of the fire extinguisher. Measurements were provided by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>	K010064	<p>K 064</p> <p>Corrective Action for residents affected: Maintenance Director lowered the fire extinguisher into the position where it was 60 inches above the floor. This was completed on 8/12/2013.</p> <p>Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. Maintenance Director lowered the therapy fire extinguisher so it was 60 inches above the floor. This was completed on 8/12/2013.</p> <p>Measures to ensure this practice does not recur: Maintenance director assessed all fire extinguishers to ensure that they are all 60 inches above the floor. The maintenance director will monitor monthly to ensure that all the fire extinguishers in the building are 60 inches above the floor and document findings. All findings will be reviewed in quality assurance meetings monthly.</p> <p>The corrective action will be monitored by: The Maintenance Director will monitor monthly to</p>	08/28/2013	

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			<p>ensure that all the fire extinguishers in the building are 60 inches above the floor and document findings. Any negative findings will be immediately corrected. All findings will be reviewed in quality assurance meetings monthly.</p> <p>Date corrected: 08-28-2013</p>		

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K010144 SS=C	<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>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 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 review of the generator log "Emergency Generator-Monthly Test</p>	K010144	<p>K 144</p> <p>Corrective Action for Residents affected: Maintenance Director was educated about the importance having the generator load test done monthly and logged in the Emergency Generator-Monthly Test Log. This was completed on 8/12/2013.</p> <p>Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. Maintenance Director was educated on the importance of having the generator load test done monthly and logged in the Emergency Generator-Monthly Test Log. This was completed on 8/12/2013.</p> <p>Measures to ensure this practice does not occur: The Maintenance Director will conduct an emergency generator load test and log it in the Emergency Generator-Monthly Test Log.</p> <p>The corrective action will be monitored by: Monitoring will be</p>	08/28/2013

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	Log" with the Maintenance Supervisor on 08/12/13 at 11:05 a.m., documentation of a generator load test for the month of December 2012 was not available for review. Based on an interview with the Maintenance Supervisor at the time of record review, the facility was without a Maintenance Supervisor at that time. 3.1-19(b)		reviewed by the Quality Assurance Committee on a monthly basis. Any negative findings will be immediately corrected. Date Corrected: 08-28-2013		

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Administrator and the Maintenance Supervisor on 08/12/13 at 11:50 a.m., the Maintenance Supervisor acknowledged a refrigerator was supplied electricity by an extension cord power strip in resident room 303.</p> <p>3.1-19(b)</p>	K010147	<p>K 147</p> <p>Corrective Action for residents affected: The Maintenance Director immediately located a nurse and respiratory therapist to transfer the medical equipment and refrigerator into the wall outlet. This was completed on 8/12/2013.</p> <p>Other residents having the potential to be affected and corrected action: The Maintenance Director checked all resident's rooms in the facility to ensure all medical equipment, refrigerators, and other high frequency items were plugged into a wall outlet and not in a power strip. This was completed on 8/12/2013.</p> <p>Measures to ensure this practice does not occur: All staff were in-serviced on 08-28-2013 the requirement of medical equipment and high current draw devices not being plugged into non fixed wiring. The Maintenance Director will monitor weekly x4 weeks and monthly thereafter to ensure that all medical equipment, refrigerators, and other high frequency items are plugged into a wall outlet.</p>	08/28/2013			

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			<p>This will be documented and reviewed in monthly quality assurance meetings.</p> <p>The corrective action will be monitored by: The Maintenance Director will monitor weekly x4 weeks and monthly thereafter to assure that all medical equipment, refrigerators, and other high frequency items are plugged into a wall outlet. Any negative findings will be immediately corrected. This will be documented and reviewed in monthly quality assurance meetings.</p> <p>Date Corrected: 08-28-2013</p>		

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K020025 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 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 could affect 2 residents in the North hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 08/12/13 at 1:20 p.m., at the nurses' station above the lay in ceiling there was a four inch square unsealed penetration in the drywall ceiling around a sprinkler pipe. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K020025	<p>K 025</p> <p>Corrective Action for Residents affected: Maintenance Director has resealed the unsealed penetration in the ceiling. This was completed on 8/16/2013.</p> <p>Other resident having the potential to be affected and corrected action: No other residents were affected by the unsealed penetration. Maintenance Director was able to reseat the area on 8/16/2013.</p> <p>Measures to ensure the practice does not recur: Maintenance Director has checked all areas of penetration to make sure there were no other ones that were unsealed. There was no other penetration that was unsealed. The maintenance director will monitor weekly x4 weeks, then monthly thereafter and document. Findings will be reviewed in Quality Assurance</p>	08/28/2013			

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			meetings. This corrective action will be monitored by: The Maintenance Director will monitor weekly x4 weeks, then monthly thereafter and document findings and be reviewed in quality assurance meetings. Any negative findings will be corrected immediately. Findings will be reviewed in Quality Assurance meetings. Date Corrected: 08-28-2013		

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K020027 SS=E	<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 Maintenance Supervisor on 08/12/13 at 1:31 p.m., the north dining room set of smoke barrier doors remained in the open position upon activation of the fire alarm . Based on an interview with the Maintenance Supervisor at the time of</p>	K020027	<p>K 027</p> <p>Corrective Action for Residents affected: Maintenance Director adjusted the self closing devices on the smoke barrier doors for the doors to close all the way. This was completed on 8/16/2013.</p> <p>Other residents having the potential to be affected and corrected action: No other residents were affected by this alleged negative practice. Maintenance Director readjusted the self-closing devices on the smoke barrier doors so they will close all the way. This was completed on 8/16/2013.</p> <p>Measures to ensure this practice does not recur: Maintenance Director observed all 4 smoke barrier doors to asses whether they all closed properly and that the self-closing devices were adjusted correctly.</p>	08/28/2013			

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 08/12/2013
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	<p>observation, the set of smoke barrier doors did release from the magnetic hold open devices, but the self closing device on each door needed to be adjusted in order to pull the smoke barrier doors closed. The Maintenance Supervisor confirmed these were smoke barrier doors.</p> <p>3.1-19(b)</p>		<p>Maintenance director will monitor monthly all smoke barrier doors for proper closing during the mandatory fire drills. All documented findings will be reviewed in Quality Assurance meetings.</p> <p>This corrective action will be monitored by: The Maintenance Director will observe all 4 smoke barrier doors to assess whether they all close properly and that self-closing devices are adjusted correctly. Maintenance Director will monitor all smoke barrier doors for proper closing during the mandatory fire drills. Any negative findings will be immediately corrected. All documented findings will be reviewed in Quality Assurance meetings.</p> <p>Date Corrected: 08-28-2013</p>		