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	03/07/2024

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: 03/07/24 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 62. Quality Review completed on 03/08/24	E 0000		
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: 03/07/24 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherrie Lamore	Administrator	03/19/2024

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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	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 62 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 03/08/24			
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, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 56 of 56 battery operated smoke alarms in the facility was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public,	K 0300	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	04/05/2024

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	if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. 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 approximately all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director and Administrator on 03/07/24 between 08:55 a.m. and 11:58 a.m., no completed itemized list for preventative maintenance of resident rooms and other areas for battery operated smoke alarms was available for review. Documentation presented titled "Detectors: Test Battery Operated Smoke Detectors" on an online program TELS, indicated that the testing had been completed for certain weeks, however was not itemized. Furthermore, weekly testing were missing during a period of 14 weeks between the months of June 2023 and November 2023. The smoke detector manufacturer manual indicated that weekly testing is required. Based on interview at the time of record review, the Maintenance Director confirmed the missing smoke detector list was not itemized like it should be. He also later acknowledged there was missing testing within the online program and no other documentation could be presented at the time of the survey. Findings were reviewed with the Maintenance Director and Administrator 3.1-19(b)		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 April 5, 2024. We respectfully request paper compliance for this survey resolution. K-300 It is the policy of this facility that the battery-operated smoke detectors are tested weekly as required by state and federal guidelines. The corrective action taken for those residents found to be affected by the deficient practice include: All residents have the potential to be affected by the deficient practice but none were identified. The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include: Maintenace Director or designee have an itemized form of locations that will be implemented to confirm compliance with this standard. Maintenance director or designee will complete a audit of all battery operated smoke detectors weekly to comply with the standard. Those test results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six months to ensure completion on time. Any issues	

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			that arise will be addressed immediately. 4/5/2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect approximately 2 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 03/07/24 between 12:02 p.m. and 1:24 p.m., when the GFCI electric receptacle in the restroom of room 412 was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. The surveyors tester indicated an "open hot." Based on interview at the time of record review, the Maintenance Director confirmed the GFCI did not trip when tested approximately three times. The finding was reviewed with the Maintenance Director and Administrator during the exit	K 0511	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 April 5, 2024. We respectfully request paper compliance for this survey resolution. K511 It is the policy of this facility that the GFCI electric receptacle be tested as required by state and federal guidelines. The corrective action taken for those residents found to be affected by the deficient practice include: All residents have the potential to be affected:	04/05/2024

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	conference. 3.1-19(b)		The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include: GFCI in room 412 was immediately replaced, an audit of all GFCI in the building was completed. The corrective action taken to monitor the performance to assure compliance through quality assurance is: Maintenance director will audit weekly for three weeks and then monthly to comply with standards of guidelines for testing. Those test results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six months to ensure completion on time. Any issue that arises will be reported and fixed immediately. Compliance date -4/5/2024	
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			

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	Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director and Administrator on 03/07/24 between 08:55 a.m. and 11:58 a.m., no documentation was available to confirm a second shift fire drill for the third quarter of 2023 was conducted. A fire drill dated 08/2023 had an inservice sheet signed from a fire drill, however no time was documented on the sheet to determine if it was a second shift drill. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation and stated a normal fire drill sheet had not been made and agreed a time was not accurately documented. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	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 April 5, 2024. We respectfully request paper compliance for this survey resolution. K-0712 It is the policy of this facility that the fire drill documentation will contain proper information as required by state and federal guidelines. The corrective action taken for those residents found to be affected by the deficient practice include: All residents have the potential to be affected. The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include: Maintenance director will ensure all proper documentation is completed on all fire drills every quarter for each shift and reviewed by the administrator. results will be printed and added to the monthly Quality Assurance Performance Improvement meeting for six months to ensure	04/05/2024

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			compliance. Completion date-4/5/2024	