

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/13/2023
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/11/2023 | |
| NAME OF PROVIDER OR SUPPLIER CHASE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN 46947 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| K 000 | <p>INITIAL COMMENTS</p> <p>A Life Safety Code and Pre-Occupancy Survey to the additions of: resident rooms # 301 through #305 and resident rooms #316 through #320 from single to double occupancy, a kitchen addition, the main entrance update, the addition of an activities room, and a storage closet was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 07/11/23</p> <p>Facility Number: 000021 Provider Number: 155710 AIM Number: 100275270</p> <p>At this Pre-Occupancy survey, Chase Center was found 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.</p> <p>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 54 at the time of this survey.</p> <p>All areas where residents have customary access</p> | | | K 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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 000 | Continued From page 1 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 07/12/23 | K 000 | | | |