STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 00 B. WING	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHALET REHABILITATION AND HEALTHCARE CENTER	4851 TINCHER RD INDIANAPOLIS, IN 46221

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 30, 31, April 1, 2, and 3, 2025 Facility number: 000229 Provider number: 155336 AIM number: 100266850 Census Bed Type: SNF/NF: 76 Total: 76 Census Payor Type: Medicare: 7 Medicaid: 40 Other: 29 Total: 76 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 10, 2025.	F 0000		
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, record review, and interview, the facility failed to ensure reasonable accommodation of needs for 1 of 18 residents observed for call light access. (Resident 52) Finding includes: On 3/30/25 at 8:36 a.m., Resident 52 was observed sitting up in his wheelchair in his room. The touch pad call light was observed to be wrapped around	F 0558	F- 558 Reasonable Accommodations Needs/Preferences The facility respectfully requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth	04/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tanequa Footman	Executive Director	04/22/2025

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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	and clipped to the plug in cord at the foot of the bed between Resident 52's bed and the wall, out of reach of Resident 52. On 3/31/25 at 9:12 a.m., Resident 52 was observed in bed with the touch pad call light wrapped up and attached with a clip to the plug in cord at the foot of bed between the bed and the wall, out of reach of Resident 52. During an interview at that time, Resident 52 indicated he was unable to reach the call light. During an interview on 3/31/25 at 9:20 a.m., RN 2 indicated that the call light was not in within Resident 52's reach. During an interview on 3/31/25 at 9:23 a.m., the Director of Nursing (DON) indicated that Resident 52 could not reach his call light. During an observation on 4/2/25 at 9:02 a.m., Resident 52 was observed in bed with his eyes closed. The touch pad call light was observed to be lying on the floor. During an interview on 4/2/25 at 9:12 a.m., RN 2 indicated that Resident 52's call light was not accessible to the resident. The clinical record for Resident 52 was reviewed on 3/31/25 at 10:30 a.m., the diagnoses included, but were not limited to, severe protein calorie malnutrition and heart valve replacement. On 3/31/25 at 10:11 a.m., the Regional Support provided an undated Call Light Policy and indicated it was the current policy in use by the facility. The policy indicated call lights would be accessible when in the room.		on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified: • Call light provided for resident # 52 and clipped to linens within easy reach of resident. Care plan updated to reflect. 2. How the facility identified other residents: • Any resident that resides within the facility has the potential to be affected. • An audit was conducted to determine that call lights were accessible to facility residents, any areas of concern were immediately addressed. 3. Measures put into place/ System changes: • Staff educated on components of F558 Reasonable Accommodations Needs/Preferences, including accessibility of call lights. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing /designee who will audit call light accessibility for 10 residents 5 days weekly to include all shifts. • Concerns will be corrected when identified and reviewed during daily morning meetings as well as	

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	3.1-3(v)(1)		reviewed monthly during Quality Assurance Meeting. • Audits will continue daily to include all shifts for 6 months and or until 100% compliance is achieved for 3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance 4-25-2025	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessment was correctly coded to reflect the hospice election status for 1 of 2 residents reviewed for hospice. (Resident 44) Finding includes: On 4/2/25 at 11:41 a.m., the clinical record of Resident 44 was reviewed. The diagnosis included, but was not limited to, acute kidney failure. A physician's order, dated 8/8/24, indicated Resident 44 was admitted hospice. An annual MDS assessment, dated 1/16/25, indicated Resident 44 was not receiving hospice services. During an interview on 4/2/25 at 10:57 a.m., the	F 0641	**F 641D Accuracy of Assessments** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1 Immediate actions taken for those residents identified: Resident #44 MDS was	04/25/2025

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	MDS Coordinator indicated Resident 44 had been receiving hospice services for "a long time" and indicated MDS assessment should have been updated. During an interview on 4/2/25 at 11:02 a.m., the Executive Director indicated the facility followed the RAI (Resident Assessment Instrument) manual regarding MDS assessment accuracy. On 4/2/25 at 12:01 p.m., the Executive Director provided a copy of the CMS RAI Version 3.0 Manual (Center for Medicare and Medicaid Services Resident Assessment Instrument), dated October 2019, and indicated it was the current manual in use by the facility. A review of the manual indicated, "if a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS..." 3.1-31(d)		modified to accurately reflect resident's hospice status. 2 How the facility identified other residents: Audit was conducted of Significant Change MDS assessments completed over the last 30 days to ensure coding was accurate. 3 Measures put into place/ System changes: In-service completed for MDS with regards to accuracy of MDS. MDS will follow the RAI Guidelines for completion of MDS. 4 How the corrective actions will be monitored: MDS/Director of Nursing will complete an audit of 4MDS' per month to validate accuracy. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 4-25-2025	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation and interview, the facility failed to ensure a person-centered comprehensive care plan was accurately developed or implemented for residents' advanced directives, for 3 of 18 residents reviewed for advanced directive preferences. (Resident 23, Resident 29, Resident 281) Finding includes: 1. On 3/30/25 at 10:45 a.m., Resident 23's clinical record was reviewed. Resident 23's diagnoses included, but were not limited to, chronic obstructive pulmonary disorder and chronic pancreatitis. A physician's order, dated 11/26/24 and with no end date, indicated that Resident 23 had an advanced directive, or code status, of do not resuscitate or DNR (a medical order that instructs medical professionals not to attempt CPR if a patient's heart stops beating or breathing; this allows the patient to die naturally). A POST (Indiana Physician Orders for Scope of Treatment) form, prepared 11/26/24, indicated Resident 23 had selected do not attempt resuscitation/DNR. The form was signed by the resident. The care plan for Resident 23 lacked a section reflecting the resident's advanced directive preferences. 2. On 3/30/25 at 11:00 a.m., Resident 29's clinical record was reviewed. Resident 29's diagnoses included, but were not limited to, chronic	F 0656	F656 D Develop/Implement Comprehensive Care Plans The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Identified resident #23, #29, and #281 advance directive preferences, orders and care plans were updated to accurately reflect residents advance directive preferences. 2) How the facility identified other residents: An audit was conducted on all facility residents to verify that advance directives, orders and care plans were accurately reflected.	04/25/2025

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	respiratory failure, congestive heart failure, and type 2 diabetes mellitus. A physician's order, dated 1/17/25 and with no end date, indicated Resident 29 had an advanced directive, or code status, of CPR (cardiopulmonary resuscitation, also called a full code status, where the medical order indicates to attempt CPR if resident is without pulse and breath). A POST form, prepared 1/14/25, indicated Resident 29 had selected to attempt resuscitation/CPR if found without pulse and breath. The form was signed by the resident. The care plan for Resident 29 lacked a section reflecting resident's advanced directive preferences. 3. On 3/30/35 at 11:30 a.m., Resident 281's clinical record was reviewed. Resident 281's diagnoses included, but were not limited to, COPD, congestive heart failure, and chronic kidney disease. A physician's order, dated 2/24/25 and with no end date, indicated Resident 281 had an advanced directive, or code status, of DNR. A POST form, prepared 1/17/25, indicated Resident 281 had selected do not attempt resuscitation/DNR. The form was signed by the resident. The care plan for Resident 281 lacked a section reflecting resident's advanced directive preferences. During an interview on 4/1/25 at 10:30 a.m., the DON (Director of Nursing) indicated that		Identified areas of concern were immediately addressed. Care plans are initiated/reviewed upon admission-readmission, annually, quarterly, for significant change and as needed. Care plans are additionally reviewed and updated as needed during scheduled care plan meetings. 3) Measures put into place/ System changes: In-service conducted by MDS Coordinator for the interdisciplinary team to review procedures for development of comprehensive care plans. Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually, with significant change and as needed. Advance directive orders will be reviewed during new admission audits. 4) How the corrective actions will be monitored: The Director of Nursing and MDS Coordinator will randomly review three residents" care plan records weekly ensuring that care plans have been developed that accurately reflect advance directive preferences, orders and care plans are updated.	

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	advanced directive preferences should be included on residents' care plans. On 4/1/25 at 1:35 p.m., the DON provided an undated policy titled "Care Plans Protocol," and indicated that it was the policy currently in use by the facility. A review of the policy indicated that the care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial well-being and care plans should be completed or modified timely. 3.1-35(a)		MDS coordinator will review during scheduled care plan meetings to ensure care plans are reflective of resident's status. Any issues identified will be immediately addressed. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months, at which time the IDT will determine if changes are needed to the plan of care. 5) Date of compliance: 4-25-2025	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure an advanced directive care plan was updated when the resident's code status preference was changed for 1 of 18 residents reviewed. (Resident 7) Finding includes: On 4/1/25 at 9:55 a.m., Resident 7's clinical record was reviewed. The diagnosis included, but was not limited to, chronic obstructive pulmonary disease. Current Physician orders, dated 4/1/25, included, but was not limited to, "Code Status: CPR (cardiopulmonary resuscitation), start date 1/27/25" with no end date noted.	F 0657	F657 D Care Timing and Revision The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	04/25/2025

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	The annual Minimum Data Set (MDS) assessment, dated 2/6/25, indicated Resident 7 was cognitively intact. Resident 7's care plan included, but was not limited to, " ...[Resident 7] has an established advanced directive of POST [Indiana Physician Orders for Scope of Treatment] form indicating DNR [do not attempt resuscitation/do not resuscitate] code status." The care plan was initiated on 10/1/2014 and was considered current through 5/28/25. On 4/1/25 at 12:55 p.m., the Executive Director provided a copy of Resident 7's hospital discharge summary document. A review of the document, dated 1/27/25, indicated Resident 7's code status preference was "attempt resuscitation/CPR [full code status]." The POST form, signed by Resident 7 on 1/27/25, indicated Resident 7 had chosen "Attempt Resuscitation/CPR." The clinical record lacked a revised code status care plan for Resident 7 whose code status preference, dated 1/27/25, was changed from DNR to full code status. During an interview on 3/31/25 at 10:51 a.m., Resident 7 indicated she had changed her code status preference from DNR to full code at the end of January. During an interview, on 4/1/25 at 10:00 a.m., the Director of Nursing (DON) indicated Resident 7's care plan should have been updated at the time the resident's code status preference was changed from DNR to full code.		1) Immediate actions taken for those residents identified: Identified resident #7 had his advance directive care plan updated to reflect the residents code status preference. 2) How the facility identifies other residents: Any resident had the potential to be affected, however none were identified to have been negatively impacted. Audit was conducted on advance directive/code status orders to ensure that care plans were accurate, updated and reflective of resident's preference. 3) Measures put into place/ System changes: Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually. Advance directive/code status care plans will be completed upon admission and reviewed at least annually, quarterly and with significant change or should resident change advance directive preference. 4) How the corrective actions will be monitored: The Director of Nursing /designee will randomly review 3 residents 'care plan records weekly to determine that advance	

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	On 4/1/25 at 1:35 p.m., the DON provided an undated copy of the Care Plans Protocol and indicated that it was the current policy in use by the facility. A review of the document indicated, " ...the care plan should be revised on an on-going basis to reflect changes in the resident, and the care the resident is receiving ..." 3.1-35(d)(1) 3.1-35(d)(2)(B)		directives/code status care plans are accurate and meet resident's preferences. Any issues identified will be immediately addressed. The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the IDT can make recommendations to the plan of care. 5) Date of compliance: 4-25-2025	