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	08/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/23/21 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Emergency Preparedness survey, Chateau Rehabilitation & Health Care was found 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 85 at the time of this survey. Quality Review completed on 08/25/21	E 0000		
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: 08/23/21 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Life Safety Code survey, Chateau Rehabilitation & Health Care was found not in compliance with Requirements for Participation	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility is fully protected by a Type II EES 350 kW Diesel poewed generator. The facility has a capacity of 99 and had a census of 85 at the time of this survey. All areas providing customary access to the residents were sprinklered. The facility had a detached garage and three sheds providing facility services including storage of old equipment, new beds, mattresses and maintenance supplies that were not sprinklered. Quality Review completed on 08/25/21			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or			

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	automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 4 of 4 hazardous rooms were protected in accordance with 19.3.5.9. This deficient practice could affect 40 residents in three smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/23/21 between 11:30 a.m. and 1:30 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) The conference room was larger than 50 square feet, contained over 20 boxes of PPE supplies, and the corridor door was not equipped with a self-closing device.	K 0321	**K 321 E Hazard Areas** **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 action taken for those residents identified:**	09/03/2021

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	b) The B wing soiled utility room which contained trash and dirty linen did not latch into the frame due to a bent frame. c) The C wing soiled utility room which contained trash and dirty linen did not latch into the frame due to the latch not working. d) The door to the laundry room which contained fuel fired equipment would not self-close due to the door rubbing on the floor. Based on interview at the time of observation, the Maintenance Director agreed all four rooms were hazardous areas, and the doors to the rooms were not self-closing or did not latch into the frame This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		All doors in the facility were evaluated by the Plant Operations staff and corrections were made as needed to ensure compliance. The PPE boxes identified by the surveyor in the conference room were relocated to a proper storage area in the facility. *Conference room photo submitted **2.) How the facility identified other residents:** No residents were affected by this practice. **3.) Measures put into place/ Systemic changes:** Audits of all facility doors will be completed by the Plant Operations staff or designee weekly x3 months; then monthly x3 months to ensure compliance is maintained. **4.) How the corrective actions will be monitored:** Plant Operations staff or designee will audit all facility doors and the conference room weekly x3 months; then monthly x3 months to ensure compliance is maintained. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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. An IDR is requested as all deficiencies have been	

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			corrected. Date or Correction- 9-3-21	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 2 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing	K 0741	**K 741 E Smoking Regulations** **The facility requests paper compliance for this citation.** This Plan of Correction is the	09/03/2021

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	cover devices. This deficient practice could affect staff and 20 residents using the service exit. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/23/21 at 9:30 a.m., in the staff smoking area and outside the service exit there were over 20 cigarette butts disposed on the ground around the exit. Also, there was a plastic trashcan containing cigarette butts and trash. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		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 action taken for those residents identified:** The designated smoking area was cleaned of debris. Staff re-educated on smoking policy. **2.) How the facility identified other residents:** No residents were affected by this deficient practice. **3.) Measures put into place/ Systemic changes:** A smoking area audit will be completed weekly x3 months (11/23/21), then monthly x3 months (2/23/22) by the Plant Operations staff or designee. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater 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.	

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			An IDR is requested as all deficiencies have been corrected related to thhis citation. Date or Correction- 9-3-21	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 3 of 3 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables	K 0920	**K 920 E Electrical Equipment** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or	09/03/2021

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	shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 10 residents. Findings include: Based on observations during a tour of the facility with the Maintenance on 08/23/21 between 11:30 a.m. and 1:30 a.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Unit-Manager office, in room 224, and in room 117. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		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 action taken for those residents identified:** Refrigerators that were found to be plugged into a power strip were plugged directly into an AC outlet. **2.) How the facility identified other residents:** No residents were affected by this deficient practice. **3.) Measures put into place/ Systemic changes:** Refrigerators that were found to be plugged into a power strip were plugged directly into an AC outlet. The Plant Operations staff or designee will audit weekly x3 months (11/23/21), then monthly x3 months (2/23/22) to ensure ongoing compliance. Any issues identified will be immediately corrected per Executive Director. **4.) How the corrective actions will be monitored:** The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA	

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			Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. An IDR is requested as all deficiencies related to this citation have been corrected. Date or Correction- 9-3-21	