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	10/04/2023

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 Complaint IN00418876. Complaint IN00418876 - Federal/state deficiencies related to the allegations are cited at F684 and F698. Survey dates: October 4, 2023 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 5 Medicaid: 63 Other: 16 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 10, 2023	F 0000	10-29-2023 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 October 4, 2023, a complaint survey (IN00418876) 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 deficiencies. 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
Monique Augustine		10/25/2023

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, Monique L. Augustine Health Facility Administrator	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to provide care and services for non-pressure related wound and skin impairments for 1 of 1 residents reviewed (Resident C). Findings include: On 10/4/23 at 9:48 A.M., Resident C's significant other was interviewed. The resident was admitted to the facility following a month long hospitalization for sepsis with septic shock resulting in kidney failure and need for dialysis. She wanted to come to the facility for in-house dialysis treatment but was told it wasn't possible. The facility indicated they would provide transportation to and from an off-site dialysis center. At the first treatment, the resident had been sent back to the facility, prior to dialysis, due to leaking fluids from several wounds. After returning to the facility, she was bandaged up and sent back to dialysis where she received a partial treatment due to scheduling issues at the center. Her 2nd dialysis treatment was on 10/2/23 and she continued to leak fluids from her wounds. During the treatment, the resident became unresponsive and was sent to the hospital where she remained	F 0684	F 684 D Quality of Care 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: • Resident C no longer resides within the facility. 2) How the facility identified other residents: • Any resident residing in the facility with skin impairments had the potential to be affected. Audit conducted to determine	10/31/2023

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	with a diagnosis of sepsis. The Clinical Manager of the dialysis center told the family the resident would no longer be able to receive treatment at their facility due to infection control issues with the leaking wounds. On 10/4/23 at 10:08 A.M., Resident C's record was reviewed. Diagnoses included ESRD (End Stage Renal Disease) with dependence on renal dialysis, hypotension (low blood pressure) of hemodialysis, lymphedema, and morbid obesity. A care plan, dated 9/12/23, indicated the resident was at risk for and had impaired skin integrity. She had lymphatic wounds to her left and right legs, mid-abdomen, buttocks, right posterior calf and left posterior thigh. The goals were to remain free of new skin breakdown, show signs of healing, and be free from signs and symptoms of infection. Interventions included: complete skin inspection every 7-10 days and as needed; complete wound evaluation to monitor the progress of skin condition; medications per physician orders; notify physician of new skin breakdown or worsening skin condition; and wound consult as needed. An admission progress note, dated 9/12/23 at 9:23 p.m., indicated the resident had been admitted to the facility alert and oriented. She had multiple scattered open areas to both lower legs, bottom, and abdomen and redness between skin folds. A hospital discharge summary, dated 9/12/23, had wound care instructions which were: -Wound treatment #1: To both lower leg wounds, wash with gauze and normal saline. Apply Melgisorb (antimicrobial dressing used for wounds with high volumes of drainage), cover with mepilex border and change daily.		treatments were completed per order. Any identified issues were reported to the physician for review. Care plans were updated as needed. 3) Measures put into place/ System changes: • Licensed Nursing staff were educated on the completion of Weekly Skin Observation Assessments, Completion of Non-Pressure Assessments, and care plans were reviewed and updated as required. • Wound Physician/ Wound Care Group will round weekly to address residents with wounds and skin concerns as well as any new areas identified. • Weekly skin assessments will be completed on current residents. 4) How the corrective actions will be monitored: • Director of Nursing/designee is the responsible party for this Plan of Correction with Executive Director oversight. • Director of Nursing/designee will review UDA 3 days a week to determine Weekly Skin Assessments; Non-Pressure assessments are completed timely, accurately and documented. • Director of Nursing/ADON/Designee will audit 5 residents treatment records weekly to determine treatments were provided, documentation	

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	-Wound treatment #2: wash buttocks, perineum, breast/abdominal folds, and posterior upper thighs with wipes and pat dry. Mix equal parts of antifungal (for yeast) cream and zinc oxide. Apply a thick layer on the area 2 times per day and as needed for soilage. If soiled, wash off only the affected areas and reapply mixture to protect the skin as much as possible. A wound care NP (Nurse Practitioner) note, dated 9/13/23 at unknown time, indicated the resident had recently been admitted to the facility and was seen for multiple wounds and skin condition. She had swelling to both legs, had chronic lymphedema, had wounds to her mid abdomen, left lateral lower leg, left posterior thigh, buttocks, and right posterior calf. All wounds were to be cleaned with soap and water, Zinc Oxide paste applied, and left open to air every shift. The wounds to her left posterior thigh and right posterior calf had a scant amount of serosanguineous (wound fluids that contain blood and serum) drainage. The resident had lower extremity swelling and intermittent leg elevation and lymphedema pumps were recommended. 9/15-9/20/23, Resident C was hospitalized with abdominal pain and sepsis. A nurse note, dated 9/20/23 at 1:50 p.m., indicated the resident returned to the facility from the hospital. She hadn't wanted to be moved after transferring to bed and the hoyer lift pad remained under the resident with incontinent pads. The resident continued with scattered wounds on both lower legs due to lymphedema. Her backside was not checked at the time. The resident re-admission skin assessment		present, changes were communicated to physician and care plan updated. • Wound Physician will round weekly and review with Director of Nursing/designee concerns for immediate address or changes in treatment orders. • Care Plans will be reviewed to ensure they reflect residents' status and or changes in resident condition. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5.) Date of compliance:	

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	completed on 9/20/23 indicated the resident had wound/skin concerns present with no changes in skin integrity and had multiple open areas on her backside. There was no assessment of the location, size, surrounding skin, or drainage of her wounds completed. A progress note, dated 9/22/23 at 10:57 a.m., indicated the resident had been sent to the dialysis center but was being sent back to the facility due to open wounds on her body seeping onto the floor of the center; an infection control issue. At 11:36 a.m., the resident arrived back to the facility, her wounds dressed and taken back to the dialysis center for treatment. A wound care NP note, dated 9/27/23, indicated the resident had current wounds to her left lateral lower leg, left posterior thigh, buttocks, right posterior calf, left anterior lower leg and right lower leg. The note hadn't indicated the resident had large amounts of uncontained drainage from the wounds. A progress note, dated 10/2/23 at 4:03 p.m., indicated the dialysis center called to report the resident had been sent to the hospital from the center due to unresponsiveness. The nurse was informed the dialysis center would not allow the resident to return for treatment due to infection control concerns. On 10/4/23 at 11:45 A.M., the Clinical Manager of the outpatient dialysis center was interviewed. She indicated Resident C had received only 2 treatments at the center since her admission to the facility and acceptance to their center. The first visit the resident had at the center was on 9/22/23. When the resident arrived, she was observed with "soaked socks, gown, and pads" sitting beneath			

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	her. There were fluids running off her legs and lying in a pool on the floor beneath her. The resident had to be sent back to the facility as all the fluids were infection control issues for the resident and resident's at the center. She indicated the resident returned to the center after being sent back and having "bandaids" applied to her wounds however, due to chair time constraints, she couldn't get the full dialyzed time on the machine (approximately 4 hours). The resident had her 2nd dialysis treatment on 10/2/23 but continued with seeping wounds and puddles of fluids. The facility allowed her to be placed on the dialysis machine because she had missed visits the week before but were unable to let her come back after the visit due to continued infection control issues and inability to contain body fluids. On 10/4/23 at 1:17 P.M., the DON (Director of Nursing) was interviewed. She indicated staff should document individual wounds and notify the physician, medical NP or wound care NP with changes in the wound or new wounds. She indicated the resident's extreme lymphedema led to her skin splitting apart making it difficult to contain the seeping fluids. She provided a current facility policy, titled "Wound Documentation" which stated: "On admission/readmission a licensed nurse will complete a skin assessment and document any wounds or skin conditions...Wounds will be assessed weekly and documented on the skin pressure and/or non-pressure forms until healed by a licensed nurse...If areas are identified after admission the licensed nurse will assess the areas and complete applicable skin pressure and/or non-pressure forms. The licensed nurse will notify the medical provider for orders...." This Citation relates to Complaint IN00418876.			

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F 0698 SS=D Bldg. 00	3.1-37(a) 483.25(l) Dialysis Based on interview and record review, the facility failed to ensure ongoing communication an with a dialysis facility for 1 of 2 residents receiving dialysis services (Resident C). Findings include: On 10/4/23 at 9:48 A.M., Resident C's significant other was interviewed. The resident was admitted to the facility following a month long hospitalization for sepsis with septic shock resulting in kidney failure and need for dialysis. She wanted to come to this facility for in-house dialysis treatment but were told it wasn't possible. The facility indicated they would provide transportation to and from an off-site dialysis center. He alleged since being admitted to the facility, she had only received 2 dialysis treatments. At the first treatment, the resident had been sent back to the facility, prior to dialysis, due to leaking fluids from several wounds. After returning to the facility, she was bandaged up and sent back to dialysis where she received a partial treatment due to scheduling issues at the center. The resident hadn't received the next 2 treatments due to breakdown of the facility's hoyer lift and inability to physically transfer her. Her 2nd dialysis treatment was on 10/2/23 and she continued to leak fluids from her wounds. During the treatment, the resident became unresponsive and was sent to the hospital where she remains with a diagnosis of sepsis. The Clinical Manager of the dialysis center told he and the family the resident would no longer be able to receive	F 0698	F-698D Dialysis The facility respectfully requests a desk review for this citation Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified: • Resident C no longer resides at this facility. 2. How the facility identified other residents: • Any residents receiving dialysis have the potential to be affected by practice. • Audit was conducted on those residents currently receiving dialysis. Communication binders updated for all dialysis residents. • Licensed nurses were educated on communication and documentation with dialysis centers. 3. Measures put into place/	10/31/2023

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	treatment at their facility due to infection control issues with the leaking wounds. On 10/4/23 at 10:08 A.M., Resident C's record was reviewed. Diagnoses included ESRD (End Stage Renal Disease) with dependence on renal dialysis, hypotension (low blood pressure) of hemodialysis, lymphedema, and morbid obesity. An admission progress note, dated 9/12/23 at 9:23 p.m., indicated the resident had been admitted to the facility alert and oriented. She had multiple scattered open areas to both lower legs, bottom, and abdomen and redness between skin folds. She required use of a hoyer lift for transfers. She would have dialysis on M-W-F. Her vital signs were to be taken prior to going to dialysis to see if dialysis center would take her or give orders to have the resident dialyzed at the hospital. A physician order, dated 9/12/23, indicated to call the Clinical Manager at the dialysis center with the resident's vital signs prior to transporting to the center. The order hadn't indicated to cancel the resident's dialysis if her vital signs were abnormal. A progress note, dated 9/13/23 at 10:09 a.m., indicated dialysis was canceled due to low blood pressure. Dialysis center was notified. A medical NP (Nurse Practitioner) note, dated 9/14/23 at unknown time, indicated the resident had been visited to establish care. While hospitalized, she had been treated for septic shock due to multi-drug resistant bacteria and candida (yeast). She developed acute kidney failure due to sepsis which required dialysis. She had hypotension which required blood pressure raising medications (Midodrine) to treat. She was		System changes: • Nursing staff are educated in communication and documentation with dialysis centers. • Resident dialysis schedules/run times will be reviewed during morning/ clinical meetings. • Notifications will be reported to the Executive Director, DON/designee and physician of any resident that does not receive scheduled dialysis treatments with explanation of reasons. Documentation will reflect notification in the clinical record. • The transportation scheduler will provide a weekly resident dialysis schedule with transportation information to DON/ADON and Executive Director. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing /designee with Executive Director oversight who will audit 3 times weekly those residents receiving dialysis treatment to determine communication, documentation and transportation requirements has been completed. • Identified issues will be immediately addressed with re-education as required. • Audits will continue 3 times weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months.	

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	admitted to the facility for rehabilitation and outpatient dialysis. She had a long history of lymphedema of both lower extremities and had used lymphedema pumps at home. The assessment and plan were to use the lymphedema pumps twice daily for 15-60 minutes, dialysis 3x/week: Midodrine as ordered; send 2 tabs with the resident to dialysis. The medical NP note hadn't indicated the resident had not gone to dialysis on 9/13/23 as scheduled and there was no documentation the NP had been aware of or gave orders to cancel the treatment due to low blood pressure. 9/15-9/20/23, Resident C was hospitalized with abdominal pain and sepsis. A progress note, dated 9/22/23 at 10:57 a.m., indicated the resident had been sent to the dialysis center as scheduled however, was being sent back to the facility due to having the wrong hoyer pad placed under her and open wounds on her body which were seeping onto the floor of the center which was an infection control issue. At 11:36 a.m., the resident arrived back to the facility, her wounds dressed and taken back to the dialysis center for treatment. An after visit summary, dated 9/25/23, indicated the resident had dialysis completed on this day at the hospital. There were no progress notes or orders related to the resident having dialysis at the hospital rather than the dialysis center as scheduled. On 9/27/23, the resident was scheduled for dialysis at the dialysis center. There was no documentation completed to indicate the resident had gone to and received dialysis on this day.		• Review of audits per IDT monthly during QA. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Compliance	

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	A medical NP note, dated 9/28/23, indicated the resident had been seen for a post-hospital visit. There was no documentation the resident had gone to dialysis at the hospital on 9/25/23 or if she'd had dialysis on 9/27/23. There were no new orders and the resident was to continue with outpatient dialysis 3x/week. A medical NP note, dated 9/29/23, indicated the resident was seen for abnormal labs. She received dialysis and had missed her treatment on 9/27/23, because transportation hadn't shown up to take the resident to the dialysis center. The plan was for the facility to send the resident to the ER due to missed dialysis treatments. A progress note, dated 9/29/23 at 12:03 p.m., indicated transportation had not shown up at the facility to take resident to dialysis. The DON (Director of Nursing) contacted transportation. The transportation came to the facility to transport the resident to the ER for dialysis treatment. At 4:56 p.m., the case manager at the hospital called and indicated the resident hadn't qualified for hospital dialysis and was being sent back to the facility without treatment. Lab work was scheduled for the morning and the NP was aware. There was no documentation provided to indicate the dialysis center had been notified of the hospital not dialyzing the resident or to see if there would be an opening the following day for the resident to get her treatment. A progress note, dated 10/2/23 at 4:03 p.m., indicated the dialysis center called to report the resident had been sent to the hospital from the center due to unresponsiveness. The nurse was			

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	informed the dialysis center would not allow the resident to return for treatment due to infection control concerns. On 10/4/24 at 11:24 A.M., the ADON (Assistant Director of Nursing) was interviewed. She indicated the facility bariatric mechanical hoyer lift had broken down the morning of 9/25/23. A rental hoyer lift was ordered and brought to the facility the same day. The resident was sent to the hospital where she received her dialysis. On 9/26/23, staff indicated the rental lift's battery wasn't charging. The resident hadn't been able to go to her dialysis appointment on 9/27/23 due to the mechanical lift not working. On 9/29/23, transportation hadn't shown up in the morning but came in the afternoon to take the resident to the ER for treatment. The resident was transferred into her wheelchair with the lift. The resident returned to the facility after not having her treatment and wanted to get into bed. The ADON indicated on 9/30/23, another hoyer lift was rented as well as a second one to have on hand in case one or the other didn't work. On 10/4/23 at 11:45 A.M., the Clinical Manager of the outpatient dialysis center was interviewed. She indicated Resident C had received only 2 treatments at the center since her admission to the facility and acceptance to their center. Her first treatment was to have been done on 9/13/23 however, the facility canceled it without notifying her or the center. She indicated on 9/12/23, she had spoken with the nurse and informed her the resident had a history of hypotension so she asked the facility to contact her with the resident's vital signs prior to transporting her to the center. If the resident's blood pressure was too low, the Clinical Manager would contact the Nephrologist (kidney doctor) who would determine if the			

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	resident could or couldn't have her treatment and the Clinical Manager would let the facility know. The first visit the resident had at the center was on 9/22/23. When the resident arrived, she was observed with "soaked socks, gown, and pads" sitting beneath her. There was fluids running off her legs and lying in a pool on the floor beneath her. The resident had to be sent back to the facility as all the fluids were infection control issues for the resident and resident's at the center. She indicated the resident returned to the center after being sent back and having "bandaids" applied to her wounds however, due to chair time constraints, she couldn't get the full dialyzed time on the machine (approximately 4 hours). The Clinical Manager indicated the resident missed her scheduled dialysis times on 9/25, 9/27, and 9/29/23 due to a broken hoyer lift and inability to transfer her. The resident returned on 10/2/23 for her scheduled time but continued with weeping wounds and puddles of fluids. The facility allowed her to be placed on the dialysis machine because she had missed visits the week before but were unable to let her come back after the visit due to continued infection control issues and inability to contain body fluids. During dialysis, the resident became unresponsive and was sent to the hospital where she was admitted to the intensive care unit with sepsis. On 10/4/23 at 3:55 P.M., the Clinical Support Nurse was interviewed. She indicated the facility had a policy for pre and post dialysis assessments of the resident and physician orders for dialysis should be followed as ordered, but had no policy regarding care coordination and communication between outpatient dialysis centers and the facility. This Federal tag relates to Complaint IN00418876.			

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	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	3.1-37(a)			