STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155710	A. BUILDING -- B. WING	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHASE CENTER	2 CHASE PARK LOGANSPORT, IN 46947

(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: 12/09/24 Facility Number: 000021 Provider Number: 155710 AIM Number: 100275270 At this Emergency Preparedness survey, Chase Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 101 certified beds. At the time of the survey, the census was 77. Quality Review completed on 12/11/24	E 0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during this inspection. I would like to formally request your consideration for granting this facility paper compliance. Chase Center submits this plan of correction (POC) in accordance with specific regulatory requirements. The submission of the POC does not indicate an admission by Chase Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Chase Center. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact myself, Lacey Schnurpel, Administrator at 574-753-4137.	
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: 12/09/24 Facility Number: 000021 Provider Number: 155710	K 0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during this inspection. I would like to formally request your consideration for granting this facility paper compliance. Chase Center submits this plan of correction (POC) in accordance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lacey R. Schnurpel	Administrator	12/24/2024

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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	AIM Number: 100275270 At this Life Safety Code survey, Chase 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 with a partial basement was constructed in 1972 and was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated detectors in all resident sleeping rooms. The building is partially protected by an 80-kW emergency generator powered by natural gas. The facility has a capacity of 101 and had a census of 77 at the time of this survey. All areas where residents have customary access were sprinklered. All areas which provided facility services were sprinklered except the two detached buildings which include a generator housed in a wood frame building and a wood frame laundry building which were not sprinklered. Quality Review completed on 12/11/24		with specific regulatory requirements. The submission of the POC does not indicate an admission by Chase Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Chase Center. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact myself, Lacey Schnurpel, Administrator at 574-753-4137.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1.1 Delayed-Egress Locking Systems allows	K 0222	1. The Maintenance Director adjusted the sensitivity to the 15 second delay setting on the front door on 12/09/2024 and corrected the door immediately.	12/23/2024

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	approved, listed, delayed-egress locks shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (1) The door leaves shall unlock in the direction of egress upon activation of one of the following: (a) Approved, supervised automatic sprinkler system installed in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detections system in accordance with section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) A readily visible, durable sign in letters not		2. An audit of all doors was performed on 12/10/2024 and all doors were working properly and no concerns with functionality noted. 3. The Maintenance team conducts a weekly inspection of all doors to ensure proper functionality and working condition. All results of the weekly inspection will be reviewed weekly at the morning meeting. 4. The door inspections will continue to be performed by the Maintenance team for 6 months and results will be reviewed at the monthly Quality Assurance Meeting and review of results will determine further audits.	

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	less than 1 in. (25mm) high and at least 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". (5) The egress side of the doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with 7.9. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observations made on 12/09/24 with the Director of Maintenance (DOM) during a tour of the facility at 9:20 a.m., the facility main entrance / exit was provided with delayed egress lock and was provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door, however, when the door was pushed and tested, the irreversible process to release the lock was not initiated. After three failed attempts, the DOM was asked to test the door, and he too could not get the irreversible process to release the lock to initiate either. Based on an interview at the time of the observation, the DOM agreed that the irreversible process to release the lock was not initiated stating that he would have his assistant look at the door. This finding was reviewed with the DOM and the facility Administrator at the exit conference on 12/09/24. 3.1-19(b)			
K 0223 SS=E	NFPA 101 Doors with Self-Closing Devices			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors was only held open by a release device complying with LSC 7.2.1.8.2 that automatically closes such doors upon activation of the fire alarm system. This deficient practice could affect at least 10 residents, staff and visitors entering the 200 Hall. Findings include: Based on observations made on 12/09/24 with the Director of Maintenance (DOM) during a tour of the facility at 10:08 a.m., the set of barrier doors leading to the 200 Hall did not close completely due to a medicine cart being stored in the corridor between them. There was a fourteen-inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the DOM acknowledged these smoke barrier doors did not close completely due to the location of the medical cart stored in the corridor between them. The DOM then immediately moved the cart to a location further down the hall that allowed the barrier doors to fully close. He then reminded staff there about the need to keep the barrier doors clear in the event of a fire emergency and continued the tour of the facility. This finding was reviewed with the DOM and the facility Administrator at the exit conference on 12/09/24. 3.1-19(b)	K 0223	1. The Maintenance Director removed the ice chest that was placed in the doorway of the fire doors immediately upon observation on 12/09/2024. 2. An audit was performed by the Maintenance team on 12/10/24 to ensure the ice chests were not parked in front of the fire doors. All doors were properly functioning and nothing was obstructing them. 3. An audit will be performed weekly to ensure nothing is obstructing the fire doors in the facility. These results will be reviewed at the morning meeting with managers weekly. 4. All results and any corrective actions will be reviewed with the Quality Assurance team at the monthly QAPI meeting. The audit will be conducted weekly for 6 months and the QAPI team will review the need to continue the audit or discontinue after review.	12/23/2024