STATEMENT OF DEFICIENCES AND FLAN OF CORRECTION AD PRANDERSERTING DENTIFICATION NUMBER X2 MULTIPLE CONSTRUCTION X3 DATE SURVEY COMPLETED OTHERSERTING B VINCE X3 DATE SURVEY COMPLETED OTHERSERTING COMPLETED OTHERSERTING X3 DATE SURVEY COMPLETED OTHERSERTING COMPLETED OTHERSERTING X3 DATE SURVEY COMPLETED OTHERSERTING COMPLETED OTHERSERTING <t< th=""><th></th><th>T OF HEALTH AND HU R MEDICARE & MEDIC</th><th></th><th></th><th></th><th></th><th>RM APPROVED IB NO. 0938-039</th></t<>		T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
NAME OF PROVIDER OF SUPPLIER 455 TINCHER RD CHALET REHABILITATION AND HEALTHCARE CENTER 455 TINCHER RD OWIDER PLANDING INFORMATION FROM PROVIDER PLANDING INFORMATION TAC REQUILATION VOLLS: IDENTIFYING INFORMATION Bidg An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with AC CFR 483.73. Survey Date: 07/18/23 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 A this Emergency Preparedness survey, Chaler Rehabilitation and Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 88 certified beds, with a current census of 71. Facility# 000229 Provider# 155336 AIM# 100266850 Quality Review completed on 07/19/23 Facility# 000229 Provider and State Licensure Survey Previder Kerbalitation and Healthcare Center Rehabilitation and Healthcare Center (census of 71. Facility# 000229 Provider# 155336 AIM# 100266850	STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	ONSTRUCTION	COMPLETED	
conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. ISDH Survey Date: 07/18/23 ISDH Facility Number: 000229 ATT: Brenda Buroker Provider Number: 155336 Director of Division Long Term At this Emergency Preparedness survey, Chalet Director of Division Long Term Rehabilitation and Healthcare Center was found 2 North Meridian Street not in compliance with Emergency Preparedness 2 North Meridian Street Requirements for Medicare and Medicaid Indianapolis, Indiana 46204 Participating Providers and Suppliers, 42 CFR Facility# 000229 Quality Review completed on 07/19/23 Provider# 155336 AIM# 100266850 Re: Life Safety Code Recertification and State Licensure Survey Chalet Rehabilitation and Healthcare Center 4851 Tincher RD External	CHALET (X4) ID PREFIX TAG E 0000	REHABILITATION SUMMARY (EACH DEFICIEN REGULATORY O	I AND HEALTHCARE CENTER STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	4851 T INDIAN ID PREFIX TAG	INCHER RD NAPOLIS, IN 46221 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		conducted by the In accordance with 42 Survey Date: 07/1 Facility Number: 0 Provider Number: 100 At this Emergency Rehabilitation and not in compliance of Requirements for N Participating Provi 483.73 The facility has 88 census of 71. Quality Review co	ndiana Department of Health in 2 CFR 483.73. 8/23 000229 155336 0266850 Preparedness survey, Chalet Healthcare Center was found with Emergency Preparedness Medicare and Medicaid iders and Suppliers, 42 CFR certified beds, with a current mpleted on 07/19/23		ISDH ATT: Brenda Buroker Director of Division Long Terr Care 2 North Meridian Street Indianapolis, Indiana 46204 Facility# 000229 Provider# 155336 AIM# 100266850 Re: Life Safety Code Recertification and State Licensure Survey Chalet Rehabilitation and Healthcare Center 4851 Tincher RD Indianapolis, IN 46221	n	

Edward Hughes

Administrator

000229

(X6) DATE 08/01/2023

PRINTED: 08/04/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

	T OF DEFICIENCIES OF CORRECTION	, ,		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		
	ROVIDER OR SUPPLIE		4851 T	ADDRESS, CITY, STATE, ZIP COD		
		I AND HEALTHCARE CENTER		NAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
				Dear Ms. Buroker:		
				On 07/18/2023 a Life Safety Recertification and State Licensure Survey was condu Enclosed please find the Statement of Deficiencies with facilities Plan of Correction fo alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliant We respectfully request a de review that the facility has achieved substantial compliant with the applicable requireme as of the date set forth in the of Correction of 08/02/2023.	cted. n our r the of nce. sk nce nts	
				Please feel free to call me wi any further questions at 317-856-4851. Respectfully submitted, Edward Hughes	th	
				Executive Director, Chalet Healthcare and Rehabilitation		

MO8D21 Facility ID: 000229

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/18/2023 155336 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4851 TINCHER RD CHALET REHABILITATION AND HEALTHCARE CENTER INDIANAPOLIS, IN 46221 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 08/31/2023 Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/23 ISDH Facility Number: 000229 ATT: Brenda Buroker Provider Number: 155336 AIM Number: 100266850 Director of Division Long Term Care At this Life Safety Code survey, Chalet Rehabilitation and Healthcare Center was found 2 North Meridian Street not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Indianapolis, Indiana 46204 Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and Facility# 000229 410 IAC 16.2. Provider# 155336 This one-story facility was determined to be of Type V (111) construction and is fully sprinklered. AIM# 100266850 The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping Re: Life Safety Code rooms. The facility has a capacity of 88 and had a Recertification and State census of 71 at the time of this visit. Licensure Survey All areas where residents have customary access Chalet Rehabilitation and were sprinklered except for two detached storage Healthcare Center buildings which were each not sprinklered and used for facility storage. 4851 Tincher RD Quality Review completed on 07/19/23 Indianapolis, IN 46221 Event ID: MO8D21 Facility ID: 000229 Page 3 of 15 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/04/2023

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/18/2023		
	PROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD JAPOLIS, IN 46221		
X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIEN EFIX (EACH DEFICIENCY MUST BE PRECEDED		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
				Dear Ms. Buroker:		
				On 07/18/2023 a Life Safety Recertification and State Licensure Survey was condu Enclosed please find the Statement of Deficiencies wit facilities Plan of Correction for alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of complia We respectfully request a der review that the facility has achieved substantial complia with the applicable requirement as of the date set forth in the of Correction of 08/02/2023.	ucted. ch our or the of unce. esk nce ents	
				Please feel free to call me w any further questions at 317-856-4851. Respectfully submitted, Edward Hughes	ith	
				Executive Director, Chalet Healthcare and Rehabilitation	٦	

MO8D21 Facility ID: 000229

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If continuation sheet P

Page 4 of 15

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION (X3)	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u> </u>	COMPLETED
		155336	B. WING	(07/18/2023
	PROVIDER OR SUPPLIE	R N AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD TINCHER RD NAPOLIS, IN 46221	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
(0291	NFPA 101				
SS=C	Emergency Light	ina			
Bldg. 01	Emergency Light	-			
		ng of at least 1-1/2-hour			
		led automatically in			
	accordance with	-			
	18.2.9.1, 19.2.9.1				
		ion and interview, the facility	K 0291	K- 291	08/02/2023
		of 2 battery backup lights were	K 0291	It is the practice of Chalet	08/02/2022
		annually for 90 minutes over		Rehabilitation and Healthcare	
		sure the light would provide		Center to assure that the	
		riods of power outages, and a		Emergency Lighting CFR(s):	
		visual inspections and tests was		NFPA 101	
		2.9.1 requires emergency		Is in accordance with LSC	
	-	rovided in accordance with		19.2.9.1 which requires	
		on 7.9.3.1.1 (1) requires		emergency lighting shall be	
		shall be conducted monthly,		provided in accordance with	
	-	f 3 weeks and a maximum of 5		Section 7.9. Section 7.9.3.1.1 (1)	
		its, for not less than 30		requires functional testing shall be	
		ional testing shall be		conducted monthly, with a	,
		y for a minimum of 1 1/2 hours		minimum of 3 weeks and a	
		ighting system is battery		maximum of 5 weeks between	
		Vritten records of visual		tests, for not less than 30	
		sts shall be kept by the owner		seconds, (3) Functional testing	
	-	he authority having		shall be conducted annually for a	
	1 2	leficient practice could affect all		minimum of 1 $1/2$ hours if the	
	residents in the fac	-		emergency lighting system is	
		sinty.		battery powered and (5) Written	
	Findings include:			records of visual inspections and	
	i manigo metude.			tests shall be kept by the owner	
	Based on record re	eview on 07/18/23 at 11:17 a.m.		for inspection by the authority	
	with the Maintenan			having jurisdiction.	
		Emergency Light Test Log for			
		b battery operated lights located		What corrective action(s) will	
		log also indicated that there		be accomplished for those	
	-	npleted for the months of		residents found to be affected	
	•	of 2023. The lack of monthly		by the deficient practice:	
		battery operated lights was			
	-	intenance Director at the time of		No residents, staff, or visitors were	-
		o added that the facility was		affected by the alleged deficient	
	record review, who	o acced that the facility was		practice.	

Event ID:

MO8D21 Facility ID: 000229

If continuation sheet Page 5 of 15

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155336	B. WING		07/18/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER		NAPOLIS, IN 46221		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	[×]	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETI DATE	
		ance man during that time				
	period.			How other residents having t potential to be affected by the		
	This item was disc	sussed at the exit conference		same deficient practice will b		
		nce Director and the facility		identified and what corrective	9	
	Administrator on ()7/18/23 at 2:15 p.m.		action(s) will be taken: All residents, staff, and visitors		
	3.1-19(b)			that use or visit the facility have		
				the potential to be affected by alleged deficient practice. No	the	
				residents, staff, or visitors were	e	
				affected by the alleged deficier	nt	
				practice.		
				What measures will be put in		
				place or what systemic changes will be made to		
				ensure that deficient practice		
				does not recur: Maintenance Director Support	has	
				in-serviced maintenance direct		
				and administrator on testing of		
				emergency lighting. Testing of emergency lighting will be add		
				to TELS to inform Maintenance		
				Director and Administrator whe		
				testing is do. The alleged defic practice will not recur when the		
				facility is without a Maintenanc		
				Director.		
				How the corrective action(s)		
				will be monitored to ensure the	ne	
				deficient practice will not recur, i.e., what quality		
				assurance program will be pu	ıt	
				into place: Administrator will monitor TELS	Sfor	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 07/18/2023	
	PROVIDER OR SUPPLIE	AND HEALTHCARE CENTER	4851	i address, city, state, zip cod TINCHER RD NAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE	
				 the testing of the facilities emergency lighting. Administres maintenance director or designed will bring and discuss any issues with the emergency lighting to QA/PI meeting for review and continued compliance is achief for 3 consecutive months. Date of Compliance: 08/02/2	ynee ues o eved	
(0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with I Inspection, Testin Water-based Fire Records of system inspection and tes secure location and	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, sting are maintained in a nd readily available. - system last checked				
	coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on record re- failed to document accordance with N	RKS information on non-required or partial er system. , and NFPA 25 view, and interview; the facility sprinkler system inspections in FPA 25. NFPA 25, Standard for	K 0353	K- 353 It is the practice of Chalet Rehabilitation and Healthcar	08/02/20:	
	Water-Based Fire F Edition, Section 5.2 sprinkler systems s	ting, and Maintenance of Protection Systems, 2011 2.4.2 states gauges on dry pipe hall be inspected weekly to i in good condition and that		Center to assure that the Sprinkler System - Maintenance and Testing pe CFR(s): NFPA 101. Is in accordance with, Testing		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/18/2023	
	PROVIDER OR SUPPLIE	R NAND HEALTHCARE CENTER	4851 TI	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	normal water supp Section 5.1.2 state connections shall I maintained in acco 13.1.1.2 states Tak inspection, testing valve components records shall be m and maintenance of components and sl authority having ju deficient practice of in the facility. Findings include: Based on review of entitled "Sprinkler 02/21/23, 05/11/22 there were no doct inspections noted. inspection docume control valves was Based on interview the Maintenance I sprinkler system g and monthly contr documentation, fo was not available a	bly pressure is being maintained. s valves and fire department be inspected, tested, and ordance with Chapter 13. Section ole 13.1.1.2 shall be utilized for and maintenance of valves, and trim. Section 4.3.1 states ade for all inspections, tests, of the system and its hall be made available to the urisdiction upon request. This could affect all clients and staff of the SafeCare documentation : Report of Inspection" dated 3, 08/19/2022, and 11/21/2023, umented weekly sprinkler gauge In addition, monthly entation for all sprinkler system is also not available for review. v at the time of record review, Director acknowledged weekly auge inspection r the aforementioned periods		and Maintenance of Water-Bas Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that they are good condition and that normal water supply pressure is being maintained. Section 5.1.2 state valves and fire department connections shall be inspected tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall b made available to the authority having jurisdiction. What corrective action(s) will be accomplished for those residents, staff, or visitors w affected by the alleged deficien practice. How other residents having th potential to be affected by the same deficient practice will by identified and what corrective action(s) will be taken: All residents, staff, and visitors that use or visit the facility have	in in iss , , , , , , , , , , , , , , , , , ,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MO8D21 Facility ID: 000229

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PRINTED: 08/04/2023 FORM APPROVED

	Γ OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 07/18/2023	
	ROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	4851	t address, city, state, zip cod TINCHER RD NAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) the potential to be affected by	DATE	
				alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficier practice.	e	
				What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur: Maintenance Director Support in-serviced maintenance direct and administrator on testing of gauges on dry pipe sprinkler systems. Testing of gauges on pipe sprinkler systems shall be inspected weekly to ensure that they are in good condition and normal water supply pressure in being maintained will be added TELS to inform Maintenance Director and Administrator whet testing is do. Adding testing to TELS will assure this alleged deficient practice does not recor when the facility is without a Maintenance Director.	has tor dry at that is d to en	
				How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pu- into place: Administrator will monitor TELS the testing of the facilities gauge on dry pipe sprinkler systems	u t S for	

	R MEDICARE & MEDI						B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPL	
		155336	B. WIN	G		07/18	/2023
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD		
					CHER RD		
CHALET	REHABILITATION	I AND HEALTHCARE CENTER			POLIS, IN 46221		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
					shall be inspected weekly to		
					ensure that they are in good condition and that normal wate		
						er.	
					supply pressure is being maintained. Administrator,		
					maintenance director or desigr		
					will bring and discuss any issue		
					with the emergency lighting to	63	
					QA/PI meeting for review and		
					continued compliance is achiev	ved	
					for 3 consecutive months.	, cu	
					Date of Compliance: 08/02/20	23	
0355	NFPA 101						
SS=E	Portable Fire Ext	inquishers					
Bldg. 01	Portable Fire Ext	0					
Blag. 01		nguishers are selected,					
		ed, and maintained in					
		NFPA 10, Standard for					
	Portable Fire Ext						
	18.3.5.12, 19.3.5	-					
		ion and interview, the facility	K 035	55	K-355		08/02/202
		of 22 portable fire extinguishers	11 051		It is the practice of Chalet		00/02/202
		ccordance with NFPA 10. NFPA			Rehabilitation and Healthcare)	
	10, Standard for P	ortable Fire Extinguishers, 2010			Center to assure that all		
	Edition, Section 6.	1.3.8.1 states fire extinguishers			Portable fire extinguishers ar	е	
	having a gross wei	ght not exceeding 40 lb. shall			selected, installed, inspected		
		the top of the fire extinguisher			and maintained in accordanc		
	is not more than fi	ve feet above the floor. This			with NFPA 10, Standard for		
	deficient practice of	could affect 14 residents, 4 staff,			Portable Fire Extinguishers.		
	and 2 visitors in th	e facility.			18.3.5.12, 19.3.5.12, NFPA		
					10§483.25(d		
	Findings include:						
					What corrective action(s) will		
		ions made with the			be accomplished		
		ctor during a tour of the facility			for those residents found to b	be	
		/18/23, the portable fire			affected by the		
	-	ted on the wall in the West			deficient practice:		
	Nurses' Station wa	s mounted with the top of the			No residents, staff, or visitors v	vere	1

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155336	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION	(X3) DATE SURVEY COMPLETED 07/18/2023	
	PROVIDER OR SUPPLIEI	AND HEALTHCARE CENTER	4851 T	address, city, state, zip cod INCHER RD IAPOLIS, IN 46221		
CHALET (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OI extinguisher five fe Based on interview Maintenance Direc aforementioned me would lower it as so This item was discu with the Maintenan	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION wet six inches above the floor. the time of observation, the tor agreed with the assurement and added that he			d ble ble le	
				place or what systemic changes wil be made to ensure that deficient practi e does not recur: Maintenance Director Support I	c	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/04/2023

FORM APPROVED

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/18/2023	
	PROVIDER OR SUPPLIE	R AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD VAPOLIS, IN 46221		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE	
ζ 0761				 in-serviced maintenance direct and administrator on testing of gauges on installation, minimul and maximum mounting height an ABC portable fire extinguish All mounted portable fire extinguishers in the facility are now in compliance. Any new portable fire extinguisher place the facility will be mounted per regulations. How the corrective action(s) will be monitored to ensure th deficient practice will not recur, i.e., what quality assurance program will be pu- into place: Administrator, maintenance director or designee will monitor for improper height of mounted portable fire extinguishers durin daily walking rounds. Administrator, maintenance director or designee will bring a discuss any improperly mounted ABC portable fire extinguisher QA/PI meeting for review and continued compliance. Date of Compliance: 08/02/200 	m t for her. d in he tt hg and ed to	
SS=E Bldg. 01	interview, the facil inspection and test assemblies were co	on, records review, and ity failed to ensure annual ing of 5 of 5 fire door ompleted in accordance of LSC nunicating openings in dividing	K 0761	K-761 It is the practice of Chalet Rehabilitation and Healthcare Center to assure that all Maintenance, Inspection &	08/02/202	

	DEPARTMENT OF HEALTH AND HUMAN SERVICES TENTERS FOR MEDICARE & MEDICAID SERVICES						RM APPROVED B NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	ЛLDING	01	COMPL	
		155336	B. WING		51	07/18/2023	
		100000	D. W			07/10/	2023
NAME OF F	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COD		
TWINE OF 1	KO VIDEK OK BOI I EIEK	-		4851 T	INCHER RD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER		INDIAN	NAPOLIS, IN 46221		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	fire barriers require	d by 19.1.1.4.1 shall be			Testing – Doors Fire doors		
	•	prridors and shall be protected			assemblies are inspected an	d	
		osing fire door assemblies.			tested annually in accordance		
		3.) LSC 8.3.3.1 Openings			with NFPA 80, Standard for F		
		re protection rating by Table			-	ii e	
	-	ected by approved, listed,			Doors and Other Opening		
	-				Protectives. Non-rated doors	,	
		semblies and fire window			including corridor doors to		
		accompanying hardware,			patient rooms and smoke		
	Ũ	, closing devices, anchorage,			barrier doors, are routinely		
		nce with the requirements of			inspected as part of the facil	ity	
		for Fire Doors and Other			maintenance program.		
	Opening Protectives	s, except as otherwise			Individuals performing the		
	specified in this Code. NFPA 80 5.2.1 states fire				door inspections and testing	l	
	door assemblies shall be inspected and tested not less than annually, and a written record of the				possess knowledge, training	or	
					experience that demonstrate	S	
	inspection shall be s	signed and kept for inspection			ability. Written records of		
	-	80, 5.2.4.1 states fire door			inspection and testing are		
	-	visually inspected from both			maintained and are available	1	
		verall condition of door			for review. 19.7.6, 8.3.3.1 (LS		
	assembly.				5.2, 5.2.3 (2010 NFPA 80)	0)	
	usseniory.				5.2, 5.2.5 (2010 MITA 00)		
	NFPA 80, 5.2.4.2 st	ates as a minimum, the			What corrective action(s) wil	I	
	following items sha	ll be verified:			be accomplished		
	(1) No open holes o	r breaks exist in surfaces of			for those residents found to	be	
	either the door or fr	ame.			affected by the		
	(2) Glazing, vision	light frames, and glazing beads			deficient practice:		
		ely fastened in place, if so			No residents, staff, or visitors	were	
	equipped.	· · · · · · · · · · · · · · · · · · ·			affected by the alleged deficie		
		, hinges, hardware, and			practice.		
		eshold are secured, aligned,					
		-			How other residents her in a	ha	
	-	er with no visible signs of			How other residents having t	me	
	damage.				potential to be		
	(4) No parts are mis				affected by the same deficien	nt	
		do not exceed clearances			practice will be		
	listed in 4.8.4 and 6				identified and what correctiv	е	
	· · / ·	device is operational; that is,			action(s) will be taken:		
		pletely closes when operated			All residents, staff, and visitors		
	from the fully open	position.			have the potential to be affected	ed	
	(7) If a coordinator	is installed, the inactive leaf			by the alleged deficient practic		
	closes before the ac	tive leaf.					
					<u> </u>		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDIC						CM APPROVED B NO. 0938-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155336	B. WING			07/18/		
		100000	Divinto			01/10/	2020	
NAME OF F	PROVIDER OR SUPPLIEF	t.			DDRESS, CITY, STATE, ZIP COD			
					NCHER RD			
CHALET	REHABILITATION	AND HEALTHCARE CENTER		NDIAN	APOLIS, IN 46221			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re -	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE	
	(8) Latching hardwa	are operates and secures the			What measures will be put in			
	door when it is in th			place				
	(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or				or what systemic changes wi	nges will		
					be made			
	frame.				to ensure that deficient practic			
	 (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. 				e does not recur:			
					Maintenance Director Support	has		
					in-serviced maintenance direct			
	-	ice could affect all occupants.		and administrator on Ins				
	1	Ĩ			all smoke barrier and other			
	Findings include:				opening protectives . Administ			
	8				took and passed online training			
	Based on record rev	view with the Maintenance			course offered through Americ			
	Director on 05/09/18 at 11:45 a.m., no annual				Health Care Association for Life			
	inspection of the fire door assemblies were				Safety: Fire and Smoke Door			
	available for review			Inspection Training. Administrator				
	inspection documer		inspected all smoke barrier and					
	Based on interview			other opening protectives.				
	the Maintenance Di		Maintenance director is scheduled					
	inspection was not conducted for the fire door				to take American Health Care			
	-	st year and confirmed there			Association for Life Safety: Fire	е		
		ors within the facility that			and Smoke Door Inspection			
	needed to be inspec	-			Training. Inspection of all smol	ke		
	1	2			barrier and other opening			
	This item was discu	ussed at the exit conference			protectives will be added to TE	LS.		
	with the Maintenan	ce Director and the facility			Smoke barrier and other openi			
	Administrator on 07	-			protectives will be added to TE	-		
		-			to inform Maintenance Directo			
	3.1-19(b)				and Administrator when testing			
					do. The alleged deficient pract			
					will not recur when the facility i	is		
					without a Maintenance Directo			
					How the corrective action(s)			
					will be monitored to ensure t	he		
					deficient practice will not			
					recur, i.e., what quality			
					assurance program will be p	ut		
					into place:			
					•			

FORM CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 08/04/2023 FORM APPROVED

EPARTMENT	FORM APPROVED OMB NO. 0938-039				
ENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 07/18/2023	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
				Administrator will monitor TE the testing of the facilities sm barrier and other opening protectives. Administrator, maintenance director or desi will bring and discuss any iss with the smoke barrier and o opening protectives to QA/PI meeting for review and contii compliance is achieved for 3 consecutive months. Date of Compliance: 08/02/2	gnee sues ther nued

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