PRINTED: 06/09/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155249	B. WING		05/23/2022
NAME OF I	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				RANDY CHASE COVE	
CHATEA	U REHABILITATIO	ON AND HEALTHCARE CENTER	FORT \	WAYNE, IN 46815	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F 0000					
Dida 00					
Bldg. 00	This visit was for the	he Investigation of Complaints	F 0000		
		380520, and IN00380768.	F 0000		
	11,003,03,3,11,00	300320, and 11.00300700.			
	Complaint IN0037	8375 - Substantiated. No			
	deficiencies related	to the allegations are cited.			
	_	0520 - Substantiated.			
		iencies related to the			
	allegations are cited	d at F600, F609, and F610.			
	Complaint IN0038	0768 - Substantiated. No			
	_	to the allegations are cited.			
		to the unegations are chee.			
	Survey dates: May	20 and 23, 2022			
	Facility number: 00				
	Provider number: 1				
	AIM number: 1002	266910			
	Cancus Dad Tymas				
	Census Bed Type: SNF/NF: 93				
	Total: 93				
	Census Payor Type	e:			
	Medicare: 5				
	Medicaid: 69				
	Other: 19				
	Total: 93				
	These deficiencies	raflect State Findings sited in			
	accordance with 41	reflect State Findings cited in			
	accordance with 41	10 IAC 10.2-3.1.			
	Quality review con	npleted May 26, 2022			
	1, 11, 15, 15, 15, 15, 15, 15, 15, 15, 1	1 7			
F 0600	483.12(a)(1)				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§483.12 Freedom from Abuse, Neglect, and

Free from Abuse and Neglect

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

SS=D

Bldg. 00

(X6) DATE

TITLE

PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETI			ETED	
		155249	B. WING 05/23/2022			/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CHATEA	LI DELLA DIL ITATIO	N AND LIEALTHOADE CENTED			RANDY CHASE COVE		
CHATEA	U REHABILITATIO	N AND HEALTHCARE CENTER		FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Exploitation						
The resident has the right to be free from							
	abuse, neglect, m	isappropriation of resident					
	property, and exp	loitation as defined in this					
	subpart. This incl	udes but is not limited to					
	freedom from corp	ooral punishment,					
		ion and any physical or					
		not required to treat the					
	resident's medical	l symptoms.					
	§483.12(a) The fa	cility must-					
	§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or						
	involuntary seclus	ion;					
	Based on interview	and record review, the	F 0	600	F-600D Free from Abuse,		06/09/2022
	facility failed to ens	sure residents were free from	Neglect and Exploitation				
	abuse for 1 of 3 res	idents reviewed (Resident D.		The facility respectfully			
					requests a desk review for the		
	Findings include:				citation		
	On 5/20/22 at 12:2:	5 P.M., Resident D's record			Preparation, submission, an	ıd	
		gnoses included, but were not			implementation of this Plan		
		t enterocolitis (inflammation			Correction does not constitu		
		ract), end stage renal disease			an admission of or agreemen		
	with dialysis, and d				with the facts and conclusion		
]				set forth on the survey repor		
	On 5/20/22 at 10:56	6 A.M., Resident D,			Our Plan of Correction is		
		cility as interviewable, was			prepared and executed to		
		in incident on 5/16/22.			continuously improve the		
	Resident D indicate	ed CNA 3 (Certified Nurse			quality of care and to comply	/	
	Assistant) and CNA	A 5 came to his room to help			with all applicable state and		
		orning around 5:00 a.m. He			federal regulatory		
	had a soiled brief a	nd needed to be changed. CNA			requirements.		
	3 indicated he didn'	t need changed before getting					
	up. Resident D repe	eated himself and CNA 3					
	argued with him for	r several minutes, finally					
		d checked his brief. CNA 3					
	-	hanged, undid the tabs on his			1. Immediate actions taken	for	
	brief and began wir	oing his bottom roughly. He			those residents identified:		

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Event ID:

344X11

Facility ID: 000153

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155249	B. WI	NG		05/23/2022	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
OLIATEA	LI DELLABILITATIO	N AND LIEAL THOADE OFNED			RANDY CHASE COVE		
CHATEA	U KEHABILITATIOI	N AND HEALTHCARE CENTER		FORT WAYNE, IN 46815			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	yelled out in pain ar	nd told the CNA that he was			Residents D identified to have		
	sore down there due	e to frequent diarrhea. CNA 3			been involved in verbal alterca	tion	
	continued to wipe h	im roughly and "kept digging			were identified to not having be	een	
	and digging" at his	rectum. He then felt a cold			adversely affected. Social		
	spray on his bottom	followed by the smell of			services will follow residents fo	or	
	Febreeze air fresher	ner. He asked CNA 3 if she			psychosocial issues. Allegation	ı	
	had sprayed the air	freshener on his bottom and			was reported to ISDH . Physic	cian	
	she replied she had	because he "stunk" and			and families/or responsible par	ties	
	"smelled like st".	As the 2 CNA's turned him			were notified.		
	over onto his back,	CNA 3 sprayed the air			2. How the facility identified		
	freshener on his bar	e chest all the way down to			other residents: Any resident		
	his feet. He yelled a	t CNA 3, asked her why she		had the potential to have been			
	had done that. She r	replied for him to "shut up",			affected however none were		
	repeated he stunk ar	nd smelled like st. Resident			identified. Interviews were		
	D then told the CNA	A's they needed to get his			conducted with residents and r	no	
	weight before dialys	sis using the hoyer lift. CNA			resident reported feeling fearful		
	3 indicated he didn't	t need a weight done. CNA 2		and stated they felt safe in facility.			
	indicated to the other	er CNA to just get his weight.			No new allegations were repor	ted.	
	CNA 3 continued to	argue with the resident as					
	she tried to figure or	ut how to get the weight from			3. Measures put into place/		
	the lift. He told her	how to do it which angered			System changes: Facility staff	f	
	her further and she l	kept telling him to shut up.			educated on components of F	600	
	After the weight wa	s gotten, he asked CNA 3	Abuse, Neglect, and Exploitation.			on.	
	what his weight was	s and she refused to tell him.			Special focus was placed on		
	He indicated he wer	nt to dialysis as planned but			immediate intervention to prev	ent	
	thought about what	the CNA had said, done to			abuse, and internal reporting o	f	
	him, he was upset a	nd felt it needed to be			abuse to the administrator.		
	reported. He called	the Administrator on his					
	phone and told him	what had occurred. The					
	Administrator assur	ed him the incident would be			4. How the corrective action	s	
	investigated. The A	dministrator indicated CNA 3			will be monitored: The		
	was an agency staff	member and he would not			responsible party for this plan	of	
	allow her to come b	ack to work in the facility.			correction is the Executive		
	Resident D indicate	d that same evening, around			Director/designee who will		
	7:00 p.m., CNA 3 w	vas back to work a 12 hour			interview three residents week	ly	
	shift on his hallway				related to abuse (post daily 6		
					week audits) Three facility staf	f	
	A review of the nur	sing schedule for resident D's			will be interviewed weekly(pos	t	
	area indicated CNA	3 was scheduled to work on			daily audits for 6 weeks)to incl	ude	
	5/16/22 from 7 PM	to 7 AM			all shifts to determine		

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Event ID:

344X11

Facility ID: 000153

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		JILDING	00	(X3) DATE (COMPL 05/23/	ETED	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 BF	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE VAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	interviewed and ind been started of the in reported to the India provided a current of titled "Abuse, Negle Resident Property" the right to be free f and mental abuseI subjected to abuse b limited to, facility st	teers, staff of other agencies"		understanding of abuse report guidelines. Identified areas of concern will be immediately reported per guidelines and additional education provided required. All staff will be educ on abuse upon hire, annually as needed. Abuse audits will reviewed during scheduled morning meetings and monthly during Quality Assurance. Auwill continue daily for 6 weeks 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 3 consecutive months. The QAC Committee will identify any tree or patterns and make recommendations to revise the plan of correction as indicated 5. Date of Compliance 6-9-2	as ated and be dits to differ and seconds	
F 0609 SS=D Bldg. 00	abuse, neglect, ex the facility must: §483.12(c)(1) Ens violations involving exploitation or mis of unknown source resident property, but not later than 2 is made, if the eve	onse to allegations of ploitation, or mistreatment, ure that all alleged gabuse, neglect, treatment, including injuries e and misappropriation of are reported immediately, 2 hours after the allegation				

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Event ID:

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Facility ID: 000153

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	LETED
		155249	B. W	ING		05/23	/2022
				CTREET	ADDRESS CITY STATE ZIR CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
CHATEA	LI DELIADII ITATIO	N AND HEALTHCARE CENTER			RANDY CHASE COVE		
CHATEA	U REHABILITATIO	N AND HEALTHCARE CENTER		FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	bodily injury, or no	ot later than 24 hours if the					
		the allegation do not involve					
		result in serious bodily					
	injury, to the admi	inistrator of the facility and					
		ncluding to the State					
		nd adult protective services					
		rovides for jurisdiction in					
	_	cilities) in accordance with					
	State law through	established procedures.					
		port the results of all					
	_	he administrator or his or					
	her designated representative and to other						
		ance with State law,					
		tate Survey Agency, within					
		the incident, and if the					
	_	s verified appropriate					
	corrective action r		l				
		and record review, facility	F 0	509	F-609 D Reporting Alleged		06/09/2022
	_	t timely an allegation of staff			Violations		
		or 1 of 1 residents reviewed			The facility respectively		
	(Resident D).				requests a desk review for the	1IS	
	Findings in abud				citation		
	Findings include:				Propagation submission or	vd.	
	On 5/20/22 at 12:24	5 P.M., Resident D's record			Preparation, submission, ar implementation of this Plan		
		gnoses included, but were not			Correction does not constitu		
		t enterocolitis (inflammation					
	•	ract), end stage renal disease			an admission of or agreemed with the facts and conclusion		
	with dialysis, and d	· -			set forth on the survey repor		
	with diarysis, and d	nuoces.			Our Plan of Correction is		
	On 5/20/22 at 10:56	6 A.M., Resident D,			prepared and executed to		
		cility as interviewable, was			continuously improve the		
		an incident that occurred on			quality of care and to comply	,	
		ent alleged a CNA had sprayed			with all applicable state and	•	
		ner on his bare bottom, chest			federal regulatory		
		rgued and cursed at him. There			requirements.		
	_	present during the incident					
		A's being the perpetrator. He					
		trator on his phone and told					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155249 B. WING 05/23/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE CHATEAU REHABILITATION AND HEALTHCARE CENTER FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) him what had occurred. The Administrator assured him the incident would be investigated. 1. Immediate actions taken for those residents identified: The Administrator indicated CNA 3 was an agency staff member and he would not allow her Resident D allegation was to come back to work in the facility. reported to ISDH related to 5/16/22 event. Residents D was On 5/20/22 at 12:39 P.M., the Administrator was interviewed per Social Service interviewed and indicated the incident had been Director to determine that resident reported to the Indiana Department of Health on felt safe and secure within the 5/17/22 after he fully understood the facility and no psychosocial circumstances surrounding the incident and staff issues remained. Residents was assessed, and care plans members involved. reviewed and updated as On 5/20/22 at 2:10 P.M., QMA 7 was required. Allegations will be reported immediately to ISDH per interviewed. He indicated he had worked a double shift on 5/16/22, from 5:30 a.m. to 10:30 p.m. requirements. Physician and but hadn't been on Resident D's hall until the families/or responsible parties were notified. afternoon shift. He'd heard other staff talking 2. How the facility identified about an incident during the day and Resident D told him about it in the evening. other residents: No other resident identified to have been On 5/23/22 at 10:47 A.M., CNA 5 was affected related to the 5/16/22 interviewed. She indicated she had been the other incident which occurred with CNA with CNA 3 when getting Resident D up for CNA 3 Audit was conducted of facility dialysis and was a witness to the incident. She indicated she hadn't known what to do and had residents to determine if any never seen an aide speak with a resident like that. allegations were outstanding. No After the resident was placed in his wheelchair further allegations noted and taken to dialysis, CNA 5 went to the 3. Measures put into place/ employee breakroom where she shared with System changes: Facility staff coworkers what she had just witnessed. She educated on components of F609 Reporting Alleged Violations. indicated one of the nurses had been in the breakroom and she had told her a little bit of the 4. How the corrective actions story but hadn't been told to report it to anyone will be monitored: The else. When asked if she thought Resident D had responsible party for this plan of been abused, she indicated she believed that to be correction is the Executive true. Director and the Director of Nursing who will interview three On 5/23/22 at 2:30 P.M., the Assistant Director residents (ED) and staff of Nursing (ADON) was interviewed. An Indiana (DON)weekly related to abuse.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249	A. BUILDING <u>00</u> B. WING	(X3) DATE SURVEY COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, Z 6006 BRANDY CHASE CON FORT WAYNE, IN 46815	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE THE APPROPRIATE Y) COMPLETION DATE
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 abuseWhen 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.	Identified areas of of immediately reported guidelines and additeducation provided All staff will be educted upon hire, annually needed. Abuse autoreviewed during soft morning IDT meeting monthly during Quanch Audits will continue and or until 100% of achieved for 3 consistent months. The QA Condidentify any trends of make recommendate the plan of correction indicated. 5. Date of Complete immediately reported to the plan of correction indicated.	ed per itional as required. cated on abuse and as lits will be neduled ngs and ality Assurance. for 6 months compliance is secutive committee will or patterns and tions to revise on as
F 0610 SS=D Bldg. 00 Hashington System 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation System \$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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		ĺ	ILDING	instruction 00	(X3) DATE : COMPL 05/23 /	ETED	
CHATEA	PROVIDER OR SUPPLIER U REHABILITATIO	N AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	investigations to the her designated reposition officials in accordational including to the Standard working days of alleged violation is corrective action resignated in the secondard secondard in the secondard secondard in the secondard secondar	oort the results of all ne administrator or his or presentative and to other ance with State law, ate Survey Agency, within the incident, and if the s verified appropriate nust be taken. and record review, the	F 06	510	F-610 D		06/09/2022
	allegation of abuse measures were in pl	roughly investigate an and ensure immediate lace to prevent further abuse ion was in process for 1 of 1 D).			Investigate/Prevent/Correct Alleged Violation The facility respectively requests a desk review for th citation	is	
	was reviewed. Diag limited to, recurrent of gastrointestinal to with dialysis, and d On 5/20/22 at 10:56 identified by the facinterviewed about a 5/16/22. Resident E Nurse Assistant) an help him get up in the had a soiled bried CNA 3 indicated he getting up. Resident argued with him for turned him over and agreed he needed cl brief and began wip yelled out in pain and	A.M., Resident D, cility as interviewable, was n incident that occurred on 0 indicated CNA 3 (Certified d CNA 5 came to his room to the morning around 5:00 a.m. of and needed to be changed. It is didn't need changed before to D repeated himself. CNA 3 reseveral minutes, finally d checked his brief. CNA 3 manged, undid the tabs on his bring his bottom roughly. He and told the CNA that he was			Preparation, submission, an 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 those residents identified: Resident D allegation was investigated and reported to IS related to 5-16-22 event.	of te nt ns t.	
		e to frequent diarrhea. CNA 3 im roughly and "kept digging			Residents D was interviewed p Social Service Director to	oer	

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If continuation sheet

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f '		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155249	B. WI	ING		05/23/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			6006 BF	RANDY CHASE COVE		
CHATFA	U REHABII ITATIO	N AND HEALTHCARE CENTER			VAYNE, IN 46815		
					, 100.10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		rectum. He then felt a cold			determine if residents felt safe		
		followed by the smell of			and secure within the facility a		
		ner. He asked CNA 3 if she			no ongoing psychosocial issue		
		freshener on his bottom. She			noted. Care plans reviewed a		
	-	ause he "stunk" and "smelled			updated as required. Allegation		
		CNA's turned him over onto			will be investigated and report	ed	
	-	rayed the air freshener on his			immediately to ISDH per		
		ay down to his feet. He yelled			requirements.		
		r why she had done that, she					
		shut up" and repeated that he			2. How the facility identified	l	
		ike st. Resident D then told			other residents: No other		
		needed to get his weight			resident identified to have bee		
		g the hoyer lift. CNA 3			affected related to the 5-16-22		
		need a weight done. CNA 2			altercation between CNA 3 an	d	
		er CNA to just get his weight.			resident D		
		argue with the resident as			Audit was conducted of facility	/	
	_	ut how to get the weight from			residents to determine if any		
		how to do it which angered			allegations were outstanding.		
		kept telling him to shut up.			allegations are noted, facility v	vill	
	_	s gotten, he asked CNA 3			report and investigate per		
	-	s and she refused to tell him.			regulation.		
		nt to dialysis as planned but					
	_	the CNA had said, done to			3. Measures put into place/		
		and felt it needed to be			System changes: Facility stat		
	•	the Administrator on his			educated on components of F	610	
	•	what had occurred. The			Investigate/Prevent/Correct		
		red him that the incident			Alleged Violation.		
	U	ed. The Administrator			Investigation forms reviewed v	vith	
		as an agency staff member and			Executive Directors.		
		her to come back to work in			Education provided to facility		
	-	nt D indicated he hadn't heard			on completion of investigation		
		it it that day but that same			any allegation and documenta	ition	
	-	0 p.m., CNA 3 was back to			requirements.		
		t on his hallway. Resident D					
		d QMA 7 (Qualified			4. How the corrective action	าร	
	· ·	out the incident. Around 7:00			will be monitored: The		
		tht CNA 3 into the resident's			responsible party for this plan	of	
		he had been the one who he'd			correction is the Executive		
		h that morning. The resident			Director and the Director of		
	indicated at first he	wasn't sure because of her			Nursing who will interview thre	ee	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249	A. BUILDING 00 B. WING	COMPLETED 05/23/2022
NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815 ID PREFIX CROSS-REFERENCE TO THE APPROPRIATE OF THE APPROPRIATE	N (X5) BE BE COMPLETION RIATE
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 abuildentified areas of concern immediately reported and investigated per guidelines additional education provide required. All staff will be edion abuse upon hire, annual as needed. Abuse audits an investigation process will be reviewed during scheduled morning IDT meetings and monthly during Quality Assi Audits will continue for 6 meand or until 100% complian achieved for 3 consecutive months. The QA Committee identify any trends or patter make recommendations to the plan of correction as indicated. 5. Date of Compliance 6-	use. will be and ed as ucated ly and ed and ee urance. onths ce is e will ns and revise

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2022
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	incident. The reside because CNA 3 had scheduler that CNA 4:30 p.m. (5/16/22). CNA 3 to work her 6 p.m. that evening schedule her on a di Resident D's room. morning of 5/17/22 was on the Do Not was no longer allow. On 5/20/22 at 2:10 interviewed. He ind shift on 5/16/22, fro but hadn't been on I afternoon shift. He'd during the day and QMA 7 saw that CN work on his hall wh because there was a involving her and shuilding. He asked down to Resident D the QMA asked the the one involved in after hearing her vo Resident D confirm then escorted CNA she needed to leave indicated, approximate received a call on his scheduler who want been asked to leave resident had identifit the morning incider building while an in QMA 7 indicated the consequence of the confirmation of the confirmat	th the resident about the int couldn't tell by the picture worn a mask. CNA 2 told the 3 was her cousin. At around is she was instructed to allow scheduled 12 hour shift from until 6 a.m. 5/17/22 but to fferent hall away from The scheduler indicated the is she told her cousin that she Return list at her agency and red to work at the facility. P.M., QMA 7 was icated he had worked a double im 5:30 a.m. to 10:30 p.m. Resident D's hall until the distance he had worked a double im 5:30 a.m. to 10:30 p.m. Resident D told him about it. INA 3 was at the facility to ich he hadn't understood in allegation of abuse in shouldn't have been in the eithe CNA to come with him it's room. While in the room, resident if CNA 3 had been the incident that morning and ice and calling him a liar, and she was CNA 3. QMA 7 is from the room and told her the building immediately. He ately 20 minutes later, he is cell phone from the staff and to know why CNA 3 had and the explained that the ed the CNA being involved in at and she wasn't to be in the investigation was on-going. The scheduler told him that and that the incident had been the incident told him that and that the incident had been the incident told him that and that the incident had been the incident told him that and that the incident had been			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/23/2022
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 BF	ADDRESS, CITY, STATE, ZIP CODE RANDY CHASE COVE NAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	investigated and ever indicated CNA 3 wo other side of Reside assigned to another p.m. to 6 a.m. On 5/23/22 at 10:47 interviewed. She independent of CNA in with CNA 3 work on her hallway during the night due CNA 3 and 2 other 3 went to get up the his brief changed. Sechanged several time checking his brief a indicated the resident started cleaning his around his rectum down was very aggressive Resident D yelled of that it hurt how hard CNA 3 obtain a can from his bedside started bottom. The resident Febreeze on his botth him. CNA 3 then to like st"! After they backside, CNA 3 ag skin from his chest of the resident. CNA 3 to shut up while the hoyer lift and get his just wanted to argue him that she'd been what she was doing She indicated she had never seen an acceptance.	erything taken care of. QMA 7 orked until 10:00 p.m. on the nt D's hall and then was wing of the building from 10 A.M., CNA 5 was dicated she had been the other 3 when getting Resident D up hadn't been scheduled to y but had changed halls/wing to an altercation between staff members. She and CNA resident and he asked to have the told him he didn't need it es then finally did so after and finding it soiled. She nt told CNA 3 before she bottom that he was very sore ue to all the diarrhea but she to when wiping his bottom. ut and kept telling CNA 3 I she was wiping him. She saw of Febreeze air freshener and and spray it on his bare t asked if CNA 3 had sprayed from and she nodded yes to ld him "he stunk" and "smelled to turned back onto his tain sprayed the residents bare down to his feet which upset continued to tell the resident by tried to get him into the s weight. She believed CNA 3 with him and kept telling an aide for 10 years and knew and to keep his mouth shut. and the speak with a resident like			DATE
ı	uns. After the reside	ent was placed in his			

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155249	B. WI	ING		05/23/	/2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			RANDY CHASE COVE		
CHATEA	I I REHABII ITATIO	N AND HEALTHCARE CENTER			VAYNE, IN 46815		
				V/ (1142, 114 16616			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		en to dialysis, CNA 5 went to					
		room where she shared with					
		had just witnessed. She					
		nurses had been in the					
		had told her a little bit of the					
		n told to report it to anyone					
		she thought Resident D had					
		dicated she believed that to be					
	true.						
	On 5/23/22 at 2:30	P.M., the Assistant Director					
) was interviewed. An Indiana					
	• • •	ed 5/17/22 at 3:45 p.m.,					
	_	nt had been reported to the					
		I indicated she went and spoke					
		ter receiving the allegation.					
		l examined his bottom for					
		cumented it therefore couldn't					
	• •	nt had been assessed for					
	injury.						
		P.M., the Administrator					
	-	copy of the facility policy,					
		ect, and Misappropriation of					
		which stated "Residents had					
	_	from verbal, sexual, physical,					
		Residents must not be					
	-	by anyone, including, but not					
	limited to, facility s						
		nteers, staff of other agencies					
		When incidents involving					
	-	istreatment are reported and spected perpetrator: remove					
		diately, staff to notify					
		or and he or she must conduct					
	-	loyee and resident, employee					
		(suspended) immediately					
	pending outcome of						
	-	be notified immediately of					
	situation, and he/she						
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155249		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/23/2022	
NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	investigation immediatelyAll residents will be assessed immediately by the attending nurse upon notification of alleged abuse, neglect or mistreatmentThe resident's physician and family shall be notified of the allegation and the results of the nurse's examinationThe 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)						

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