STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING -- B. WING	01/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 11/10/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/03/23 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this PSR survey, Chateau Rehabilitation & Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 99 and had a census of 83 at the time of this survey. Quality Review completed on 01/09/23	E 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility requests paper compliance for this citation.	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/10/22 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 01/03/23 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this PSR survey, Chateau Rehabilitation &	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility requests paper compliance for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Goran Prentoski	RDO	01/17/2023

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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	155249	A. BUILDING 01 B. WING	01/03/2023

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	Health Care 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 with a walk up mechanical room was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility is fully protected by a Type II EES 350 kW Diesel poewed generator. The facility has a capacity of 99 and had a census of 83 at the time of this survey. All areas providing customary access to the residents were sprinklered. The facility had a detached garage and three sheds providing facility services including storage of old equipment, new beds, mattresses and maintenance supplies that were not sprinklered. Quality Review completed on 01/09/23			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and			

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	* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director on 01/03/23 at 12:20 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were not self-closing due to the springs to close the doors were disconnected. Based on interview at the time of observation, the Maintenance Director stated the attic hatch smoke doors are kept closed but the self-closing devices (the springs) were not working properly and would need to be changed. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. This deficiency was cited on 11/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)	K 0223	Deficiency ID: K _ 0223 Completion Date: 1/18/2023 12:00:00 AM Plan of Correction Text: K223 Doors with Self-Closing Devices The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: All residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/	01/18/2023

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			System changes: Maintenance Director has replaced the springs to the three attic hatch smoke doors to allow for self-closing 4)How the corrective actions will be monitored: The Maintenance Director/designee will audit the three attic hatch smoke doors for proper mechanism and closing weekly. Maintenance Director/designee will present the audit monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 1/18/2023	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in			

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	smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview; the facility failed to ensure 2 of 3 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect 25 residents in therapy and the activities room Findings include: Based on records review with the Maintenance Director on 01/03/23 at 12:15 p.m., no current documentation of a semiannual kitchen exhaust system inspection for the cooktops with a fire-extinguishing system in the therapy gym and activities room was available for review. Based on interview at the time of record review, the Maintenance Director stated the two fire-extinguishing system have not been inspected	K 0324	Deficiency ID: K _ 0324 Completion Date: 1/18/2023 12:00:00 AM Plan of Correction Text: K324: Cooking Facilities The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff, and residents that	01/18/2023

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	and a contractor is scheduled to perform the inspection in January 2023. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. This deficiency was cited on 11/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Semi-Annual Inspection of cooktops with a fire extinguishing system in the Physical Therapy and Activities have been completed 4)How the corrective actions will be monitored: The Maintenance Director/designee will monitor all inspections moving forward. Maintenance Director/designee will bring current and future inspections to Quality Assurance Meeting monthly for 6 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: 1/18/2023	
K 0761 SS=F Bldg. 01	Based on records review and interview, the facility failed to ensure 10 of 10 smoke barrier door assemblies are routinely inspected and repaired as part of the facility maintenance program. Also, the facility failed to ensure annual inspection and testing of 3 of 3 fire door assemblies and 2 of 2 oxygen room fire doors met the requirements of NFPA 80. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection	K 0761	Deficiency ID: K _ 0761 Completion Date: 1/18/2023 12:00:00 AM Plan of Correction Text: K761-Maintencance, Inspection & Testing-Door The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.	01/18/2023

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	by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 01/03/23 at 12:20 p.m., the following smoke/fire doors were not inspected: A.) Annual inspections: no documentation of an		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: All residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: A- Annual inspection and testing of 3 Fire Doors and 2 Oxygen Room Doors has been completed and up to date B-Routine inspection on 6 Corridor Smoke Doors, Attic Smoke Door in upper Mechanical Room and the 3 Attic Smoke Door Hatches in the upper Mechanical Room have been completed and are up to date 4) How the corrective actions will be monitored: The Maintenance Director/designee will monitor all inspections moving forward. Maintenance Director/designee	

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	annual inspection for the three fire door assemblies and the two O2 room fire doors were available for review. B.) Routine inspections: no documentation was available for review of a routine inspection for the six corridor smoke door assemblies, the attic smoke door in upper mechanical room, and the three attic smoke door hatches in upper mechanical room. Based on interview at the time of records review, the Maintenance Director stated the fire doors were inspected on the annual fire alarm inspection, but the inspection was for the hold open devices and not a NFPA 80 door inspection. The Maintenance Director did agree a door inspection based off NFPA 80 was not conducted. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. This deficiency was cited on 11/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		will bring current and future inspections to Quality Assurance Meeting monthly for 6 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: 1/18/2023	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in			

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	the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 4 of 4 flexible extension cords and power strips were installed properly, used in a safe manor, and met the required UL rating of 1363A or 60601-1 in patient care locations in accordance with NFPA 99. This deficient practice can affect 8 residents. Findings include: Based on observations with the. Maintenance Director on 01/03/23 between 12:20 p.m. and 12:30 p.m., the following rooms had extension cords or improper use of power-strips: A.) An extension cord was in use in resident room 211. B.) Power-strips in rooms 134, 216 and 211 were in use within 6 feet of a resident care area that did not meet UL 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director, acknowledged power-strips and extension cords were misused in the facility.	K 0920	Deficiency ID: K _ 0920 Completion Date: 1/18/2023 12:00:00 AM Plan of Correction Text: K920 Electrical Equipment-Power Cords and Extension Cords The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for	01/19/2023

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	The finding was reviewed with the Maintenance Director and Administrator during the exit conference. This deficiency was cited on 11/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: All residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: Maintenance Director/Designee has removed or corrected the power cords/extension cords listed as follows: A. Extension cord in Resident Room 211 was removed. B. Power strips noted in resident rooms 134, 216 and 211 were removed. 4)How the corrective actions will be monitored: The Maintenance Director/designee will complete a documented visual inspection of 5 random offices or resident rooms weekly to ensure no extension cords or unapproved power strips are present. Maintenance Director/designee will present the audit monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and	

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			make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 1/18/2023	