	T OF HEALTH AND HU R MEDICARE & MEDIO				FORM APPROVED OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY COMPLETED 07/17/2024	
	PROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD TINCHER RD NAPOLIS, IN 46221		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	T 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	
Bldg	conducted by the I accordance with 42 Survey Date: 07/1 Facility Number: 0 Provider Number: 100 At this Emergency Rehabilitation and compliance with E Requirements for I Participating Provi 483.73 The facility has 88 census of 68.	7/24 000229 155336	E 0000	K 000 Dear Ms. Buroker: On 07/17/2024 a Life Safety O Recertification and Emergence Preparedness Survey was conducted for Chalet Rehabilitation and Healthcare Center. Enclosed please find to Statement of Deficiencies with facilities Plan of Correction for alleged deficiencies. By submitting the enclosed mater Chalet Rehabilitation and Healthcare Center is not admit the truth or accuracy of any specific findings or allegations We reserve the right to contest findings or allegations as part any proceedings and submit th responses pursuant to our regulatory obligations. We respectfully request a dest review that the facility has achieved substantial compliant with the applicable requirement as of the date set forth in the F of Correction of 08/17/2024. Survey Date: July 17,2024 Facility Number: 100266850 Please feel free to call me with any further questions at 317-856-4851. Respectfully submitted, Edward Hughes, HFA	y the nour the rial, tting st the of hese k k nce nts Plan	
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE	

Edward Hughes

Executive Director

(X6) DATE 08/05/2024

PRINTED:

08/07/2024

Any define cystatement 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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	ì í	JILDING	construction (X3) DATE SURVEY COMPLETED 07/17/2024		
	PROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER		4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221		
(X4) ID PREFIX TAG	(EACH DEFICIE)	T 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)	ЛЕ	(X5) COMPLETION DATE
< 0000					Executive Director, Chalet Healthcare and Rehabilitation		
Bldg. 01							
	Licensure Survey	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0	000	K 000 Dear Ms. Buroker: On 07/17/2024 a Life Safety C Recertification and Emergenc Preparedness Survey was		
	Survey Date: 07/1				conducted for Chalet Rehabilitation and Healthcare		
	Facility Number: Provider Number: AIM Number: 100	155336			Center. Enclosed please find Statement of Deficiencies with facilities Plan of Correction for alleged deficiencies. By	n our	
	Rehabilitation and not in compliance Participation in Me Subpart 483.90(a), 2012 edition of the Association (NFP)	Code survey, Chalet Healthcare Center was found with Requirements for edicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection A) 101, Life Safety Code (LSC), ng Health Care Occupancies and			alleged deficiencies. By submitting the enclosed mater Chalet Rehabilitation and Healthcare Center is not admit the truth or accuracy of any specific findings or allegations We reserve the right to contess findings or allegations as part any proceedings and submit to responses pursuant to our regulatory obligations.	itting 5. st the of	
	Type V (111) cons The facility has a f detection in the co the corridor. The f smoke detectors in	lity was determined to be of truction and is fully sprinklered. The alarm system with smoke tridor and in all areas open to accility has battery operated stalled in all resident sleeping thas a capacity of 88 and had a time of this visit.			We respectfully request a des review that the facility has achieved substantial compliar with the applicable requirement as of the date set forth in the l of Correction of 08/17/2024. Survey Date: July 17,2024 Facility Number: 000229 Provider Number: 155336	nce nts	
	were sprinklered e	sidents have customary access xcept for two detached storage ere each not sprinklered and prage.			AIM Number: 100266850 Please feel free to call me with any further questions at	h	

	R MEDICARE & MEDI					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTII A. BUILDI B. WING	ple construction ng <u>01</u>			
	PROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	48	REET ADDRESS, CITY, STATE, ZIP (851 TINCHER RD IDIANAPOLIS, IN 46221	COD		
				-			
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREI	FIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	RECTION HOULD BE APPROPRIATE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY 317-856-4851. Respectfully submitted Edward Hughes, HFA Executive Director, Ch Healthcare and Rehat	nalet	DATE	
< 0300 SS=F Bldg. 01	Section 18.3 and requirements tha provided K-tags, information, along Safety Code or N should be include Based on record re- interview; the facil documentation for of smoke detectors sleeping rooms wa 4.6.12.3 states exis to the public, if no maintained. NFPA Signaling Code, 20 and Tests states fin maintained and tes manufacturer's pub- requirements of CI Inspection, testing shall satisfy the re- conform to the equ published instructi could affect all res Findings include: Based on review o	r RKS section any LSC	K 0300	K 300 It is the practice of Cl Rehabilitation and He Center to assure that documentation for the maintenance of smoke installed in all resident rooms is completed. N 4.6.12.3 states existin features obvious to the not required by the Co maintained. NFPA 72, Fire Alarm and Signali 2010 Edition, 29.10 M and Tests states fire-v equipment shall be ma and tested in accordar manufacturer's publish instructions and per th requirements of Chapi 72, 14.2.1.1.1 Inspect and maintenance prog satisfy the requirement	ealthcare the preventative e detectors t sleeping VFPA 101 in g life safety e public, if ode, shall be , National ing Code, aintenance varning aintained nce with the ned ter 14. NFPA ion, testing, grams shall	08/03/202	

DEPARTMENT	OF HEALTH	AND HUMAN	SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	B. WING	01	(X3) DATE SURVEY COMPLETED 07/17/2024	
	NAME OF PROVIDER OR SUPPLIER CHALET REHABILITATION AND HEALTHCARE CENTER		4851 TINC	dress, city, state, zip cod CHER RD POLIS, IN 46221		
CHALET (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY O month period with Maintenance Direct 9:15 a.m. to 12:35 listing of resident st testing documentat 2024 was not avail interview at the tim Executive Director operated smoke de sleeping rooms, ea April 2024 and agin resident sleeping ro documentation for not available for re with the Executive Director during a t p.m. to 2:10 p.m. of room smoke detect had an installation manufacture date of These findings were	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the Executive Director and the tor during record review from p.m. on 07/17/24, an itemized deeping room smoke detector ion for May 2024 and June able for review. Based on ne of record review, the stated the facility has battery tectors installed in all resident ch detector was replaced in eed an itemized listing of boom smoke detector testing May 2024 and June 2024 was view. Based on observations Director and the Maintenance bour of the facility from 12:35 n 07/17/24, all resident sleeping fors are battery operated and date of April 2024 with a	INDIANAF		de de de ot	
			d n P F V	locument to be used for all nonthly smoke detector preventative maintenance che low the corrective action(s) vill be monitored o ensure the deficient practi		

PRINTED: 08/07/2024 FORM APPROVED

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	· /	ILDING	DNSTRUCTION 01	COMI	(X3) DATE SURVEY COMPLETED 07/17/2024	
	PROVIDER OR SUPPLIE	R AND HEALTHCARE CENTER		4851 T	address, city, state, zip (INCHER RD IAPOLIS, IN 46221	COD		
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking Facilities Cooking equipme accordance with Ventilation Contro Commercial Cooking equipme accordance with Ventilation Contro Commercial Cooking equipme accordance with Ventilation Contro Commercial Cooking appliances such toasters) are use cooking in accord 19.3.2.5.2 * cooking facilitie smoke compartm patients comply 18.3.2.5.3, 19.3.2 * cooking facilitie with 30 or fewer p conditions under	ent is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited lance with 18.3.2.5.2, s open to the corridor in ents with 30 or fewer vith the conditions under			will not recur, i.e., what quality assu program will be put in Executive Director, ma director or designee w the use of the newly of document to be used monthly smoke detect preventative maintena Executive Director, ma director or designee w discuss any issues wit created document use monthly smoke detect preventative maintena to QA/PI meeting for r continued compliance Date of Compliance: 08/03/2024	nto place: aintenance vill monitor reated for all for ance checks. aintenance vill bring and th the newly ed for all for ance checks review and		

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155336	B. WING		07/17/2024
	PROVIDER OR SUPPLIEI)	STREET	ADDRESS, CITY, STATE, ZIP COD	
				INCHER RD	
CHALET	REHABILITATION	AND HEALTHCARE CENTER	INDIAN	IAPOLIS, 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 APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	NFPA 96 per 9.2.	3 are not required to be			
	enclosed as haza	rdous areas, but shall not			
	be open to the co	rridor.			
	18.3.2.5.1 through	า 18.3.2.5.4, 19.3.2.5.1			
	through 19.3.2.5.	5, 9.2.3, TIA 12-2			
		view, observation and	K 0324	K 324	08/17/202
		ty failed to ensure 1 of 1		It is the practice of Chalet	
		exhaust systems was		Rehabilitation and Healthcare	
	-	er working order. NFPA 96,		Center to ensure 1 of 1 kitchen	
		ation Control and Fire		range hood exhaust systems wa	s
	Protection of Comr	nercial Cooking Operations,		maintained in proper working	
		on 4.1.3 states the following		order. NFPA 96, Standard for	
		kept in working condition:		Ventilation Control and Fire	
	(1) Cooking equipr			Protection of Commercial Cooki	a
	(2) Hoods	lient		Operations, 2011 Edition, Section	•
	(3) Ducts (if applic	able)		4.1.3 states the following	
	(4) Fans			equipment shall be kept in worki	ng
	(4) Fairs (5) Fire-extinguishi	ng aquinmont		condition:	ng
		or energy control equipment			
				(1) Cooking equipment	
		es maintenance and repairs		(2) Hoods	
	· ·	on all components at intervals		(3) Ducts (if applicable)	
		in good working condition.		(4) Fans	
	-	ice could affect over two		(5) Fire-extinguishing equipment	
	kitchen staff.			(6) Special effluent or energy	
				control equipment	
	Findings include:			Section 4.1.3.1 states	
				maintenance and repairs	
		the kitchen range hood		shall be performed on all	
		pection contractor's "Job		components at intervals	
	-	cumentation dated 02/27/24		necessary to maintain good	
		Director and the Maintenance		working condition.	
	-	ord review from 9:15 a.m. to		What corrective action(s) will	
	-	7/24, deficiencies were noted		be	
		nge hood exhaust system. The		accomplished for those reside	n
	"Notes" section of	the 02/27/24 inspection report		ts found to be	
	stated "fan sounds	oud went turnt on upon		affected by the deficient praction	c
	arrival sounds like	bearing in motor being out". In		e: No kitchen staff, residents,	
		the "Notes" section of the		other staff, or visitors were affec	ted
	kitchen range hood	exhaust system inspection		by the alleged deficient practice.	

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Event ID:

Y8OL21 Facility ID: 000229

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/17/2024
SUMMARY (EACH DEFICIE REGULATORY C documentation dat working. Worker on interview at the Executive Director motor for the kitch awaiting for the m observations with Maintenance Director	The formation of the facility at the facility of the facility	STREET 4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD VAPOLIS, IN 46221 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: All kitchen staff, residents, other and visitors that use or visit the facility have the potential to be affected by the alleged deficient	ATE (X5) COMPLETIC DATE the be ve staff, ne e
the kitchen range l operation. Based observations, the I fan for the kitchen operation. These findings we	2 2:10 p.m. on 07/17/24, the fan for nood system was not in on interview at the time of the Executive Director agreed the range hood system was not in re reviewed with the Executive faintenance Director during the		practice. No kitchen staff, residents, other staff, or visito were affected by the alleged deficient practice. Executive Director and maintenance dir have been in contact with HF (Harrell-Fish Inc) Mechanical contractors located in Bloomington, Indiana to repa range hood exhaust system. What measures will be put i place or what systemic changes will be m to ensure that deficient practice does recur: Maintenance and kitch staff will be in-serviced on the importance of the kitchen ran hood exhaust systems prope working order and how to rep any issues when it is not prop working. How the corrective action(s will be monitored to ensure the deficient pracci will not recur, i.e., what quality assurance program will be put into pla Executive Director, Maintena Director, Food Service Direct designee will monitor the use the newly repaired kitchen ra	ector I ir the n ade not ien e ge r ort ort oerly) tice ce: nce or, or of

	R MEDICARE & MEDI					-	1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	î /	ILDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/17/2024	
	PROVIDER OR SUPPLIE			4851 TI	DDRESS, CITY, STATE, ZIP COD NCHER RD		
CHALET	REHABILITATION	AND HEALTHCARE CENTER			APOLIS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETIO DATE
					hood exhaust system daily d walking rounds for proper wa order. Executive Director, Maintenance Director, Food Service Director, or designed bring and discuss any issues the newly repaired kitchen ra hood exhaust system to QA/ meeting for review and contin compliance. Date of Compliance: 08/17/2024	will with nge PI	
(0361 SS=E Bldg. 01	Corridors - Areas Spaces (other that treatment rooms waiting areas, nu and cooking facil in accordance wi and 19.3.6.1. 18.3.6.1, 19.3.6.7						
	failed to ensure 1 of separated from the of resisting the pass sprinklered buildin 19.3.6.1(7). LSC other than patient a rooms, and hazard corridor and unlim space and corridor in the same smoke an electrically sup detection system in (b) Each space is p sprinklers, and (c) access to required	on and interview, the facility of 1 therapy rooms were corridor by a partition capable sage of smoke as required in a g, or met an Exception per .9.3.6.1(7) states that spaces deeping rooms, treatment bus areas shall be open to the ited in area, provided: (a) The s which the space opens onto compartment are protected by ervised automatic smoke a accordance with 19.3.4, and rotected by an automatic The space does not to obstruct exits. This deficient practice 0 residents, staff and visitors in	K 03	361	K 361 It is the practice of Chalet Rehabilitation and Healthca Center to ensure 1 of 1 thera rooms were separated from to corridor by a partition capabl resisting the passage of smo required in a sprinklered built or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treat rooms, and hazardous areas be open to the corridor and unlimited in area, provided: (space and corridors which the space opens onto in the sam	apy the e of ke as ding ment shall a) The e	08/08/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X4) ID

TAG

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/17/2024 155336 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4851 TINCHER RD CHALET REHABILITATION AND HEALTHCARE CENTER INDIANAPOLIS, IN 46221 SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the vicinity of the relocated Therapy Room by the smoke compartment are protected main dining room. by an electrically supervised automatic smoke detection Findings include: system in accordance with 19.3.4, and (b) Each space is protected Based on observations with the Executive by an automatic sprinklers, and Director and the Maintenance Director during a (c) The space does not to obstruct tour of the facility from 12:35 p.m. to 2:10 p.m. on access to required exits. 07/17/24, the corridor wall for the relocated Therapy Room by the main dining room did not What corrective action(s) will extend to the ceiling above to separate this be treatment room from other spaces with smoke accomplished for those residen resistant partitions and doors. A one foot gap ts found to be was noted in between the top of the corridor wall affected by the deficient practic to the Therapy Room and the ceiling above. In e: No residents, staff, or visitors addition, the corridor door to the Therapy Room were affected by the alleged was equipped with a thumb twist deadbolt lock deficient practice. which required a key to unlock the door from the How other residents having the corridor side of the door. The corridor door to the potential to be affected by the room was not equipped with a positive latching same deficient practice will be mechanism to latch the door into the door frame identified and what corrective when tested to close multiple times. Based on action(s) will be taken: All interview at the time of the observations, the residents, staff, and visitors that Executive Director stated the Therapy Room was use or visit the facility have the relocated within the facility to its current location potential to be affected by the in October 2023 and the Therapy Room was not alleged deficient practice. No separated from the corridor with smoke resistant residents, staff, or visitors were partitions and doors. affected by the alleged deficient practice. Maintenance Director. These findings were reviewed with the Executive maintenance assistant or Director and the Maintenance Director during the contracted construction company exit conference. will ensure 1 of 1 therapy room in question are separated from the 3.1-19(b) corridor by a partition capable of resisting the passage of smoke. This will be accomplished by installing plexiglass incased by

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Y80L21

Facility ID: 000229

quarter round solid wood moldings. The therapy door will have a positive latching

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	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number 155336	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X3) DATE SURVEY COMPLETED 07/17/2024
	ROVIDER OR SUPPLIE	R I AND HEALTHCARE CENTER	4851 T	address, city, state, zip cod INCHER RD IAPOLIS, IN 46221	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y 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 APPROPRIATE DEFICIENCY)	DATE
				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 partition capable of resisting the passage of smoke as required 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 monite all patient sleeping rooms and treatment area rooms for compliance of being separated from the corridor by a partition capable of resisting the passag of smoke daily during walking rounds. Executive Director, Maintenance Director, or design with any patient sleeping rooms treatment area rooms that are r separated from the corridor by a partition capable of resisting the passage of smoke to QA/PI meeting for review and continue compliance.	st de ot e of a a e in a c e c e or c e or c e or c e or c e or c e or c e or c e or c e a e e in a c e e in a c e e in a c e in a c e i in a c e i i i i i i i i i i i i i i i i i i i

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED
		155336	B. WI	NG		07/17	/2024
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
CHAI FT	REHABILITATION	I AND HEALTHCARE CENTER			INCHER RD IAPOLIS, IN 46221		
(X4) ID		STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG					CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	
TAG	REGULATORY U	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Date of Compliance: 08/08/2024		
					00,00,2021		
< 0712	NFPA 101						
SS=F	Fire Drills						
Bldg. 01	Fire Drills						
	Fire drills include	the transmission of a fire					
	alarm signal and	simulation of emergency fire					
	conditions. Fire d	rills are held at expected					
	and unexpected	times under varying					
	conditions, at lea	st quarterly on each shift.					
	The staff is famili	ar with procedures and is					
		are part of established					
	routine. Where c	Irills are conducted between					
	9:00 PM and 6:0	0 AM, a coded					
		nay be used instead of					
	audible alarms.						
	19.7.1.4 through	19.7.1.7					
		view and interview, the facility	K 07	712	K 712		08/08/202
		quarterly fire drills on the third	11 0 /	12	It is the practice of Chalet		00/00/202
		rters. This deficient practice			Rehabilitation and Healthcard	e	
	-	s, staff and visitors.			Center to conduct quarterly fire		
		,			drills and document quarterly f		
	Findings include:				drills for all shift for all quarters		
					the year.		
	Based on review o	f Direct Supply TELS Logbook			_ ,		
		ire Drills" and "Fire Drill			What corrective action(s) will	l	
		ation with the Executive			be		
	-	laintenance Director during			accomplished for those resid	len	
		n 9:15 a.m. to 12:35 p.m. on			ts found to be		
		ntation of a fire drill conducted			affected by the deficient prac	tic	
		cent twelve month period on the			e: No residents, staff, or visitor		
		ird quarter (July, August,			were affected by the alleged	-	
		vas not available for review.			deficient practice.		
		v at the time of record review,			How other residents having t	he	
		ctor stated the facility operates			potential to be affected by th		
		<i>v</i> , additional fire drill			same deficient practice will b		
		s not available for review and			identified and what corrective		
		tion of a fire drill conducted on				C	
	-	e third quarter 2023 was not			action(s) will be taken: All residents, staff, and visitors that	ot	
	The muro shift in th				T LESIGEOUS SIGULAND VISITORS IN	ai	

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155336	(X2) MULTIPLE C A. BUILDING B. WING			
	PROVIDER OR SUPPLIE	R NAND HEALTHCARE CENTER	4851 T	ADDRESS, CITY, STATE, ZIP COD INCHER RD NAPOLIS, IN 46221		
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETI
TAG	available for revie These findings we	R LSC IDENTIFYING INFORMATION w. re reviewed with the Executive faintenance Director during the	TAG	Use or visit the facility have potential to be affected by alleged deficient practice. It residents, staff, or visitors of affected by the alleged defi- practice. Executive Director Maintenance Director, or maintenance assistant has completed and docume all fire drills since Septemb when the alleged fire drill w documented or completed. What measures will be put place or what systemic changes will be to ensure that deficient practice door recur: Maintenance staff w in-serviced on the important completing and documental fire drills to be conducted a unexpected and unpredictat times and days. How the corrective action will be monitored to ensure the deficient pra- will not recur, i.e., what quality assurance program will be put into p Executive Director, Mainten Director, or designee will m fire drill schedule and documentation monthly for months or until 100% comp is met. Executive Director, or d will bring and discuss any i with the fire drill schedule of documentation to QA/PI me for review and continued	the No were icient r, ented er vas not it in made es not rill be nce of ng all it able (s) actice ce lace: nance nonitor 3 obliance esignee ssues or	DATE

PRINTED: 08/07/2024 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155336 B. WING 07/17/2024 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 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE compliance. Date of Compliance: 08/08/2024

Event ID: FORM CMS-2567(02-99) Previous Versions Obsolete

Y80L21

Facility ID: 000229

If continuation sheet

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