STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 01 B. WING	06/02/2025

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey that exited on 04/07/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR Subpart 483.90(a). Survey Date: 06/02/2025 Facility Number: 000150 Provider Number: 155246 AIM Number: 100267000 At this Life Safety survey, Chesterton Manor was found not in compliance with Requirements for 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 78 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 06/04/25	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 effective 6/11/2025. We respectfully request paper compliance for this survey resolution	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SHERRIE LAMORE	Administrator	06/09/2025

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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K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 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 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 06/02/2025 at 9:08 a.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	K 0324	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 residents found to be affected by the deficient practice includes: All residents have the potential to be affected, But none identified. 1- The measures of systemic changes that have been put in place to ensure that the deficient practice does not recur include: The stove and deep fryer were moved and positioned under the kitchen hood and marked on the floor so that it is always placed correctly for the purpose of maintenance and cleaning. Please see attached pictures. 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 the general checklist. The Dietary Manager has been inserviced on proper placement of stove and fryer.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	06/11/2025

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	ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on observation with the Maintenance Director on 06/02/2025 at 9:08 a.m., black tape had been applied to the floor outlining the location of the exhaust hood; however, it did not identify where the cooking equipment would be returned to after maintenance or cleaning to be protected by the fire-extinguishing system. Based on interview with the Maintenance Director, he stated that he did not believe the equipment could be located in any other location due to the location of the gas valves. Based on observation the cooking equipment was connected to flexible gas lines that would allow the equipment to be relocated outside of the fire-extinguishing system protection. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. This deficiency was cited on 04/07/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		no stop date. The date the systemic change will be completed: 6/11/2025	
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	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.	06/11/2025

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	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 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 06/02/2025 at 08:48 a.m., the facility failed to provide documentation of completed 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. Documentation provided during the survey included forms that were not filled in to show testing had been completed. Based on interview with the Maintenance Director on 06/02/2025 at 8:48 a.m., he stated "I am still learning how to use the machine." This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		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. All PCREE equipment was tested and any repairs were completed on 6/4/25.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 PCREE equipment is inspected and documented . This will continue for no less than 3 months and compliance is achieved. 5 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	

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	This deficiency was cited on 04/07/2025. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. Date of compliance 6/11/2025	