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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 35099 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 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. 3.1-3(v)(1)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 36746 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 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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45292 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 [DATE] 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 [DATE] 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 [DATE], 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 [DATE] at 11:00 a.m., Resident 29's clinical record was reviewed. Resident 29's diagnoses included, but were not limited to, chronic respiratory failure, congestive heart failure, and type 2 diabetes mellitus. A physician's order, dated [DATE] 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 [DATE], 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 [DATE] 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 [DATE] and with no end date, indicated Resident 281 had an advanced directive, or code status, of DNR. A POST form, prepared [DATE], indicated Resident 281 had selected do not attempt resuscitation/DNR. The form was signed by the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for Resident 281 lacked a section reflecting resident's advanced directive preferences. During an interview on [DATE] at 10:30 a.m., the DON (Director of Nursing) indicated that advanced directive preferences should be included on residents' care plans. On [DATE] 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. 3XXX,d+[DATE](a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38466 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 [DATE] 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 [DATE], included, but was not limited to, Code Status: CPR (cardiopulmonary resuscitation), start date [DATE] with no end date noted. The annual Minimum Data Set (MDS) assessment, dated [DATE], 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 [DATE] and was considered current through [DATE]. On [DATE] 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 [DATE], indicated Resident 7's code status preference was attempt resuscitation/CPR [full code status]. The POST form, signed by Resident 7 on [DATE], 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 [DATE], was changed from DNR to full code status. During an interview on [DATE] 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 [DATE] 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. On [DATE] 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 . 3XXX,d+[DATE](d)(1) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3XXX,d+[DATE](d)(2)(B)