STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155473	A. BUILDING 01 B. WING	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHALET VILLAGE HEALTH AND REHABILITATION CENTER	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	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). Survey Date: 08/13/15 Facility Number: 000546 Provider Number: 155473 AIM Number: 100267370 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. 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 31 at	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 defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	the time of this survey. All areas where the residents have customary access were sprinklered. The facility had an unsprinklered shed with storage of maintenance equipment and activity supplies.			
K 0025 SS=E Bldg. 01	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 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 20 residents in two of five smoke compartments. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 08/13/15 between at 11:15 a.m. and	K 0025	1.No residents were affected by this allegednegative practice. All ceilingpenetrations were filled and covered on 8-21-2015. 2.No residents were affected by this allegednegative practice. All ceilingpenetrations were filled and covered on 8-21-2015. 3.In an effort to ensure ongoing compliance withceiling penetrations, the Director of Maintenance was educated and in-servicedover the importance of filling the ceiling penetrations in a timelymanner. The Director of Maintenanceand/or designee will monitor ceiling penetrations 1x a week for 4 weeks, thenmonthly thereafter to ensure there are no	09/12/2015

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	1:00 p.m., the following was noted: a.) in the ceiling of the electrical room by the boiler room there were eight unsealed penetrations around electrical conduit measuring a quarter inch to a half inch in size. b.) in the ceiling of the of the closet in the Medical Records/Housekeeping Office there were three unsealed penetrations around wires and PVC tubing measuring a quarter inch in size. Based on interview at the time of observation, the Director of Maintenance acknowledged and provided the measurements of the penetrations. 3.1-19(b)		findings of ceilingpenetrations. Any negative findings willbe forwarded to the Administrator immediately and corrected. 4.The Director of Maintenance and/or designee willreport findings and corrective actions of any ceiling penetrations to the Q.A.committee monthly x3 months, then quarterly thereafter and the plan will beadjusted accordingly.	
K 0050 SS=C Bldg. 01	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 Based on record review and interview, the facility failed to conduct quarterly fire drills for third shift at unexpected times for 4 of 4 quarters. This deficient practice affects all occupants.	K 0050	1.No residents were affected by this allegednegative practice. A fire drill wascompleted on 3rd shift on 8-21-15 at 2:30 A.M. 2.No residents were affected by this allegednegative practice. A fire drill wascompleted on 3rd	09/12/2015

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	Findings include: Based on record review of the "Monthly Fire Drill Record" forms with the Director of Maintenance on 08/13/14 between 09:50 a.m. and 10:43 a.m., all third shift fire drills took place between 5:12 a.m. and 5:50 a.m. for the last four quarters. Based on interview, this was confirmed by the Director of Maintenance at the time of record review. 3.1-19(b) 3.1-51(c)		shift on 8-21-15 at 2:30 A.M. 3.In an effort to ensure ongoing compliance withfire drills being held at unexpected times under varying conditions, theDirector of Maintenance was educated and in-serviced over the significance offire drills being held at unexpected times under varying conditions. The administrator and/or designee willmonitor fire drills conducted on all shifts monthly x6 months a then quarterlythereafter. Any negative findings willbe taken care of immediately and corrected. 4.The Administrator, Director of Maintenance,and/or designee will report findings and corrective actions of any fire drillsto the Q.A. committee monthly x3 months, then quarterly thereafter and the planwill be adjusted accordingly.	
K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to adopt a battery replacement program and a maintenance program to ensure 44 of 44 single station battery operated smoke alarms would operate properly. NFPA 70 at Section 10.4.8 states where batteries are used as a source of energy; they shall be replaced in accordance with the alarm equipment manufacturer's published instructions. Section 10.5.1 states fire alarm equipment shall be maintained in	K 0130	1. No residentswere affected by this alleged negative practice. All smoke alarms will be tested and cleaned by8-31-2015. 2.No residents were affected by this allegednegative practice. All smoke alarms willbe tested and cleaned by 8-31-2015. 3.In an effort to ensure ongoing compliance with smokealarms, the Director of Maintenance was educated and in-serviced on the policyof fire battery operated smoke alarms which includes battery activation	09/12/2015

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	accordance with the alarm equipment manufacturer ' s published instructions. This deficient practice affects all residents of the facility. Findings include: Based on record review with Director of Maintenance on 08/13/15 at 10:10 a.m.; the weekly smoke alarm test check list did show a monthly function test, but did not indicate when or if the single station battery operated smoke alarms had the batteries replaced, nor when cleaning and maintenance was conducted. Based on an interview during records review, the Director of Maintenance stated there is no documentation for a battery replacement or cleaning and maintenance program of the single station battery operated smoke alarm. Also, when asked what the manufacturer recommendations for cleaning, maintenance, and battery replacement was; the Director of Maintenance did not know the manufacturer recommendations for cleaning, maintenance, and battery replacement. 3.1-19(b)		andde-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 were cleaned by the facilities fire protection company on April 30th,2015 and annual cleaning will be ongoing through the company. The documentation of the cleaning is in the facility.Any negative findings will be forwarded to the Administrator immediately andcorrected. 4.The Director of Maintenance and/or designee willreport findings and corrective actions of any smoke alarms to the Q.A.committee monthly x3 months, then quarterly thereafter and the plan will beadjusted accordingly.	
K 0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice was not in a resident treatment area but could affect any staff exiting the service hall. Findings include: Based on an observation during a tour of the facility with the Director of Maintenance on 08/13/15 at 12:18 p.m., the mechanical ventilation system was not working where transferring of oxygen took place in the oxygen storage room outside the service hall. Base on an interview at the time of observation, the Director of Maintenance confirmed the oxygen room mechanical vent was not	K 0143	1.No residents were affected by this allegednegative practice. The vent is being repaired to provide the area used for transferring oxygen to have continuous ventilationand will be installed by 8-31-2015. 2.No residents were affected by this allegednegative practice. The vent is being repaired to provide the area used for transferring oxygen to have continuous ventilation and will be installed by 8-31-2015. 3.In an effort to ensure ongoing compliance withproper mechanic ventilation in areas used for transferring of oxygen, theDirector of Maintenance was educated and in-serviced on proper ventilation inthese specific areas. The Director ofMaintenance and/or designee will monitor the mechanic ventilation weekly x3months and	09/12/2015

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	working. 3.1-19(b)		monthly thereafter to ensure there are no findings of problems withthe mechanical ventilation. Any negativefindings will be forwarded to the Administrator immediately and corrected. 4.The Director of Maintenance and/or designee willreport findings and corrective actions of the mechanical ventilation of thearea used for transferring of the oxygen to the Q.A. committee monthly x3months, then quarterly thereafter and the plan will be adjusted accordingly.	