

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 08/25/2016
--	---	--	---

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
K 0000 Bldg. 01	<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: 08/25/16</p> <p>Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370</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 resident rooms. The facility has a capacity of 80 and had a census of 38 at</p>	K 0000	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 08/25/2016
--	---	--	---

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
K 0038 SS=E Bldg. 01	<p>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 completed on 08/29/16 - DA</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> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 delayed egress locks in the facility was accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the</p>	K 0038	<ol style="list-style-type: none"> No residents were affected by this alleged negative practice. All exit doors will be tested and fixed by 9-10-2016. No residents were affected by this alleged negative practice. All exit doors will be tested and fixed by 9-10-2016. In an effort to ensure ongoing compliance with all exit doors with delayed egress locks, the Director of Maintenance was educated and in-service on the policy of exit doors with delayed egress locks. The Director of Maintenance will monitor all exit doors with delayed egress locks weekly for a month, bi-weekly for a month, and then monthly thereafter. Any negative findings will be forwarded to the Administrator and corrected. The Director of Maintenance 	09/24/2016

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 08/25/2016
--	---	--	---

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>release device required in 7.2.1.5.4 that shall not be required to exceed 15 seconds nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 08/25/2016 at 12:35 p.m., the Therapy exit was provided with delayed egress lock and was provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. However, the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate times. Based on interview at the time of observation, the Maintenance Supervisor stated the aforementioned exit is a facility exit, is equipped with a delayed egress lock and the necessary signage, but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate</p>		<p>and/or designee will report findings and corrective actions of any exit doors to the Q.A. committee monthly x3 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 08/25/2016	
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			
K 0052 SS=F Bldg. 01	times. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, 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 initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least	K 0052	1. No residents were affected by this allegednegative practice. All smoke ductdetectors were tested to ensure they were working by 9-10-2016. 2. No residents were affected by this allegednegative practice. All smoke ductdetectors were tested to be ensure they were working by 9-10-2016. 3. In the efforts to ensure ongoing compliance withhall smoke duct detectors, the Director of Maintenance was educated andin-serviced on the policy of smoke duct detectors. The Director of Maintenance will monitor	09/24/2016			

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 08/25/2016	
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			
K 0130 SS=F Bldg. 01	<p>annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 08/25/2016 at 10:35 p.m., in the north mechanical room there was a smoke duct detector on the duct work to a furnace marked " Not Working. " Based on interview at the time of observation, the Maintenance Supervisor did not know if it was a working duct detector and had no documentation available to show if the duct detector was inspected.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 78 of 78 single station smoke alarms would operate. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review with</p>	K 0130	<p>allsmoke duct detectors to ensure they work weekly x3 months, bi-weekly x3 months,and monthly thereafter. Any negativefindings will be forwarded to the Administrator and corrected.</p> <p>4. The Director of Maintenance and/or designee willreport findings and corrective actions of any smoke duct detectors to the Q.A.committee monthly x3 months, then quarterly thereafter and the plan will beadjusted accordingly.</p> <p>1. Noresidents were affected by this alleged negative practice. All smoke alarms will be tested and cleanedby 9-10-2016.</p> <p>2. Noresidents were affected by this alleged negative practice. All smoke alarms will be tested and cleanedby 9-10-2016.</p> <p>3. In an effort to ensure ongoing compliance withsmoke alarms, the Director of Maintenance was educated and in-serviced on thepolicy of fire battery operated</p>	09/24/2016			

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 08/25/2016
--	---	--	---

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>Maintenance Supervisor on 08/25/16 at 11:40 a.m., the facility did not have documentation indicating a battery replacement program for the seventy eight single station smoke detectors in resident rooms. Based on an interview at the time of records review, the Maintenance Supervisor acknowledged there was no documentation for the replacement of single station smoke alarms batteries.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview; the facility failed to implement and maintain a preventive maintenance and a battery replacement program for battery operated smoke alarms installed in 42 of 42 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Supervisor on 08/25/16 at 12:15 p.m., it was noted the resident rooms in the facility had battery operated smoke alarms, but no documentation of a battery test or cleaning for the alarms was</p>		<p>smoke alarms which includes battery activationand de-activation, activating the alarm, testing the alarm, and cleaning thealarm. The Director of Maintenance willdo ongoing monitoring of smoke alarms on a weekly basis. All of the battery operated smoke alarms werecleaned by the facilities fire protection company on April 21st,2016 and annual cleaning will be ongoing through the company. The documentation of the cleaning is in thefacility. Any negative findings will be forwarded to the Administratorimmediately and corrected.</p> <p>4. The Director of Maintenance and/or designee willreport findings and corrective actions of any smoke alarms to the Q.A.committeemonthly x3 months, then quarterly thereafter and the plan will be adjustedaccordingly.</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 08/25/2016
--	---	--	---

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
K 0144 SS=F Bldg. 01	<p>available for review. Based on an interview during record review, the Maintenance Supervisor acknowledged there was no available documentation to confirm a monthly function testing, or cleaning, was conducted on the battery operated smoke alarms.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators ran under load for 30 minutes and was allowed a 5 minute cool down period after a load test. 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</p>	K 0144	<ol style="list-style-type: none"> No residents were affected by this allegednegative practice. The generator waschecked and documented to be sure that it ran under load for 30 minutes and itwas then allowed a 5 minute cool down. No residents were affected by this allegednegative practice. The generator waschecked and documented to be sure that it ran under load for 30 minutes and itwas then allowed a 5 minute cool down. In an effort to ensure ongoing compliance withthe generator, the Director of Maintenance was educated and in-serviced on thepolicy on the preventative maintenance of the generator. The Director of Maintenance will monitor thegenerator, with 30 	09/24/2016

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 08/25/2016	
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>minutes. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Maintenance Supervisor on 08/25/16 at 11:54 a.m., the generator log form documented the generator was tested under load monthly, however, the form did not indicate that the generator ran for at least 30 minutes and had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p>		<p>minutes under load and a 5 minute cool down, weekly for 3months, bi-weekly for 3 months and then monthly thereafter. 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 actions for the generator to the Q.A. committee monthly x3 months, then quarterly thereafter and the plan will be adjusted accordingly</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2016

FORM APPROVED

OMB NO. 0938-0391

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 08/25/2016
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	
	3.1-19(b)				