DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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	05/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 the Investigation of Complaints IN00378375, IN00380520, and IN00380768. Complaint IN00378375 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00380520 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F609, and F610. Complaint IN00380768 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 20 and 23, 2022 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 5 Medicaid: 69 Other: 19 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 26, 2022	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and			

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 determined that other safegaurds 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.

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	Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed (Resident D. Findings include: On 5/20/22 at 12:25 P.M., Resident D's record was reviewed. Diagnoses included, but were not limited to, recurrent enterocolitis (inflammation of gastrointestinal tract), end stage renal disease with dialysis, and diabetes. On 5/20/22 at 10:56 A.M., Resident D, identified by the facility as interviewable, was interviewed about an incident on 5/16/22. Resident D indicated CNA 3 (Certified Nurse Assistant) and CNA 5 came to his room to help him get up in the morning around 5:00 a.m. He had a soiled brief and needed to be changed. CNA 3 indicated he didn't need changed before getting up. Resident D repeated himself and CNA 3 argued with him for several minutes, finally turned him over and checked his brief. CNA 3 agreed he needed changed, undid the tabs on his brief and began wiping his bottom roughly. He	F 0600	**F-600D Free from Abuse, Neglect and Exploitation** **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:**	06/09/2022

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	yelled out in pain and told the CNA that he was sore down there due to frequent diarrhea. CNA 3 continued to wipe him roughly and "kept digging and digging" at his rectum. He then felt a cold spray on his bottom followed by the smell of Febreeze air freshener. He asked CNA 3 if she had sprayed the air freshener on his bottom and she replied she had because he "stunk" and "smelled like s--t". As the 2 CNA's turned him over onto his back, CNA 3 sprayed the air freshener on his bare chest all the way down to his feet. He yelled at CNA 3, asked her why she had done that. She replied for him to "shut up", repeated he stunk and smelled like s--t. Resident D then told the CNA's they needed to get his weight before dialysis using the hoyer lift. CNA 3 indicated he didn't need a weight done. CNA 2 indicated to the other CNA to just get his weight. CNA 3 continued to argue with the resident as she tried to figure out how to get the weight from the lift. He told her how to do it which angered her further and she kept telling him to shut up. After the weight was gotten, he asked CNA 3 what his weight was and she refused to tell him. He indicated he went to dialysis as planned but thought about what the CNA had said, done to him, he was upset and felt it needed to be reported. He called the Administrator on his phone and told him what had occurred. The Administrator assured him the incident would be investigated. The Administrator indicated CNA 3 was an agency staff member and he would not allow her to come back to work in the facility. Resident D indicated that same evening, around 7:00 p.m., CNA 3 was back to work a 12 hour shift on his hallway. A review of the nursing schedule for resident D's area indicated CNA 3 was scheduled to work on 5/16/22 from 7 PM to 7 AM		Residents D identified to have been involved in verbal altercation were identified to not having been adversely affected. Social services will follow residents for psychosocial issues. Allegation was reported to ISDH . Physician and families/or responsible parties were notified. **2. How the facility identified other residents:** Any resident had the potential to have been affected however none were identified. Interviews were conducted with residents and no resident reported feeling fearful and stated they felt safe in facility. No new allegations were reported. **3. Measures put into place/ System changes:** Facility staff educated on components of F 600 Abuse, Neglect, and Exploitation. Special focus was placed on immediate intervention to prevent abuse, and internal reporting of abuse to the administrator. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive Director/designee who will interview three residents weekly related to abuse (post daily 6 week audits) Three facility staff will be interviewed weekly(post daily audits for 6 weeks)to include all shifts to determine	

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	On 5/20/22 at 12:39 P.M., the Administrator was interviewed and indicated an investigation had been started of the incident and it had been reported to the Indiana Department of Health. He provided a current copy of the facility policy, titled "Abuse, Neglect, and Misappropriation of Resident Property" which stated "Residents had the right to be free from verbal, sexual, physical, and mental abuse...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident...." This Federal tag relates to Complaint IN00380520. 3.1-27(a)(b)		understanding of abuse reporting guidelines. Identified areas of concern will be immediately reported per guidelines and additional education provided as required. All staff will be educated on abuse upon hire, annually and as needed. Abuse audits will be reviewed during scheduled morning meetings and monthly during Quality Assurance. Audits will continue daily for 6 weeks to determine compliance then decrease to three residents and three staff weekly to include all shifts 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 6-9-22**	
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious			

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	bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, facility staff failed to report timely an allegation of staff to resident abuse for 1 of 1 residents reviewed (Resident D). Findings include: On 5/20/22 at 12:25 P.M., Resident D's record was reviewed. Diagnoses included, but were not limited to, recurrent enterocolitis (inflammation of gastrointestinal tract), end stage renal disease with dialysis, and diabetes. On 5/20/22 at 10:56 A.M., Resident D, identified by the facility as interviewable, was interviewed about an incident that occurred on 5/16/22. The resident alleged a CNA had sprayed Febreeze air freshener on his bare bottom, chest and legs, and had argued and cursed at him. There had been 2 CNA's present during the incident with one of the CNA's being the perpetrator. He called the Administrator on his phone and told	F 0609	**F-609 D Reporting Alleged Violations** **The facility respectively 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.**	06/09/2022

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	him what had occurred. The Administrator assured him the incident would be investigated. The Administrator indicated CNA 3 was an agency staff member and he would not allow her to come back to work in the facility. On 5/20/22 at 12:39 P.M., the Administrator was interviewed and indicated the incident had been reported to the Indiana Department of Health on 5/17/22 after he fully understood the circumstances surrounding the incident and staff members involved. On 5/20/22 at 2:10 P.M., QMA 7 was interviewed. He indicated he had worked a double shift on 5/16/22, from 5:30 a.m. to 10:30 p.m. but hadn't been on Resident D's hall until the afternoon shift. He'd heard other staff talking about an incident during the day and Resident D told him about it in the evening. On 5/23/22 at 10:47 A.M., CNA 5 was interviewed. She indicated she had been the other CNA with CNA 3 when getting Resident D up for dialysis and was a witness to the incident. She indicated she hadn't known what to do and had never seen an aide speak with a resident like that. After the resident was placed in his wheelchair and taken to dialysis, CNA 5 went to the employee breakroom where she shared with coworkers what she had just witnessed. She indicated one of the nurses had been in the breakroom and she had told her a little bit of the story but hadn't been told to report it to anyone else. When asked if she thought Resident D had been abused, she indicated she believed that to be true. On 5/23/22 at 2:30 P.M., the Assistant Director of Nursing (ADON) was interviewed. An Indiana		**1. Immediate actions taken for those residents identified:** Resident D allegation was reported to ISDH related to 5/16/22 event. Residents D was interviewed per Social Service Director to determine that resident felt safe and secure within the facility and no psychosocial issues remained. Residents was assessed, and care plans reviewed and updated as required. Allegations will be reported immediately to ISDH per requirements. Physician and families/or responsible parties were notified. **2. How the facility identified other residents:** No other resident identified to have been affected related to the 5/16/22 incident which occurred with CNA 3 Audit was conducted of facility residents to determine if any allegations were outstanding. No further allegations noted **3. Measures put into place/ System changes:** Facility staff educated on components of F609 Reporting Alleged Violations. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive Director and the Director of Nursing who will interview three residents (ED) and staff (DON)weekly related to abuse.	

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	incident report, dated 5/17/22 at 3:45 p.m., indicated the incident had been reported to her. She indicated she had been notified, on 5/17/22 by the visiting Nurse Practitioner (NP), that this incident had occurred. Staff had not reported the incident to her and she hadn't been aware of it prior to notification by the NP. Staff were to immediately report allegations of abuse to the Administrator, Director of Nursing, and/or ADON. On 5/20/22 at 12:39 P.M., the Administrator provided a current copy of the facility policy, titled "Abuse, Neglect, and Misappropriation of Resident Property" which stated "Residents had the right to be free from verbal, sexual, physical, and mental abuse...When incidents involving abuse, neglect or mistreatment are reported and an employee is a suspected perpetrator: remove the employee immediately, staff to notify immediate supervisor... Administrator must be notified immediately of situation, and he/she must conduct an investigation immediately...." This Federal tag relates to IN00380520. 3.1-28(c)		Identified areas of concern will be immediately reported per guidelines and additional education provided as required. All staff will be educated on abuse upon hire, annually and as needed. Abuse audits will be reviewed during scheduled morning IDT meetings and monthly during Quality Assurance. Audits will continue 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 6/9/22**	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse and ensure immediate measures were in place to prevent further abuse while the investigation was in process for 1 of 1 residents (Resident D). Findings include: On 5/20/22 at 12:25 P.M., Resident D's record was reviewed. Diagnoses included, but were not limited to, recurrent enterocolitis (inflammation of gastrointestinal tract), end stage renal disease with dialysis, and diabetes. On 5/20/22 at 10:56 A.M., Resident D, identified by the facility as interviewable, was interviewed about an incident that occurred on 5/16/22. Resident D indicated CNA 3 (Certified Nurse Assistant) and CNA 5 came to his room to help him get up in the morning around 5:00 a.m. He had a soiled brief and needed to be changed. CNA 3 indicated he didn't need changed before getting up. Resident D repeated himself. CNA 3 argued with him for several minutes, finally turned him over and checked his brief. CNA 3 agreed he needed changed, undid the tabs on his brief and began wiping his bottom roughly. He yelled out in pain and told the CNA that he was sore down there due to frequent diarrhea. CNA 3 continued to wipe him roughly and "kept digging	F 0610	**F-610 D Investigate/Prevent/Correct Alleged Violation** **The facility respectively 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:** Resident D allegation was investigated and reported to ISDH related to 5-16-22 event. Residents D was interviewed per Social Service Director to	06/09/2022

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	and digging" at his rectum. He then felt a cold spray on his bottom followed by the smell of Febreeze air freshener. He asked CNA 3 if she had sprayed the air freshener on his bottom. She replied she had because he "stunk" and "smelled like s--t"! As the 2 CNA's turned him over onto his back, CNA 3 sprayed the air freshener on his bare chest all the way down to his feet. He yelled at CNA 3, asked her why she had done that, she replied for him to "shut up" and repeated that he stunk and smelled like s--t. Resident D then told the CNA's that they needed to get his weight before dialysis using the hoyer lift. CNA 3 indicated he didn't need a weight done. CNA 2 indicated to the other CNA to just get his weight. CNA 3 continued to argue with the resident as she tried to figure out how to get the weight from the lift. He told her how to do it which angered her further and she kept telling him to shut up. After the weight was gotten, he asked CNA 3 what his weight was and she refused to tell him. He indicated he went to dialysis as planned but thought about what the CNA had said, done to him. He was upset and felt it needed to be reported. He called the Administrator on his phone and told him what had occurred. The Administrator assured him that the incident would be investigated. The Administrator indicated CNA 3 was an agency staff member and he would not allow her to come back to work in the facility. Resident D indicated he hadn't heard anything more about it that day but that same evening, around 7:00 p.m., CNA 3 was back to work a 12 hour shift on his hallway. Resident D indicated he had told QMA 7 (Qualified Medication Aid) about the incident. Around 7:00 p.m., QMA 7 brought CNA 3 into the resident's room and asked if she had been the one who he'd had the incident with that morning. The resident indicated at first he wasn't sure because of her		determine if residents felt safe and secure within the facility and no ongoing psychosocial issues noted. Care plans reviewed and updated as required. Allegations will be investigated and reported immediately to ISDH per requirements. **2. How the facility identified other residents:** No other resident identified to have been affected related to the 5-16-22 altercation between CNA 3 and resident D Audit was conducted of facility residents to determine if any allegations were outstanding. If allegations are noted, facility will report and investigate per regulation. **3. Measures put into place/ System changes:** Facility staff educated on components of F610 Investigate/Prevent/Correct Alleged Violation. Investigation forms reviewed with Executive Directors. Education provided to facility staff on completion of investigation for any allegation and documentation requirements. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive Director and the Director of Nursing who will interview three	

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	mask but then she started calling him a liar and he recognized her voice and knew immediately she'd been the CNA from the morning incident. QMA 7 then escorted CNA 3 out of his room. The resident indicated he couldn't understand how CNA 3 had been allowed to come back to work after he'd been told by the Administrator that he'd take care of it and wouldn't allow the CNA to come back to the facility. When asked, he indicated he wasn't aware of having any injury to his bottom and added, on Thursday 5/19/22, the NP had come in, examined his bottom and said she was checking to make sure he hadn't sustained a chemical burn from the Febreeze spray. He indicated, on Wednesday 5/18/22, CNA 5 came to his room, apologized to him for what had happened and indicated she hadn't known what to do or say during the incident but would never allow another CNA to talk like that to him or any other resident again. On 5/20/22 at 12:39 P.M., the Administrator was interviewed, indicated an investigation had been started of the incident and it had been reported to the Indiana Department of Health. He indicated CNA 3 worked on 5/16/22 from 6 p.m. to 6 a.m. but then told she was not to return to the facility. The agency, whom CNA 3 worked for, was notified on 5/17/22 that she was no longer allowed to work at the facility. The staff scheduler was interviewed on 5/20/22 at 1:00 P.M. She indicated she had overheard the phone conversation between the Administrator and Resident D. She told the Administrator that CNA 3 was her cousin and she had a photo of her on her cell phone. She was instructed to show Resident D the photo so he could confirm CNA 3 was the one involved in the incident. The staff scheduler went to the residents room where CNA		residents (ED) and staff (DON)weekly related to abuse. Identified areas of concern will be immediately reported and investigated per guidelines and additional education provided as required. All staff will be educated on abuse upon hire, annually and as needed. Abuse audits and investigation process will be reviewed during scheduled morning IDT meetings and monthly during Quality Assurance. Audits will continue 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 6-9-22**	

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	2 was in talking with the resident about the incident. The resident couldn't tell by the picture because CNA 3 had worn a mask. CNA 2 told the scheduler that CNA 3 was her cousin. At around 4:30 p.m. (5/16/22), she was instructed to allow CNA 3 to work her scheduled 12 hour shift from 6 p.m. that evening until 6 a.m. 5/17/22 but to schedule her on a different hall away from Resident D's room. The scheduler indicated the morning of 5/17/22, she told her cousin that she was on the Do Not Return list at her agency and was no longer allowed to work at the facility. On 5/20/22 at 2:10 P.M., QMA 7 was interviewed. He indicated he had worked a double shift on 5/16/22, from 5:30 a.m. to 10:30 p.m. but hadn't been on Resident D's hall until the afternoon shift. He'd heard about the incident during the day and Resident D told him about it. QMA 7 saw that CNA 3 was at the facility to work on his hall which he hadn't understood because there was an allegation of abuse involving her and she shouldn't have been in the building. He asked the CNA to come with him down to Resident D's room. While in the room, the QMA asked the resident if CNA 3 had been the one involved in the incident that morning and after hearing her voice and calling him a liar, Resident D confirmed she was CNA 3. QMA 7 then escorted CNA 3 from the room and told her she needed to leave the building immediately. He indicated, approximately 20 minutes later, he received a call on his cell phone from the staff scheduler who wanted to know why CNA 3 had been asked to leave. He explained that the resident had identified the CNA being involved in the morning incident and she wasn't to be in the building while an investigation was on-going. QMA 7 indicated the scheduler told him that CNA 3 could work and that the incident had been			

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	155249	A. BUILDING 00 B. WING	05/23/2022

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investigated and everything taken care of. QMA 7 indicated CNA 3 worked until 10:00 p.m. on the other side of Resident D's hall and then was assigned to another wing of the building from 10 p.m. to 6 a.m.

On 5/23/22 at 10:47 A.M., CNA 5 was interviewed. She indicated she had been the other CNA in with CNA 3 when getting Resident D up for dialysis. CNA 3 hadn't been scheduled to work on her hallway but had changed halls/wing during the night due to an altercation between CNA 3 and 2 other staff members. She and CNA 3 went to get up the resident and he asked to have his brief changed. She told him he didn't need it changed several times then finally did so after checking his brief and finding it soiled. She indicated the resident told CNA 3 before she started cleaning his bottom that he was very sore around his rectum due to all the diarrhea but she was very aggressive when wiping his bottom. Resident D yelled out and kept telling CNA 3 that it hurt how hard she was wiping him. She saw CNA 3 obtain a can of Febreeze air freshener from his bedside stand and spray it on his bare bottom. The resident asked if CNA 3 had sprayed Febreeze on his bottom and she nodded yes to him. CNA 3 then told him "he stunk" and "smelled like s--t"! After they turned back onto his backside, CNA 3 again sprayed the residents bare skin from his chest down to his feet which upset the resident. CNA 3 continued to tell the resident to shut up while they tried to get him into the hoyer lift and get his weight. She believed CNA 3 just wanted to argue with him and kept telling him that she'd been an aide for 10 years and knew what she was doing and to keep his mouth shut. She indicated she hadn't known what to do and had never seen an aide speak with a resident like this. After the resident was placed in his

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	wheelchair and taken to dialysis, CNA 5 went to the employee breakroom where she shared with coworkers what she had just witnessed. She indicated one of the nurses had been in the breakroom and she had told her a little bit of the story but hadn't been told to report it to anyone else. When asked if she thought Resident D had been abused, she indicated she believed that to be true. On 5/23/22 at 2:30 P.M., the Assistant Director of Nursing (ADON) was interviewed. An Indiana incident report, dated 5/17/22 at 3:45 p.m., indicated the incident had been reported to the ADON. The ADON indicated she went and spoke with the resident after receiving the allegation. She thought she had examined his bottom for injury but hadn't documented it therefore couldn't be sure if the resident had been assessed for injury. On 5/20/22 at 12:39 P.M., the Administrator provided a current copy of the facility policy, titled "Abuse, Neglect, and Misappropriation of Resident Property" which stated "Residents had the right to be free from verbal, sexual, physical, and mental abuse...Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident...When incidents involving abuse, neglect or mistreatment are reported and an employee is a suspected perpetrator: remove the employee immediately, staff to notify immediate supervisor and he or she must conduct interview with employee and resident, employee must be sent home (suspended) immediately pending outcome of final investigation, Administrator must be notified immediately of situation, and he/she must conduct an			

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	investigation immediately...All residents will be assessed immediately by the attending nurse upon notification of alleged abuse, neglect or mistreatment...The resident's physician and family shall be notified of the allegation and the results of the nurse's examination...The facility will keep evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress...." This Federal tag relates to Complaint IN00380520. 3.1-28(d)			