DEPARTMENT OF HEALTH AND HUN	MAN SERVICES
CENTERS FOR MEDICARE & MEDICA	AID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING			COMPLETED		
		155336	B. WING			09/06/2022	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE.	DATE
E 0000							
E 0007 SS=F Bldg	conducted by the Inaccordance with 42 Survey Date: 09/06 Facility Number: 00 Provider Number: 1002 At this Emergency I Rehabilitation and Front in compliance with Requirements for Marticipating Provided 483.73 The facility has 88 of census of 71. Quality Review conductive The requirement at American MET as evidenced by 403.748(a)(3), 446. 441.184(a)(3), 482. 483.73(a)(3), 484. 485.68(a)(3), 494. EP Program Paties \$403.748(a)(3), \$484.1184(a)(3), \$484.1184(a)(3), \$483.73(a)(3),	200229 155336 266850 Preparedness survey, Chalet Healthcare Center was found with Emergency Preparedness Idedicare and Medicaid Hers and Suppliers, 42 CFR Certified beds, with a current Impleted on 09/14/22 42 CFR, Subpart 483.73 is NOT by: 3.54(a)(3), 418.113(a)(3), 2.15(a)(3), 483.475(a)(3), 102(a)(3), 485.625(a)(3), 727(a)(3), 485.920(a)(3), 62(a)(3) Int Population 416.54(a)(3), §418.113(a)(3), §460.84(a)(3), §482.15(a)(3), 33.475(a)(3), §484.102(a)	E 00	000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does a constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provision of federal and state law.	of n of not f or he d use	
	§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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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING COMPLETED B. WING 09/06/2022		
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	develop and main preparedness plai and updated at lea must do the follow (3) Address [patie including, but not the type of service ability to provide in continuity of operator of authority and substitution of authority and substitution of authority and substitution of authority and main preparedness plan and updated at lea must do all of the (3) Address reside but not limited to, services the LTC for provide in an eme operations, including and succession plans and succession plans and succession plans in accordance including delegation plans in accordance	nt/client] population, imited to, persons at-risk; is the [facility] has the in an emergency; and ations, including delegations accession plans.** Seat §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan following: ent population, including, persons at-risk; the type of fracility has the ability to argency; and continuity of ang delegations of authority ans. at risk" does not apply to: CE, HHA, CORF, CMCH,	E 0007	E007 EP Program Patient Population The facility requests paper compliance for this citation. This Plan of Correction is th center's credible allegation of compliance. Preparation and/or execution this plan of correction does	n of

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. BUILDING B. WING		COMPLETED 09/06/2022	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD JAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	plan on 09/06/22 be with the Maintenand Nursing (DON) prefacility assessment, continuity of operat or succession plans. time of record reviewas no facility assess continuity of operat and succession plan Preparedness plan. This finding was rev	the Emergency Preparedness tween 9:25 a.m. and 1:05 p.m. ce Supervisor and Director of sent, the plan did not include a plus, no policy regarding ions, delegations of authority Based on interview at the w, the DON agreed that there essment, policy regarding ions, delegation of authority, in the Emergency viewed with the Maintenance N during the exit conference.		constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute is required by the provision 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 potentiate 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 facility assessment policy indicating continuity of operations, delegation of authority and succession in 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	the ad use ins or the all the all the ine

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. BUILDING B. WING		COMPLETED 09/06/2022	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 TI	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
E 0015 SS=F Bldg	(1), 482.15(b)(1), 4485.625(b)(1) Subsistence Need §403.748(b)(1), §4 §441.184(b)(1), §4 §483.73(b)(1), §48 [(b) Policies and proparedness policing on the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policing be reviewed and use [annually for LTC of the policies and prothe following:	8.113(b)(6)(iii), 441.184(b) 183.475(b)(1), 483.73(b)(1), 185 for Staff and Patients 18.113(b)(6)(iii), 160.84(b)(1), §482.15(b)(1), 13.475(b)(1), §485.625(b)(1) 170cedures. [Facilities] 171 implement emergency 172 cies and procedures, based 173 plan set forth in paragraph 174 risk assessment at 175 fthis section, and the 176 an at paragraph (c) of this 177 ies and procedures must 177 pdated every 2 years 178 ies and procedures must 178 pdated every 2 years 179 ies and procedures must 187 pdated every 2 years 187 ies and procedures must 188 pdated every 2 years 188 ies and procedures must 189 pdated every 2 years 189 ies and procedures must 189 pdated every 2 years 180 ies and procedures must 180 pdated every 2 years 180 pdate		Committee during QAPI Meetings to ensure complet of any new necessary upda and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify trends or patterns and make recommendations to revise plan of correction as indical 5) Date of compliance: 09/29/2022.	tes / for le any e the

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Event ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED	
155336 B. WING 09/06/2022	
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 4851 TINCHER RD	
CHALET REHABILITATION AND HEALTHCARE CENTER INDIANAPOLIS, IN 46221	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE	
CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE	.ON
TAG REGULATOR FOR ESCIDENTIFT IN GINFORWATION TAG DATE	
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.	22
Based on record review and interview, the facility failed to ensure emergency preparedness policies E 0015 E015 Subsistence Needs for	J22
failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The E015 Subsistence Needs for Staff and Patients	
provision of subsistence needs for staff and The facility requests paper	

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STATEMENT OF AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022
	DER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD FINCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE
pla (i) sur	ce, include, but a Food, water, med oplies. (ii) Alterna	ney evacuate or shelter in re not limited to the following: lical, and pharmaceutical ate sources of energy to peratures to protect resident		compliance for this citation This Plan of Correction is t center's credible allegation compliance.	he
hea sto Fir and with con Fir Band pla with Nu add pro em rec cor los res	alth and safety an rage of provision to detection, extinuted (D) Sewage and the 42 CFR 483.73 and affect all occurrence of the first of the Maintenance of the Mainte	d for the safe and sanitary s; (B) Emergency lighting; (C) guishing, and alarm systems; waste disposal in accordance b(b)(1). This deficient practice		Preparation and/or executive this plan of correction does constitute admission or agreement by the provider the truth of the facts allege conclusions set forth in the statement of deficiencies. plan of correction is prepara and/or executed solely bed it is required by the provisit of federal and state law. 1) Immediate actions taken those residents identified No resident was found to be affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents reside at the community has the potential to be affected the alleged deficient practic 3) Measures put into place/System changes: Facility has reviewed and updated the sewage and was management emergency preparedness plan. Communication of updates have been completed with Staff, Residents, and neces visitors. Additional trainin will take course as necessaring on an annual basis. 4) How the corrective action will be monitored:	of of od or e The red ause ions for e I s that ave by ce aste

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		l í	ILDING NG	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022	
	PROVIDER OR SUPPLIE	R AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
E 0018 SS=F Bldg	403.748(b)(2), 41 and (v), 441.184(483.475(b)(2), 48 485.920(b)(1), 48 Procedures for Tr §403.748(b)(2), § (ii) and (v), §441. §482.15(b)(2), § (1), §494.62(b)(1) [(b) Policies and preparedness policy on the emergency (a) of this section paragraph (a)(1) communication pr section. The policy	6.54(b)(1), 418.113(b)(6)(ii) b)(2), 482.15(b)(2), 3.73(b)(2), 485.625(b)(2), 6.360(b)(1), 494.62(b)(1) racking of Staff and Patients 416.54(b)(1), §418.113(b)(6) 184(b)(2), §460.84(b)(2), 83.73(b)(2), §483.475(b)(2), 485.920(b)(1), §486.360(b)			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 update and compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise to plan of correction as indicated. 5) Date of compliance: 09/29/2022.	nt es for e iny

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		B. W	JILDING ING		09/06		
	133330		D. W.			09/00	12022
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER			NCHER RD APOLIS, IN 46221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		facilities]. At a minimum, rocedures must address					
	the following.j						
	[(2) or (1)] A syste	em to track the location of					
	-, , , ,-	sheltered patients in the					
	[facility's] care du	ring an emergency. If					
		sheltered patients are					
		he emergency, the [facility]					
		ne specific name and					
	location of the rec	eiving facility or other					
	location.						
		141.184(b), LTC at					
	- , ,	Ds at §483.475(b), PACE at ies and procedures. (2) A					
	- , , -	e location of on-duty staff					
	_ ·	idents in the [PRTF's, LTC,					
		care during and after an					
	_	-duty staff and sheltered					
	residents are relo	-					
	emergency, the [F	PRTF's, LTC, ICF/IID or					
	_	ment the specific name					
		e receiving facility or other					
	location.						
	*[For Inpatient Ho	spice at §418.113(b)(6):]					
	Policies and proce						
		on from the hospice, which					
	includes consider	ation of care and treatment					
	needs of evacuee	s; staff responsibilities;					
		entification of evacuation					
	1 ' '	imary and alternate means					
		with external sources of					
	assistance.						
	, ,	ack the location of hospice					
		ty and sheltered patients in					
	· ·	e during an emergency. If byees or sheltered patients					
		ng the emergency, the					
	I are relocated dull	ng the emergency, the	- 1				1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336	A. BUILDING B. WING	onstruction 	COMPLETED 09/06/2022
NAME OF PROVIDER OR SUPPLIER CHALET REHABILITATION AND HEALTHCARE CENTER	4851 TI	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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	PREFIX	E018 Procedures for Tracking of Staff and Patients	TE COMPLETION DATE
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		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution	of n of
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		this plan of correction does a constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The	f or

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155336			 UILDING	DNSTRUCTION	(X3) DATE : COMPL 09/06/	ETED
NAME OF PROVIDER OR SUPPLIER CHALET REHABILITATION AND HEALTHCARE CENTER			4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	with the Maintenant Nursing (DON) pre procedures that inc location of on-duty in the LTC facility' emergency was ava- interview at the tim Maintenance Super system to track the sheltered residents in the available pla This finding was re-	etween 9:25 a.m. and 1:05 p.m. are Supervisor and Director of esent, no policies and lude a system to track the staff and sheltered residents is care during and after an atlable for review. Based on the of record review, the evisor confirmed there was no location of on-duty staff and in the event of an emergency in. Eviewed with the Maintenance on during the exit conference.		plan of correction is prepare and/or executed solely becaute it is required by the provision 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 reside at the community have the potential to be affected by the alleged deficient practice. 3) Measures put into place/System changes: Emergency Preparedness plans 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 necess 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 in completed as necessary with the facility staff, residents and visitors. The report will be reviewed in Quality Assuran Meeting monthly for 6 month or until 100% compliance is	use ns or that e by an I y ary. ary. ce	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. BUILDING B. WING		COMPLETED 09/06/2022	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				achieved. The QA Committed will identify any trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance:	the
E 0023 SS=F Bldg	441.184(b)(5), 482 483.73(b)(5), 484. 485.68(b)(3), 485. 486.360(b)(2), 491 Policies/Procedure Documentation §403.748(b)(5), § (3), §441.184(b)(5) (5), §483.73(b)(5), §484.102(b)(4), § (5), §485.727(b)(3)	416.54(b)(4), §418.113(b)), §460.84(b)(6), §482.15(b) §483.475(b)(5), 485.68(b)(3), §485.625(b)		09/29/2022.	
	must develop and preparedness policon the emergency (a) of this section, paragraph (a)(1) o communication plasection. The polic be reviewed and u years [annually for	rocedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at f this section, and the an at paragraph (c) of this ies and procedures must pdated at least every 2 LTC facilities]. At a cies and procedures must ing:]			
	documentation tha	A system of medical at preserves patient ats confidentiality of patient			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. BUILDING CO			(X3) DATE COMPL 09/06/	ETED		
		PROVIDER OR SUPPLIEF	AND HEALTHCARE CENTER		4851 TII	DDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION information, and secures and maintains		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Р.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
		*[For RNHCIs at § procedures. (5) A documentation that (i) Preserves patie (ii) Protects confidinformation. (iii) Secures and records. *[For OPOs at §44 procedures. (2) A documentation that actual donor information, and seavailability of procedures included to ensure emand procedures included to ensure emand procedures included and procedures and maintain procedures and maintain procedures and maintain and procedures and maintain and procedures and maintain and procedures and maintain procedures and procedures and maintain procedures and maintain procedures and maintain procedures and procedu	Ado3.748(b):] Policies and system of care at does the following: ent information. Identiality of patient maintains the availability of asystem of medical at preserves potential and mation, protects and actual donor decures and maintains the wids. Wiew and interview, the facility ergency preparedness policies ude a system of medical	E 002	23	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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepare and/or executed solely becaut it is required by the provision of federal and state law. 1) Immediate actions taken for those residents identified	e of n of not f or he d use ns	09/29/2022

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		,	LDING	NSTRUCTION	COMPL 09/06/	ETED	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Supervisor confirmed Preparedness plan of medical documenta information, protect information, and see availability of record This finding was re-	d review, the Maintenance ed the facility's Emergency loes not include a system of tion that preserves resident ts confidentiality of resident cures and maintains the ds. viewed with the Maintenance N 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 to 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 Plansensure preservation of medic 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 audit in-servicing and monthly audit in the plan. The report will be reviewed in Quality Assurance Meeting monthly of months or until 100% compliance is achieved. The QA Committee will identify an trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 09/29/2022	e y to cal of	

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PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

NAME OF PROVIDER OR SUPPLIER		amp ppm :	A. BUILDING COMPLETED B. WING 09/06/2022		
CHALET REHABILITATION AND HEAL	THCARE CENTER	4851 TII	.ddress, city, state, zip cod NCHER RD APOLIS, IN 46221		
(X4) ID SUMMARY STATEMENT C PREFIX (EACH DEFICIENCY MUST BE I TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
E 0024 SS=F Bldg ## 403.748(b)(6), 416.54(b)(5), 4 ## 483.73(b)(6), 484.102(b)(5), 4 ## 485.68(b)(4), 485.727(b)(4), 4 ## 491.12(b)(4), 494.62(b)(5) ## Policies/Procedures-Voluntee \$403.748(b)(6), \$416.54(b)(5) \$441.184(b)(6), \$460.84(b)(7) \$483.73(b)(6), \$483.475(b)(6) \$485.68(b)(4), \$485.625(b)(6) \$485.68(b)(4), \$485.625(b)(6) \$485.68(b)(4), \$485.625(b)(6) \$485.920(b)(5), \$491.12(b)(4) ## [(b) Policies and procedures. ## must develop and implement preparedness policies and procedures policies p	at 8.113(b)(4), 883.475(b)(6), 885.625(b)(6), 885.920(b)(5), ars and Staffing (a), §418.113(b)(4), (b), §482.15(b)(6), (c), §484.102(b)(5). The [facilities] emergency ocedures, based of the in paragraph ament at at an, and the araph (c) of this ocedures must east every 2 es]. At a ocedures every 2 es]. At a ocedures every 2 es]. At a ocedures every 2 es].				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. Bl	A. BUILDING B. WING		COMPLETED 09/06/2022		
	F PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TE	(X5) COMPLETION DATE	
	employees in an emergency staffin process and role of Federally designal professionals to a an emergency. Based on record reversided to ensure emergency or other strategies, including integration of State care professionals to an emergency in active 483.73(b)(6). This all occupants. Findings include: Based on review of plan on 09/06/22 be with the Maintenan Nursing (DON) presided exists an emergency in active with the Maintenan Nursing (DON) presided exists and interview Maintenance Super provided did not ada an emergency. This finding was resided as a superprovided was resided as a superprovided exists and the superprovided did not ada an emergency.	the use of hospice emergency and other g strategies, including the for integration of State and ted health care ddress surge needs during view and interview, the facility ergency preparedness policies ude the use of volunteers in the mergency staffing g the process and role for or Federally designated health to address surge needs during cordance with 42 CFR deficient practice could affect when the facility's plan did not solunteers in an emergency, at the time of review, the visor confirmed the plan dress the use of volunteers in wiewed with the Maintenance N during the exit conference.	EO	024	E024: Policies/Procedures-Volunte 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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaute it is required by the provision 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 freside at the community have the potential to be affected by the alleged deficient practices. 3) Measures put into place/System changes: Facility has assessed review.	e of n of not f or he d use ns or	09/29/2022

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022
	PROVIDER OR SUPPLIE	R AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221	•
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION DATE
				and updated its policy re to use of volunteers in the event of an emergency. 4)How the corrective act will be monitored: The Maintenance Director/designee will at staff members per mont ensure understanding or plan. Completion of in in-servicing and monthly will be presented to the Committee during QAPI Meetings to ensure compliance. The report be reviewed in Quality Assurance Meeting month of months or until 100% compliance is achieved. QA Committee will ident trends or patterns and in recommendations to reviplan of correction as inception of compliance: 09/29/2022.	tions udit 5 h to f the itial y audits QAPI twill thly for The ify any nake vise the
E 0025 SS=F Bldg	482.15(b)(7), 483 485.625(b)(7), 48 Arrangement with §403.748(b)(7), § (7), §460.84(b)(8 (7), §483.475(b)(6 §485.920(b)(6), § [(b) Policies and pure paredness point the emergency	418.113(b)(5), §441.184(b) 3), §482.15(b)(7), §483.73(b) 7), §485.625(b)(7),			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 7	ADDRESS, CITY, STATE, ZIP COD FINCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	communication pla section. The polic be reviewed and u years [annually for minimum, the polic address the follow				
	§441.184,(b) Hosp LTC Facilities at § procedures. (7) [o arrangements with other providers to of limitations or ce	§418.113(b), PRFTs at bitals at §482.15(b), and 483.73(b):] Policies and r (5)] The development of a other [facilities] [and] receive patients in the event essation of operations to nuity of services to facility			
	§483.475(b), CAH at §485.920(b) an §494.62(b):] Polici (6), (8)] The devel with other [facilitie receive patients in cessation of opera	60.84(b), ICF/IIDs at Is at §486.625(b), CMHCs Id ESRD Facilities at Ities and procedures. (7) [or opment of arrangements Is] [or] other providers to Ithe event of limitations or ations to maintain the Itees to facility patients.			
	procedures. (7) The arrangements with providers to receive limitations or cess	n other RNHCIs and other we patients in the event of ation of operations to nuity of non-medical			
	Based on record rev failed to ensure eme and procedures incl arrangements with o	regency preparedness policies ude the development of other LTC facilities and other eresidents in the event of	E 0025	E025 Arrangements with Oth Facilities The facility requests paper compliance for this citation. This Plan of Correction is the	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022
CHALET	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD FINCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION DATE
	the continuity of se accordance with 42	tion of operations to maintain rvices to LTC residents in CFR 483.73(b)(7). This		center's credible allegation of compliance.	
	accordance with 42 deficient practice of Findings include: Based on review of plan on 09/06/22 be with the Maintenan Nursing (DON) preemergency prepared including the develother LTC facilities residents in the eve of operations was non interview at the Maintenance Super documentation of a facilities was not as the survey. This finding was residents in the 42 deficiency of the 42 december 12 december 13 december 14 december 14 december 15 december 16 decemb	CFR 483.73(b)(7). This build affect all occupants. The Emergency Preparedness between 9:25 a.m. and 1:05 p.m. ce Supervisor and Director of disent, documentation of dness policies and procedures opment of arrangements with and other providers to receive int of limitations or cessation of available for review. Based time of record review, the		Preparation and/or executivis plan of correction doconstitute admission or agreement by the provide the truth of the facts alleg conclusions set forth in the statement of deficiencies. plan of correction is preparation and/or executed solely be it is required by the proviso of federal and state law. 1) Immediate actions taken those residents identified No resident was found to affected by the finding. 2) How the facility identified other residents: Visitors, staff and residen reside at the community he potential to be affected the alleged deficient pract 3) Measures put into place System changes: Emergency Preparedness has been reviewed and updated to ensure a track plan is in place in the ever relocation of residents is necessary. The facility is partnered with a sister fact which is capable of housin and meeting the needs of residents and staff if neces 4) How the corrective action will be monitored:	es not r of red or he The ared cause sions n for be d ts that have d by cice e/ plan ing nt sility ng the essary.
				The Maintenance Director/designee will aud	lit 5

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155336	A. BUILDING B. WING			
	ROVIDER OR SUPPLIER		STREET 4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221	00/00/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0033 SS=F Bldg	403.748(c)(4)-(6), (4)-(6), 441.184(c) 483.475(c)(4)-(6), (4)-(5), 485.625(c) 485.727(c)(4), 485, 494.62(c)(4)-(6), §418.113(c)(4)-(6), §460.84(c)(4)-(6), §460.84(c)(4)-(6), §483.73(c)(4)-(6), §484.102(c)(4)-(5), (4)-(6), §485.727(c), §491.12(c)(4), §45, [(c) The [facility] man emergency preplan that complies), §416.54(c)(4)-(6),), §441.184(c)(4)-(6), §441.184(c)(4)-(6), §482.15(c)(4)-(6), §483.475(c)(4)-(6),), §485.68(c)(4), §485.625(c) c)(4), §485.920(c)(4)-(6), 04.62(c)(4)-(6). Hust develop and maintain eparedness communication with Federal, State and	TAG	staff members per month to ensure understanding of the plan. Completion of initial in-servicing and monthly aud will be presented to the QAP Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly 6 months or until 100% compliance is achieved. The QA Committee will identify a trends or patterns and make recommendations to revise plan of correction as indicated by 100 patterns and make 100 patterns	dits el for e iny the	
	local laws and mu	st be reviewed and updated				

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at least every 2 years [annually for LTC

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022			
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	include all of the f	-						
	medical documen [facility's] care, as	charing information and tation for patients under the necessary, with other or maintain the continuity of						
	release patient inf under 45 CFR 16 provision is not re	e event of an evacuation, to formation as permitted 4.510(b)(1)(ii). [This quired for HHAs under RFs under §485.68(c)]						
	about the general patients under the	eans of providing information condition and location of [facility's] care as 5 CFR 164.510(b)(4).						
	for sharing inform documentation for care, as necessar maintain the conti written election st	(403.748(c):] (4) A method ation and care repatients under the RNHCI's y, with care providers to nuity of care, based on the atement made by the er legal representative.						
	means of providin general condition	Cs at §491.12(c):] (4) A g information about the and location of patients care as permitted under 45						
	Based on record rev lacked an emergend communication pro method for sharing documentation for facility's care, as ne	view and interview, the facility	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 compliance.	e			

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	UILDING	ONSTRUCTION	(X3) DATE COMPL 09/06/	ETED
	OF PROVIDER OR SUPPLIE ET REHABILITATION	AND HEALTHCARE CENTER	4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	client information a 164.510(b)(1)(ii); (information about t location of resident permitted under 45 accordance with 42 practice could affect. Based on review of plan on 09/06/22 be with the Maintenan Nursing (DON) pre available for a comincluded (4) A metimedical documenta LTC facility's care, care providers to m (5) A means, in the release residents in 45 CFR 164.510(b) information about t location of resident Based on interview the Maintenance Statistically is emergency confirmed there was to indicate a methomedical documenta LTC facility's care. This finding was resident in 164.510(b) information about t location of resident based on interview the Maintenance Statistically is emergency confirmed there was to indicate a methomedical documenta LTC facility's care.	The Emergency Preparedness etween 9:25 a.m. and 1:05 p.m. ce Supervisor and Director of esent, no documentation was munication program that hod for sharing information and tion for residents under the as necessary, with other health aintain the continuity of care; event of an evacuation, to formation as permitted under of (1)(ii); (6) A means of providing the general condition and sunder the facility's care. at the time of record review, approvisor searched the preparedness program but so no communication program defor sharing information and tion for residents under the		Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. In plan of correction is prepare and/or executed solely becall it is required by the provision 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 reside at the community have the potential to be affected by the alleged deficient practical. 3) Measures put into place/System changes: Facility has reviewed and updated as necessary its Emergency Preparedness Process for sharing informal and medical documentation with other necessary parties in place. 4) How the corrective actions will be monitored: The Maintenance Director/designee has re-educated staff members all other necessary parties. Any changes to the plan will communicated to the IDT Committee during QAPI	not of for The ed nuse nor that re by e lan tion s is	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/05/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED	
		155336	B. W	ING		09/06/2022		
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	<u> </u>	4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FILL PREFIX (EACH CORRECTIVE ACTION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	·E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE		
E 0034 SS=F Bldg	441.184(c)(7), 483.73(c)(7), 484.483.73(c)(7), 484.485.68(c)(5), 495.491.12(c)(5), 494.1184(c)(7), §483.73(c)(7), §483.73(c)(7), §485.68(c)(5) (5), §485.625(c)(7), §491.12(c)(5), §491.12	ccupancy/Needs 416.54(c)(7), §418.113(c)(7) 482.15(c)(7), §460.84(c)(7), 83.475(c)(7), §484.102(c) , §485.68(c)(5), §485.727(c) 7), §485.920(c)(7), 94.62(c)(7). Inust develop and maintain eparedness communication is with Federal, State and list be reviewed and updated lears [annually for LTC mmunication plan must ollowing:			Meetings to ensure completic of re-education with staff. The report will be reviewed in Quality Assurance Meeting monthly to ensure no change 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 by 10 Date of compliance: 09/29/2022	he es es		
	information about	the [facility's] occupancy,						

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needs, and its ability to provide assistance, to the authority having jurisdiction, the

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155336	B. W	ING		09/06/2022	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221		
	1				1	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
TAG				IAG		DATE	
	Incident Command Center, or designee.						
*[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs,							
		rovide assistance, to the					
		urisdiction, the Incident					
	Command Center	r, or designee.					
	*[For Inpatient Ho	spice at §418.113(c):] (7) A					
		g information about the					
	hospice's inpatien	t occupancy, needs, and					
its ability to provide assistance, to the							
authority having jurisdiction, the Incident							
	Command Center						
		view and interview, the facility	E 0	034	E034: Information on	09/29/2022	
	lacked an emergeno				Occupancy/Needs		
		gram that included a means of			The facility requests paper		
		ion about the LTC facility's and its ability to provide			compliance for this citation.		
		and its ability to provide athority having jurisdiction or			This Plan of Correction is the		
		and Center, or designee in			center's credible allegation (compliance.		
		CFR 483.73(c)(7). This			Preparation and/or execution	n of	
		ould affect all occupants.			this plan of correction does		
		1			constitute admission or		
	Findings include:				agreement by the provider of the truth of the facts alleged		
		the Emergency Preparedness			conclusions set forth in the		
	-	etween 9:25 a.m. and 1:05 p.m.			statement of deficiencies. T		
		ce Supervisor and Director of			plan of correction is prepare		
		sent, a communication plan			and/or executed solely beca		
		ns of providing information			it is required by the provisio	ns	
		lity's occupancy, needs, and its			of federal and state law.		
		ssistance, to the authority			1)Immediate actions taken for	or	
		or the Incident Command			those residents identified		
	_	in accordance with 42 CFR			No resident was found to be		
		ot available for review. Based time of record review then			affected by the finding.		
		of record review then ofference, the Maintenance			2)How the facility identified other residents:		
		ed the communication plan did				that	
	_	rementioned occupancy,			Visitors, staff and residents reside at the community hav		
	I not include the alor	ememorica occupancy,	1		I reside at the community hav	· E	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/06/2022		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) D BE OPRIATE COMPLETION DATE		
	AHJ, IC, or designed. This finding was re Supervisor and DO	view with the Maintenance N during the exit conference.		the potential to be affects the alleged deficient prace 3) Measures put into place System changes: Facility has reviewed and updated as necessary its Emergency Preparedness to ensure the communicate plan included occupancy needs, and ability to pro- assistance to the AHJ, IC designee. 4)How the corrective act will be monitored: The Maintenance Director/designee has re-educated staff member all other necessary partical Any changes to the plan communicated to the IDT Committee during QAPI Meetings to ensure component of re-education with staff report will be reviewed in Quality Assurance Meeti monthly to ensure no ch or until 100% of education been achieved. The QA Committee will identify a trends or patterns and m recommendations to rev plan of correction as ind 5) Date of compliance: 09/29/2022	ctice ce/ d s s Plan ation //, vide c, or ions ers and es. will be f pletion f. The n ng anges on has eny take ise the		
E 0035 SS=F Bldg	483.475(c)(8), 48: LTC and ICF/IID \$ §483.73(c)(8); §4:	Sharing Plan with Patients					

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Event ID:

WWNR21 Facility ID: 000229

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155336	B. WIN	NG		09/06/	/2022
	PROVIDER OR SUPPLIE	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SECY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION PS at §483.73(c):]	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[(c) The LTC facil maintain an emer communication procedured and upon communication procedured and upon communication procedured and upon communication procedured and upon communication procedured and the second and the facility has residents and their accordance with 42 deficient practice of the second and the maintain procedured and the facility has residents and their accordance with 42 deficient practice of the second and s	gency preparedness an that complies with d local laws and must be lated at least annually. The lan must include all of the says and maintain an aredness communication is with Federal, State and last be reviewed and updated lears. The communication is all of the following:] Sharing information from the last the facility has bropriate, with residents [or families or representatives.	E 00	235	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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provision of federal and state law.	ne of on of not of d or The ed nuse	09/29/2022

PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPI A. BUILDIN B. WING	(X3) DATE SURVEY COMPLETED 09/06/2022		
	PROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	485	EET ADDRESS, CITY, STATE, ZIP 51 TINCHER RD DIANAPOLIS, IN 46221	COD
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE	SHOULD BE COMPLETION
	families or represe the time of record Supervisor acknow the method to shar emergency prepare This finding was re	ntatives. Based on interview at review, the Maintenance vledged the documentation of e information was not in the		1)Immediate actions those residents iden No resident was fou affected by the finding 2)How the facility identer residents: Visitors, staff and reside at the commutate potential to be at the alleged deficient 3) Measures put into System changes: Facility has reviewed updated as necessa Emergency Prepared to ensure a communicate of presentative. A compared to ensure a communication of Designee will also the plan with resident upcoming Resident Meeting. 4)How the corrective will be monitored: The Maintenance Director/designee has lother necessary parts and the communicated to the communicated to the communicated to the communicated to the committee during Quite and the side of the communicated to the communicated to the committee during Quite and the side of the committee during Quite and the side of the communicated to the committee during Quite and the side of the committee of the c	staken for atified and to be ang. sentified seldents that unity have a seldents that unity have a seldents plan and and ary its and are also and and ary its and are also and are also and are are also and are are

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER 155336	A. BUILDING B. WING		COMPLETED 09/06/2022		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000	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 change 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: 5) Date of compliance: 6) Date of compliance: 7) Date of compliance: 7) Date of correction is the center's credible allegation of compliance.	on d n es as the ed.		
	not in compliance w Participation in Mec Subpart 483.90(a), I 2012 edition of the I Association (NFPA)	00229 155336 266850		Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becative is required by the provision of federal and state law.	not f or he ed use		

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Event ID:

 $WWNR21 \quad \text{Facility ID:} \quad 000229$

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING	E CONSTRUCTION G <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155336	B. WING		09/06/2022
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	485	EET ADDRESS, CITY, STATE, ZIP COD 1 TINCHER RD IANAPOLIS, IN 46221	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR This one story facility Property (111) const. The facility has a findetection in the corresponding to the	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Ity was determined to be of ruction and fully sprinklered. The alarm system with smoke ridor and in all areas open to scility has battery operated	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
	smoke detectors ins rooms. All resident surveyed. The facil had a census of 71 a All areas where resi were sprinklered. T storage buildings w sprinklered.	talled in all resident sleeping sleeping rooms were ity has a capacity of 88 and at the time of this visit. dents have customary access the facility has two detached			
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of was continuously made to the standard of the standard failed to ensure 1 of was continuously made to the standard failed to ensure 1 of was continuously made to the standard failed to ensure 1 of was continuously made to the standard failed to ensure 1 of was continuously made to the standard failed to ensure 1 of was continuously made to the standard failed to the st	Ays, corridors, exit cations, and accesses are in Chapter 7, and the means uously maintained free of full use in case of is modified by 18/19.2.2 1	K 0211	K211: Means of Egress-Generative facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of	ne of n of not
	the Maintenance Su	pervisor, there was a pred in the short west corridor		the truth of the facts alleged conclusions set forth in the	l or

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/06/2022		
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP COD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER	4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION	COM	(X5) PLETION
TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ATE
		transfilling/storage room.			statement of deficiencies. T	-	
		at the time of observation, the visor acknowledged the			plan of correction is prepare		
	_	ing stored in the short west			and/or executed solely beca it is required by the provisio		
	corridor.				of federal and state law.		
	Th:- £., 1:	:			1)Immediate actions taken for	or	
	_	viewed with the Maintenance ector of Nursing during the exit			those residents identified No resident was found to be		
	conference.	5 6			affected by the finding.		
	2.1.10(1.)				2)How the facility identified		
	3.1-19(b)				other residents: Visitors, staff and residents	that	
					reside at the community hav	I	
					the potential to be affected by	- I	
					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	I	
					free of obstruction.		
					4)How the corrective actions		
					will be monitored: The Maintenance		
					Director/designee has		
					re-educated staff members t	0	
					ensure corridors are free of obstruction. Maintenance		
					Director/designee will audit	all	
					hallways weekly for 6 month		
					to ensure hallways are free of obstruction. The audit will l		
					reviewed in Quality Assuran		
					Meeting monthly to ensure n		
					changes or until 100% of	.	
					education has been achieved The QA Committee will ident		
					any tronde or nattorne and	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	ULTIPLE CO JILDING	onstruction 01	(X3) DATE SURVEY COMPLETED		
THE TERM	201111011	155336	B. WI		<u>v.</u>	09/06/2022	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					make recommendations to revise the plan of correction indicated. 5) Date of compliance:	as	
K 0222 SS=F Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special locking arrows of the result of the resul	king arrangements for the seds of the patient are sking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the			09/29/2022		

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	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> COM		(X3) DATE SURVEY COMPLETED 09/06/2022				
	F PROVIDER OR SUPPLIES	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed a systems installed 7.2.1.6.1 shall be assemblies servir contents in buildin an approved, sup detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTF LOCKING ARRAL Access-Controller installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOB LOCKING ARRAL Elevator lobby ex accordance with on door assembling throughout by an automatic fire det approved, superv system. 18.2.2.2.4, 19.2.2.2	delayed-egress locking in accordance with permitted on door ag low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 ROLLED EGRESS NGEMENTS degress Door assemblies dance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS it access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an ised automatic sprinkler 2.2.4	K 0222	Kana Farrago Dogra	00/20/2022		
	failed to ensure the 5 exits was readily a clinical diagnosis measures. Doors v egress shall not be that requires the us	on and interview, the facility means of egress through 5 of accessible for residents without requiring specialized security vithin a required means of equipped with a latch or lock e of a tool or key from the 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 compliance. Preparation and/or execution this plan of correction does	ne of on of		

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
		155336	B. W	ING		09/06/	2022
				CENTER	ADDRESS STEW STATE STREET		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
0114157	DELLA DIL ITA TIONI	AND HEALTHOADE OF HED			INCHER RD		
CHALE	REHABILITATION	AND HEALTHCARE CENTER		INDIAN	IAPOLIS, IN 46221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	19.2.2.2.4. Door-locking arrangements shall be				constitute admission or		
	permitted in accordance with 19.2.2.2.5.2. This				agreement by the provider o	f	
	^	ould affect all residents staff			the truth of the facts alleged		
	_	g to exit the facility.			conclusions set forth in the	0.	
	and visitors incoming	5 40 5			statement of deficiencies. The	ho	
	Findings include:				plan of correction is prepare		
	i mangs merade.				and/or executed solely becar		
	Based on observation	ons on 09/06/22 between 1:05			it is required by the provision		
					of federal and state law.	113	
	p.m. and 3:00 p.m. during a tour of the facility with						
	the Maintenance Supervisor, the following was				1)Immediate actions taken fo	и	
	noted: a. The Maintenance Supervisor was able to open				those residents identified No resident was found to be		
	the south exit door in the West Hall with a four						
	digit code, however, when the door was closed				affected by the finding.		
					2)How the facility identified		
		ypad stayed activated and			other residents:		
		ff during several attempts.			Visitors, staff and residents t		
		tit door could not be reopened			reside at the community have		
		arm was activated. The			the potential to be affected b	-	
	-	or did release when the fire			the alleged deficient practice)	
	alarm was activated				3) Measures put into place/		
		ors had the keypad code posted			System changes:		
		he top of the door which was			a. The South Exit Door in the		
	not easily identified				West Hall was evaluated and		
		at the time of observations,			repaired as necessary.		
		pervisor agreed the code to			b. All five exit doors have the l	-	
	. –	be located near the keypad,			code posted at a visible level r	near	
		would get the facility's fire			the keypad.		
		ne in and look at the keypad to			4)How the corrective actions		
	figure out what was	s causing the keypad to alarm.			will be monitored:		
					The Maintenance		
	These findings were	e reviewed with the			Director/designee has		
	•	visor and Director of Nursing			re-educated staff members o	f	
	during the exit conf	ference.			the location of the key codes	5.	
					Maintenance Director/design	ee	
	3.1-19(b)				will audit all 5 exit doorways		
					weekly to ensure codes are		
					present and visible weekly fo	or	
					6 months. The audit will be		
					reviewed in Quality Assurance	ce	
					Meeting monthly to ensure n		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	FICATION NUMBER A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED 09/06/2022	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD FINCHER RD NAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				changes or until 100% of education has been achieved. The QA Committee will ident any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 09/29/2022	ify	
K 0281 SS=E Bldg. 01	discharge, is arrar and shall be either or capable of auto manual intervention 18.2.8, 19.2.8	ans of Egress ans of egress, including exit aged in accordance with 7.8 continuously in operation matic operation without on.				
	failed to ensure 1 of properly lighted and darkness. LSC 7.8. be arranged so that lighting unit does not level of less than 0.0 designated area. The affect up to 32 residuisitors on the West Findings include: Based on observation p.m. and 3:00 p.m. the Maintenance Surball exit was provided the exit door, however sidewalk from the Vertical properties of the properties o	us deficient practice could ents as well as staff and	K 0281	K281: Illumination of Means 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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaute is required by the provision of federal and state law. 1) Immediate actions taken for those residents identified.	e of n of not f or the od use ns	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 09/06/2022	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview Maintenance Super the sidewalk and ag exterior light provide	viewed with the Maintenance		No resident was found to be affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents to reside at the community have the potential to be affected by the alleged deficient practices. 3) Measures put into place/System changes: Facility is working with a vendor to provide lighting to the 250-foot sidewalk located 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 update the IDT of the additional lightning. No additional measures are required for the citation at this time. 5) Date of compliance: 09/29/2022	e y d at ed
K 0293 SS=C Bldg. 01	accordance with 7 illumination also so lighting system. 19.2.10.1 (Indicate N/A in or	al signs are displayed in .10 with continuous erved by the emergency ne-story existing less than 30 occupants			
		exit travel is obvious.) ation and interview, the	K 0293	K293: Exit Signage	09/29/2022

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	OF CORRECTION	IDENTIFICATION NUMBER 155336	A. BUILDI B. WING		01	COMPL 09/06/	ETED
	PROVIDER OR SUPPLIER REHABILITATION	AND HEALTHCARE CENTER	48	351 TIN	DDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	III PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	facility failed to pro 5 areas of exit disch 7.10. LSC 7.10.1.2 exit doors that obvious identifiable as exits, approved sign that it direction of exit acc horizontal compone an exit enclosure shor directional exit sit the egress path is not practice could affect as staff and visitors. Findings include: Based on observation p.m. and 3:00 p.m. of the Maintenance Susigns at the north ere East had the direction the way of exit was barrier doors. Base observation, the Mathe directional arrow popped out on either This finding was resupervisor and Direction of the Supervisor and Direction of the Supervisor and Direction of the Supervisor of the facility failed to ensecutive of the facility exit. LSC 7 passage, or stairway way of exit access a staff access a staff and the direction of the facility exit. LSC 7 passage, or stairway way of exit access a stairway way of exi	perly install exit signage at 2 of arge in accordance with LSC and exits, other than main exterior busly and clearly are shall be marked by an some readily visible from any ess. LSC 7.10.1.2.2 states and the egress path within all be marked by approved exit agns where the continuation of the obvious. This deficient that at least all residents, as well some on 09/06/22 between 1:05 during a tour of the facility with pervisor, the illuminated EXIT and of both the West Hall and conal arrows popped out when straight through the smoke don interview at the time of intenance Supervisor agreed we should not have been			The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provision 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 is reside at the community have the potential to be affected by the alleged deficient practices. 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 courtyal were properly labelled as no and exit. 4) How the corrective actions will be monitored: The Maintenance Director/designee has updated.	of n of not f f or the ed use ns or that ee by	

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AND PLAN OF CORRECTION ID:		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/06/2022	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	STREET ADDRESS, CITY, STATE, ZIP COD 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 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.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
				the IDT of the corrections. A additional measures are required for this citation at t time. 5) Date of compliance: 09/29/2022		
	p.m. and 3:00 p.m. of the Maintenance Su room door to the co NO EXIT sign. Base the observation, the the east side dining not an exit to the pudid not have a NO EXIT significant to the pudid not hav	ons on 09/06/22 between 1;05 during a tour of the facility with pervisor, the east side dining urtyard was not posted with a sed on interview at the time of Maintenance Supervisor said room door to the courtyard is blic way and acknowledged it EXIT sign posted. Wiewed with the Maintenance actor of Nursing during the exit				
K 0324 SS=F Bldg. 01	Ventilation Contro Commercial Cook * residential cookin appliances such a toasters) are used cooking in accorda 19.3.2.5.2	nt is protected in IFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, open to the corridor in				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 01 COM			
AND PLAN	OF CURRECTION	155336	B. W		<u>U I </u>	09/06/2	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			INCHER RD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER			IAPOLIS, IN 46221		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	BETCHENCT		DATE
	•	ents with 30 or fewer rith the conditions under					
	18.3.2.5.3, 19.3.2						
		in smoke compartments					
	_	atients comply with					
		18.3.2.5.4, 19.3.2.5.4.					
		protected according to					
	NFPA 96 per 9.2.3	3 are not required to be					
		rdous areas, but shall not					
	be open to the co						
		18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5		17.0	224			00/00/000
		ration and interview, the	K 0	324	K324: Cooking Facilities		09/29/2022
	_	sure the cook tops in 2 of 2 at the switch when not in use.			The facility requests paper compliance for this citation.		
		es within a smoke compartment,			This Plan of Correction is th		
		nercial cooking equipment that			center's credible allegation	I	
		neals for 30 or fewer persons			compliance.	"	
		provided that the cooking			Preparation and/or execution	n of	
		ith all the following conditions:			this plan of correction does		
		ining the cooking equipment			constitute admission or		
	is not a sleeping roo				agreement by the provider o	f	
		ining the cooking equipment			the truth of the facts alleged or		
	shall be separated fi	rom the corridor by partitions			conclusions set forth in the		
	complying with 19.	3.6.2 through 19.3.6.5.			statement of deficiencies. T	he	
	(3) The requiremen	ts of 19.3.2.5.3(1) through (10)			plan of correction is prepare	ed	
	and (13) are met.				and/or executed solely beca		
		A switch meeting all the			it is required by the provisio	ns	
	following is provide				of federal and state law.		
		, or a switch located in a			1)Immediate actions taken fo	or	
		is provided within the cooking			those residents identified		
	_	ates the cooktop or range. sed to deactivate the cooktop			No resident was found to be		
	* /	the kitchen is not under staff			affected by the finding. 2)How the facility identified		
	supervision.	the known is not under starr			other residents:		
	_	ice could affect all residents			Visitors, staff and residents	that	
	_	al Therapy Room and Activity			reside at the community hav		
	Room.				the potential to be affected b		
					the alleged deficient practice	- 1	
	Findings include:				3) Measures put into place/		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/06/2022		
	OF PROVIDER OR SUPPLIE LET REHABILITATION	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) II PREFI TAG	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	p.m. and 3:00 p.m. the Maintenance St stoves in the Physic rooms. When check stove top appliance the individual cook interview at the tim Maintenance Superstoves were not dear This finding was resupervisor and Direconference. 3.1-19(b) 2. Based on observation of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction stregarding the properstinguishers and the fire-extinguishing of instructions for material extinguishing system of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control Commercial Cooking states instruction strength of the Usystem in 1 of 1 kit Ventilation Control	ne kitchen and shall be aloyees by management. This ould affect kitchen staff. ons on 09/06/22 between 1:05 during a tour of the facility with supervisor, the kitchen was			System changes: 1. Facility has ensured the cooktop stoves in the Physic Therapy and Activity rooms have been deactivated accordingly. No other stove of this nature exist in this building. 2. Kitchen Staff was re-educated on the proper us 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 th UL300 hood fire suppression system. Maintenance Director/designee will audit skitchen staff members weekl to ensure proper understand on usage for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no change or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicated. 5) Date of compliance: 09/29/2022	es se ne n 5 y lling es as	
	Based on observati p.m. and 3:00 p.m. the Maintenance Si	during a tour of the facility with			5) Date of compliance:	ed.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155336	A. BUILDING 01 COMPLETED B. WING 09/06/2022				
		100000	b. WII			09/06/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD NCHER RD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER			APOLIS, IN 46221		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
K 0346 SS=F Bldg. 01	interview with kitch what she would do it the hood. She walke K-Class fire extinguthe extinguisher firs. This finding was revenue Supervisor and Directon Conference. 3.1-19(b) NFPA 101 Fire Alarm System Fire Alarm - Out of Where required fire.	viewed with the Maintenance extor of Nursing during the exit		TAG	DEFICIENCE		DATE
	period, the authoribe notified, and the evacuated or an a provided for all parshutdown until the been returned to see 9.6.1.6 Based on record reversal failed to provide a comprosted or protection of 71 of 71 procedures to be fol alarm system has to four hours or more if accordance with LS deficient practice affacility. Findings include: Based on record reversal mand 1:05 p.m. v. Supervisor present,	ity having jurisdiction shall e building shall be pproved fire watch shall be rties left unprotected by the i fire alarm system has	K 03	346	K346: Fire Alarm System-Our 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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. To plan of correction is prepare and/or executed solely because	e of n of not f or he d	09/29/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/06/2022				
		ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	IAU	Preparedness plan, In The plan only stated under a fire watch to one person to walk into each resident roor smoke every 30 massigned to check rojob until the fire was include when and was performed, whom to if a fire watch is reconstituted in the fire was included in the fire was included when and was performed, whom to if a fire watch is reconstituted in the fire was included in the fire watch is reconstituted in the fire was included in the fire watch is reconstituted in the fire was interview at the fire was interview at the fire was not a comprocedure.	however, it was incomplete. I "In the event the facility is he head nurse shall appoint the halls of the building going pom to check for possible fire minutes. When they are poms, this is to be their only tech is over." The plan did thy a fire watch is being to contact, with phone numbers, quired, plus, contacting the stoff Health (IDOH) with the ting the Incident Reporting the IDOH Gateway. Based on time of record review, the visor agreed the fire watch mplete fire watch policy and wiewed with the Maintenance tector of Nursing during the exit			it is required by the provision 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 for reside at the community have the potential to be affected by the alleged deficient practices. 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 I 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 of the facility fire watch plan. Maintenance Director/Design 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 change or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise to	chat e y e o ife	DATE	

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155336	B. WING		09/06/2022
	PROVIDER OR SUPPLIEF	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				plan of correction as indicate	ed.
				5) Date of compliance: 09/29/2022	
K 0353	NFPA 101				
SS=F	_	- Maintenance and Testing			
Bldg. 01		- Maintenance and Testing - Maintenance and Testing			
Diag. 01	1 '	er and standpipe systems			
	•	ted, and maintained in			
		NFPA 25, Standard for the			
		g, and Maintaining of			
	-	Protection Systems.			
		n design, maintenance,			
		sting are maintained in a			
	1	nd readily available.			
		system last checked			
	a) Date spilitiel	system last checked			
	b) Who provided	system test			
	c) Water system	supply source			
	Provide in REMAR	RKS information on			
	coverage for any	non-required or partial			
	automatic sprinkle	er system.			
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25			
	Based on observ	ration and interview, the	K 0353	K353: Sprinkler System-	09/29/2022
	facility failed to ens	sure sprinkler heads in 2 of 6		Maintenance and Testing	
	_	ts covered with corrosion were		The facility requests paper	
	_	5, 2011 edition, at 5.2.1.1.1		compliance for this citation.	
	_	show signs of leakage; shall		This Plan of Correction is the	e
		, foreign materials, paint, and		center's credible allegation of	of
		nd shall be installed in the		compliance.	
		(e.g., up-right, pendent, or		Preparation and/or execution	•
	· ·	nore, at 5.2.1.1.2 any sprinkler		this plan of correction does	not
	_	any of the following shall be		constitute admission or	
		age (2) Corrosion (3) Physical		agreement by the provider o	
	- ' '	f fluid in the glass bulb heat		the truth of the facts alleged	or
	responsive element	(5) Loading (6) Painting		conclusions set forth in the	

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unless painted by the sprinkler manufacturer.

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statement of deficiencies. The

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155336	B. W	ING		09/06/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			NCHER RD		
CHALET	REHABII ITATION	AND HEALTHCARE CENTER			APOLIS, IN 46221		
			ı				Γ
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	This deficient practice could affect all resident, as				plan of correction is prepare		
	well as kitchen staff and visitors within the smoke				and/or executed solely beca		
	compartments.				it is required by the provision	ns	
	Eindines includes				of federal and state law.		
	Findings include:				1)Immediate actions taken fo	or	
	Rosed on observation	ons on 09/06/22 between 1:05			those residents identified		
		during a tour of the facility with			No resident was found to be		
		ipervisor, the following was			affected by the finding.		
		ipervisor, the following was			2)How the facility identified		
	noted:	winddan haada thuuyahayt tha			other residents:	414	
	a. There were 12 sp kitchen covered wit	prinkler heads throughout the			Visitors, staff and residents		
		rinkler head in the East Hall			reside at the community hav		
	_				the potential to be affected b	-	
		ered with corrosion.			the alleged deficient practice)	
	Based on interview				3) Measures put into place/		
		nintenance Supervisor agreed			System changes:		
		tioned sprinkler heads were			1. Sprinkler heads noted to ha		
	covered with corros	sion and should be replaced.			corrosion in 2 of 6 areas are o	n	
	7F1 ' C' 1'	t 1 th d Mit			order to be replaced.		
	-	viewed with the Maintenance			a. Sprinkler escutcheon in the		
	-	ector of Nursing during the exit			medical supplies room was		
	conference.				repaired		
	2.1.10/1->				b. Sprinkler escutcheon in the		
	3.1-19(b)				east hall pantry was repaired		
	2 D- 1 1	arian and intent			c. Sprinkler escutcheon in the		
		ration and interview, the			MDS Coordinator officer was		
	•	sure the ceiling in 3 of 6			repaired.		
		compartments was maintained			4)How the corrective actions	;	
	-	eads to function to their full			will be monitored:		
		ficient practice could affect			The Maintenance	_	
	mostiy staff, plus re	esidents in the adjacent areas.			Director/designee will audit s		
	Findings 1 1 1				random sprinkler heads wee	кіу	
	Findings include:				to ensure they are in proper		
	D11				working order for 6 months.		
		ons on 09/06/22 between 1:05			The audit will be reviewed in		
	p.m. and 3:00 p.m. during a tour of the facility with				Quality Assurance Meeting		
	the Maintenance Supervisor, the following was				monthly to ensure no change		
	noted:				or until 100% of education ha	as	
	_	cutcheon in the Medical			been achieved. The QA		
	L Sunnlies Room was	hanging down one inch from	1		Committee will identify any		1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/06/2022		
	ROVIDER OR SUPPLIER REHABILITATION	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	sprinkler pipe to the b. The sprinkler eso Pantry was hanging	cutcheon in the East Hall down one inch from the e half inch gap around the			trends or patterns and make recommendations to revise t plan of correction as indicate 5) Date of compliance: 09/29/2022		
	c. The sprinkler esc Coordinator Office from the ceiling lea around the sprinkler Based on interview observation, the Ma	eutcheon in the MDS was hanging down one inch ving a one half inch gap r pipe to the attic space. at the time of each eintenance Supervisor gaps to the attic space in each			03/23/2022		
	_	viewed with the Maintenance ector of Nursing during the exit					
K 0354 SS=F Bldg. 01	extent and duration been determined, are inspected and recommendations management or do and the fire depart having jurisdiction the sprinkler system 10 hours in a building or portion evacuated or an approvided until the returned to service 18.3.5.1, 19.3.5.1,	er system is impaired, the en of the impairment has areas or buildings involved risks are determined, are submitted to esignated representative, tment and other authorities have been notified. Where em is out of service for more 24-hour period, the of the building affected are pproved fire watch is sprinkler system has been es.					
		view and interview, the facility	K 0	354			09/30/2022

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	onstruction <u>0</u> 1	(X3) DATE SURVEY COMPLETED	
		155336	B. WI	ING		09/06/2	2022
	PROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	•	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to provide a	complete written policy			K354: Sprinkler System-Ou	t of	
	~ ·	ares to be followed for the			Service		
	protection of 71 of	71 residents in the event the			The facility requests paper		
	automatic sprinkle	r system has to be placed			compliance for this citation		
	out-of-service for	10 hours or more in a 24-hour			This Plan of Correction is to	he	
	period in accordan	ce with LSC, Section 9.7.5. LSC			center's credible allegation	of	
	9.7.6 requires sprir	nkler impairment procedures			compliance.		
	comply with NFPA	A 25, 2011 Edition, the Standard			Preparation and/or execution	on of	
	_	Testing and Maintenance of			this plan of correction does	s not	
		Protection Systems. NFPA 25,			constitute admission or		
	_	e procedures that the			agreement by the provider	of	
		nator shall follow. A.15.5.2 (4)			the truth of the facts allege	d or	
		tch should consist of trained			conclusions set forth in the		
	_	tinuously patrol the affected			statement of deficiencies.	-	
	1	s to fire extinguishers and the			plan of correction is prepar	II	
		notify the fire department are			and/or executed solely bec		
	_	consider. During the patrol of			it is required by the provisi	ons	
	_	n should not only be looking			of federal and state law.		
		g sure that the other fire			1)Immediate actions taken	for	
		of the building such as egress			those residents identified		
		ystems are available and			No resident was found to be	е	
		ly. This deficient practice			affected by the finding.		
	could affect all occ	supants in the facility.			2)How the facility identified		
					other residents:		
	Findings include:				Visitors, staff and residents		
	D 1 1	. 00/06/221 4 0.25			reside at the community ha	II	
		view on 09/06/22 between 9:25			the potential to be affected	-	
	_	with the Maintenance			the alleged deficient practic		
		, the facility provided a "Fire document from the Emergency			3) Measures put into place/		
					System changes:		
		however, it was incomplete. ed "In the event the facility is			Facility has ensured the		
		the head nurse shall appoint			following items have been ordered for replacement or		
		the halls of the building going			repaired		
	-	room to check for possible fire			1. A) The 12 sprinkler hea	ade	
		minutes. When they are			throughout the kitchen cov		
	1	rooms, this is to be their only			with corrosion will be repla		
	job until the fire watch is over." The plan did				by Safe care		
	include when and why a fire watch is being				B) The Sprinkler head in the	9	
		to contact, with phone numbers,			East Hall janitor closet cover	II	
	1	,г	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 COMPLET B. WING 09/06/20			ETED		
	PROVIDER OR SUPPLIE	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Indiana Departmen web link for contact System located on an interview at the Maintenance Super policy was not a co procedure. This finding was re-	quired, plus, contacting the t of Health (IDOH) with the ting the Incident Reporting the IDOH Gateway. Based on time of record review, the visor agreed the fire watch mplete fire watch policy and eviewed with the Maintenance ector of Nursing during the exit			with corrosion will be replace by Safe care. 2. Facility Fire watch policy is been reviewed and updated in necessary. Staff members have been re-educated on an necessary updates. 4) How the corrective actions will be monitored: The Maintenance Director/designee has re-educated all staff member on the facility fire watch plan specifically related to and in coordination to the Emergen preparedness plan on what it do if the Sprinkler system go down. Maintenance Director/Designee will audit staff members weekly to ensure proper understanding for 6 months. Maintenance Director/Designee will audit sprinkler heads weekly and it sprinkler system itself weekl for proper working order weekly for 6 months. The audits will be reviewed in Quality Assurance Meeting monthly to ensure no change or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise it plan of correction as indicate 5) Date of compliance: 09/30/2022	nas as ny s cy oo ees 5 g 5 hee y	

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Event ID:

WWNR21 Facility ID: 000229

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONSTRUCTION (X3) DATE SULL A. BUILDING 01 COMPLE B. WING 09/06/2			ETED		
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Buil Barrie Subdivision of Buil Barrie Subdivision of Buil Barrier Construction 2012 EXISTING Smoke barriers shall be proposed in duct penetration systems where an is installed for smoth to the smoke barrier 19.3.7.3, 8.6.7.1(1) Describe any mechanter system in REMAR Based on observation failed to ensure 1 of protected to maintain smoke barriers to be with LSC Section 8. Hour fire resistive raccould affect up to 32 visitors. Findings include: Based on observation p.m. and 3:00 p.m. of the Maintenance Sumula above the West doors had two, two with wires running the stopped. Based on interview Maintenance Supervalue and 3:00 p.m. of the Maintenance Su	Iding Spaces - Smoke Iding Spa	K 0		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 this plan of correction does a constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely becaut it is required by the provision 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	e of n of not f or he d use	09/29/2022

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PRINTED: 10/05/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE CONS A. BUILDING B. WING	STRUCTION 01	(X3) DATE SURVEY COMPLETED 09/06/2022
	PROVIDER OR SUPPLIER REHABILITATION AND HEALTHCARE CENTER	4851 TIN	DRESS, CITY, STATE, ZIP COD CHER RD POLIS, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	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 reside at the community had the potential to be affected the alleged deficient practices. System changes: Facility has repaired the two two-inch holes located in the West Hall North smoke barrowalls. 4) How the corrective action will be monitored: The Maintenance Director/designee has re-educated staff members the facility fire watch plan. Maintenance Director/Designee will audit smoke barrier wall weekly to ensure proper integrity for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no change or until 100% of education in the been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated. Date of compliance:	ve by e o, e ier s on nee ls ges nas
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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		A. BU	A. BUILDING 01 COM B. WING 09/0			survey .eted /2022	
	PROVIDER OR SUPPLIED Γ REHABILITATION	R AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD INCHER RD IAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	provided K-tags, information, along Safety Code or N should be include Based on observati failed to ensure 1 of current inspection of was in safe operating Section 19.1.1.3.1 if designed, construct to minimize the porrequiring the evacut deficient practice of and visitors. Findings include: Based on observation p.m. and 3:00 p.m. the Maintenance So in the Mechanical I expiration date of the time of observation of the time of the time of observation of the time of observatio	but are deficient. This g with the applicable Life FPA standard citation, ed on Form CMS-2567. on and interview, the facility of 1 fuel-fired boiler had a certificate to ensure the boiler eng condition. NFPA 101, requires all health facilities to be eted, maintained, and operated essibility of a fire emergency lation of occupants. This ould affect all residents, staff ons on 09/06/22 between 1:05 during a tour of the facility with expervisor, the fuel-fired boiler Room had a certificate with an 01/23/20. Based on interview at etion, the Maintenance led the expiration date of the d said he has been trying to get ethe boiler but has not been expiewed with the Maintenance ector of Nursing during the exit	K 0		K500: Building Services-Ott The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. In plan of correction is preparand/or executed solely becaute it is required by the provision 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 reside at the community has the potential to be affected the alleged deficient practice. System changes: Facility has arranged inspection of its boiler system changes: Facility has arranged inspection of its boiler system. Will be monitored: The Maintenance Director/designee has been re-educated to ensure	the of on of on of of dor e The red ause ons for e that ve by ce	09/29/2022

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 09/06/2022
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				understanding on important of maintaining current inspection records. Boiler inspections will be brought QAPI when necessary. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no chang or until 100% of education he been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicated. 5) Date of compliance: 09/29/2022	to ges as
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0511	K511: Utilities- Gas and Elec	otric 09/29/2022
	provided with groun (GFCI) protection a 70, NEC 2011 Editi Circuit-Interrupter I states, ground-fault personnel shall be p 210.8(A) through (Circuit-interrupter stacessible location.	Fover 10 wet locations, was and fault circuit interrupter gainst electric shock. NFPA on at 210.8 Ground-Fault Protection for Personnel, circuit-interruption for rovided as required in C). The ground-fault all be installed in a readily See 215.9 for ground-fault		The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the	ne of on of not of

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Event ID:

WWNR21 Facility ID: 000229

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155336	B. W	ING		09/06/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u>. </u>
NAME OF I	PROVIDER OR SUPPLIE	R			INCHER RD	
CHALET	REHABII ITATION	AND HEALTHCARE CENTER			IAPOLIS, IN 46221	
	1	7.11.5 11.2 11.107 11.12 02.11.211				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	1	protection for personnel on			statement of deficiencies. T	
	feeders.				plan of correction is prepare	
	1 1	velling Units. All 125-volt,			and/or executed solely beca	use
	single-phase, 15- and 20-ampere receptacles				it is required by the provisio	ns
		ations specified in 210.8(B)(1)			of federal and state law.	
	through (8) shall ha	-			1)Immediate actions taken for	or
	1 ^ ^	protection for personnel.			those residents identified	
	(1) Bathrooms				No resident was found to be	
	(2) Kitchens				affected by the finding.	
	(3) Rooftops				2)How the facility identified	
	(4) Outdoors				other residents:	
	_	(3) and (4): Receptacles that are			Visitors, staff and residents	
		ole and are supplied by a			reside at the community hav	
		cated to electric snow-melting,			the potential to be affected b	· 1
		e and vessel heating equipment			the alleged deficient practice)
	_	to be installed in accordance			3) Measures put into place/	
	with 426.28 or 427				System changes:	
	_	(4): In industrial establishments			The two electric receptacles	in
	_ ·	nditions of maintenance and			the West Hall Soiled Utility	
	_	that only qualified personnel			Room were repaired.	
		sured equipment grounding			4)How the corrective actions	;
		as specified in 590.6(B)(2)			will be monitored:	
	_	for only those receptacle			The Maintenance	
		oly equipment that would			Director/designee will audit	
	_	eard if power is interrupted or			electrical receptacles weekly	•
	1 -	at is not compatible with GFCI			to ensure proper integrity an	
	protection.	, , , , , , , , , , , , , , , , , , , ,			functional status for 6 month	
		eceptacles are installed within			The audit will be reviewed in	1
		outside edge of the sink.			Quality Assurance Meeting	
	_	(5): In industrial laboratories,			monthly to ensure no chang	
	_	supply equipment where			or until 100% of education h	as
	_	would introduce a greater			been achieved. The QA	
	_	mitted to be installed without			Committee will identify any	
	GFCI protection.	(5). Farrance 1. 1. 1. 1.			trends or patterns and make	
	_	(5): For receptacles located in			recommendations to revise	
	_	ns of general care or critical			plan of correction as indicate	ea.
		care facilities other than those				
	covered under				5) Date of compliance:	
		protection shall not be required.			09/29/2022	
	(6) Indoor wet loca	uons	1		1	ĺ

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	ì	UILDING	nstruction 01	(X3) DATE COMPI 09/06	LETED
	PROVIDER OR SUPPLIEI	AND HEALTHCARE CENTER		4851 TII	DDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF	E NATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ' '	vith associated showering					
	facilities	- h d -ii1					
	electrical	e bays, and similar areas where					
		ent, electrical hand tools.					
		Wet Locations, requires all					
		ed equipment within the area of					
		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 observati	ons on 09/06/22 between 1:05					
	p.m. and 3:00 p.m.	during a tour of the facility with					
	the Maintenance Su	upervisor, two electric					
	receptacles in the V	Vest Hall Soiled Utility Room					
		eet of the sink and hopper					
		e) and were provided with					
	_	however, when both were					
		testing device, the circuit was					
		sting device showed an Open Based on interview at the time					
		Maintenance Supervisor					
		ceptacles in the West Hall					
	1 -	n were not properly wired and					
	therefore not GFCI						
	This finding was no	viewed with the Maintenance					
	_	eviewed with the Maintenance ector of Nursing during the exit					
	conference.	color of reasong during the east					
	3.1-19(b)						
K 0711	NFPA 101						
SS=F	Evacuation and R						
Bldg. 01	Evacuation and R						
	There is a written	plan for the protection of all					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155336	B. W	ING		09/06/	2022
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of an emergency. Employees are per kept informed with and a copy of the with telephone opplan addresses the of staff per 18/19. of the fire safety per 18/19.2.2. 18.7.1.1 through 11.7.2.2, 18.7.2.3. 19.7.2.1.2, 19.7.2.1.2. Based on record revertailed to provide a community of the fire safety per per failed to provide a community of the fire safety per	view and interview, the facility complete facility specific clan for the protection of 71 of trately address all life safety em addressing all items 101, 2012 edition, Section 1.2.2 requires a written health care ty plan that shall provide for alarm to fire department one call to fire department rms mmediate area moke compartment loors and building for	KO	711	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 this plan of correction does a constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by the provision 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 to reside at the community have	of n of not f or he d use ns	09/29/2022

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	JLTIPLE CO ILDING	INSTRUCTION 01	(X3) DATE S COMPLE	
		155336	B. WI	NG		09/06/2	2022
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	raining program for equipment is limited in Equipment in use ii. Medical emergentiii. Patient lift and to This deficient praction the event of an entire in the event of an en	and carts in use cy equipment not in use cansport equipment ice could affect all occupants		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) the potential to be affected be 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 local in resident rooms 4) How the corrective actions will be monitored: The Maintenance Director/designee will audit a staff members weekly to ensure proper understanding and response to a battery-operated smoke alart for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly	e ted 5	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	Supervisor and Direconference. 3.1-19(b) NFPA 101 Smoking Regulations Smoking Regulations shall include not be provisions:	gulations gulations shall be adopted and not less than the following shall be prohibited in any room,			ensure no changes or until 100% of education has been achieved. The QA Committe will identify any trends or patterns and make recommendations to revise to plan of correction as indicated. 5) Date of compliance: 09/29/2022	ee the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/06/2022	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851	FADDRESS, CITY, STATE, ZIP COD FINCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	used or stored and location, and such signs that read NC posted with the interpretation of the provided secondary signs with smoking is prohibited prominently placed secondary signs with smoking shall not (3) Smoking by paresponsible shall let (4) The requirement apply where the properties of the provided shall be readily away smoking is (6) Metal contained devices into which shall be readily away smoking is permitted to ensure cigal disposed of at 2 of 2 smoked by resident practice could affect in the Maintenance Surnoted: Based on observation of the Maintenance Surnoted: a. The resident smoking is paper trash a significant signifi	d at all major entrances, vith language that prohibits be required. vitients classified as not be prohibited. Int of 18.7.4(3) shall not atient is under direct Incombustible material and be provided in all areas permitted. It is with self-closing cover of ashtrays can be emptied allable to all areas where	K 0741	K741: Smoking Regulations The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation compliance. Preparation and/or execution this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. The plan of correction is prepara and/or executed solely beca- it is required by the provision	ne of on of not of d or The ed nuse

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 09/06/2022
	PROVIDER OR SUPPLIE	AND HEALTHCARE CENTER	4851 7	ADDRESS, CITY, STATE, ZIP COD FINCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
	area. b. The staff smoking exit door had a smooth the top of the tower had paper trash study were at least 15 cignaround the staff sm. Based on interview observation, the Macknowledged the process of the cignarette butts and the ground at each local transfer of the cignarette butts and the ground at each local transfer of the cignarette butts and the cignarette butts are cignarette butts and the cignarette butts and the cignarette butts and the cignarette butts are cignarette cignarette butts are cignarette cign	at the time of each aintenance Supervisor paper trash mixed with the the cigarette butts on the		of federal and state law. 1)Immediate actions take those residents identified No resident was found to affected by the finding. 2)How the facility identification other residents: Visitors, staff and reside reside at the community the potential to be affect the alleged deficient pra 3) Measures put into pla System changes: A) The metal trash can heen removed in the Resmoking area. An additiself-closing ash tray has provided. The 25 cigare Butts identified have becleaned up. B) The smoke tower locathe staff smoking area heen repaired. 2 additions smoking towers are on a provide additional prote. The 15 identified cigareth have been cleaned up. 4)How the corrective active will be monitored: The Maintenance Director/designee will accigarette disposal units areas 5 times per week the ensure proper integrity, functional status and cleanliness for 6 months audit will be reviewed in Quality Assurance Meetimonthly to ensure no chor until 100% of education of the proper integrity.	en for ad o be fied ents that have ted by ctice ce/ have sident tional is been ated in as anal order to ction. It butts tions udit the and in and in and in a second in a

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Event ID:

WWNR21 Facility ID: 000229

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 01 COMPLETED B. WING 09/06/2022			ETED	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		4851 TI	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Based on observation interview; the facility annual inspection a room fire door asset LSC 19.1.1.4.1.1. dividing fire barrier permitted only in compartment of the permitted on the per	on, record review, and ty failed to ensure a complete and testing of 1 of 1 oxygen mbly was in accordance with Communicating openings in rs required by 19.1.1.4.1 shall be porridors and shall be protected osing fire door assemblies. 3.) LSC 8.3.3.1 Openings are protection rating by Table tected by approved, listed, semblies and fire window r accompanying hardware,	K 07	TAG	been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise t plan of correction as indicate 5) Date of compliance: 09/29/2022 K761: Maintenance, Inspectic & 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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the	che ed. on of n of not f or	
	and sills in accorda NFPA 80, Standard Opening Protective specified in this Co door assemblies shalless than annually, inspection shall be by the AHJ. NFPA assemblies shall be sides to assess the cassembly.	s, closing devices, anchorage, nee with the requirements of a for Fire Doors and Other s, except as otherwise de. NFPA 80 5.2.1 states fire all be inspected and tested not and a written record of the signed and kept for inspection .80, 5.2.4.1 states fire door visually inspected from both overall condition of door			statement of deficiencies. The plan of correction is prepare and/or executed solely because it is required by the provision 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 is reside at the community have the potential to be affected by the alleged deficient practices.	d use ns or that e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLI	
		155336	B. W	ING		09/06/	2022
CHALET	- I	AND HEALTHCARE CENTER		4851 TI INDIAN	ADDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	either the door or fr	or breaks exist in surfaces of			3) Measures put into place/ System changes:		
		light frames, and glazing beads			Annual inspection of the		
	are intact and securely fastened in place, if so				oxygen transfilling room fire		
	equipped.				door assembly was complete	ed.	
		e, hinges, hardware, and			4)How the corrective actions		
	, ,	eshold are secured, aligned,			will be monitored:		
		er with no visible signs of			The Maintenance		
	damage.				Director/designee will audit t	he	
	(4) No parts are mis				oxygen transfilling room fire		
	` /	do not exceed clearances			assembly monthly to ensure		
	listed in 4.8.4 and 6				proper integrity and function		
		device is operational; that is,			status for 6 months. The au	dit	
	from the full open p	pletely closes when operated			will be reviewed in Quality	.	
		is installed, the inactive leaf			Assurance Meeting monthly ensure no changes or until	το	
	closes before the ac				100% of education has been		
		are operates and secures the			achieved. The QA Committe	_	
	door when it is in th	-			will identify any trends or	"	
		vare items that interfere or			patterns and make		
	prohibit operation a	are not installed on the door or			recommendations to revise t	he	
	frame.				plan of correction as indicate	ed.	
		ications to the door assembly			5) Date of compliance:		
	_	ed that void the label.			09/29/2022		
		edge seals, where required, are					
		their presence and integrity.					
	_	ice could affect at least 32 visitors on the West Hall.					
	residents, starr, and	visitors on the west fian.					
	Findings include:						
	Based on record rev	view on 09/06/22 between 9:25					
		with the Maintenance					
	-	the facility was able to					
		tion dated 08/08/22 for an					
	•	f one oxygen transfilling room					
	_	however, the documentation					
	was not complete.	The inspection report provided					
	only included: Clos	e, Latch, and Closer. It did not					
	include other items	such as, the door, frame,					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		JILDING	nstruction 01	COME	E SURVEY PLETED 6/2022	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 TII	DDRESS, CITY, STATE, ZIP COD NCHER RD APOLIS, IN 46221		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROP	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION
TAG	hinges, hardware, la Based on interview the Maintenance Su for other items but of and Closer. Based of the facility with there was one oxyg- assembly noted in the	at the time of record review, apervisor said he does check conly documents Close, Latch, on observations during a tour the Maintenance Supervisor, en transfilling room fire door the facility. Viewed with the Maintenance ector of Nursing during the exit	TAG	DETICIENCE		DATE
	3.1-19(b)					
K 0923 SS=D Bldg. 01	Storag Gas Equipment - 0 Storage Greater than or ecceptorage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 cccostorage locations enclosure or within space of non- or liconstruction, with that can be secure stored with flamma from combustibles sprinklered) or enconcombustible cominimum 1/2 hr. fit Less than or equal in a single smoke cylinders available patient care areas	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated as by 20 feet (5 feet if closed in a cabinet of construction having a are protection rating. all to 300 cubic feet compartment, individual as for immediate use in a with an aggregate volume and to 300 cubic feet are not				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155336	B. W	ING		09/06/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	₹			NCHER RD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER	_	INDIAN	APOLIS, IN 46221		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	•	red in an enclosure.					
		handled with precautions					
	as specified in 11.6.2. A precautionary sign readable from 5 feet is						
		ate of a cylinder storage					
	_	sign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN	` ,					
		d so cylinders are used in					
		y are received from the					
	supplier. Empty c	ylinders are segregated					
		. When facility employs					
	1 -	gral pressure gauge, a					
	-	e considered empty is					
	-	ty cylinders are marked to					
		Cylinders stored in the open					
	are protected from						
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)	on and interview the facility	17.0	022	KOOO Coo Facility and Callin	al a	00/20/2022
		on and interview, the facility inders of nonflammable gases	K 0	923	K923: Gas Equipment- Cylin	aer	09/29/2022
	-	re properly secured from falling			and Container Storage		
		cooms. NFPA 99, Health Care			The facility requests paper compliance for this citation.		
		12 Edition, Section 11.3.3 states			This Plan of Correction is the	Δ	
		amable gases with a total			center's credible allegation of		
	_	less than greater than 8.5 cubic			compliance.		
	_	Seet) shall comply with 11.3.3.1			Preparation and/or execution	n of	
	· ·	A 99, Section 11.3.3.2 states			this plan of correction does		
		lling cylinders specified in			constitute admission or		
	_	accordance with 11.6.2. Section			agreement by the provider o	f	
	11.6.2.3(11) states f	freestanding cylinders shall be			the truth of the facts alleged		
		supported in a proper cylinder			conclusions set forth in the		
		deficient practice could affect			statement of deficiencies. T	_	
	2 residents, staff and	d visitors.			plan of correction is prepare		
					and/or executed solely beca		
	Findings include:				it is required by the provisio	ns	
		00/06/00 1			of federal and state law.		
		ons on 09/06/22 between 1:05			1)Immediate actions taken fo	or	
		during a tour of the facility with			those residents identified		
	the Maintenance Su	pervisor, there was one E size			No resident was found to be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155336	B. W	ING		09/06/	2022
		AND HEALTHCARE CENTER STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZIP COD 4851 TINCHER RD INDIANAPOLIS, IN 46221 ID REQUIDEDS BLANGE CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0927	floor and was not su stand or otherwise s interview at the tim Maintenance Super oxygen cylinder in cylinder stand or oth This finding was re	room 41 freestanding on the apported in a proper cylinder secured from falling. Based on e of the observation, the visor acknowledged the E size room 41 was not supported in a herwise secured from falling. viewed with the Maintenance ector of Nursing during the exit			affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents of 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 we 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 of random Resident rooms were to ensure oxygen cylinders in present are stored correctly of months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure on changes or until 100% of education has been achieved. The QA Committee will identicated any trends or patterns and make recommendations to revise the plan of correction indicated. 5) Date of compliance: 09/29/2022	e y as as fi kly f for ce o	
SS=E	-	Transfilling Cylinders					
Bldg. 01		Transfilling Cylinders					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155336		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/06/2022	
	PROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	4851 ⁻	TADDRESS, CITY, STATE, ZIP COD TINCHER RD NAPOLIS, IN 46221	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI TAG DEFICIENCY)		(X5) COMPLETION DATE
	another is in according any gas from one prohibited in patie to liquid oxygen occontainers over 50 under 11.5.2.3.1 (liquid oxygen containers under 50 conditions under 11.5.2.2 (NFPA 98) 1. Based on observing facility failed to enswhere oxygen transprovided with propoventilation. This deleast 32 residents, st. Hall. Findings include: Based on observation p.m. and 3:00 p.m. the Maintenance Sustorage/transfilling working mechanical however, it was heat the time of observation. This finding was resupervisor and Director of the st. Supervisor of the st. Supervisor and Director of the st. Supervisor and Director of the st. Supervisor of	11.5.2.3.2 (NFPA 99).	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 this plan of correction does constitute admission or agreement by the provider of the truth of the facts alleged conclusions set forth in the statement of deficiencies. In plan of correction is prepare and/or executed solely becan it is required by the provision 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 reside at the community have	n of not of l or The ed nuse ons

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		01	COMPLETED	
		155336	B. WING			09/06/2022	
NAME OF PROVIDER OR SUPPLIER				4851 TI	NCHER RD		
CHALET REHABILITATION AND HEALTHCARE CENTER			INDIANAPOLIS, IN 46221				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY) DATE		
	facility failed to ens			the potential to be affected by			
	storage/transfer location was used properly and in				the alleged deficient practice)	
	accordance with NFPA 99. NFPA 99, Health Care				3) Measures put into place/		
	Facilities Code, 2012 Edition, Section 11.5.2.3.1(1)				System changes:		
	states, (transfilling shall occur in) A designated				1. Mechanical ventilation		
	area separated from any portion of a facility				located in the oxygen storag		
	wherein patients are housed, examined, or treated				room has been cleaned and	IS	
	by a fire barrier of 1 hour fire-resistive				in proper working order.	.4	
	construction. This deficient practice could affect				2. Qualified Medical Assistar noted in the 2567 has been	IL	
	up to 32 residents, staff and visitors on the West Hall smoke compartment.					\n	
	rian smoke compartment.				re-educated on proper oxyge transferring. All other staff	, 111	
	Findings include:				noted to be qualified to re-fill	ı	
					oxygen have been		
	Based on observation on 09/06/22 at 2:38 p.m.				re-educated.		
	during a tour of the facility with the Maintenance				4)How the corrective actions		
	Supervisor, while inspecting the facility's smoke				will be monitored:		
	barrier walls a hissing noise was heard and the				The Maintenance		
	oxygen transfilling room door was being held wide				Director/designee will audit &	5	
	open while oxygen transfilling from a large liquid				staff members weekly to	•	
	tank to a small portable tank was occurring by				ensure proper knowledge of		
	staff. When asked, the staff person said she was				trans-filling of oxygen for 6		
	the Qualified Medical Assistant. She further said				months. Mechanical		
	"I've been trained, but forgot to close the door".				ventilation fan will be audited	d	
	ĺ	S			weekly for cleanliness and		
	This finding was re	viewed with the Maintenance			proper working order. The		
	Supervisor during the exit conference.			audits will be reviewed in			
					Quality Assurance Meeting		
	3.1-19(b)				monthly to ensure no change	es	
					or until 100% of education ha	as	
					been achieved. The QA		
				Committee will identify any			
				trends or patterns and make			
					recommendations to revise t	he	
					plan of correction as indicate	ed.	
				5) Date of compliance:			
					09/29/2022		