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

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155249		A. BU	A. BUILDING Co			) DATE SURVEY COMPLETED 09/04/2024	
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
E 0000								
E 0032 SS=F	conducted by the In accordance with 42  Survey Date: 09/04  Facility Number: 00  Provider Number: 1  AIM Number: 100  At this Emergency Rehabilitation and I not in compliance w Requirements for M Participating Provided 483.73. The facility census of 74 at the 10  Quality Review conductive was accorded to the 10 days and 10 days are seen according to the 10 days are seen accordi	200153 55249 266910  Preparedness survey, Chateau Healthcare Center was found with Emergency Preparedness Iedicare and Medicaid Iters and Suppliers, 42 CFR has a capacity of 99 and had a	E 00	000				
Bldg	Based on record reversal failed to ensure the communication plant alternate means for following: (i) LTC tribal, regional, or league agencies in accorda This deficient pract staff and visitors.  Findings include:  Based on record reversal failed to ensure the failed of the failed o	view and interview, the facility emergency preparedness in includes (3) Primary and communicating with the facility's staff (ii) Federal, State, ocal emergency management ince with 42 CFR 483.73(c)(3). ice could affect all residents, view and interview with the Regional Director of Plant	E 00	032	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 this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of	of ot ement the	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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155249			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/04/2024	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE	
	Operations, and Ma a.m. to 12:38 p.m. of Preparedness Common address primary communication. Barecord review, the Edocument that provide 1) primary Federal, State, tribaremergency manager provide an alternate staff or Federal, Statemergency manager review the Regional created a draft of a for communicating.  This finding was redicted to the Director, Regional 1.	intenance Director from 9:18 in 09/04/24, the Emergency nunication Plan provided did and alternate means for sed on interview at time of executive Director provided a ided a primary means of other entities but failed to means for communicating with l, regional, and local ment agencies; 2) failed to means for communicating te, tribal, regional and local ment agencies. During record Director of Plant Operations orimary and alternate means		correction is prepared and/or executed solely because it is required by the provisions of federal and state law.  1.) What corrective action(s) to be accomplished for those residents found to have been affected by the deficient practice.  1.) How other residents havin potential to be affected by the alleged deficient practice.  2.) How other residents havin potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?  1.) All residents have the potento be affected.  2.) How other residents havin potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?  3.) What residents have the potento be affected.  3.) What measures will be purplace or what systemic change will be made to ensure that the deficient practice does not receive the made to include the primary and alternate forms of communication.	will ice? as g the tial s of tinto es e cur? ess hree	
				4.) How the corrective action( will be monitored to ensure th deficient practice will not recu what quality assurance progra will be put into place?	e r,	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/04/2024
	ROVIDER OR SUPPLIER U REHABILITATIOI	N AND HEALTHCARE CENTER	6006	ET ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE T WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI. DEFICIENCY)	
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w Department of Heal 483.90(a).  Survey Date: 09/04  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety ( Rehabilitation and I not in compliance w Participation in Mec Subpart 483.90(a), I 2012 edition of the I Association (NFPA Chapter 19, Existing 410 IAC 16.2.  This one-story facility one-story facility of the I Type V (111) constitutions.	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR  2/24  20153 255249 266910  Code survey, Chateau Healthcare Center was found with Requirements for dicare/Medicaid, 42 CFR Life Safety from Fire and the National Fire Protection 101, Life Safety Code (LSC), g Health Care Occupancies and ity was determined to be of ruction and was fully	K 0000	The Maintenance Director vall 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	erified nave
	sprinklered. The fac	cility has a fire alarm system			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155249	A. BU B. WI		01	09/04/	
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		6006 BI	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	NTE.	(X5) COMPLETION DATE
K 0372 SS=E Bldg. 01	with smoke detection to the corridors, and rooms. The facility memory care unit. It and had a census of All areas where the access were sprinkle All areas providing sprinklered.  Quality Review consumplified North Subdivision of Buil Barrie Based on observation failed to ensure the passage of a pipe the compartment barrie the smoke resistance Section 19.3.7.3 requestion of the continuous from the section of the continuous from the section of the continuous from	on in the corridors, areas open I in the resident sleeping has a dialysis unit and a The facility has a capacity of 99 174 at the time of this survey. residents have customary ered.  facility services were  Inpleted on 09/06/24  Iding Spaces - Smoke  In and interview, the facility penetrations caused by the rough 1 of 4 smoke rs was protected to maintain the of each smoke barriers to be redance with LSC Section 8.5 Inimum 1/2 hour fire resistive 8.5.2.1 requires smoke barriers of an an outside wall to an a floor to a floor, or from a moke barrier, or by use of a ft. 8.5.6.2 requires penetrations yes, conduits, pipes, tubes, milar items to accommodate that, plumbing, and stems that pass through a wall, ag assembly constructed as a rough the ceiling membrane of smoke barrier assembly, shall stem or material capable of sment of smoke. In the first product of the stems of the steff and the stems of the ste	K 0:		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 this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions s 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.	of ot ment the et	09/16/2024

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	OF CORRECTION	IDENTIFICATION NUMBER  155249	A. BUILDING B. WING	01	COMP: 09/04	
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION .D BE OPRIATE	(X5) COMPLETION DATE
	from 12:45 p.m. to Executive Director, Operations, and Ma barrier wall above t had an unsealed hal Based on interview Maintenance Direct the gap around the p This finding was re Director, Regional	on during tour of the facility 3:10 p.m. on 09/04/24 with the Regional Director of Plant intenance Director, the smoke he doors in the service hall, f inch gap around a pipe. at the time of observation, the or stated he was unaware of pipe.  viewed with the Executive Director of Plant Operations, irector at the exit conference.		residents:  • Visitors, staff, and reside reside in the community h potential to be affected by alleged deficient practice.  3) Measures put into place System changes:  • The facility has assessed audited identified smoke be walls to ensure the walls a protected to maintain smoresistance.  • Any penetrations identifications identifications identifications identifications.  • The Maintenance Director/designee will inspection of inspection presented to the QAPI Conduring QAPI Meetings to ecompliance.  • The report will be review Quality Assurance Meetin monthly for 6 months or un 100% compliance is achief months.  • The QA Committee will in any trends or patterns and recommendations to revisiplan of correction as indices.  • 9-16-2024	ave the  of th	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and	Electric				

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	PROVIDER OR SUPPLIEI AU REHABILITATIO	N AND HEALTHCARE CENTER		6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
		on and interview, the facility	K 0	511	K511 E Utilities-Gas and Elec	tric	09/16/2024
		f 1 electrical receptacle at the			The facility requests paper		
		on was protected. NFPA 70,			compliance for this citation.		
		le 406.6, Receptacle Faceplates			This plan of correction is the		
		uires receptacle faceplates shall completely cover the opening			facility's credible allegation of		
		mounting surface. This			compliance.  Preparation and/or execution	of	
	_	ould affect staff at the nurses'			this plan of correction does no		
	station in 1 of 4 sm				constitute admission or agree		
		F			by the provider of the truth of		
	Findings include:				facts alleged or conclusions s		
					forth in the statement of		
	Based on observation during tour of the facility				deficiencies. The plan of		
		3:10 p.m. on 09/04/24 with the		correction is prepared a			
		, Regional Director of Plant	executed solely because it is				
		nintenance Director, the		required by the provisions of			
	_	the C-Hall nurses' station was			federal and state law.		
	_	interview at the time of the			1)Immediate actions taken for	•	
		gional Director of Plant			those residents identified:		
		nere was a screw in the center			No resident was found to be		
	broken off.	d he believed the cover had			affected by the finding.		
	broken oii.				The faceplate identified at nurse's station C-Hall was		
	This finding was re	viewed with the Executive			immediately corrected.		
		Director of Plant Operations,			2)How the facility identified o	ther	
		Director at the exit conference.			residents:		
					Staff working at 1 of 4 nurse	s'	
	3.1-19(b)				stations (C-Hall) had the pote		
					to be affected by the alleged		
					practice, however none were		
					identified.		
					3)Measures put into		
					place/System changes		
					A facility audit was conducte	d to	
					determine if faceplates were	41= -	
					installed and completely cove	rine	
					opening and seat against the mounting surface.		
					Any identified issues were		
					immediately corrected.		
	1		1				

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	OF CORRECTION	IDENTIFICATION NUMBER  155249	A. BUILDING B. WING	01	COMPLETED 09/04/2024
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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
				4)How the corrective action we monitored:  • The Maintenance Director/designee will present weekly audit of 5 GFCI receptacles monthly to the QA Committee during QAPI Meetito ensure completion of any necessary updates and compliance.  • The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved months.  • The QA Committee will identicany trends or patterns and marecommendations to revise the plan of correction as indicated 5)Date of Compliance:  • 9-16-2024	a API ings ew  for 3 tify ake e
K 0712 SS=F Bldg. 01	failed to conduct quin 1 of 4 quarters. L conducted quarterly conditions. This def residents, staff and visite include:  Based on record revex Executive Director, Operations, and Maa.m. to 12:38 p.m. conducted in the conduction of the conduction	iew and interview, the facility arterly fire drills for 1 of 1 shift SC 19.7.1.6 requires drills to be on each shift under varied icient practice affects all visitors.  iew and interview with the Regional Director of Plant intenance Director from 9:18 in 09/04/24, there was no 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 this plan of correction does not constitute admission or agreed by the provider of the truth of facts alleged or conclusions of forth in the statement of deficiencies. The plan of correction is prepared and/or	ot ment the

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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 01 B. WING 09/04/2024 155249 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE CHATEAU REHABILITATION AND HEALTHCARE CENTER FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE fourth quarter of 2023. Based on record review of executed solely because it is the "Perform Fire Drills" form two second shift required by the provisions of and one third shift fire drills were conducted in the federal and state law. fourth quarter; however, no first shift fire drill 1)Immediate actions taken for documentation was available. Based on interview those residents identified at the time of record review, the Maintenance No individuals were found to be Director stated he was aware that two fire drills affected by the finding. had been conducted during the second shift of 2)How the facility identified other the fourth quarter and no first shift drill during the residents: fourth quarter was conducted. All individuals had the potential to be affected by the alleged This finding was reviewed with the Executive practice, however none were Director, Regional Director of Plant Operations, identified. and Maintenance Director at the exit conference. 3) Measures put into place/ System changes: 3.1-19(b) Facility completed required fire 3.1-51(c) 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 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

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recommendations to revise the

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	F OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/04/2024	
NAME OF PROVIDER OR SUPPLIER  CHATEAU REHABILITATION AND HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  plan of correction as indicated 5.) Date Certain		(X5) COMPLETION DATE	
K 0920 SS=E Bldg. 01	Extens Based on observatifailed to ensure flet substitute for fixed Resource office and smoke compartment wiring and equipm NFPA 70, National Edition, Article 40 specifically permit shall not be used as a structure. This deresidents, staff and compartments.  Findings include:  Based on observatifrom 12:45 p.m. to Executive Director Operations, and Morange flexible extra portable air conditions.	ent - Power Cords and  on and interview, the facility xible cords were not used as a wiring in 1 of 1 Human d above the ceiling in 1 of 3 hts. LSC 9.1.2 requires electrical ent shall be in accordance with l Electrical Code. NFPA 70, 2011 0.8 requires that, unless ted, flexible cords and cables as a substitute for fixed wiring of efficient practice affects visitors in 2 of 4 smoke  on during tour of the facility 3:10 p.m. on 09/04/24 with the h, Regional Director of Plant aintenance Director, 1) an ension cord was used to power attioning unit in the Human the C-Hall. Based on interview ion the Maintenance Director fixed wiring receptacle on the	K 0	920	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 no constitute admission or agreer by the provider of the truth of t facts alleged or conclusions so forth in the statement of deficiencies. The plan of corre is prepared and/or executed s because it is required by the provisions of federal and state 1) Immediate actions taken for those residents identified:  No resident was found to be affected by the finding. 2) How the facility identified of residents:  Visitors, staff, and residents:	et ment che et ection olely law	09/16/2024	

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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

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alleged practice.

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reside at the community have the

• Facility audit was conducted to

identify any flexible cords were not

potential to be affected by the

being used as a substitute for

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 09/04/2024
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	did not know why it  This finding was re- Director, Regional I			fixed wiring 3) Measures put into place/System changes: • The orange flexible extension cord has been removed from Human Resources office and the ceiling above the service 4) How the corrective action with monitored: • The Maintenance Director/designee will present weekly audit (extension cords five rooms to the QAPI Commoduring QAPI Meetings to ension completion of any new necessupdates and compliance. • The report will be reviewed Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved 3 months. • The QA Committee will identify any trends or patterns and material recommendations to revise the plan of correction as indicated 5) Date of Correction: • 9-16-02024	the in hall will be  t a s) of nittee ure sary in d time tify ake ne
K 0923 SS=E Bldg. 01	Storag Based on observation failed to ensure 1 of gases such as oxyge falling. NFPA 99, I 2012 Edition, Section nonflammable gases	Cylinder and Container on and interview, the facility 6 6 cylinders of nonflammable on were properly secured from Health Care Facilities Code, on 11.3.2 states storage for s greater than 8.5 cubic meters less than 85 cubic meters	K 0923	K923E Gas Equipment Cylind and Container Storage The facility requests paper compliance for this citation. This plan of correction is the facility's credible allegation of compliance.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155249		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  09/04/2024	
	PROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	600	EET ADDRESS, CITY, STATE, ZIP COD 6 BRANDY CHASE COVE RT WAYNE, IN 46815	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	ON (X5) D BE COMPLETION DATE
	(3000 cubic feet) sh through 11.3.2.3. Never cylinder or contained 11.6.2.3. Section 1 cylinders shall be properties or compartments.  Findings include:  Based on observation from 12:45 p.m. to Executive Director, Operations, and Matype oxygen cylinder floor not properly of proper cylinder standard transfilling and store the nurses' station in interview at the time Maintenance Direct aforementioned control.	all comply with 11.3.2.1 IFPA 99, Section 11.3.2.6 states or restraints shall comply with 1.6.2.3(11) states freestanding reperly chained or supported stand or cart. This deficient it visitors, staff and esidents in 1 of 3 smoke  on during tour of the facility 3:10 p.m. on 09/04/24 with the Regional Director of Plant intenance Director, one 'E' er was standing upright on the hained or supported in a d or cart, in the oxygen age room located across from in the C-Hall. Based on er of observation, the or acknowledged the		Preparation and/or execution this plan of correction does constitute admission or age by the provider of the truth facts alleged or conclusion forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it required by the provisions federal and state law.  1)Immediate actions taken those residents identified:  No resident was found to affected by the finding.  2)How the facility identified residents:  Visitors, staff, and resider reside in the community has potential to be affected by alleged practice.  3)Measures put into place changes  The identified E type oxycylinder was properly chained/supported in a cyl cart in transfilling storage reacross from nurses' station C-Hall  Staff were educated on postorage.  4)How the corrective action monitored:  The Maintenance Director/designee will presweekly audit of 02 storage monthly to the QAPI Commensure safe, proper storage completion.  The report will be reviewed.	on of s not reement of the s set  /or is of for be dother ints that ave the the system gen inder coom in on roper 02 in will be ent a areas inittee to e

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION				(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155249	B. WING			09/04/2024	
NAME OF PROVIDER OR SUPPLIER  CHATEAU REHABILITATION AND HEALTHCARE CENTER				6006 BF	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE VAYNE, IN 46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY 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
					Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved months.  • The QA Committee will ident any trends or patterns and ma recommendations to revise the plan of correction as indicated 5)Date of Compliance:  • 9-16-2024	ify ke e	

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