STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00390451. Complaint IN00390451- Unsubstantiated due to lack of evidence. Survey dates: September 23, 26, 27, 28, and 29, 2022 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 6 Medicaid: 66 Other: 14 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 4, 2022	F 0000		
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident			

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

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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	or other residents. Based on observation, interview and record review, the facility failed to ensure adaptive call lights were provided for 1 of 5 residents reviewed (Resident 41). During an observation conducted on 9/23/22 at 2:15 PM, Resident 41 was seated in his wheelchair with bilateral upper extremity contractures observed. Both arms were bent at the elbows completely with arms held tight to the body. Both hands were observed with thumbs pulled in close to the palm of the hand. No splints, braces, or other assistive devices were observed. During an observation on 9/27/22 at 1:58 PM Resident 41 was observed lying in bed with a call light cord lying in his lap. Resident 41 was unable to reach the call light to activate it. A record review conducted at 9:15 AM on 9/23/22 included a Minimum Data Set (MDS) dated 7/10/22. The MDS indicated there were range of motion limitations to upper and lower extremities on both sides of the body. The MDS included a Basic Interview for Mental Status (BIMS) score of 1 out of 15, which indicated he was cognitively impaired and unable to be interviewed. The MDS indicated Resident 41 had diagnoses including Cerebral palsy and major depressive disorder. During an observation conducted on 9/27/22 at 1:50 PM with Certified Nursing Assistant (CNA) 5, passive range of motion exercises were performed with less than 90-degree range of motion of each elbow joint observed. Resident 41 also had visible stiffness and inability to voluntarily grip with his hands.	F 0558	**F- 558 Reasonable Accommodations Needs/Preferences** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Soft touch call light provided for resident 41 **2. How the facility identified other residents:** Any resident that requires an adaptive call light/equipment has the potential to be affected by practice. **3. Measures put into place/ System changes:** Staff educated on components of F558 Reasonable Accommodations Needs/Preferences, including the	10/14/2022

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	During an interview with CNA 5 on 9/27/22 at 1:50 PM, CNA 5 indicated Resident 41 was unable to use his call light. CNA 5 indicated she believed Resident 41 could activate a soft touch call light with his chin. Resident 41 demonstrated he was able to move his head in all directions and touch his chest with his chin when asked. A policy last revised 2/19/21 titled "Call Light" indicated all residents should have a call light available within easy access. 3.1-3(v)(1)		identifying any residents that require adaptive equipment to alert staff of resident needs. Residents in facility audited for adaptive equipment needs, no other residents requiring adaptive call lights identified. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit new resident admissions for need of adaptive equipment to monitor compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	

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F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review the facility failed to ensure residents or family were offered participation in care plan meetings for 5 of 9 residents reviewed. (Residents 17, Resident 18,	F 0657	**F-657 Care Plan timing and Revision** **The facility respectfully requests a desk review for this citation**	10/14/2022

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	Resident 35, Resident 52 and Resident 80). Findings include: 1. Resident 17's record review began on 9/23/22 at1:44 p.m. Diagnoses included diabetes, heart failure, dementia, bipolar disorder, and constipation. During an interviewon 9/23/22 at 3:02 p.m. the resident's spouse indicated she had not been made aware of care plan meetings since the facility changed management last year. A quarterly Minimum Data Set (MDS) assessment dated 7/12/22 indicated the resident had severe cognitive impairment and required extensive staff assistance for personal needs. Progress notes from January 2022 through September 2022 did not indicate the resident or the resident's spouse had been present at a care plan meeting. During an interview on 9/29/22 at 11:57 a.m. the DON indicated she was aware the facility was behind on care plans. She indicated she started at the facility on 7/1/22 and was trying to get caught up. 2. During an interview on 9/29/22 at 9:25 a. m., Resident 18 indicated he had not attended a care plan meeting since he was admitted to the facility about eight months earlier. A record review on 9/26/22 at 4:49 pm indicated the resident's diagnoses included spinal cord injury from a gunshot wound, right hand contracture from a gunshot wound, and		**Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Residents 17, 18, 35 52 and 80 were offered and scheduled a care plan **2. How the facility identified other residents:** All other residents residing in the facility have the potential to be affected by practice. Residents reviewed for any urgent care conference needs and offered accordingly. All other residents will be offered care conference attendance with quarterly MDS assessments. **3. Measures put into place/ System changes:** Department heads educated on components of F657 Care Plan timing and	

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	paraplegia of legs. A quarterly Minimum Data Set (MDS) assessment dated 7/14/22 indicated the resident had no cognitive deficit. The MDS indicated the resident needed extensive assistance with transfers, bed mobility, and personal care. The MDS assessment did not indicate the resident had a traumatic spinal cord injury. Progress notes from 1/4/22 through 9/29/22 did not indicate the resident had been present at a care plan meeting. 3. In an interviewon 9/23/22 at 11:23 a.m. Resident 35 indicated she had not been aware of care plan meetings since her son passed away last year. She indicated prior to her son passing away he was her Power of Attorney (POA) and she needed assistance in getting to care plan meetings. A record review on 9/27/22 at 3:05 p.m. indicated the resident's diagnoses included diabetes, heart failure, rheumatoid arthritis, right leg above the knee amputation, and left leg above the knee amputation. A quarterly MDS assessment dated 8/22/22 indicated the resident had a slight cognitive deficit and required moderate staff assistance for personal needs. The resident's progress notes from January 2022 through 9/2022 did not indicate the resident was present at a care pan meeting. 4. In a phone interview on 9/26/22 at 11:38 AM, Resident 52's brother, his Power of Attorney, indicated he had only been to one care plan meeting and had not been invited to additional care plan meetings.		revision including the required time frames for offering resident care plan. Facility MDS coordinators will .provide team with calendar of quarterly MDS assessments to schedule care plans with resident and responsible party.. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit MDS calendar vs care plan schedule weekly for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	

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	On 9/29/22 at 12:54 PM, Resident 52's record was reviewed. Diagnoses included hypoxic ischemic encephalopathy, dementia with behavior disturbances, generalize anxiety disorder, diabetes type 2 and dysphasia during oropharyngeal phase. The resident's care plan meeting notes indicated Resident 52 had a care plan meeting on 2/16/22 and 3/7/22 with the family. There were no other notes to indicate a care plan meeting had been offered to the residnet or family. Resident 52's quarterly Minimum Data Set (MDS) assessment was completed on 8/11/22. In an interview on 9/28/22 at 11:28 AM, the Director of Nursing indicated no care plan meeting had been scheduled for Resident 52 since 3/7/22. 5. During a family interview conducted on 9/26/22 at 1:58 PM, the family member of Resident 80 indicated the facility had not contacted her to schedule a care plan meeting in a very long time. A record review conducted on 9/16/22 at 2:11 PM indicated the last documented family contact regarding a care plan meeting occurred on 3/18/22. A Minimum Data Set (MDS) dated 9/10/22 indicated Resident 80 had diagnoses including Dementia in other diseases classified elsewhere with behavior disturbance. A Brief Interview for Mental Status (BIMS) score of 8/15 indicated Resident 80 was cognitively impaired and unable to be interviewed. During an interview conducted with the Administrator in Training (AIT), the AIT indicated care plan meetings should be scheduled routinely			

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	with residents, families, and facility staff. The AIT indicated the Social Services Director normally scheduled these meetings. The AIT indicated the Social Services Director was on a leave of absence and the individual covering her work had recently left the company. A policy titled "Care Plan Protocol," undated, was provided by the Administrator in Training (AIT) on 9/29/22 at 1:49 PM. The policy indicated care plans should be scheduled within seven (7) days of completion date (of MDS) and scheduled by the MDS coordinator. The policy also indicated the Social Service/designee should invite the resident and Care Plan representative (family/responsible parties) and document progress notes during the care plan meeting. 3.1-35(d)(2)(B)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan			

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	must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA,			

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	IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on observation, interview, and record review the facility failed to assist in appropriate discharge planning for 1 of 1 resident reviewed. (Resident 18) Findings include: Resident 18's record review began on 9/26/22 at 4:49 p.m. Diagnoses included spinal cord injury from a gunshot wound, right hand contracture from a gunshot wound, and paraplegia of legs. A quarterly Minimum Data Set (MDS) assessment dated 7/14/22 indicated the resident had no cognitive deficit. The MDS indicated the resident needed extensive assistance with transfers, bed mobility, and personal care. The MDS assessment did not indicate the resident had a traumatic spinal cord injury.	F 0660	**F-660 Discharge Planning Process** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	10/14/2022

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	The resident's care plan initiated 1/4/22 did not indicate there was a discharge plan. During an interview with the resident on 9/29/22 at 9:25 a. m. he indicated he was planning to discharge to his own apartment. He indicated the facility staff had not assisted him with planning for discharge. He indicated his Medicaid case manager was waiting on a facility transition plan in order to move forward. The resident indicated the Director of Nursing (DON) and the Administrator had been made aware of this need several times. During an interview with the DON on 9/29/22 at 11:57 a.m. she indicated she was aware of the resident's plan to discharge home. She indicated the facility did not have a social worker and a corporate social worker was to start on 10/1/22, but no plans to move forward with Resident 18's discharge had been made. 3.1-12(a)(18)(19)		**1. Immediate actions taken for those residents identified:** Careplan meeting held for resident 18 to identify discharge preferences and needs. **2. How the facility identified other residents:** All other residents residing in the facility with discharge needs have the potential to be affected by practice. **3. Measures put into place/ System changes:** Department heads educated on components of F660 Discharge planning process and utilization of Discharge planning tool. Discharge planning to be initiated during first scheduled care conference to establish goals and needs. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit MDS care plan schedule and discharge planning tool weekly for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until	

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			100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed ensure pressure ulcer care was provided to promote healing and prevent infection in 1 of 1 resident reviewed (Resident 30). During an interview conducted on 9/23/22 at 3:12 P.M., Resident 30 indicated she received wound care treatment twice daily from nursing staff. During a record review performed on 9/23/22 at	F 0686	**F-686 Treatment svcs to Prevent/Heal Pressure Ulcers** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute**	10/14/2022

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	3:32 P.M,, a Minimum Data Set (MDS) dated 7/7/22 indicated Resident 30 had diagnoses including pressure ulcer of the sacrum, unstageable, spina bifida, and type 2 diabetes mellitus with diabetic neuropathy. A Brief Interview for Mental Status (BIMS) score of 14/16 indicated Resident 30 was cognitively intact and able to be interviewed. An order dated 8/18/22 indicated the wound should be cleansed with normal saline, Silvakollagen gel was to be applied into the wound bed and a long strip of calcium alginate was to be packed into the wound bed. The wound should then be covered with a dry dressing. During a dressing change observation on 9/29/22 at 10:01 AM, Licensed Practical Nurse (LPN) 10 asked the Assistant Director of Nursing (ADON) to cut a piece of calcium alginate from a packaged large square to the appropriate size to fit the wound. The ADON removed a pair of bandage scissors from LPN 10's pocket, opened the package of calcium alginate and moved toward cutting the calcium alginate. The surveyor stopped the procedure and asked the ADON to not continue until the scissors were disinfected. During the time of the procedure, LPN 10 asked if they could use the wound cleanser to clean the scissors. LPN 10 indicated she was unsure of the facility policy. A policy dated 1/9/18 titled Dressing Change-(clean/non-sterile) indicated necessary supplies should be placed on the overbed table after it had been disinfected and/or a protective barrier is placed on the table. The policy also indicated scissors should be sanitized.		**an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Wound care performed following policy and procedure on resident 30. ADON and LPN 10 immediately educated on properly preparation for aseptic wound care procedure **2. How the facility identified other residents:** All other residents with wound care treatment orders have the potential to be affected by practice. **3. Measures put into place/ System changes:** ADON and LPN 10 and nursing staff provided education on wound care procedure including disinfection of equipment and utilizing a clean work space to prepare dressing change supplies	

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	3.1-40(2)		**4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will observe one wound dressing change weekly for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, and record review, the facility failed to ensure range of motion was maintained in 1 of 2 residents reviewed (Resident 41). During an observation conducted on 9/23/22 at 2:15 PM, Resident 41 was seated in his wheelchair with bilateral upper extremity contractures observed. Both arms were bent at the elbows completely with arms held tight to the body. Both hands were observed with thumbs pulled in close to the palm of the hand. No splints, braces, or other assistive devices were observed. During an observation conducted on 9/26/22 at 9:13 AM, Resident 41 was observed lying in bed with no splints, braces or other assistive devices observed. During an observation conducted on 9/27/22 at 1:58 PM, Resident 41 was observed lying in bed. Certified Nursing Assistant (CNA) 5 partially extended Resident 41's elbow joint, revealing less than 90 degrees of range of motion. The skin on the antecubital space (inner aspect of the elbow) was darker in color than the rest of the resident's skin with a darkened crease observed. A record review conducted at 9:15 AM on 9/23/22 included a Minimum Data Set (MDS) dated 7/10/22. The MDS indicated there were range of motion limitations to upper and lower extremities on both sides of the body. The MDS included a Basic Interview for Mental Status (BIMS) score of	F 0688	**F-688 Increase/Prevent Decrease in ROM/Mobility** **The facility respectfully requests a desk review for this citationPreparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified:** Referral/ consult made to therapy to determine if resident appropriate for splint/brace for contracture management. Careplan and orders updated to reflect recommendations for resident 41. **2. How the facility identified other residents:** All other residents with limited mobility range of motion have potential to be affected by practice. Audit conducted to	10/14/2022

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	1 out of 15, which indicated the resident was cognitively impaired and unable to be interviewed. The MDS indicated Resident 46 had diagnoses including cerebral palsy and major depressive disorder. No therapy evaluations for splints, braces or assistive devices were availabe for review in the medical record. No restorative programs were available ofr review in the medical record. Documentation of range of motion exercises was not found in the medical record. A care plan dated 1/19/22 indicated staff should maintain good body alignment to prevent contractures and braces and splints should be used as ordered. The care plan indicated Occupational Therapy (OT) should monitor, document, and treat as needed. The care plan indicated caregivers should be encouraged to use and correctly apply all splints and braces. A current policy, dated 11/17/21, titled Contracture Management indicated the facility should provide rehabilitation screens, restorative services, appropriate equipment, and assistance as needed. The policy indicated range of motion exercises were the most common treatment. 3.1-42(a)(2)		identify residents with contractures. **3. Measures put into place/ System changes:** Staff educated on ROM Orders and care plans updated as indicated for residents identified with contractures and/or limited range of motion. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will observe audit 5 residents for completion of range of motion. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure oxygen tubing and supplies were maintained for 1 of 1 resident reviewed (Resident 86). During an observation on 9/23/22 at 2:01 PM, a nasal cannula, tubing used to deliver oxygen through the nostrils, used by Resident 86 was not dated. A humidifier bottle was attached the oxygen concentrator, a machine used to produce oxygen, was not dated. During an observation on 9/26/22 at 12:09 PM, Resident's 's oxygen tubing remained undated, and a small amount water remained in the humidifier bottle. The oxygen concentrator was on, set at 3 liters per minute. The tubing and nasal cannula were lying on the floor underneath Resident 86's wheelchair where she was seated. Resident 86 had a nasal cannula in place attached to a portable tank set to 3 liters per minute. The nasal cannula had a partial piece of clear tape with no visible date written on it. During an interview on 9/26/22 at 12:09 PM, LPN (Licensed Practical Nurse) 11 indicated tubing should be replaced weekly and dated. LPN 11 also indicated tubing that was not in use should be secured in a dated plastic bag which should also be changed weekly. A record review conducted on 9/26/22 at 12:25 PM, indicated Resident 86 had diagnoses including chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with	F 0695	**F-695 Respiratory/ Tracheostomy Care and Suctioning** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Oxygen tubing and humidification bottle were replaced with respiratory storage bag and dated for resident 86 **2. How the facility identified other residents:** All other residents requiring oxygen therapy	10/14/2022

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	hypoxia. Oxygen was ordered to be administered at 3 liters per minute by nasal cannula. A current policy, undated, titled Policy for Oxygen Concentrator indicated oxygen tubing should be dated and changed weekly and humidifier bottles should be changed weekly or as needed. 3.1-47(a)(6)		have the potential to be affected by practice. Audit conducted on all residents receiving oxygen therapy, tubing and humidifiers changed and dated as indicated. **3. Measures put into place/ System changes:** Staff educated oxygen tubing maintenance, tubing and humidification change and dating requirement. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit 5 residents receiving oxygen therapy for appropriate storage/ dating of tubing and humidification. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services,			

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	consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure pre and post dialysis assessment documentation was available for 1 of 4 residents reviewed. (Resident 29). Findings include: On 9/23/22 at 12:03 PM, a facility matrix, provided by the Administrator in Training (AIT), indicated Resident 29 received hemodialysis. In an interview on 9/27/22 at 9:07 AM, Resident 29 indicated he received dialysis at the facility five days each week. On 9/27/22 at 12:31 PM, Resident 29's record was reviewed. The resident's diagnoses included hemiplegia and hemiparesis due to a cerebral infarction that effected the left non-dominant side, end stage renal disease, diabetes mellitus type 2, and morbidity. Resident 29's comprehensive Minimum Data Set (MDS) assessment, dated 7/19/22, was reviewed. The MDS indicated his Brief Interview for Mental Status (BIMS) score was 15, he was alert, oriented and interviewable. He had an active diagnosis of renal insufficiency, renal failure, or end-stage renal disease (ESRD) which required dialysis. An order, dated 6/30/22, indicated the resident received dialysis treatments Monday through Friday daily. A review of Resident's 29's pre and post Dialysis Hand off Communication Report indicated the	F 0698	**F-698** **Dialysis** **The facility respectfully requests a desk review for this citationPreparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified:** Communication binders updated for resident 29. **2. How the facility identified other residents:** All other residents receiving dialysis have the potential to be affected by practice. Resident in facility requiring dialysis audited for completion of assessments. Communication binders updated for all dialysis residents. **3. Measures put into place/ System changes:** Nursing staff educated on requirements of pre	10/14/2022

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	following: 9/27/99 Only the post assessment was completed. 9/26/22 Only the post assessment was completed. 9/23/22 Only the post assessment was completed. 9/19/22 Only the pre assessment was completed. 9/16/22 Only the pre assessment was completed. 9/15/22 Only the pre assessment was completed. 9/13/22 No pre or post assessment was completed. 9/12/22 Only the pre assessment was completed. 9/9/22 No pre or post assessment was completed. In an interview on 9/29/22 at 1:40 PM, the Assistant Director of Nursing indicated the pre and post Dialysis Hand Off Communication Report between the facility and the in-house dialysis provider should have been completed but were not on all days he received hemodialysis. On 9/29/22 at 2:45 PM, a guideline titled " Most Common Complications of a Vascular Access," undated, provided by the AIT, indicated post dialysis assessment included documentation of vital signs after dialysis. The guidelines indicated the fistula site would be assessed for presence/absences of bruit/thrill and catheter site assessed for drainage and dressing condition every shift. On 9/29/22 at 1:48 PM, a guideline titled "Dialysis Monitoring," revision 2/19/21, provided by the Administrator in Training, indicated to listen for a bruit/thrill of fistula and document on the medical administration record every shift. No policy was provided for communication between facility and in-house hemodialysis company. 3.1-37(a)		and post assessment completion requirements for all dialysis residents. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit 5 residents weekly who are receiving dialysis treatment for completion of pre and post dialysis assessments. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	

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F 0742 SS=D Bldg. 00	483.40(b)(1) Treatment/Srvcs Mental/Psychoscial Concerns §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; Based on observation, interview and record review the facility failed to provide services for 1 of 1 resident reviewed who was paralyzed after a traumatic incident. (Resident 18). Findings include: During an interview on 9/26/22 at 1:42 pm Resident 18 indicated he had social service needs related to nightmares, counseling, panic and physical symptoms related to being shot. He indicated there was not a social service director employed at the facility to assist him with his needs. A record review on 9/26/22 at 4:49 pm indicated the resident's diagnoses included a spinal cord injury from a gunshot wound, right hand contracture from a gunshot wound, and paraplegia of legs. A quarterly Minimum Data Set (MDS) assessment dated 7/14/22 indicated the resident had no cognitive deficit. The MDS indicated the resident needed extensive assistance with transfers, bed	F 0742	**F-742 Treatment /srvs/ Mental/ Psychosocial Concerns** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	10/14/2022

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	mobility, and personal care. The MDS assessment did not indicate the resident had a traumatic spinal cord injury. The resident's care plan initiated 1/4/22 indicated the resident exhibited behaviors of anger and aggression, but did not address his nightmares or physical symptoms. During an interview on 9/29/22 at 9:27 a.m. the resident indicated he had nightmares about the shooting that left him paralyzed from the waist down. He indicated he would wake up covered in sweat with his heart beating out of his chest and pulling his trigger finger as if he was reliving the shooting. He indicated the incident was traumatic. He indicated he was usually irritable and in a bad mood after waking with nightmares related to the shooting. He indicated he also felt traumatized after nearly dying in May 2022. He indicated he was in the hospital for a week, was diagnosed with sepsis, and had to have a blood transfusion after receiving urethral damage during a urinary catheter change at the facility. He indicated the hospitalization in May 2022 reminded him of his hospitalization after he had been shot. He indicated he had never been offered counseling services or been able to resolve his guilt over taking another life. During an interview on 9/28/22 at 10:59 the Director of Nursing (DON) indicated the resident should have been assessed for trauma upon admission. She indicated the facility did not have a social service director on staff. She indicated a corporate social service director was scheduled to start on 10/1/22. A current Facility Assessment Tool dated 8/1/22 provided by the Administrator on 9/29/22 at 2:15		1. **What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 18 care plan updated to include resident history of Post Traumatic Stress Disorder. Resident offered Greenhouse services for talk therapy. **2. How will other residents having the potential to be affected by the same deficient practice be identified and what will corrective action be.** Audits conducted of residents that have diagnosis of PTSD. Care plans updated as indicated. Any other residents with PTSD have the potential to be affected. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Residents will be identified upon admission and reviewed during clinical meeting for diagnosis Post Traumatic Stress Disorder. Resident with psychosocial concerns/ diagnosis will be referred to and followed by appropriate psychiatric service providers as indicated. Nursing staff educated on appropriate care and of residents with PTSD diagnosis, trauma informed care.	

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	pm indicated the facility was equipped to provide care for residents with trauma and or PTSD. The Centers for Disease Control and Prevention (CDC) define a traumatic event as a serious injury or a threat of serious injury or death. Symptoms of trauma related stress and post traumatic disorder (PTSD) can include but are not limited to fear, grief, depression, guilt, irritability, anger and reliving traumatic events through dreams and flashbacks (CDC, 2022). 3.1-43(a)(1)		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** The responsible party for this plan of correction will be the Director of Nursing/designee. Audits will be conducted weekly of orders/ careplans and diagnosis for new admissions/ current residents for PTSD or other psychosocial diagnosis concerns will receive appropriate referrals and services as indicated. Audits to be reviewed in Quality assurance meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance : 10-14-22	
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review the facility failed to monitor for side effects of opioid medications for 4 of 6 residents reviewed. (Residents 18, Resident 29, Resident 45, and Resident 191) Findings include: 1. During an interview on 9/26/22 at 1:42 p.m., Resident 18 indicated he had pain from back spasms. He indicated he was treated for pain with a muscle relaxer and hydrocodone. A record review on 9/26/22 at 4:49 pm indicated the resident's diagnoses included a spinal cord injury from a gunshot wound, right hand contracture from a gunshot wound, constipation and paraplegia of legs. A quarterly Minimum Data Set (MDS) assessment dated 7/14/22 indicated the resident had no cognitive deficit. The MDS indicated the resident needed extensive assistance with transfers, bed mobility, and personal care. The MDS assessment	F 0757	**F-757 Drug Regimen is Free from Unnecessary Drugs** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:**	10/14/2022

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	155249	A. BUILDING 00 B. WING	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

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	did not indicate the resident had a traumatic spinal cord injury. A physician order dated 2/15/22 indicated the resident was to be administered hydrocodone 4 times a day for pain. The physician orders did not indicate the resident was to be monitored for side effects of hydrocodone. The resident's medication administration record (MAR) dated July and August 2022 indicated the resident received hydrocodone 4 times a day for pain. 2. During an interview on 9/26/22 at 11:18 a.m., Resident 45 indicated he is administered hydrocodone for pain. He indicated he had constipation on Friday 9/22/22 and then had loose stools after taking medications to relieve constipation. A record review on 9/27/22 at 12:31 p.m. indicated the resident had diagnoses including but not limited to diabetes, coronary artery disease, chronic kidney disease, and constipation. A physician order dated 9/20/22 indicated the resident was to be administered hydrocodone every 6 hours as needed for pain. Physician's orders did not indicate the resident was to be monitored for side effects of opioid pain medication. A progress note dated 9/27/22 at 12:31 p.m. indicated the resident refused to go to dialysis due to discomfort related to constipation. 3. Resident 191's record review began on 9/27/22 at 2:54 p.m. The review indicated the resident had		Opiod medication monitoring orders entered for residents 18, 29, 45, 191 **2. How the facility identified other residents:** All other residents residing in the facility that are prescribed opioid medications have the potential to be affected by practice. Audits of residents prescribed opioid medications reviewed for side effect monitoring orders. Orders for monitoring updated as indicated. **3. Measures put into place/ System changes:** Nursing staff educated on components of F757 including the need for medication side effect monitoring for opioid medications upon admission and or medication changes. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit orders during clinical meeting for opioid medication orders. 5 times for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends	

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	diagnoses of heart failure, diabetes, anxiety, chronic kidney disease, and diverticulitis. A comprehensive MDS assessment dated 8/28/22 indicated the resident had mild cognitive deficit and required extensive assistance for mobility and personal care. A physician order dated 9/5/22 indicated the resident was to be administered hydrocodone every 6 hours for pain. Physician's orders did not indicate the resident was to be monitored for side effects of opioid pain medication. The resident's MAR dated September 2022 indicated the resident received hydrocodone 4 times a day starting 9/6/22. During an interview on 9/28/22 at 10:59 A.M., the Director of Nursing (DON) indicated the residents should have been assessed for side effects of hydrocodone such as constipation and sedation. She indicated she was not sure as to why the residents were not being monitored for side effects. The Centers for Disease Control and Prevention (CDC) indicates residents who receive opioid medications should be monitored for side effects including but not limited to constipation and sedation. (CDC, 2018). Reference Centers for Disease Control and Prevention (2018). CDC.gov/opioids/basics/prescribed.html#side-effect4. On 9/27/22 at 12:31 PM, Resident 29's record was reviewed. There was no order to monitor the side effects of tramadol HCl Tablet 50mg tablet (an		or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10-14-2022**	

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	opioid) given twice a day for osteoarthritis. The resident's diagnoses included hemiplegia and hemiparesis on the left non-dominant side, end stage renal disease, diabetes mellitus type 2, morbidity, anxiety disorder, recurrent major depressive disorder, insomnia and osteoarthritis. Resident 29's comprehensive Minimum Data Set (MDS) assessment, dated 7/19/22, was reviewed. The MDS indicated his Brief Interview for Mental Status (BIMS) score was 15, he was alert, oriented and could understand and be understood. A review of the resident's current care plan, last reviewed 8/8/22, indicated he was to be medicated as ordered, monitored for effectiveness and the medical doctor or nurse practitioner were to be notified as needed. A review of Resident 29's medication administration record (MAR) dated 9/1/22 to 9/28/22 indicated the resident's anticoagulation, sedative/hypnotic, and antidepressant medications were monitored for side effects. The resident's medication, tramadol HCl Tablet 50mg tablet (an opioid), given twice a day for osteoarthritis was not monitored for side effects. On 9/29/22 at 2:21 PM, a current policy titled "Medication Monitoring Medication Management Section 8.4 Medication Management," copyright 2007 by PharMerica Corp, provided by the Director of Nursing, addressed antipsychotics, sedative/hypnotics, and psychopharmacological side effect monitoring. No policy was received to address the monitoring of opioid side effects by the survey exit. 3.1-48(a)(1)-(6)			

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure residents' medications were properly labeled, dated, and not utlized after expiration for 6 of 31 residents reviewed. (Resident 2, Resident 3, Resident 11, Resident 30, Resident 41, and Resident 50). Findings include: 1. An observation on 9/28/22 at 10:25 PM of	F 0761	**F-761 Label/Store Drugs and Biologicals** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions**	10/14/2022

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	Resident 2's guaifenesin liquid 100mg/5mg indicated the medication expired 8/20/21. On 9/28/22 at 11:37 AM, Resident 2's record was reviewed. Diagnoses included dementia, senile degeneration of brain, diabetes mellitus type 2, and dysphagia. 2. An observation, on 9/27/22 at 10:20 AM, of Resident 3's polyethylene glycol 3350 powder indicated no open date. On 9/28/22 at 11:38 AM, Resident 3's record was reviewed, Diagnoses included Parkinson's disease, schizoaffective disorder of bipolar type, anxiety disorder, morbidity, chronic pain and constipation. 3. An observation on 9/27/22 at 10:21 AM of Resident 11's polyethylene glycol 3350 powder indicated no open date. On 9/28/22 at 11:39 AM, Resident 11's record was reviewed. Diagnoses included dementia, anorexia, depressive disorder, unsteadiness on feet, pain in knees, hypothyroidism, and constipation. 4. An observation on 9/28/22 at 10:29 AM of Resident 30's nicotine patch indicated it was expired and there was no current order for a nicotine patch. On 9/28/22 at 11:40 AM, Resident 30's record was reviewed. Diagnoses included spina bifida, schizoaffective disorder of bipolar type, anxiety, acquired left below the knee amputation, unstageable sacral pressure ulcer, and constipation. 5. An observation on 9/27/22 at 10:32 AM of		**set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** All expired medications removed for residents for resident 2, 30,41. Medications clearly labeled including for residents 3,11, 50. **2. How the facility identified other residents:** Any resident prescribed medications administered by nursing staff have the potential to have be affected. All medications carts audited for expired medications and medications without appropriate labeling. Medications removed or labeled as indicated. **3. Measures put into place/ System changes:** Nursing staff educated on components of F 761 Label/Store Drugs and Biologicals, including removal/ disposal of expired medications and appropriately dating and labeling of medications. **4. How the corrective actions**	

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	Resident 41's ferrous sulfate solution had expired 10/12/21. On 9/28/22 at 11:40 AM, Resident 41's record was reviewed. Diagnoses included cerebral palsy, hypothyroidism, nutritional deficiency, and iron deficiency anemia. 6. An observation on 9/27/22 at 10:15 AM of Resident 50's prostat liquid label was unreadable. On 9/28/22 at 11:41 AM, Resident 50's record was reviewed. Diagnoses included respiratory failure, chronic obstructive pulmonary disease, diabetes mellitus with diabetic neuropathy, hypothyroidism, heart failure, and obesity. In an interview on 9/27/22 at 10:20 AM, QMA 9 indicated multi-dose medications should be dated with the date opened. On 9/28/22 at 11:37 AM, a current policy titled "Medication Storage, Labeling and Expiration Dates," dated 6/10/21, provided by the Administrator, indicated the following: medications and biologicals were not to be retained longer than recommended by the manufacturer or supplier guidelines, the facility was to record the date open on the medication container, and the facility was to destroy and reorder medications and biologicals with soiled, illegible, worn, or damaged labels. On 9/29/222 at 2:21 AM, a current policy titled "Medication Monitoring Medical Management Section 8.4 Medication Management," copyright 2007 PharMerica Corp, provided by the Director of Nursing, indicated residents were to receive medications only if ordered by the prescriber.		**will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee who will audit medication carts for expired medications and proper legible labeling of medications for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** **10/14/22**	

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	3.1-25(j)(m)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, that facility failed to ensure an environment free of hazards in the dining area with potential to effect 22 residents. During an observation on 9/23/22 at 12:15 PM a cordless drill and open toolbox filled with hand tools were observed on a table in the main dining room. Resident 72 was seated at the table and the drill was within his reach. The table was positioned near a fire exit which was observed to be blocked by a ladder. 22 residents were present in the dining room. On 9/23/22 at 12:23 PM Maintenance 6 returned to the area and was interviewed. Maintenance 6 indicated tools should not be left unattended within the reach of residents and ladders should not be left blocking exit doors. During a record review conducted on 9/26/22 at 9:58 AM, a Minimum Data Set (MDS) dated 9/2/22, indicated Resident 72 had diagnoses including depression and non-Alzheimer's dementia. A Brief Interview for Mental Status (BIMS) was scored 8/15, which indicated Resident 72 was cognitively impaired. During an observation on 9/23/22 at 11:40 AM, the door of room 116 was observed to have a section of paint about 12 x 18 inches scraped off	F 0921	**F-921** **Safe/Functional/Sanitary/ Comfortable Environment** **The facility respectfully requests a desk review for this citationPreparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Tool box, drill and ladder removed from dining area away from 22 residents including resident 72. Maintenance work order placed paint issues on doors of rooms 116 and 227. **2. How the facility identified other residents:** All residents that receive meals in the dining room have the potential to be affected by practice. **3. Measures put**	10/14/2022

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	in the lower middle of the door. Edges of the scraped area were jagged and irregular. During an observation on 9/24/22 at 10:59, the door of room 227 was observed to have several rounded scrape marks of chipped paint with jagged edges spanning most of the width of the door. During an interview conducted on 9/28/22 at 11:35 AM, the Administrator indicated Maintenance 6 was no longer employed at the facility and he had no current maintenance staff. He indicated a maintenance assistant typically performed the task of paint repairs and the position had been vacant for about 6 weeks. Policies regarding tool storage, clear pathways to fire exits and paint repairs were requested from the Administrator. No policies were received at the time of exit. 3.1-19(f)		**into place/ System changes:** Maintenance and other staff educated on components of F 921 Safe/Functional/Sanitary/Comfortable Environment, including securing tools away from resident reach, and fixing, reporting and maintaining painted areas of facility **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Administrator/designee who will audit facility for unsecured tools, items in line of egress and chipped paint for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 10/14/22**	