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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chalet Rehabilitation and Healthcare Center	4851 Tincher Rd Indianapolis, IN 46221

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect a resident's rights to be free from verbal and mental abuse by the Administrator for 1 of 3 residents reviewed for abuse. (Administrator, Resident B)Finding includes:On 3/5/26 at 9:15 a.m., the clinical record for Resident B was reviewed. The diagnoses included, but were not limited to, bipolar disorder (a chronic mental health condition characterized by intense mood swings to extreme highs to severe lows) and PTSD (Post-traumatic stress disorder; a chronic mental health condition triggered by experiencing or witnessing terrifying events, causing symptoms such as nightmare, flashback, severe anxiety, and avoidance of triggers lasting over a month).The admission Minimum Data Set (MDS) assessment, dated 1/15/26, indicated Resident B was cognitively intact.On 3/5/26 at 9:00 a.m., a facility reportable incident report was reviewed. The report was submitted to the Indiana Department of Health on 2/26/26 and a follow-up report was submitted on 2/27/26. The report indicated that on 2/19/26 the facility Administrator was involved in verbal altercations against Resident B. The report indicated the Administrator's behaviors displayed against Resident B on 2/19/26 .violated the resident's rights and met the definition of abuse. As a result of the facility's investigation, the Administrator was suspended on 2/27/26 at which time the Administrator resigned her position. During an interview on 3/5/26 at 10:30 a.m., the Regional Director of Operations (RDO) and the Chief Nursing Officer (CNO) indicated on 2/27/26 at 1:30 p.m. Resident B reported that on 2/19/26 the Administrator was in and out of Resident B's room as other staff were directed to pack up the resident's belongings. The verbal altercations between the Administrator and Resident B were described as continually escalating, with the Administrator speaking to Resident B in disrespectful, mocking, and intimidating tones. The CNO and the RDO had witnessed video clips from Resident B's phone. The RDO and CNO stated the clips showing portions of the negative interactions of the Administrator towards Resident B confirmed that the statements and tone of the Administrator towards Resident B violated policy and expectations. The actions of the Administrator were noted as both verbally and mentally abusive towards Resident B. The RDO and the CNO noted that the interactions were described as and appeared as escalating in nature, with the Administrator having plenty of opportunities to either attempt deescalation or walk away and cool down rather than continue.On 3/5/26 at 1:13 p.m., the RDO provided an undated copy of a document titled Video Evidence Summary, and indicated the document was a narrative and transcript of Resident B's phone recorded video clips from the events occurring on 2/19/26. A review of the contents of the video indicated that the Administrator was degrading, mocking, and intimidating towards Resident B, including but not limited to the following:- Video 1: Administrator stated, Let's record each other.' This was noted as a response to Resident B recording the Administrator. It was determined the Administrator was only pretending to record Resident B but was done in a mocking manner. Administrator stated, You are an unpaid customer and I can't keep you here.- Video 2: Administrator stated, You are handicapped. Aren't you handicapped? Resident B stated, Shame, shame. I haven't done anything to you. Administrator then responded, You're right. You haven't paid your bill, and then stated, You have to pay your bill.- Video 3: Administrator's voice was heard partway through the video clip and stated Resident B needs to exit immediately. When Resident B (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Chalet Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4851 Tincher Rd Indianapolis, IN 46221	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responded to this asking where they should go, Administrator responded, Not my problem, and then stated, Leave my building. I need you to leave.- Video 5: Administrator referred to the resident as handicapped, another individual responded, Unfortunately, yes I am. Resident B stated they had done nothing to the Administrator, Administrator responded saying resident had not paid their bill.- Video 6: Administrator was standing near doorway and tells Resident B they needed to exit the room. Resident B stated they are handicapped and asked where they should go. Administrator responded Resident B needed to leave the room and that they would determine the next steps once resident left the room. Administrator said again the resident is an unpaid customer and cannot remain in the facility. Resident B stated their insurance confirmed the bill would be handled. Administrator stated they are not continuing that discussion.During an interview on 3/5/26 at 2:10 p.m., the RDO, CNO, and Regional Nursing Consultant stated the Administrator's statements and tone qualified for verbal and mental abuse against Resident B.On 3/5/26 at 10:28 a.m., the CNO provided a policy titled Abuse Prevention and Prohibition, dated 12/1/23, and indicated it was the policy currently in use by the facility. A review of the policy indicated that the facility was to .ensure that all residents are free from abuse, neglect, misappropriation of their property, and exploitation. This includes, but is not limited to freedom from.verbal, mental, sexual, or physical abuse.This deficient practice was corrected on 3/2/26 after the facility implemented a systemic plan of correction that included the following actions: all staff were educated on abuse prevention and reporting, with ongoing monitoring and audits.This citation relates to Intakes 2785050 and 2794931.410 IAC (Indiana Administrative Code) 16.2-3.1-27(a)(1)410 IAC (Indiana Administrative Code) 16.2-3.1-27(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an incident of alleged staff to resident verbal and mental abuse was immediately reported to facility management, as indicated by facility policy, for 1 of 3 residents reviewed for reporting resident abuse. (Resident B, Administrator, Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, and Housekeeping Supervisor) Finding includes: On 3/5/26 at 9:00 a.m., facility reportable incident report was reviewed. The report was submitted to the Indiana Department of Health on 2/26/26, a follow-up report was submitted on 2/27/26, and a new update was submitted on 3/4/26. The report indicated that on 2/19/26 the facility Administrator was involved in verbal altercations against Resident B. The report indicated the Administrator's behaviors displayed against Resident B on 2/19/26 .violated the resident's rights and met the definition of abuse. Additionally, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staffing Coordinator, and Housekeeping Supervisor witnessed the Administrator's verbal altercations against Resident B. The identified staff failed to intervene and failed to report the abuse allegation to the facility's compliance hotline. As a result of the facility's investigation, the Administrator was suspended on 2/27/26 at which time the Administrator resigned her position and the other staff members were terminated. During an interview on 3/5/26 at 10:11 a.m., Licensed Practical Nurse (LPN) 3 indicated alleged abuse situations were to be immediately reported to management or to the facility's compliance hotline if it was related to the Administrator. During an interview on 3/5/26 at 10:15 a.m., LPN 4 indicated all alleged abuse was to be immediately reported to management or to the facility's compliance hotline if it was related to the Administrator. During an interview on 3/5/26 at 10:20 a.m., the local Ombudsman indicated Resident B reported on 2/27/26 at 12:05 p.m., that in mid-February, the Administrator was in Resident B's room. The Administrator had spoken to Resident B in a mocking, undignified and intimidating tone, and was disrespectful and unprofessional. Resident B indicated there were multiple staff members who witnessed the Administrator's verbal and mental abuse. The Ombudsman immediately notified the Chief Nursing Officer (CNO) of Resident B's abuse allegation. During an interview on 3/5/26 at 10:30 a.m., the CNO indicated on 2/27/26 at 1:00 p.m., the Ombudsman informed her of the abuse allegations involving the Administrator and Resident B. The CNO immediately interviewed Resident B who reported that on 2/19/26 the Administrator was in Resident B's room. The Administrator spoke with the resident in a mocking, undignified, and intimidating tone, and was disrespectful and unprofessional. Resident B indicated there were multiple staff members, who were in and out of her room, and witnessed the Administrator's verbal and mental abuse. Resident B identified the following staff members who witnessed the alleged verbal abuse: DON, ADON, Staffing Coordinator, and Housekeeping Supervisor. The CNO indicated that the verbal and mental abuse allegation had not been reported to the facility management or to the facility compliance hotline. During an interview on 3/5/26 at 3:10 p.m., the CNO indicated the staff who witnessed the verbal and mental abuse allegation should have immediately reported the allegation to the facility administration or to the facility compliance hotline. The DON, ADON, Staffing Coordinator, and Housekeeping Supervisor were terminated for failure to intervene and failed to report the alleged abuse. On 3/5/26 at 1:13 p.m., the Regional Director of Operations (RDO) provided an undated copy of the Video Evidence Summary and indicated the document was a narrative of Resident B's 2/19/26 phone video recordings that Resident B had provided to the CNO and RDO. A review of the document included, but was not limited to, .When the resident asks where she should go, [Administrator] responds, ?Not my problem.' The document indicated the Administrator's tone was degrading, mocking, and intimidating toward Resident B. On 3/5/26 at 10:28 a.m., the CNO provided a copy of the Abuse and Incident Reporting Policy, dated 4/8/24, and indicated it was the current policy in use by the facility. A review of the document indicated, .The facility will ensure all alleged violations involving mistreatment.verbal abuse may be considered a type of mental (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse.are reported immediately to the administrator or other officials.abuse also includes.verbal abuse.may be considered a type of mental abuse.if staff are aware of or witness any abuse that occurs, it must be reported. This deficient practice was corrected on 3/2/26 after the facility implemented a systemic plan of correction that included the following actions: all staff were educated on abuse prevention and reporting, with ongoing monitoring and audits. This citation relates to Intakes 2785050 and 2794931. 410 IAC (Indiana Administrative Code) 16.2-3.1-28(c)