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	09/29/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00416160, IN00416339, and IN00416441. Complaint IN00416160 - No deficiencies related to the allegations are cited. Complaint IN00416339 - No deficiencies related to the allegations are cited. Complaint IN00416441 - Federal/state deficiencies related to the allegations are cited at F742. Survey dates: September 29, 2023 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 6 Medicaid: 64 Other: 16 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 2, 2023	F 0000	10-12-2023 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey Chateau Rehabilitation and Healthcare Center 6006 Brandy Chase Cove Fort Wayne, IN 46815-7601 Dear Ms. Buroker: On September 29, 2023, a complaint survey (IN00416160, IN00416339,) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our formal request for a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction. Please feel free to call me with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Vasil	Executive Director	10/12/2023

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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			any further questions at 1 (260) -486-3001. Respectfully submitted, Cathy S. Vasil Executive Director	
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 implement an effective behavioral care plan for 1 of 1 resident's reviewed (Resident Y). Findings include: On 9/29/23 at 2:01 P.M., Resident Y was observed lying in bed in her room. Her room had several cardboard boxes sitting on the floor and furniture. There was an empty glass, liquid on the floor and privacy curtain near her bed. She was wearing a hospital gown, was crying, expressed anger, and	F 0742	F 742 Treatment Mental/Psychosocial Concerns 1) Immediate actions taken for those residents identified. • Resident Y plan of care was reviewed by the IDT team and plan of care to include individualized interventions to manage residents' behavior and anxiety. • Nurse practitioner orders for Lamictal and Buspar were clarified and implemented.	10/13/2023

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	indicated she was being neglected. She had issues with incontinence and alleged staff refused to "clean" her up. She sat up in a bariatric bed with folded blankets, clothes, and papers piled up around her. She complained of staff not repositioning her becasue getting off her left side difficult. She always had to lie on her back and it caused her pain. She indicated she had been neglected in several nursing homes over the past 4 years and had hoped this one would be different but it wasn't and she was ready to "give up". She began to cry harder and shared about some traumas she had lived through but still affected her. She expressed anger she wasn't "allowed" to have a carafe of coffee in her room any longer because she had accidentally spilled it causing a 2nd degree burn to her thigh. The dietary staff who had brought in the carafe hadn't brought a cup so she poured the coffee into her water pitcher and when tried to snap the lid on, ended up spilling the hot coffee onto her lap. She indicated her room was a mess because staff had refused to help her do a thorough inventory list and she had no family to help do it. She indicated there were certain staff she didn't like and had told one of the CNA's (Certified Nurse Aide) not to come back into her room alleging the CNA had refused to change out her wet incontinent pad. Staff hadn't answered her call light timely and then staff got angry when she called the facility on her phone. She indicated she had to wait one night for an hour and 45 minutes. On 9/29/23 at 1:00 P.M., Resident Y's record was reviewed. Diagnoses included paralysis of legs, bi-polar disorder, major depressive disorder, generalized anxiety disorder, insomnia, opioid and alcohol abuse, and chronic pain syndrome. An admission MDS (Minimum Data Set)		2) How the facility identified other residents: • Any resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty or who has a history of trauma is at risk to be affected by the deficient practice. 3) Measures put into place/ System changes: • Progress notes completed by medical providers during the last 30 days were reviewed by the ADON or designee to ensure that any recommendations and/or orders have been implemented and included in the resident plan of care. • The social services department will identify current residents with a diagnosed mental disorder, who displays psychosocial adjustment difficulty, or who has a history of trauma to determine whether the plan of care effectively addresses will be assessed by the IDT team. • The team will review the plan of care to ensure it effectively addresses the behavioral and psychosocial needs of the resident to ensure the highest practicable mental and psychosocial well-being. • All nursing staff will be in-serviced on or before 10/ 13 /23 on process for reviewing progress notes from providers to ensure all recommendations/physician	

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	assessment, dated 9/12/23, indicated the resident had no cognitive impairment. She had several mood indicators almost daily and included little interest or pleasure in doing things, feeling down, depressed, or hopeless, trouble falling or staying asleep/sleeping too much, feeling tired and having little energy, and feeling bad about herself or she was a failure and let herself or her family down. She had no behaviors or refusals of care. A care plan, revised 9/18/23, indicated the resident was at risk for impaired psychosocial well-being, sensory, communication, and cognitive deficits due to anxiety, bi-polar disorder, depression, mood disorder, and PTSD from trauma experienced in her life. She had behaviors of refusing care, refusing to use her call light, refusing showers, refusing care in pairs, using derogatory language towards staff, and confabulations about her care. The goal was her needs and preferences would be met as practicable and she would be free from psychosocial complications. Interventions included: Administer medications per physician order and monitor for effectiveness and side effects; behavioral health consults as needed; follow up with psych services; and triggers to avoid due to her trauma and PTSD. A physician order, dated 9/5/23, was for Lamotrigine 25 mg (milligrams): give 2 tablets by mouth at bedtime for bipolar disorder. She was not prescribed any other psychotropic medications. She was ordered Baclofen 15 mg by mouth 3 times per day for muscle spasms and Gabapentin 300 mg by mouth: 3 times per day for nerve pain. She was not prescribed opioid pain medications and her pain was evaluated daily. A September 2023 MAR (Medication		orders are implemented and noted per policy. • Education is additionally provided in documenting any new onset of behavior or other displays of psychosocial adjustment or trauma related symptoms in the EMR. • Education provided on implementing resident specific interventions as indicated in plan of care to assist in effectively managing residents behavioral and psychosocial needs was emphasized. • The EMR 24hour report will serve as the communication tool for nursing to document any changes in resident condition related to displays of worsening/new onset of behaviors or symptoms of difficulty with psychosocial adjustment or trauma in residents EMR. • The plan of care will be updated with any new onset or needed changes in the plan of care to effectively manage residents' psychosocial well-being. • The EMR-24hour report tool will be routinely reviewed by the IDT team to ensure that residents with mental disorders and behavioral issues are addressed. 4) How the corrective actions will be monitored: • The QA audit tool will be completed 3x weekly by the SSD or other designee to monitor for	

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	Administration Record), indicated staff were to monitor the residents behaviors of restlessness, agitation, increase in complaints, cussing, psychosis, aggression, and refusing care. The order was started and discontinued the same day, on 9/6/23. There were no behaviors documented in the MAR. Progress notes indicated the following: -9/8/23 at 2:49 p.m., the SSD (Social Services Designee) completed a social history with the resident. The resident shared trauma which occurred over her lifetime and how those traumas continued to impact her life. She agreed to be seen by psych (psychiatric) services. -9/14/23 at 9:48 p.m., the resident had been telephoning the nurse desk for assistance with care. She was reminded to use her call light. The resident indicated she shouldn't have to turn on her call light for care. She was reminded staff cared for everyone and she needed to turn on her call light. Resident Y was tearful and stated "no one came in" and the nurse pointed out the pitcher with water and ice in it on her bedside table which indicated someone had been in her room although the resident disputed and indicated the pitcher had been there for 13 hours. She continued to call the nurse desk and when answered would curse and hang up. -9/16/23 at 10:44 a.m., staff were alerted the resident had spilled hot coffee onto her left inner thigh which was reddened. The resident requested to go to the hospital for treatment. At 5:31 p.m., the resident returned from the hospital. She was unfriendly and hostile towards staff. She wanted to argue with staff and cursed at them. The resident was prescribed Percocet 5-325		ongoing compliance. • Any issues identified will be corrected upon discovery and results of the audits will be logged on facility QAPI log and communicated during the facility monthly QAPI meeting for a minimum of 6 months 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) D.O.C 10/13/23	

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	mg-give 1 tablet by mouth every 6 hours as needed for pain which she requested and was administered as ordered. -9/20/23 at 4:15 a.m., the QMA (Qualified Medication Aide/CNA) went in to change the resident and the resident's incontinent pad was dry. The resident indicated it was wet and wanted it changed. The QMA went out of the room, got a clean pad and changed her. The resident demanded to see the pad and when the QMA showed it to her, the resident alleged the QMA showed her a different pad and not hers. She called the QMA a liar. On 9/21/23 at unknown time, the medical NP (Nurse Practitioner) visited the resident. Resident Y complained of pain to the burn area on her left thigh due to urinary incontinence. She requested the Percocet be discontinued as it was "too much" and requested Norco for pain. Orders were given for Norco 5-325 mg-give 1 tablet by mouth every 6 hours as needed for pain. A psychiatry progress note, dated 9/24/23 at unknown time, indicated the resident had been seen for medication management of mood symptoms. She was seen in her room where she was observed to be very tearful, frustrated and anxious. She complained about incontinence and needing to be changed more frequently. She understood staff were busy but wished there could be quicker responses to her requests. "I am paralyzed. I can't get up on my own, I am dependent on others." and "I am mentally breaking down". She had been thinking about a loved one who had died by suicide. She had a history of alcohol and opioid dependence. She admitted to several suicide attempts in the past but no current suicidal impulses. She was			

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	prescribed Lamictal (Lamotrigine) for bipolar disorder; medication was somewhat effective. She presented with anxiety, chronic pain, irritability, resignation, and sadness. Her mood was dejected with crying, depression, frustration, and irritability. Assessment and Plan was to increase the dose of Lamictal for mood lability. Her anxiety was unstable and would consider anti-anxiety medication. Orders for the visit were to increase Lamictal to 100 mg by mouth 1/2 tablet 2 times per day. Start Buspar 10 mg by mouth-take 1 tablet 2 times per day for anxiety. The practitioner would revisit in 2 weeks. A nurse progress note, dated 9/28/23 at 4:21 p.m., indicated during care of the resident, a bottle of gin, tucked within her skin folds, slid out and to the floor. The resident indicated she didn't drink anymore, it wasn't hers and she hadn't known where it had come from. The resident gave permission to the nurse to remove the bottle and place in the medication room. Review of physician orders and 9/2023 MAR hadn't indicated the resident's Lamictal had been increased as documented in the psych progress note of 9/24/23 nor were there orders to start Buspar for anxiety. The resident's care plan hadn't addressed the resident's substance use disorder and it's management. On 9/29/23 at 2:51 P.M., the Administrator, DON (Director of Nursing), and ADON (Assistant Director of Nursing) were interviewed. They indicated they hadn't been aware of orders to increase the resident's Lamictal and start Buspar from the psych NP. The DON indicated physician orders for medications should be followed as ordered. The resident's care plan hadn't addressed the resident's anxiety and substance use. Her			

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	behaviors of anxiety were not documented or plan of care put in place to manage the behaviors. This Federal tag relates to IN00416441. 3.1-43(a)(1)			