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	04/07/2025

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: 04/07/2025 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 73. Quality Review completed on 04/09/25	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 effectivefor survey April 7th 2025 Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
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: 04/07/2025 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 effectivefor survey April 7th 2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherrie Lamore	Administrator	04/21/2025

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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	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 73 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 04/09/25		Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1.) Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or	K 0324	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 5/9/2025. We respectfully request	05/09/2025

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	removed. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview with the Maintenance Director on 04/07/2025 at 11:56 a.m., the kitchen hood fire suppression system pull station was mounted 58 ½ inches above the floor near the cooking area in the kitchen. Based on observation interview with the Maintenance Director on 04/07/2025 at 11:56 a.m., the Maintenance Director observed the measurement taken with a tape measure and acknowledged the pull station was mounted with the center of the pull station handle at 58 ½ inches above the floor. 2.) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design		paper compliance for this survey resolution. K 324 It is the practice of this facility that federal and state guidelines be met in all contexts. *The corrective action taken for those resident found to be affected by the deficient practice include:* All residents could be affected by the potential of a failure of the cooking hood due to placement of the stove creating a potential fire. *Other residents have the potential to be affected have been identified by:* 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:* The stove was moved by to it's original positioning and placed under the hood and marked on the floor so that it is always placed correctly if moved for any reason. Safe care is scheduled for 4/22/25 to place ansul pull in proper placement between 42in to 48in from the floor. *The corrective action taken to monitor the performance to assure compliance through quality assurance is:* Positioning of the stove has been added to the monthly kitchen review and will be audited by the administrator monthly as part of	

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	manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview with the Maintenance Director on 04/07/2025 at 12:03 p.m., cooking appliances including a gas 6-burner stove with a flat-top grill, and a deep-fat-fryer, was located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, he was not aware of an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		the general checklist. Those results will be shared with the IDT during monthly QAPI meetings if any variance is noted. This will be an on-going audit with no stop date. *The date the systemic change will be completed: 5/9/2025*	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure a power strip in 1 of 50 resident rooms met UL 1363. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care	K 0920	By submitting the enclosed material, 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	05/09/2025

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	rooms (outside of vicinity) meet UL 1363. NFPA 70 section 517.2 Defines Patient Care Vicinity as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects staff and 2 residents in resident room 208. Findings include: Based on observation and interview with the Administrator and Maintenance Director on 04/07/2025 at 12:31 p.m., during a tour of the facility, resident room 208 was using a multiplug power strip for resident's personal electrical equipment including a television, that lacked a UL 1363 label on the multiplug power strip. The distance from the end of the patient's bed to the power strip measured 4 feet 4 inches at 12:31 p.m., using the surveyor's tape measure, and was acknowledged by the Maintenance Director. The Administrator removed the power strip at 12:31 p.m. during observation. The Maintenance Director stated the power strip was not one supplied by the facility, and that the resident's family must have brought the power strip in. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 5/9/2025 to the Recertification and State Licensure Survey completed April 7th 2025. We respectfully request a paper review and will provide any additional information requested. K920 The corrective action taken for those residents found to be affected by the deficient practice include: Room 208 extension cord was immediately removed and replaced with hospital grade UL rated 1363A power strip. All residents have the potential to be affected by the deficient practice. The measures or systematic changes that have been put in place to ensure that the deficient does not recur include The facility will ensure that only authorized power strips are used in the facility for electronics only. The Maintenance Director has made rounds to ensure that no other unauthorized power strips or extension cords are in use in the facility. No new issues noted. Families have been notified that power strips and extension cords are not to be used in the facility without prior authorization from the	

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			maintenance Director. The Maintenance Director or designee will make rounds weekly to ensure that no new power strips or extension cords have been installed in the facility. The Administrator or designee will monitor compliance through review of the documentation and weekly rounds. Results of the audits will be presented monthly at the Quapi meeting x's 90 days. If after 90 days of review, no trends or patterns are identified then results will be reviewed quarterly for an additional six months. The date the systematic change will be completed -5/9/2025	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the	K 0921	**K921 Electric equipment maintenance** 1 The facility allegedly failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment. Immediately manuals were gathered for the PCREE and inspections began. 2 The alleged deficient practice has the potential to affect all residents. 3 The regional maintenance director educated the maintenance director on the allegedly practice.	05/09/2025

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	development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review and interview with the Administrator and Maintenance Director on 04/07/2025 at 11:35 a.m., the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview on 04/07/2025 at 11:35 a.m. with the Maintenance Director, he stated he was not aware of the testing requirements of PCREE, but that he did see something in other documentation about testing or inspecting patient equipment. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		The inspection requirements were added to Tels to auto generate to ensure the inspections are completed and documented accordingly. 4 The Maintenance Director/Administrator/Designee will monitor to ensure all new or after any repair or modifications are made to PCREE is inspected and documented. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly and will immediately report if concerns exist and will be discussed during the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. Date of compliance 5/9/2025	