STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155336	A. BUILDING -- B. WING	04/25/2025

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

(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: 04/25/25 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 At this Emergency Preparedness survey, Chalet Rehabilitation and Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 88 certified beds, with a current census of 70. Quality Review completed on 05/01/25	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: 04/25/25 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 At this Life Safety Code survey, Chalet	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tanequa Footman	Executive Director	05/07/2025

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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	Rehabilitation and Healthcare 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 was determined to be of Type V (111) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 88 and had a census of 70 at the time of this visit. All areas where residents have customary access were sprinklered except for two detached storage buildings which were each not sprinklered and used for facility storage. Quality Review completed on 05/01/25			
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, 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,	K 0300	This plan of correction constitutes the facilities 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	05/12/2025

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	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 all residents, staff, and visitors. Findings include: Based on records review with the Maintenance Director on 04/25/25 at 11:40 a.m., preventative maintenance documentation of resident room battery operated smoke alarms for the weeks of 02/10/25 and 02/17/25 were incomplete. The rooms 21 through 46 for the week of 02/10/25 and rooms 37 through 46 for the week of 02/17/25 had not been documented as being checked. Based on interview at 11:45 a.m., the Maintenance Director stated he checked and was unable to locate any additional battery operated smoke detector testing records for the two aforementioned weeks, and added that the Maintenance Assistant did not complete the weekly testing. During the tour of the facility, battery operated smoke detectors were observed in the resident sleeping rooms. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		required by the provisions of federal and state law. The facility requests paper compliance for this citation. K300: Protection - Other 1) Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Maintenance Director will review Battery Operated Smoke Detector Log weekly to ensure log is filled in completely. 4)How the corrective actions will be monitored: The Maintenance Director/designee will present findings to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months to ensure 100% compliance is achieved. The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. 5) Date of compliance: 5/12/2025	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect more than 20 residents, staff and visitors in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant during a tour of the facility at 2:08 p.m. on 04/25/25, the Activities Office, a room greater than 50 square feet, contained a number of combustible items, such as paper goods and cardboard boxes. The door to this office was not equipped with a self-closing device. Based on interview at 2:11 p.m. with the Maintenance Director, he agreed the corridor door to the hazardous area was not equipped with a self closing device. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0321	This plan of correction constitutes the facilities 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. The facility requests paper compliance for this citation. K321: Hazardous Areas-Enclosure 1) Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the	05/12/2025

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			potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: A self-closing device was added to the Activities Office door. 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit 5 areas noted as Hazardous areas monthly and present findings to the QAPI Committee during QAPI Meetings to ensure compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 5/12/2025	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 7 cross corridor smoke doors would restrict the movement of smoke for at least 20 minutes in accordance with LSC Chapter 8. LSC 8.5.4.1 requires doors in smoke barrier shall close	K 0374	This plan of correction constitutes the facilities credible allegation of compliance. Preparation and/or execution of this plan of correction does not	05/12/2025

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	the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 30 residents, staff and visitors in two smoke compartments. Findings include: Based on observation with the Maintenance Director and Maintenance Assistant on 04/25/25 at 1:43 p.m., the East hall smoke doors by the Maintenance office had a one inch gap between the doors when closed. Based on an interview at 1:45 p.m., the Maintenance Director agreed there was a gap larger than 1/8 inch between the East hall smoke doors when closed. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		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. The facility requests paper compliance for this citation. K374: Subdivision of Building Spaces – Smoke Barriers 1) Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: East Hall Smoke Door by Maintenance Office was adjusted to required gap of no larger than 1/8 inch. All other Smoke Doors were checked to ensure compliance. 4)How the corrective actions will be monitored: The Maintenance	

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			Director/designee has audited all smoke doors and will present findings to the QAPI Committee during QAPI Meetings to ensure compliance. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 5/12/2025	