STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155336	A. BUILDING -- B. WING	07/17/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/17/24 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 At this Emergency Preparedness survey, Chalet Rehabilitation and Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 88 certified beds, with a current census of 68. Quality Review completed on 07/22/24	E 0000	K 000 Dear Ms. Buroker: On 07/17/2024 a Life Safety Code Recertification and Emergency Preparedness Survey was conducted for Chalet Rehabilitation and Healthcare Center. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. By submitting the enclosed material, Chalet Rehabilitation and Healthcare Center is not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 08/17/2024. Survey Date: July 17,2024 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 Please feel free to call me with any further questions at 317-856-4851. Respectfully submitted, Edward Hughes, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward Hughes	Executive Director	08/05/2024

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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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/17/24 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 At this Life Safety Code survey, Chalet Rehabilitation and Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 88 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinklered except for two detached storage buildings which were each not sprinklered and used for facility storage.	K 0000	Executive Director, Chalet Healthcare and Rehabilitation K 000 Dear Ms. Buroker: On 07/17/2024 a Life Safety Code Recertification and Emergency Preparedness Survey was conducted for Chalet Rehabilitation and Healthcare Center. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. By submitting the enclosed material, Chalet Rehabilitation and Healthcare Center is not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 08/17/2024. Survey Date: July 17,2024 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 Please feel free to call me with any further questions at	

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	Quality Review completed on 07/22/24		317-856-4851. Respectfully submitted, Edward Hughes, HFA Executive Director, Chalet Healthcare and Rehabilitation	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors installed in all resident sleeping rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Detectors: Test Battery Operated Smoke Detectors" for the most recent twelve	K 0300	**K 300** **It is the practice of Chalet Rehabilitation and Healthcare Center to** assure that the documentation for the preventative maintenance of smoke detectors installed in all resident sleeping rooms is completed. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the	08/03/2024

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	month period with the Executive Director and the Maintenance Director during record review from 9:15 a.m. to 12:35 p.m. on 07/17/24, an itemized listing of resident sleeping room smoke detector testing documentation for May 2024 and June 2024 was not available for review. Based on interview at the time of record review, the Executive Director stated the facility has battery operated smoke detectors installed in all resident sleeping rooms, each detector was replaced in April 2024 and agreed an itemized listing of resident sleeping room smoke detector testing documentation for May 2024 and June 2024 was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 07/17/24, all resident sleeping room smoke detectors are battery operated and had an installation date of April 2024 with a manufacture date of 2022. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		equipment manufacturer's published instructions. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient practice. Executive director created a new document to be used for all monthly smoke detector preventative maintenance checks. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Maintenance staff will be in-serviced on the use of the newly created document to be used for all monthly smoke detector preventative maintenance checks. **How the corrective action(s) will be monitored to ensure the deficient practice**	

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			will not recur, i.e., what quality assurance program will be put into place: Executive Director, maintenance director or designee will monitor the use of the newly created document to be used for all monthly smoke detector preventative maintenance checks. Executive Director, maintenance director or designee will bring and discuss any issues with the newly created document used for all monthly smoke detector preventative maintenance checks to QA/PI meeting for review and continued compliance. **Date of Compliance:** 08/03/2024	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

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	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood exhaust system inspection contractor's "Job Service Report" documentation dated 02/27/24 with the Executive Director and the Maintenance Director during record review from 9:15 a.m. to 12:35 p.m. on 07/17/24, deficiencies were noted with the kitchen range hood exhaust system. The "Notes" section of the 02/27/24 inspection report stated "fan sounds loud went turnt on upon arrival sounds like bearing in motor being out". In addition, review of the "Notes" section of the kitchen range hood exhaust system inspection contractor's "Invoice or Job #353805"	K 0324	**K 324** **It is the practice of Chalet Rehabilitation and Healthcare Center to** ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No kitchen staff, residents, other staff, or visitors were affected by the alleged deficient practice. **How other residents having the**	08/17/2024

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	documentation dated 07/01/24 indicated "Fan not working. Worker said they don't use it". Based on interview at the time of record review, the Executive Director stated the facility has ordered a motor for the kitchen range hood fan and is awaiting for the motor to be delivered. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 07/17/24, the fan for the kitchen range hood system was not in operation. Based on interview at the time of the observations, the Executive Director agreed the fan for the kitchen range hood system was not in operation. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All kitchen staff, residents, other staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No kitchen staff, residents, other staff, or visitors were affected by the alleged deficient practice. Executive Director and maintenance director have been in contact with HFI (Harrell-Fish Inc) Mechanical contractors located in Bloomington, Indiana to repair the range hood exhaust system. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Maintenance and kitchen staff will be in-serviced on the importance of the kitchen range hood exhaust systems proper working order and how to report any issues when it is not properly working. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Executive Director, Maintenance Director, Food Service Director, or designee will monitor the use of the newly repaired kitchen range	

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			hood exhaust system daily during walking rounds for proper working order. Executive Director, Maintenance Director, Food Service Director, or designee will bring and discuss any issues with the newly repaired kitchen range hood exhaust system to QA/PI meeting for review and continued compliance. **Date of Compliance:** 08/17/2024	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors in	K 0361	**K 361** **It is the practice of Chalet Rehabilitation and Healthcare Center** to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same	08/08/2024

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	the vicinity of the relocated Therapy Room by the main dining room. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:35 p.m. to 2:10 p.m. on 07/17/24, the corridor wall for the relocated Therapy Room by the main dining room did not extend to the ceiling above to separate this treatment room from other spaces with smoke resistant partitions and doors. A one foot gap was noted in between the top of the corridor wall to the Therapy Room and the ceiling above. In addition, the corridor door to the Therapy Room was equipped with a thumb twist deadbolt lock which required a key to unlock the door from the corridor side of the door. The corridor door to the room was not equipped with a positive latching mechanism to latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Executive Director stated the Therapy Room was relocated within the facility to its current location in October 2023 and the Therapy Room was not separated from the corridor with smoke resistant partitions and doors. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors that use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient practice. Maintenance Director, maintenance assistant or contracted construction company will ensure 1 of 1 therapy room in question are separated from the corridor by a partition capable of resisting the passage of smoke. This will be accomplished by installing plexiglass incased by quarter round solid wood moldings. The therapy door will have a positive latching	

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			mechanism installed to latch the door into the door frame to resist the passage of smoke. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Maintenance staff will be in-serviced on the importance of patient sleeping rooms and treatment area rooms are separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Executive Director, Maintenance Director, or designee will monitor all patient sleeping rooms and treatment area rooms for compliance of being separated from the corridor by a partition capable of resisting the passage of smoke daily during walking rounds. Executive Director, Maintenance Director, or designee will bring and discuss any issues with any patient sleeping rooms or treatment area rooms that are not separated from the corridor by a partition capable of resisting the passage of smoke to QA/PI meeting for review and continued compliance.	

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			Date of Compliance: 08/08/2024	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to document quarterly fire drills on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" and "Fire Drill Report" documentation with the Executive Director and the Maintenance Director during record review from 9:15 a.m. to 12:35 p.m. on 07/17/24, documentation of a fire drill conducted within the most recent twelve month period on the third shift in the third quarter (July, August, September) 2023 was not available for review. Based on interview at the time of record review, the Executive Director stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the third shift in the third quarter 2023 was not	K 0712	**K 712** **It is the practice of Chalet Rehabilitation and Healthcare Center** to conduct quarterly fire drills and document quarterly fire drills for all shift for all quarters of the year. **What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice:** No residents, staff, or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents, staff, and visitors that	08/08/2024

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	available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		use or visit the facility have the potential to be affected by the alleged deficient practice. No residents, staff, or visitors were affected by the alleged deficient practice. Executive Director, Maintenance Director, or maintenance assistant has completed and documented all fire drills since September when the alleged fire drill was not documented or completed. **What measures will be put in place or what systemic changes will be made to ensure that deficient practice does not recur:** Maintenance staff will be in-serviced on the importance of completing and documenting all fire drills to be conducted at unexpected and unpredictable times and days. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Executive Director, Maintenance Director, or designee will monitor fire drill schedule and documentation monthly for 3 months or until 100% compliance is met. Executive Director, Maintenance Director, or designee will bring and discuss any issues with the fire drill schedule or documentation to QA/PI meeting for review and continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 01 B. WING	07/17/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			compliance. **Date of Compliance:** 08/08/2024	