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 -- B. WING	09/06/2022

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: 09/06/22 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 09/14/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	**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.***	
E 0007 SS=F Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3).			

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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	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.]			
	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all occupants.	E 0007	**E007 EP Program Patient Population** **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***	09/29/2022

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	Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, the plan did not include a facility assessment, plus, no policy regarding continuity of operations, delegations of authority or succession plans. Based on interview at the time of record review, the DON agreed that there was no facility assessment, policy regarding continuity of operations, delegation of authority, and succession plan in the Emergency Preparedness plan. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated its Emergency Preparedness Plan to include a facility assessment policy indicating continuity of operations, delegation of authority and succession in the event of an emergency. Communication of updates have been completed with Staff and any other parties the IDT determines to be necessary.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will present the Emergency Preparedness Plan monthly to the QAPI**	

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			Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022.**	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for			

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	staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and	E 0015	**E015 Subsistence Needs for Staff and Patients** **The facility requests paper**	09/29/2022

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	residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, the plan provided did not address the loss of sewage and waste disposal to protect residents health and safety in an emergency. Based on interview at the time of records review, the Maintenance Supervisor confirmed the plan provided did not address the loss of sewage and waste disposal to protect residents health and safety in an emergency. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		**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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated the sewage and waste management emergency preparedness plan.** **Communication of updates have been completed with Staff, Residents, and necessary visitors. Additional training will take course as necessary and on an annual basis.** **4)How the corrective actions will be monitored:**	

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			The Maintenance Director/designee will present the Emergency Preparedness Plan monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022.**	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6) (ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b) (1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years			

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	[annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the			

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	hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness	E 0018	**E018 Procedures for Tracking of Staff and Patients** **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***	09/29/2022

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	plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no system to track the location of on-duty staff and sheltered residents in the event of an emergency in the available plan. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Emergency Preparedness plan has been reviewed and updated to ensure a tracking plan is in place in the event relocation of residents is necessary. The facility is partnered with a sister facility which is capable of housing and meeting the needs of the residents and staff if necessary.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will ensure to update the IDT incase a change in partnership or in the tracking plan is needed. IDT will ensure communication is completed as necessary with the facility staff, residents and visitors. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is**	

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			achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022.**	
E 0023 SS=F Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient			

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	information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, policies and procedure that included a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records was not available for review. Based on interview	E 0023	**E023: Policies/Procedures for Medical Documentation** **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**	09/29/2022

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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
	at the time of record review, the Maintenance Supervisor confirmed the facility's Emergency Preparedness plan does not include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		**No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Facility has reviewed and updated its Emergency Plan to ensure preservation of medical documentation in the event of an emergency. Staff will be re-educated on the updates. 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit 5 staff members per month to ensure understanding of the plan. Completion of initial in-servicing and monthly audits will be presented to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022**	

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	09/06/2022

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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E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and			

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	155336	A. BUILDING -- B. WING	09/06/2022

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	procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Maintenance Supervisor confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.	E 0024	**E024: Policies/Procedures-Volunteers and Staffing** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has assessed reviewed**	09/29/2022

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			and updated its policy related to use of volunteers in the event of an emergency. **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit 5 staff members per month to ensure understanding of the plan. Completion of initial in-servicing and monthly audits will be presented to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/29/2022.**	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	155336	A. BUILDING -- B. WING	09/06/2022

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of	E 0025	**E025 Arrangements with Other Facilities** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the***	09/29/2022

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	limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on interview at the time of record review, the Maintenance Supervisor confirmed documentation of arrangements with other facilities was not available for review at the time of the survey. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Emergency Preparedness plan has been reviewed and updated to ensure a tracking plan is in place in the event relocation of residents is necessary. The facility is partnered with a sister facility which is capable of housing and meeting the needs of the residents and staff if necessary.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit 5**	

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			staff members per month to ensure understanding of the plan. Completion of initial in-servicing and monthly audits will be presented to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022.	
E 0033 SS=F Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC			

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	facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility lacked an emergency preparedness communication program that included (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A	E 0033	**E033: Methods for Sharing Information** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	09/30/2022

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	means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, no documentation was available for a communication program that included (4) A method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release residents information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of residents under the facility's care. Based on interview at the time of record review, the Maintenance Supervisor searched the facility's emergency preparedness program but confirmed there was no communication program to indicate a method for sharing information and medical documentation for residents under the LTC facility's care. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated as necessary its Emergency Preparedness Plan to ensure a communication process for sharing information and medical documentation with other necessary parties is in place.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated staff members and all other necessary parties. Any changes to the plan will be communicated to the IDT Committee during QAPI**	

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			Meetings to ensure completion of re-education with staff. The report will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
E 0034 SS=F Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(7), 441.184(c)(7), 482.15(c)(7), 483.475(c)(7), 483.73(c)(7), 484.102(c)(6), 485.625(c)(7), 485.68(c)(5), 485.727(c)(5), 485.920(c)(7), 491.12(c)(5), 494.62(c)(7) Information on Occupancy/Needs §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the			

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	Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.			
	Based on record review and interview, the facility lacked an emergency preparedness communication program that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, a communication plan that included a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7) was not available for review. Based on interview at the time of record review then again at the exit conference, the Maintenance Supervisor confirmed the communication plan did not include the aforementioned occupancy,	E 0034	**E034: Information on Occupancy/Needs** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have**	09/29/2022

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	needs, and ability to provide assistance to the AHJ, IC, or designee. This finding was review with the Maintenance Supervisor and DON during the exit conference.		**the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated as necessary its Emergency Preparedness Plan to ensure the communication plan included occupancy, needs, and ability to provide assistance to the AHJ, IC, or designee.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated staff members and all other necessary parties. Any changes to the plan will be communicated to the IDT Committee during QAPI Meetings to ensure completion of re-education with staff. The report will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/29/2022**	
E 0035 SS=F Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8)			

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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
	*[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility lacked an emergency preparedness communication program that included a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness plan on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor and Director of Nursing (DON) present, the emergency preparedness communication plan failed to document a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their	E 0035	**E035: LTC and ICF/IID Sharing Plan with Patients** **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.***	09/29/2022

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	09/06/2022

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	families or representatives. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the documentation of the method to share information was not in the emergency preparedness plan. This finding was reviewed with the Maintenance Supervisor and DON during the exit conference.		**1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated as necessary its Emergency Preparedness Plan to ensure a communication process for sharing information deemed appropriate with residents, families or representative. A copy of the Emergency Preparedness Plan has been placed in the lobby of the facility. A secure message was sent out to family members or representatives indicating access to the binder. Maintenance Director of Designee will also review the plan with residents at the upcoming Resident Council Meeting.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated staff members and all other necessary parties. Any changes to the plan will be communicated to the IDT Committee during QAPI**	

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			Meetings to ensure completion of re-education with staff and all other appropriate parties. The report will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
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: 09/06/22 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.	K 0000	**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.***	

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	This one story facility was determined to be of Type V (111) construction and 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. All resident sleeping rooms were surveyed. 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. The facility has two detached storage buildings which were each not sprinklered. Quality Review completed on 09/14/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egress was continuously maintained free of obstructions. This deficient practice affects over 10 residents, as well as staff and visitors. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, there was a wheelchair scale stored in the short west corridor	K 0211	K211: Means of Egress-General **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***	09/29/2022

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	outside the oxygen transfilling/storage room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the wheelchair scale being stored in the short west corridor. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has removed the wheelchair scale.** **Maintenance Director has completed and initial audit to ensure all other corridors are free of obstruction.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated staff members to ensure corridors are free of obstruction. Maintenance Director/designee will audit all hallways weekly for 6 months to ensure hallways are free of obstruction. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and**	

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			make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored			

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	at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 5 of 5 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC	K 0222	**K222: Egress Doors** **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***	09/29/2022

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	19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all residents staff and visitors needing to exit the facility. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The Maintenance Supervisor was able to open the south exit door in the West Hall with a four digit code, however, when the door was closed the alarm on the keypad stayed activated and could not be shut off during several attempts. Furthermore, the exit door could not be reopened while the keypad alarm was activated. The maglock on the door did release when the fire alarm was activated by a pull station. b. All five exit doors had the keypad code posted on the maglock at the top of the door which was not easily identified. Based on interview at the time of observations, the Maintenance Supervisor agreed the code to the keypad should be located near the keypad, and further said he would get the facility's fire alarm vendor to come in and look at the keypad to figure out what was causing the keypad to alarm. These findings were reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** a. The South Exit Door in the West Hall was evaluated and repaired as necessary. b. All five exit doors have the key code posted at a visible level near the keypad. **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated staff members of the location of the key codes. Maintenance Director/designee will audit all 5 exit doorways weekly to ensure codes are present and visible weekly for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no**	

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			changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure 1 of 5 exit means of egress was properly lighted and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect up to 32 residents as well as staff and visitors on the West Hall. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the West Hall short hall exit was provided with light directly outside the exit door, however, there was a 250 foot sidewalk from the West Hall Short hall exit to the front of the building that was not provided with	K 0281	**K281: Illumination of Means of Egress** **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**	09/29/2022

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	emergency exterior lighting to the public way. Based on interview at the time of observation, the Maintenance Supervisor provided the footage of the sidewalk and agreed there needs to be more exterior light provided. This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		**No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Facility is working with a vendor to provide lighting to the 250-foot sidewalk located at the West Hall, short-hall exit. Temporary lighting has been placed in the interim. 4)How the corrective actions will be monitored: The Maintenance Director/designee has updated the IDT of the additional lightning. No additional measures are required for this citation at this time. 5) Date of compliance: 09/29/2022**	
K 0293 SS=C Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 1. Based on observation and interview, the	K 0293	**K293: Exit Signage**	09/29/2022

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	facility failed to properly install exit signage at 2 of 5 areas of exit discharge in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect at least all residents, as well as staff and visitors. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the illuminated EXIT signs at the north end of both the West Hall and East had the directional arrows popped out when the way of exit was straight through the smoke barrier doors. Based on interview at the time of observation, the Maintenance Supervisor agreed the directional arrows should not have been popped out on either exit sign. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 3 doors to the outside courtyard of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall		**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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **1.Facility has installed exit signage at all 5 areas of exit with the correct un-popped arrows** **2. Facility has ensured all 3 doors to the outside courtyard were properly labelled as not and exit.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has updated**	

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	be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8 inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect up to all residents, as well as staff and visitors while in the dining room. Findings include: Based on observations on 09/06/22 between 1;05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the east side dining room door to the courtyard was not posted with a NO EXIT sign. Based on interview at the time of the observation, the Maintenance Supervisor said the east side dining room door to the courtyard is not an exit to the public way and acknowledged it did not have a NO EXIT sign posted. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		**the IDT of the corrections. No additional measures are required for this citation at this time.** **5) Date of compliance: 09/29/2022**	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	1. Based on observation and interview, the facility failed to ensure the cook tops in 2 of 2 rooms was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect all residents while in the Physical Therapy Room and Activity Room. Findings include:	K 0324	**K324: Cooking Facilities** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/**	09/29/2022

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	155336	A. BUILDING 01 B. WING	09/06/2022

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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	Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, there were cooktop stoves in the Physical Therapy and Activity rooms. When checked, and not in use, these stove top appliances were not deactivated from the individual cooktop power sources. Based on interview at the time of observation, the Maintenance Supervisor confirmed both cooktop stoves were not deactivated when not in use. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the kitchen was provided with a UL 300 hood system. Based on		**System changes:** **1. Facility has ensured the cooktop stoves in the Physical Therapy and Activity rooms have been deactivated accordingly. No other stoves of this nature exist in this building.** **2. Kitchen Staff was re-educated on the proper use of the UL300 hood fire suppression system in 1 of 1 kitchen.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated kitchen staff members on proper use of the UL300 hood fire suppression system. Maintenance Director/designee will audit 5 kitchen staff members weekly to ensure proper understanding on usage for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/29/2022**	

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	interview with kitchen staff #1 (cook), when asked what she would do if there was a fire underneath the hood. She walked over and pointed to the K-Class fire extinguisher and said she would use the extinguisher first. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6			
	Based on record review and interview, the facility failed to provide a complete written policy for the protection of 71 of 71 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor present, the facility provided a "Fire Watch Procedure" document from the Emergency	K 0346	**K346: Fire Alarm System-Out of Service** **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***	09/29/2022

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	Preparedness plan, however, it was incomplete. The plan only stated "In the event the facility is under a fire watch the head nurse shall appoint one person to walk the halls of the building going into each resident room to check for possible fire or smoke every 30 minutes. When they are assigned to check rooms, this is to be their only job until the fire watch is over." The plan did include when and why a fire watch is being performed, whom to contact, with phone numbers, if a fire watch is required, plus, contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, the Maintenance Supervisor agreed the fire watch policy was not a complete fire watch policy and procedure. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		***it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility Emergency Preparedness Plan has reviewed and updated its Fire Watch policy as necessary to ensure compliance with the life safety code. Staff members have been re-educated on updates as necessary.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has re-educated staff members on the facility fire watch plan. Maintenance Director/Designee will audit 5 staff members weekly to ensure proper understanding for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the**	

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			plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
K 0353 SS=F 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			
	1. Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 6 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer.	K 0353	**K353: Sprinkler System- Maintenance and Testing** **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***	09/29/2022

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	This deficient practice could affect all resident, as well as kitchen staff and visitors within the smoke compartments. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There were 12 sprinkler heads throughout the kitchen covered with corrosion. b. There was on sprinkler head in the East Hall Janitor's Closet covered with corrosion. Based on interview at the time of each observation, the Maintenance Supervisor agreed the previously mentioned sprinkler heads were covered with corrosion and should be replaced. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 3 of 6 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect mostly staff, plus residents in the adjacent areas. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The sprinkler escutcheon in the Medical Supplies Room was hanging down one inch from		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** 1. Sprinkler heads noted to have corrosion in 2 of 6 areas are on order to be replaced. a. Sprinkler escutcheon in the medical supplies room was repaired b. Sprinkler escutcheon in the east hall pantry was repaired c. Sprinkler escutcheon in the MDS Coordinator officer was repaired. **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit 5 random sprinkler heads weekly to ensure they are in proper working order for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any**	

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	the ceiling leaving a one half inch gap around the sprinkler pipe to the attic space. b. The sprinkler escutcheon in the East Hall Pantry was hanging down one inch from the ceiling leaving a one half inch gap around the sprinkler pipe to the attic space. c. The sprinkler escutcheon in the MDS Coordinator Office was hanging down one inch from the ceiling leaving a one half inch gap around the sprinkler pipe to the attic space. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the gaps to the attic space in each of the previously mentioned areas. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		**trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/29/2022**	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility	K 0354		09/30/2022

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	failed to provide a complete written policy containing procedures to be followed for the protection of 71 of 71 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor present, the facility provided a "Fire Watch Procedure" document from the Emergency Preparedness plan, however, it was incomplete. The plan only stated "In the event the facility is under a fire watch the head nurse shall appoint one person to walk the halls of the building going into each resident room to check for possible fire or smoke every 30 minutes. When they are assigned to check rooms, this is to be their only job until the fire watch is over." The plan did include when and why a fire watch is being performed, whom to contact, with phone numbers,		**K354: Sprinkler System-Out of Service** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has ensured the following items have been ordered for replacement or repaired** **1. A) The 12 sprinkler heads throughout the kitchen covered with corrosion will be replaced by Safe care** **B) The Sprinkler head in the East Hall janitor closet covered**	

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	if a fire watch is required, plus, contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, the Maintenance Supervisor agreed the fire watch policy was not a complete fire watch policy and procedure. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		**with corrosion will be replaced by Safe care. 2. Facility Fire watch policy has been reviewed and updated as necessary. Staff members have been re-educated on any necessary updates. 4)How the corrective actions will be monitored: The Maintenance Director/designee has re-educated all staff members on the facility fire watch plan specifically related to and in coordination to the Emergency preparedness plan on what to do if the Sprinkler system goes down. Maintenance Director/Designee will audit 5 staff members weekly to ensure proper understanding for 6 months. Maintenance Director/Designee will audit 5 sprinkler heads weekly and the sprinkler system itself weekly for proper working order weekly for 6 months. The audits will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/30/2022**	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect up to 32 residents, as well as staff and visitors. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall above the West Hall north smoke barrier doors had two, two inch holes through the wall with wires running through it that were not proper fire stopped. Based on interview at the time of observation, the Maintenance Supervisor said the openings through the smoke barrier wall would be filled with a proper fire stop material as soon as possible.	K 0372	**K372: Subdivision of Building Spaces- Smoke Barrier** **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** **No resident was found to be affected by the finding.** **2)How the facility identified**	09/29/2022

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	This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		**other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Facility has repaired the two, two-inch holes located in the West Hall North smoke barrier walls 4)How the corrective actions will be monitored: The Maintenance Director/designee has re-educated staff members on the facility fire watch plan. Maintenance Director/Designee will audit smoke barrier walls weekly to ensure proper integrity for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022**	
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the			

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	provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 fuel-fired boiler had a current inspection certificate to ensure the boiler was in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the fuel-fired boiler in the Mechanical Room had a certificate with an expiration date of 01/23/20. Based on interview at the time of observation, the Maintenance Supervisor confirmed the expiration date of the fuel-fired boiler and said he has been trying to get someone to inspect the boiler but has not been able to as of yet. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)	K 0500	**K500: Building Services-Other** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has arranged inspection of its boiler system** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee has been re-educated to ensure**	09/29/2022

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	155336	A. BUILDING 01 B. WING	09/06/2022

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			understanding on importance of maintaining current inspection records. Boiler inspections will be brought to QAPI when necessary. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault	K 0511	**K511: Utilities- Gas and Electric** **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***	09/29/2022

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	circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations		***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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **The two electric receptacles in the West Hall Soiled Utility Room were repaired.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit 5 electrical receptacles weekly to ensure proper integrity and functional status for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/29/2022**	

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	(7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, two electric receptacles in the West Hall Soiled Utility Room were within three feet of the sink and hopper (currently not in use) and were provided with GFCI receptacles, however, when both were tested with a GFCI testing device, the circuit was not broken. The testing device showed an Open Ground for both. Based on interview at the time of observation, the Maintenance Supervisor agreed the GFCI receptacles in the West Hall Soiled Utility Room were not properly wired and therefore not GFCI protected. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all			

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	patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			
	Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 71 of 71 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and	K 0711	**K711: Evacuation and Relocation Plan** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have**	09/29/2022

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	training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Emergency Operations Plan-Fire Alarm/Detection" on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor present, the plan did not address staff response to battery powered smoke alarms located in all resident sleeping rooms. Based on interview at the time of record review, the Maintenance Supervisor acknowledged and agreed that the fire safety plan did not address staff response to resident room battery powered smoke alarms. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		**the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Facility has reviewed and updated its Emergency Preparedness plan to include proper response to battery operated smoke alarms located in resident rooms 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit 5 staff members weekly to ensure proper understanding and response to a battery-operated smoke alarm for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable			

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	liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 2 of 2 areas where cigarettes were smoked by residents and staff. This deficient practice could affect at least 5 residents and staff. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The resident smoking area within the courtyard had a metal trash can lined with a plastic bag and full of paper trash and over 100 cigarette butts, furthermore, there were at least 25 cigarette butts	K 0741	**K741: Smoking Regulations** **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***	09/29/2022

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	in the mulch in close proximity to the smoking area. b. The staff smoking area outside the southeast exit door had a smoke tower provided, however, the top of the tower was off the base and the base had paper trash stuffed inside. Furthermore, there were at least 15 cigarette butts on the ground around the staff smoking area. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged the paper trash mixed with the cigarette butts and the cigarette butts on the ground at each location. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		***of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **A) The metal trash can have been removed in the Resident smoking area. An additional self-closing ash tray has been provided. The 25 cigarette Butts identified have been cleaned up.** **B) The smoke tower located in the staff smoking area has been repaired. 2 additional smoking towers are on order to provide additional protection. The 15 identified cigarette butts have been cleaned up.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit the cigarette disposal units and areas 5 times per week to ensure proper integrity, functional status and cleanliness for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has**	

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			been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 09/29/2022**	
K 0761 SS=B Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure a complete annual inspection and testing of 1 of 1 oxygen room fire door assembly was in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing 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:	K 0761	**K761: Maintenance, Inspection & Testing- Doors** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice**	09/29/2022

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	(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 full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (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 at least 32 residents, staff, and visitors on the West Hall. Findings include: Based on record review on 09/06/22 between 9:25 a.m. and 1:05 p.m. with the Maintenance Supervisor present, the facility was able to provide documentation dated 08/08/22 for an annual inspection of one oxygen transfilling room fire door assembly, however, the documentation was not complete. The inspection report provided only included: Close, Latch, and Closer. It did not include other items such as, the door, frame,		**3) Measures put into place/ System changes: Annual inspection of the oxygen transfilling room fire door assembly was completed. 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit the oxygen transfilling room fire assembly monthly to ensure proper integrity and functional status for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022**	

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	hinges, hardware, label, door operation, etc. Based on interview at the time of record review, the Maintenance Supervisor said he does check for other items but only documents Close, Latch, and Closer. Based on observations during a tour of the facility with the Maintenance Supervisor, there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)			
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not			

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	required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 46 resident rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 2 residents, staff and visitors. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, there was one E size	K 0923	**K923: Gas Equipment- Cylinder and Container Storage** **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** **No resident was found to be**	09/29/2022

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	09/06/2022

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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	oxygen cylinder in room 41 freestanding on the floor and was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the E size oxygen cylinder in room 41 was not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b)		**affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Facility has removed the 1 oxygen cylinder. An audit was completed throughout the whole house to ensure no other oxygen cylinders have been stored improperly. No others were located. 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit 5 random Resident rooms weekly to ensure oxygen cylinders if present are stored correctly for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders			

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	Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transfilling takes place, was provided with properly maintained mechanical ventilation. This deficient practice could affect at least 32 residents, staff and visitors on the West Hall. Findings include: Based on observations on 09/06/22 between 1:05 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the oxygen storage/transfilling room was equipped with a working mechanically vented exhaust fan, however, it was heavily covered with dirt/dust at the time of observation. This was acknowledged by the Maintenance Supervisor at the time of observation. This finding was reviewed with the Maintenance Supervisor and Director of Nursing during the exit conference. 3.1-19(b) 2. Based on observation and interview, the	K 0927	**K927: Gas Equipment-Transfilling Cylinders** **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** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents that reside at the community have**	09/29/2022

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	facility failed to ensure 1 of 1 oxygen storage/transfer location was used properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect up to 32 residents, staff and visitors on the West Hall smoke compartment. Findings include: Based on observation on 09/06/22 at 2:38 p.m. during a tour of the facility with the Maintenance Supervisor, while inspecting the facility's smoke barrier walls a hissing noise was heard and the oxygen transfilling room door was being held wide open while oxygen transfilling from a large liquid tank to a small portable tank was occurring by staff. When asked, the staff person said she was the Qualified Medical Assistant. She further said "I've been trained, but forgot to close the door". This finding was reviewed with the Maintenance Supervisor during the exit conference. 3.1-19(b)		**the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **1. Mechanical ventilation located in the oxygen storage room has been cleaned and is in proper working order.** **2. Qualified Medical Assistant noted in the 2567 has been re-educated on proper oxygen transferring. All other staff noted to be qualified to re-fill oxygen have been re-educated.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit 5 staff members weekly to ensure proper knowledge of trans-filling of oxygen for 6 months. Mechanical ventilation fan will be audited weekly for cleanliness and proper working order. The audits will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 09/29/2022**	