STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 00 B. WING	01/04/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00421975 Complaint IN00421975 - No deficiencies related to the allegations were cited. Unrelated deficiency is cited. Survey dates: January 3 and 4, 2024 Facility number: 000229 Provider number: 155336 AIM number: 100266850 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 1 Medicaid: 42 Other: 36 Total: 79 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 8, 2024.	F 0000	January 15, 2024 CCN/Provider Number: 155336 AIM Number: 100266850 Facility ID: 000229 Complaint Survey IN004211975 Chalet Rehabilitation and Healthcare Center 4851 Tincher Rd Indianapolis, IN 46221-3780 **Re: Survey Event ID Q4UE11 Cycle Start Date: January 4, 2024** Dear Ms. Buroker: On January 4, 2024, a Complaint Survey, (IN00421975) was conducted by the Indiana State Department of Health. 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 1-15-2024. Please feel free to call me with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward Hughes		01/15/2024

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			any further questions at 317-856-4851. Respectfully submitted, Edward Hughes Executive Director, Chalet Healthcare and Rehabilitation	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or			

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	her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review the facility failed to ensure staff reported an allegation of physical abuse immediately for 1 of 3 residents reviewed for abuse. (Resident B) Finding includes: During an interview on 1/3/24 at 1:27 p.m., the Administrator indicated on 12/30/23, an allegation was made that LPN 1 (Licensed Practical Nurse) witnessed LPN 2 and QMA 1 (Qualified Medication Aide) abruptly put Resident B in bed. Once Resident B was in bed, he sat up and LPN 2 kicked Resident B. It was alleged this took place a couple weeks ago but unfortunately it was not reported until 12/30/23. During an interview on 1/4/24 at 9:50 a.m., LPN 1 indicated approximately 2 to 3 weeks ago, on evening shift after 7:00 p.m., Resident B was on the floor, on his knees, at the foot of his bed. He had a small can in his hand that LPN 1 thought was shaving cream. LPN 1 asked LPN 2 and QMA 1 to help get Resident B off the floor and into his bed. LPN 1, LPN 2, and QMA 1 entered Resident B's room to get him up and LPN 2 indicated that Resident B's legs needed to be straightened first. After Resident B's legs were straightened, QMA 1 put an arm under Resident B's left armpit and LPN 2 put an arm under Resident B's right armpit and each of them grabbed the back of Resident B's pants. Then LPN 2 and QMA 1 "flung" Resident B's upper body into his bed with Resident B's legs still hanging off the bed. LPN 1 described "flung"	F 0609	**F 609D Reporting of Alleged Violations** **The facility respectively requests a desk review for this citation.** Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **1. Immediate actions taken for those residents identified:** No further areas of concern were identified related to the 12-30-2023 event. Resident B was assessed, and no areas of concern were noted. Translator spoke with Resident B in Spanish, and he denied any contact and stated he	01/15/2024

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	as "rough". When LPN 2 and QMA 1 "flung" Resident B into bed, Resident B hit his head on the right siderail. Once Resident B hit his head, Resident B sat up and threw the can he had been holding. The can grazed QMA 1, so QMA 1 immediately left the room. Then Resident B and LPN 2 had a "back and forth". LPN 1 described the "back and forth" as talking at each other instead of to each other. LPN 2 was speaking English at Resident B and Resident B was speaking Spanish at LPN 2. LPN 2 was telling Resident B to "be quiet". LPN 2 seemed frustrated. Then, LPN 2 extended her left leg out and kicked Resident B in the lower right shin as they were still going "back and forth". LPN 1 indicated the kick didn't seem forceful, but it seemed purposeful. At that time, there was no reason for LPN 2 to extend her leg and make any contact with Resident B's leg. LPN 1 put Resident B's legs in bed, made sure Resident B was comfortable, and LPN 1 and LPN 2 left the room and went to the nurse's station. LPN 1 should have reported that she witnessed LPN 2 kick Resident B immediately but was afraid of retaliation. The clinical record for Resident B was reviewed on 1/4/24 at 1:57 p.m. The diagnoses included, but were not limited to, dementia, cerebral infarct, and cognitive communication deficit. An Admission MDS (Minimum Data Set) assessment, dated 9/6/23, indicated Resident B was severely cognitively impaired. On 1/3/24 at 10:36 a.m., the DON (Director of Nursing) provided a copy of a facility policy, titled Abuse and Incident Reporting to IDOH (Indiana Department of Health), dated 5/12/23, and indicated this was the current policy used by the		felt safe in facility. Facility education provided on reporting requirements. **2. How the facility identified other residents:** An audit was conducted over the past 60 days of risk management, and grievances, to identify any other areas of concern that may have met reporting requirements. No areas identified that met reporting requirements. **3. Measures put into place/ System changes:** Education was provided on Policy and Procedure related to reporting requirements. The Director of Clinical Services will be notified of any reportable event, assistance with reporting will be provided as required. Events will be reported per reporting guidelines. Review of the 24-hour report, grievances and risk management during scheduled IDT meetings to identify reportable events. Issues identified will be immediately addressed with additional education and or disciplinary action. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive	

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	facility. A review of the policy indicated physical abuse included kicking. The facility will ensure that all alleged violations of abuse are reported immediately to the administrator and to other officials according to state and federal regulations. 3.1-28(c)		Director/Director of Nursing/designee. Events will be audited and reviewed daily during morning/clinical meetings via the IDT team to review the 24-hour report to determine if anything had occurred that may meet the reporting requirements. Facility staff will immediately notify the Executive Director should an event occur that requires reporting. Identified areas of concern will be reported per guidelines and additional education provided as required. Staff will be educated on abuse upon hire, annually and as needed with a focus on reporting requirements. Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction. **5. Date of Correction** 1-15-2024	