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

FORM APPROVED
OMB NO. 0938-039

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	07/25/2022

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 a Recertification and State Licensure Survey. Survey dates: July 19, 20, 21, 22, and 25, 2022 Facility number: 000229 Provider number: 155336 AIM number: 100266850 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 1 Medicaid: 36 Other: 22 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 1, 2022.	F 0000	8-8-22 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Recertification and Licensure Survey Chalet Rehabilitation and Healthcare Center 4851 Tincher RD Indianapolis, IN 46221 Dear Ms. Buroker: On July 19,20,21,22 and 25 Recertification and Licensure Survey 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 August 10, 2022 Please feel free to call me with	

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 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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			any further questions at 317-856-4851. Respectfully submitted, Goran Prentoski Executive Director	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in			

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	paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 1 of 2 residents reviewed for baseline care plans. A urinary catheter baseline care plan was not developed. (Resident 164) Findings include: On 7/20/22 at 10:49 a.m., observed Qualified Medication Aide 5 providing personal care to Resident 164. Resident 164 was observed resting in bed and had a condom urinary catheter (urine collection device that fits like a condom over the penis) in place. Resident 164's clinical record was reviewed on 7/22/22 at 1:13 p.m. The diagnoses included, but were not limited to, quadriplegia, neuromuscular dysfunction of bladder (problem in which a person lacks bladder control due to a brain, spinal cord or nerve condition), and urinary retention.	F 0655	**F655 Develop/ Baseline Care Plan** **The facility request paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Identified resident #164 was assessed and care plans reviewed and revised for	08/10/2022

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	A Physician's order, with a start date of 7/20/22 and no end listed, indicated Resident 164 was admitted to the facility with a condom catheter. The Admission MDS (Minimum Data Set) assessment, dated 7/15/22, indicated Resident 164 was admitted to the facility on 7/8/22. Resident 164 was cognitively intact and had an out-dwelling urinary catheter (condom catheter). The new assessment observation document, dated 7/8/22 at 5:19 p.m., indicated Resident 164 had a condom catheter in place when the resident was admitted into the facility on 7/8/22. Resident 164's progress notes included the following: -On 7/9/22 at 12:09 a.m., indicated Resident 164 "...was admitted...alert and oriented x 4 [cognitively intact]...has...condom catheter..." -On 7/12/22 at 11:46 a.m., indicated Resident 164 "...changed condom cath [catheter]..." -On 7/13/22 at 1:17 p.m., indicated Resident 164 "...changed condom cath [catheter] per res [Resident 164] request, used supplies that he brought with him..." Resident 164's care plan, date initiated on 7/15/22, revised on 7/19/22, and valid through 7/28/22, indicated "...potential for impaired skin integrity related to needing extensive assistance with all ADLs [activities of daily living], wearing a condom catheter..." During an interview on 7/22/22 at 2:15 p.m., Resident 164 indicated he was admitted to the facility with the condom catheter.		accuracy. **2) How the facility identified other residents:** No other resident residing within facility has a condom catheter. Audit conducted for those new residents admitted to facility within last 30 days to determine baseline care plans were completed. Any identified issues were corrected. Care plans are initiated/reviewed upon admission-admission, annually, quarterly, for significant change and as needed. Baseline care plans will be reviewed within 48 hours of admission. Care plans are additionally reviewed and updated during scheduled care plan meetings. **3) Measures put into place/ System changes:** In-service conducted by MDS Coord for the interdisciplinary team to review procedures for development of baseline care plans and comprehensive care plan. New admission baseline care plans will be reviewed within 48 hours of admission to ensure diagnosis are reflective of resident condition. Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually, with significant change and as needed. **4) How the corrective actions will be monitored:** The Director of Nursing and MDS Coordinator will randomly review three residents ‘admission records	

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	During an interview on 7/22/22 at 2:20 p.m., RN 3 indicated Resident 164 was admitted to the facility with a condom catheter. During an interview on 7/22/22 at 2:24 p.m., the Unit Manager indicated Resident 164 was admitted to the facility with a condom catheter. She was unsure why a baseline urinary catheter care plan was not developed within 48 hours of admission. Resident 164's clinical record lacked supporting documentation that a urinary catheter baseline care plan was developed and implemented within 48 hours of admission into the facility. On 7/25/22 at 11:17 a.m., the Unit Manager provided an undated copy of the Admission of Resident policy and indicated it was the current policy in use by the facility. A review of the policy indicated, "...Purpose: to facilitate a smooth transition into a healthcare environment...conduct a head-to-toe observation/assessment...complete a full body skin assessment...complete a head-to-toe systems assessment...initiate a plan of care..." On 7/25/22 at 11:17 a.m., the Unit Manager provided an undated copy of the Admission Checklist document and indicated it was the current document in use by the facility. A review of the document indicated, "...continue to complete the resident's information...nursing admission assessment...catheter evaluation...baseline care plan within 24-48 hours..." 3.1-30(a)		weekly ensuring that baseline care plans have been developed that accurately reflect resident status. MDS coordinator will review during scheduled care plan meetings to ensure care plans are reflective of resident's current status. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. **5) Date of compliance:** 8-10-2022	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia -specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure staff completed the required annual dementia training for 1 of 5 staff reviewed for annual dementia training. (Certified Nursing Assistant 4) Findings include: On 7/21/22 at 11:15 a.m., CNA (Certified Nursing Assistant) 4's employee record was reviewed. CNA 4 was hired 9/6/16. CNA 4's employee record lacked the required 3 hours of annual dementia training. During an interview on 7/22/22 at 10:37 a.m., the Corporate Consultant indicated new staff were required to complete 6 hours of dementia training within 6 months of hire. Then annually, each staff member was required to complete 3 hours of	F 9999	***F 9999 FINAL OBSERVATIONS*** ***The facility requests paper compliance for this citation.*** *This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ***1)Immediate actions taken for those residents identified:*** *C.N.A. #4 completed required Dementia training.* ***2) How the facility identified other residents:*** *No resident was identified to have been affected.* ***3) Measures put into place/ System changes:*** *Education provided to facility staff on Dementia training requirements. Audit was complete by HR to identify any staff member that has not completed the required training. Any identified issues were corrected immediately.* ***4) How the corrective actions will be monitored:****The responsible party for this plan of correction is the Administrator/ Director of Nursing. Dementia*	08/10/2022

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	dementia training. The facility was unable to verify that CNA 4 had completed the required 3 hours of annual dementia training. During an interview on 7/22/22 at 3:05 p.m., the Human Resources Director indicated on 7/1/21 there was a facility ownership transfer for this facility. CNA 4's dementia training documentation was not accessible through the previous facility owner's electronic training system. Additionally, the current facility was unable to provide any documented dementia training for CNA 4. During an interview on 7/25/22 at 9:35 a.m., the Director of Nursing Services indicated annual training due dates were based off the staff member's hire date. And as such, CNA 4's dementia training was due 9/6/21 for that annual period. The facility was unable to provide documentation that indicated the training was completed by the facility's self-imposed due date. On 7/21/22 at 3:41 p.m., the Unit Manager provided a copy of the Dementia Training policy, dated 11/2021, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...shall have a minimum of dementia specific training...three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for the residents with dementia..." On 7/22/22 at 12:45 p.m., the Unit Manager provided a copy of the Staff Education Plan, dated 11/1/21, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...facility to provide a Staff Education Plan...as required based upon State and Federal		*training audits will be conducted weekly to determine ongoing compliance with required training. Issues identified will be addressed immediately.* *The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.* **5) Date of compliance**: *8-10-2022*	

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	regulations...the facility will ensure the staff education plan includes both pre-service and annual requirements...includes dementia management training..."			