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	09/04/2024

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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/04/24 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Emergency Preparedness survey, Chateau Rehabilitation and Healthcare Center was found not 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 74 at the time of this survey. Quality Review completed on 09/06/24	E 0000		
E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c)(3). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director, Regional Director of Plant	E 0032	E 0032 F Primary and Alternate Means of Communication 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	09/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monique Augustine	Executive Director	09/17/2024

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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	Operations, and Maintenance Director from 9:18 a.m. to 12:38 p.m. on 09/04/24, the Emergency Preparedness Communication Plan provided did not address primary and alternate means for communication. Based on interview at time of record review, the Executive Director provided a document that provided a primary means of contacting staff and other entities but failed to provide 1) primary means for communicating with Federal, State, tribal, regional, and local emergency management agencies; 2) failed to provide an alternate means for communicating staff or Federal, State, tribal, regional and local emergency management agencies. During record review the Regional Director of Plant Operations created a draft of a primary and alternate means for communicating. This finding was reviewed with the Executive Director, Regional Director of Plant Operations, and Maintenance Director at the exit conference.		correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were identified as being affected by the alleged deficient practice. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? • All residents have the potential to be affected. • Emergency preparedness manuals were immediately updated to reflect three means of primary and alternate communication. 3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • The Emergency Preparedness Plan was updated to include three primary and alternate forms of communication. 4.) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?	

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	155249	A. BUILDING -- B. WING	09/04/2024

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			• The Maintenance Director verified all Emergency Prep binders have been updated to reflect communication information. • Additionally, the QAPI committee will audit binders quarterly to ensure communication remains current. 5.) Date of Correction 9-16-2024	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/04/24 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Life Safety Code survey, Chateau Rehabilitation and Healthcare Center 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system	K 0000		

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	with smoke detection in the corridors, areas open to the corridors, and in the resident sleeping rooms. The facility has a dialysis unit and a memory care unit. The facility has a capacity of 99 and had a census of 74 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/06/24			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of a pipe through 1 of 4 smoke compartment barriers was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice affects residents, staff and visitors in 2 of 4 smoke compartments.	K 0372	K372E Subdivision of Building Spaces- Smoke Barrier Construction 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	09/16/2024

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	Findings include: Based on observation during tour of the facility from 12:45 p.m. to 3:10 p.m. on 09/04/24 with the Executive Director, Regional Director of Plant Operations, and Maintenance Director, the smoke barrier wall above the doors in the service hall, had an unsealed half inch gap around a pipe. Based on interview at the time of observation, the Maintenance Director stated he was unaware of the gap around the pipe. This finding was reviewed with the Executive Director, Regional Director of Plant Operations, and Maintenance Director at the exit conference. 3.1-19(b)		residents: • Visitors, staff, and residents that reside in the community have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: • The facility has assessed/ audited identified smoke barrier walls to ensure the walls are protected to maintain smoke resistance. • Any penetrations identified were corrected. 4)How the corrective actions will be monitored: • The Maintenance Director/designee will inspect smoke barrier walls monthly for functionality. • Completion of inspection will be presented to the QAPI Committee during QAPI Meetings to ensure compliance. • The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for 3 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: • 9-16-2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric			

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	Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacle at the C-Hall nurses' station was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect staff at the nurses' station in 1 of 4 smoke compartments. Findings include: Based on observation during tour of the facility from 12:45 p.m. to 3:10 p.m. on 09/04/24 with the Executive Director, Regional Director of Plant Operations, and Maintenance Director, the receptacle cover at the C-Hall nurses' station was missing. Based on interview at the time of the observation, the Regional Director of Plant Operations stated there was a screw in the center of the receptacle and he believed the cover had broken off. This finding was reviewed with the Executive Director, Regional Director of Plant Operations, and Maintenance Director at the exit conference. 3.1-19(b)	K 0511	K511 E Utilities-Gas and Electric The facility requests paper compliance for this citation. This plan of correction is the facility'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. • The faceplate identified at nurse's station C-Hall was immediately corrected. 2)How the facility identified other residents: • Staff working at 1 of 4 nurses' stations (C-Hall) had the potential to be affected by the alleged practice, however none were identified. 3)Measures put into place/System changes • A facility audit was conducted to determine if faceplates were installed and completely cover the opening and seat against the mounting surface. • Any identified issues were immediately corrected.	09/16/2024

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			4)How the corrective action will be monitored: • The Maintenance Director/designee will present a weekly audit of 5 GFCI receptacles monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. • The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for 3 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: • 9-16-2024	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 1 shift in 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director, Regional Director of Plant Operations, and Maintenance Director from 9:18 a.m. to 12:38 p.m. on 09/04/24, there was no documentation for a first shift fire drill in the	K 0712	K712 Fire Drills 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	09/16/2024

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	fourth quarter of 2023. Based on record review of the "Perform Fire Drills" form two second shift and one third shift fire drills were conducted in the fourth quarter; however, no first shift fire drill documentation was available. Based on interview at the time of record review, the Maintenance Director stated he was aware that two fire drills had been conducted during the second shift of the fourth quarter and no first shift drill during the fourth quarter was conducted. This finding was reviewed with the Executive Director, Regional Director of Plant Operations, and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified • No individuals were found to be affected by the finding. 2)How the facility identified other residents: • All individuals had the potential to be affected by the alleged practice, however none were identified. 3) Measures put into place/ System changes: • Facility completed required fire drill. • Education completed with Maintenance director per the Executive Director on the components of K712 regarding holding fire drills at expected and unexpected times under varying conditions at least quarterly on each s 4)How the corrective actions will be monitored: • The Maintenance Director/designee will ensure documentation and verification of fire drills during quarterly fire drills on each shift. • Documentation from these drills will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for 3 months. • The QA Committee will identify any trends or patterns and make recommendations to revise the	

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			plan of correction as indicated. 5.) Date Certain • 9-16-2024	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 1 of 1 Human Resource office and above the ceiling in 1 of 3 smoke compartments. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects residents, staff and visitors in 2 of 4 smoke compartments. Findings include: Based on observation during tour of the facility from 12:45 p.m. to 3:10 p.m. on 09/04/24 with the Executive Director, Regional Director of Plant Operations, and Maintenance Director, 1) an orange flexible extension cord was used to power a portable air conditioning unit in the Human Resource office in the C-Hall. Based on interview at time of observation the Maintenance Director stated there was no fixed wiring receptacle on the wall where the air conditioning unit was located. 2) An orange flexible extension cord was located in the ceiling above the service hall near the housekeeping closet. Based on interview at the time of observation, the Maintenance Director stated he was unaware of the extension cord and	K 0920	K920 Electrical Equipment – Power Cords and Extension Cords The facility requests paper compliance for this citation. This plan of correction is the facility'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 reside at the community have the potential to be affected by the alleged practice. • Facility audit was conducted to identify any flexible cords were not being used as a substitute for	09/16/2024

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	did not know why it was there. This finding was reviewed with the Executive Director, Regional Director of Plant Operations, and Maintenance Director at the exit conference. 3.1-19(b)		fixed wiring 3) Measures put into place/System changes: • The orange flexible extension cord has been removed from the Human Resources office and in the ceiling above the service hall 4) How the corrective action will be monitored: • The Maintenance Director/designee will present a weekly audit (extension cords) of five rooms to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. • The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved time 3 months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of Correction: • 9-16-02024	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 6 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters	K 0923	K923E Gas Equipment Cylinder and Container Storage The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of compliance.	09/16/2024

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	(3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and approximately 50 residents in 1 of 3 smoke compartments. Findings include: Based on observation during tour of the facility from 12:45 p.m. to 3:10 p.m. on 09/04/24 with the Executive Director, Regional Director of Plant Operations, and Maintenance Director, one 'E' type oxygen cylinder was standing upright on the floor not properly chained or supported in a proper cylinder stand or cart, in the oxygen transfilling and storage room located across from the nurses' station in the C-Hall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. This finding was reviewed with the Executive Director, Regional Director of Plant Operations, and Maintenance Director at the exit conference. 3.1-19(b)		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 reside in the community have the potential to be affected by the alleged practice. 3)Measures put into place/System changes • The identified E type oxygen cylinder was properly chained/supported in a cylinder cart in transfilling storage room across from nurses' station on C-Hall • Staff were educated on proper 02 storage. 4)How the corrective action will be monitored: • The Maintenance Director/designee will present a weekly audit of 02 storage areas monthly to the QAPI Committee to ensure safe, proper storage completion. • The report will be reviewed in	

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			Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for 3 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: • 9-16-2024	