STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155336	A. BUILDING -- B. WING	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHALET REHABILITATION AND HEALTHCARE CENTER	4851 TINCHER RD INDIANAPOLIS, IN 46221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/23 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 At this Emergency Preparedness survey, Chalet 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. Quality Review completed on 07/19/23	E 0000	08/31/2023 ISDH ATT: Brenda Buroker Director of Division Long Term 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward Hughes	Administrator	08/01/2023

Any defiencystatement 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.

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			Dear Ms. Buroker: On 07/18/2023 a Life Safety Code Recertification and State Licensure Survey was conducted. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 08/02/2023. Please feel free to call me with any further questions at 317-856-4851. Respectfully submitted, Edward Hughes Executive Director, Chalet Healthcare and Rehabilitation	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/23 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 At this Life Safety Code survey, Chalet Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 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 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and is fully sprinklered. 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 rooms. The facility has a capacity of 88 and had a census of 71 at the time of this visit. All areas where residents have customary access were sprinklered except for two detached storage buildings which were each not sprinklered and used for facility storage. Quality Review completed on 07/19/23	K 0000	08/31/2023 ISDH ATT: Brenda Buroker Director of Division Long Term 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	

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			Dear Ms. Buroker: On 07/18/2023 a Life Safety Code Recertification and State Licensure Survey was conducted. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 08/02/2023. Please feel free to call me with any further questions at 317-856-4851. Respectfully submitted, Edward Hughes Executive Director, Chalet Healthcare and Rehabilitation	

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K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages, and a written record of visual inspections and tests was provided. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 07/18/23 at 11:17 a.m. with the Maintenance Director, the Battery-Operated Emergency Light Test Log for 2023 indicated two battery operated lights located in the facility. The log also indicated that there was no testing completed for the months of January, February of 2023. The lack of monthly testing of the two battery operated lights was verified by the Maintenance Director at the time of record review, who added that the facility was	K 0291	**K- 291** **It is the practice of Chalet Rehabilitation and Healthcare Center to assure that the Emergency Lighting CFR(s): NFPA 101** Is in accordance with LSC 19.2.9.1 which requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were affected by the alleged deficient practice.	08/02/2023

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	without a maintenance man during that time period. This item was discussed at the exit conference with the Maintenance Director and the facility Administrator on 07/18/23 at 2:15 p.m. 3.1-19(b)		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient 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 director and administrator on testing of emergency lighting. Testing of emergency lighting will be added to TELS to inform Maintenance Director and Administrator when testing is do. The alleged deficient practice will not recur when the facility is without a Maintenance Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator will monitor TELS for	

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			the testing of the facilities emergency lighting. Administrator, maintenance director or designee will bring and discuss any issues with the emergency lighting to QA/PI meeting for review and continued compliance is achieved for 3 consecutive months. **Date of Compliance:** 08/02/2023	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based 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 in good condition and that	K 0353	**K- 353** **It is the practice of Chalet Rehabilitation and Healthcare Center to assure that the Sprinkler System - Maintenance and Testing per CFR(s): NFPA 101.** Is in accordance with, Testing,	08/02/2023

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	normal water supply pressure is being maintained. Section 5.1.2 states 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 be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients and staff in the facility. Findings include: Based on review of the SafeCare documentation entitled "Sprinkler: Report of Inspection" dated 02/21/23, 05/11/23, 08/19/2022, and 11/21/2023, there were no documented weekly sprinkler gauge inspections noted. In addition, monthly inspection documentation for all sprinkler system control valves was also not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged weekly sprinkler system gauge inspection documentation and monthly control valve inspection documentation, for the aforementioned periods was not available for review. This item was discussed at the exit conference with the Maintenance Director and the facility Administrator on 07/18/23 at 2:15 p.m. 3.1-19(b)		and Maintenance of Water-Based 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 in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states 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 be made available to the authority having jurisdiction. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors that use or visit the facility have	

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			the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient 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 director and administrator on testing of gauges on dry pipe sprinkler systems. Testing of gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that they are in good condition and that normal water supply pressure is being maintained will be added to TELS to inform Maintenance Director and Administrator when testing is do. Adding testing to TELS will assure this alleged deficient practice does not recur when the facility is without a Maintenance Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator will monitor TELS for the testing of the facilities gauges on dry pipe sprinkler systems	

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			shall be inspected weekly to ensure that they are in good condition and that normal water supply pressure is being maintained. Administrator, maintenance director or designee will bring and discuss any issues with the emergency lighting to QA/PI meeting for review and continued compliance is achieved for 3 consecutive months. **Date of Compliance:** 08/02/2023	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 22 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect 14 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Director during a tour of the facility at 1:01 p.m. on 07/18/23, the portable fire extinguisher mounted on the wall in the West Nurses' Station was mounted with the top of the	K 0355	**K-355** **It is the practice of Chalet Rehabilitation and Healthcare Center to assure that all Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10§483.25(d** **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were	08/02/2023

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	extinguisher five feet six inches above the floor. Based on interview at the time of observation, the Maintenance Director agreed with the aforementioned measurement and added that he would lower it as soon as possible. This item was discussed at the exit conference with the Maintenance Director and the facility Administrator on 07/18/23 at 2:15 p.m. 3.1-19(b)		affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice. The ABC portable fire extinguisher mounted on the wall in the West Nurses' Station was remounted under the maximum 60” allowable height from the floor. The administrator and maintenance director measured all 22 portable fire extinguishers mounted in the facility for proper mounted height. All mounted portable fire extinguishers in the facility are now in compliance. **What measures will be put in place or what systemic changes will be made to ensure that deficient practic e does not recur:** Maintenance Director Support has	

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			in-serviced maintenance director and administrator on testing of gauges on installation, minimum and maximum mounting height for an ABC portable fire extinguisher. All mounted portable fire extinguishers in the facility are now in compliance. Any new portable fire extinguisher placed in the facility will be mounted per regulations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administrator, maintenance director or designee will monitor for improper height of mounted portable fire extinguishers during daily walking rounds. Administrator, maintenance director or designee will bring and discuss any improperly mounted ABC portable fire extinguisher to QA/PI meeting for review and continued compliance. **Date of Compliance:** 08/02/2023	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 Communicating openings in dividing	K 0761	**K-761** **It is the practice of Chalet Rehabilitation and Healthcare Center to assure that all Maintenance, Inspection &**	08/02/2023

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	fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf.		**Testing – Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)** **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors have the potential to be affected by the alleged deficient practice.	

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CHALET REHABILITATION AND HEALTHCARE CENTER	4851 TINCHER RD INDIANAPOLIS, IN 46221

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	(8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (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. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 05/09/18 at 11:45 a.m., no annual inspection of the fire door assemblies were available for review. Furthermore, when the door inspection document was located, it was blank. Based on interview at the time of records review, the Maintenance Director stated an annual inspection was not conducted for the fire door assemblies in the last year and confirmed there were five sets of doors within the facility that needed to be inspected annually. This item was discussed at the exit conference with the Maintenance Director and the facility Administrator on 07/18/23 at 2:15 p.m. 3.1-19(b)		**What measures will be put in place or what systemic changes will be made to ensure that deficient practic e does not recur:** Maintenance Director Support has in-serviced maintenance director and administrator on Inspection of all smoke barrier and other opening protectives . Administrator took and passed online training course offered through American Health Care Association for Life Safety: Fire and Smoke Door Inspection Training. Administrator inspected all smoke barrier and other opening protectives. Maintenance director is scheduled to take American Health Care Association for Life Safety: Fire and Smoke Door Inspection Training. Inspection of all smoke barrier and other opening protectives will be added to TELS. Smoke barrier and other opening protectives will be added to TELS to inform Maintenance Director and Administrator when testing is do. The alleged deficient practice will not recur when the facility is without a Maintenance Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 01 B. WING	07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			Administrator will monitor TELS for the testing of the facilities smoke barrier and other opening protectives. Administrator, maintenance director or designee will bring and discuss any issues with the smoke barrier and other opening protectives to QA/PI meeting for review and continued compliance is achieved for 3 consecutive months. **Date of Compliance:** 08/02/2023	