STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155246	A. BUILDING -- B. WING	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

(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: 04/20/23 Facility Number: 000150 Provider Number: 155246 AIM Number: 100267000 At this Emergency Preparedness survey, Chesterton Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 100 beds. At the time of the survey, the census was 65. Quality Review completed on 04/26/23	E 0000	By submitting the enclosed materials, we are 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. The facility **requests that the plan of correction be considered our allegation of compliance effective May 12th,** 2023, for the annual survey completed April 20th, 2023.	
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: 04/20/23 Facility Number: 000150 Provider Number: 155246 AIM Number: 100267000 At this Life Safety survey, Chesterton Manor was found not in compliance with Requirements for	K 0000	By submitting the enclosed materials, we are 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. The facility **requests that the plan of correction be considered our allegation of compliance effective May 12th,** 2023, for the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherrie Lamore	Administrator	05/08/2023

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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	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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and areas open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The building is fully protected by a Natural Gas powered generator. The facility has the capacity for 100 and had a census of 65 at the time of this survey. Areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/26/23		annual survey completed April 20th, 2023.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review, observation, and interview, the facility failed to ensure 1 of 1 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority	K 0291	By submitting the enclosed materials, we are 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. The facility	05/12/2023

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	155246	A. BUILDING 01 B. WING	04/20/2023

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	having jurisdiction. This deficient practice could affect all building occupants when work is needed on the generator. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 04/20/23 at 12:30 p.m., there was a battery powered emergency light mounted outside near the generator. Based on records review at 10:00 a.m., documentation of a monthly 30 second test for the battery powered emergency light was not available for review for the months of February and March of 2023. Based on an interview at the time of record review and observation, the Maintenance Director confirmed there is a battery powered light for the generator and stated the documentation for the tests were documented wrong in 'TELS' and did not record monthly 30 second testing of the battery light. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**requests that the plan of correction be considered our allegation of compliance effective May 12th,** 2023, for the annual survey completed April 20th, 2023. Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction. **K291- Emergency Lighting** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·The emergency lights were tested immediately. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents who reside in the facility have the potential to be affected by the alleged deficient practice and emergency lighting was tested immediately. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·The policy on emergency lighting testing was reviewed by the IDT ·1:1 inservice held with maintenance director on emergency lighting testing	

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			How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits emergency lighting testing being completed between 3-5 weeks and for not less than 30 seconds. This Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee monthly for 12 months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 5/12/2023	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 fire door assemblies in the facility were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices,	K 0761	By submitting the enclosed materials, we are 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. The facility **requests that the plan of correction be considered our allegation of compliance effective May 12th,** 2023, for the annual survey completed April	05/12/2023

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	anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect approximately 15 residents and staff. .		20th, 2023. Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction. **K761- Maintenance Inspection and Testing- Doors** *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* ·Maintenance Director immediately added door inspection to annual maintenance log through the facility system called tels *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* ·All residents who reside in the facility have the potential to be affected by the alleged deficient practice ·Facility door was checked immediately and logged appropriately. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* ·1:1 inservice held with maintenance director on fire door inspections occurring annually ·A performance improvement	

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	Findings include: Based on record review between 09:08 a.m. and 11:47 a.m. on 04/20/23 with the Maintenance Director and Executive Director, no documentation could be provided for annual fire door inspection for the fire-rated oxygen storage/transfilling room. Based on observation during a tour of the facility between 11:48 a.m. and 1:00 p.m., the fire rated door located at the oxygen storage/transfilling room had a rating of 1-1/2 hours. Based on interview at the time of observation and record review, the Maintenance Director stated that the door is the only certified fire door in the facility and they have not done an annual inspection for the door and agreed that the door was rated 1-1/2 hours. Findings were reviewed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		tool has been developed to monitor fire door inspections *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits fire door inspections being completed annually. This Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee monthly for 12 months. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* May 12,2023	