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	04/25/2025

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457597, IN00457901 and IN00457935. This visit resulted in a Partially Extended Survey - Substandard Quality of Care-Immediate Jeopardy. Complaint IN00457597 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00457901 - Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00457935 - Federal/state deficiencies related to the allegations are cited at F686. Survey dates: April 22, 23, 24 and 25, 2025 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 84 Total: 84 Census Payor Type: Medicare: 5 Medicaid: 56 Other: 23 Total: 84 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 28, 2025	F 0000	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.	
F 0686 SS=J	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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 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.

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	04/25/2025

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
Bldg. 00	Ulcer Based on interview and record review, the facility failed to ensure a resident received assessment, treatment, and individualized interventions to prevent worsening of a pressure injury to the coccyx. This resulted in the resident developing an unstageable (wound bed is obscured by dead tissues) pressure injury (Resident P). The Immediate Jeopardy began on 1/16/25 when the facility failed to assess an identified pressure injury and provide appropriate treatment and interventions The Administrator, Director of Nursing (DON), Regional Support Nurse and Chief Nursing Officer were notified of the Immediate Jeopardy on April 24, 2025 at 3:49 P.M. The immediate jeopardy was removed on 4/25/25. Findings include: On 4/22/25 at 12:34 P.M., Resident P's family member was interviewed. They indicated the resident resided at the facility from 12/11/24 until 1/21/25 when the family transferred her to another facility due to alleged care issues. Upon admission to the receiving facility, family alleged Resident P was observed with a deep wound on her bottom and her feet were red, swollen, and infected. The wound on the residents bottom was black with green drainage and had to be packed with gauze dressings. The family member indicated she nor other family members were aware of the resident's wound to her bottom or extent of wounds on her feet prior to admission at the receiving facility. The resident passed away on 1/27/25. On 4/22/25 at 1:00 P.M., Resident P's record was reviewed. Diagnoses included dementia with psychotic disturbance, major depressive disorder	F 0686	**The facility respectfully requests to IDR F Tag 686 and are requesting a Face to Face. The facility disputes the citation of F Tag 686 with a scope and severity of IJ for the following reasons. A treatment was in place and completed as ordered by the physician thru the date of discharge of resident P. The surveyor did not complete interviews with the licensed nursing staff who had been completing the said treatments nor did surveyor interview the licensed staff regarding the presence of said pressure area on the coccyx. A complete head to toe skin assessment was documented on day of discharge which disputes any presence of a pressure area on the coccyx at time of discharge. Through the IDR process the facility is seeking to have this tag deleted or in its alternative reduced. The facility seeks the IDR Face to Face option to share information that was available at the time of the survey, however was not presented to surveyor due to fact it was never requested as well as the surveyor did not desire to engage in additional discussion or acceptance of additional information the facility wanted to share with**	05/06/2025

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	04/25/2025

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
	and chronic obstructive pulmonary disease. A Nurse Practitioner (NP) note, dated 12/12/24, indicated Resident P was seen for initial visit to establish care. The resident came from an inpatient psychiatric hospital after having confusion, hallucinations, and behaviors of walking non-stop with little sleep. She was admitted for long term care on the secured memory care unit. An admission Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident had moderately impaired cognition without mood indicators or behaviors. She required set up help for eating, oral hygiene, upper body dressing and personal hygiene. She was independent with bed mobility, ambulation, transfers, and toileting. She was occasionally incontinent of bowel and bladder. She was assessed to not be at risk for developing pressure ulcers, had no current pressure ulcers and was not receiving any skin or ulcer treatments. She had 4 days of occupational therapy (OT) and 5 days of physical therapy (PT) during the assessment period. A skin assessment tool (Braden Scale), dated 12/11/24 at 5:03 p.m., indicated Resident P had no impairment responding to verbal commands and no sensory deficits to limit her ability to feel pain or voice pain; the resident's skin was rarely moist; she was able to walk outside her room 2 times per day and in her room at least once every 2 hours while awake; the resident had no limitation with mobility and could make major and frequent changes in position; the resident had a poor appetite and never ate a complete meal; and had no apparent problem moving in bed and while seated, with sufficient muscle strength to lift up completely during a move. The skin assessment		**surveyor during the investigation.** **1 Immediate actions taken for those residents identified:** Resident P was discharged from the facility on 1/21/25. **2 How the facility identified other residents:** **All residents are at risk to be affected by the deficient practice.** **3 Measures put into place/ System changes:** The nurse managers completed a head-to-toe skin assessment on all residents residing in the facility on 4/24/25. An audit was conducted to ensure all treatments in place and administered as ordered for any identified skin alterations on 4/24/25. A medical records review was completed on all residents by Nursing Supervisor(s) or designee to ensure weekly skin assessments are scheduled and charge nurses in-serviced on need to complete per schedule 4/24/25. The DON and ADON initiated education on 4/24/25 to all licensed nurses on facility policies for Pressure ulcers/Skin Breakdown, clinical protocol, prevention, assessment, and	

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	04/25/2025

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
	tool indicated the resident had no risk for skin impairment. The skin assessment did not indicate the residnet had o skin impairment on admission. Care plans, initiated on 12/12/24, indicated: -Resident was at risk for decline in activities of daily living (ADL). The goal was to maintain her current level of functioning. Interventions included: No staff assist for bed mobility; Use walker during mobility; and 1 staff assist for dressing and bathing. -Resident was at risk for impaired skin integrity. The goal was to remain free of new skin breakdown. Interventions were: Assist resident with turning and repositioning as needed; complete skin inspection every 7-10 days and as needed; encourage good nutrition/hydration and assist as needed; encourage to reposition self if able; encourage/assist as needed to elevate heels off mattress as tolerated; labs per physician order; notify nurse/physician/NP of any new skin breakdown; provide pressure redistribution mattress to bed; and provide a non-irritating surface to reduce friction or shearing forces. -initiated 1/18/25, the resident had a urinary tract infection (UTI) and was at risk for complications. The goal was the UTI would resolve without complications. Interventions were: observe for antibiotic side effects; labs/cultures/diagnostic testing as ordered and report results to physician; and observe for worsening or lack of improvement in signs/symptoms of UTI. A Physical Therapy Progress Report, dated 1/8/25, the resident complained of pain on her feet when standing. She had generalized weakness and unsteady balance while standing. She		wound staging. It also included the use of appropriate treatments and interventions for skin care and management of pressure injuries. The 24-hour report tool will be reviewed routine by the nurse management team to ensure and monitor for ongoing compliance. **4 How the corrective actions will be monitored:** The DON/Designee will complete an audit weekly of observation of treatments, preventative skin care, weekly skin assessments, treatment recommendations, and orders are added and processed into the EHR and TAR, and accuracy of resident assessment of skin alterations and pressure injuries. 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	

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	04/25/2025

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
	required moderate assistance with bed mobility, transfers, and walking short distances. A Physical Therapy Discharge Summary indicated the resident received physical therapy services from 12/24 to 1/20/25. The summary indicated the resident's ability to perform bed mobility and transfers had declined due to presence of bilateral heel sores. An Occupational Therapy Progress Report, dated 1/8/25, indicated her functional skills assessment were: maximal assistance with eating and was dependent for toileting hygiene and toilet transfer. An Occupational Therapy Discharge Summary indicated the resident received occupational therapy services from 12/12/24 to 1/19/25. Her functional skills assessment indicated the resident required maximal assistance with eating and toileting transfers and was dependent for toileting hygiene. She declined in toilet transfer performance due to wounds on her feet. A weekly skin observation form, dated 1/1/25 at 12:04 p.m., indicated new foot concerns had been identified. The resident had "large purple" blisters on both heels. A Braden skin assessment tool dated 1/2/25 at 8:20 a.m., indicated Resident P had slightly limited impairment responding to verbal commands but couldn't always communicate discomfort or need to be turned; the resident's skin was occasionally moist; she was able to walk occasionally for very short distances and spent the majority of each shift in bed or chair; the resident had slightly limited mobility and could make frequent though slight changes in her body and extremity position independently; the resident's nutrition was			

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	04/25/2025

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
	probably inadequate as she rarely ate a complete meal and protein intake was only 3 servings per day; and had a potential problem for friction and shear due to moving feebly and requiring minimum assistance. During a move, skin probably skid against surfaces and she occasionally slid down while in bed or seated in a chair. The skin assessment tool indicated the resident was at risk for skin impairment. A Wound Nurse Practitioner's skin and wound note, dated 1/2/25 at 4:12 p.m., indicated Resident P was seen for skin and wound consultation. The resident was at the facility for rehabilitation and got around in a wheelchair. The resident had no history of a chronic wound or pressure ulcer. She had 2 new blisters to both heels. Physical examination indicated the resident had out of bed mobility with use of a wheelchair; she was awake and alert; confused at baseline. The resident had no lower extremity swelling (edema); had urinary incontinence; and intact skin with no open wounds. Wound assessment: Right heel had a stage 2 (Partial thickness loss of skin; may present as an intact or open/ruptured blister) pressure injury which measured 5 centimeters (cm) by 4 cm and was covered with 100% epithelial tissue (skin in the final stage of healing). The left heel had a stage 2 pressure injury measuring 4 cm by 4 cm, covered with 100% epithelial tissue. Treatment was to cleanse both heels with wound cleanser daily, followed by application of Skin Prep to base of the wounds and left open to air. Preventative treatments and recommendations were to apply moisturizer to resident's skin daily but not massage over bony prominences. The resident was to wear proper fitting footwear to prevent/minimize unwanted pressure and friction. The resident was incontinent and moisture barrier creams were to be provided after thorough skin			

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	04/25/2025

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
	care for each incontinent episode. The resident was at increased risk of skin breakdown and would recommend good hygiene and skin care to prevent skin breakdown. The wound NP recommended to continue with moderate assistance with adl's as needed; application of emollients daily; skin kept clean and dry; barrier cream as necessary; and avoidance of pressure on bony prominence by adhering to turning protocols and floating heels. The care plan on 1/2/25 was not updated to indicate changes in Resident P's condition with development of pressure injuries to both heels; decreased ability to walk; decreased ability to make major, frequent changes to her position; increased moisture due to incontinence and need for thorough skin care after each incontinent episode followed by application of barrier creams; need for interventions to address positioning and sliding down in bed or chair; and need for turning protocols. The care plan was not updated to include interventions reflected from the 1/2/25 skin (Braden) assessment and the 1/2/25 Nurse Practitioner findings. A nutrition/dietary note, dated 1/3/25 at 10:17 a.m., indicated the Interdisciplinary team (IDT) had met. Resident P had blisters to both heels; PT and OT were working with the resident; and there were no dietary recommendations. An IDT note, dated 1/3/25 at 1:58 p.m., indicated the wound NP had evaluated the resident on 1/2/25 and new orders received to cleanse wounds to both heels with wound cleanser followed by skin prep and leaving heels open to air. The resident was to wear foot booties while in bed to help protect her heels. Nursing staff were to monitor and update as needed.			

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	04/25/2025

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
	The care plan was not updated on 1/3/2025 to indicate the need to foot booties for heel protection. A weekly skin observation form, dated 1/8/25 at 9:16 a.m., indicated Resident P's skin was observed to be warm and dry with fair skin turgor. She had no foot concerns and her skin was intact without skin problems. A Wound NP skin and wound note, dated 1/9/25 at 5:14 P.M., indicated Resident P was seen for skin and wound consultation. Wounds to her heels were stable and staff were to continue Skin Prep daily to her heels. During the visit, she was assessed for reported redness to her buttocks which upon exam, was not observed. Staff were to continue use of protective creams. Wound assessment indicated the right heel remained a stage 2 pressure injury measuring 5 cm by 4 cm and covered with 100% epithelial tissue (tissue lining the surface of the wound). The left heel remained a stage 2 pressure injury measuring 4 cm by 4 cm and covered with 100% epithelial tissue. The documentation did not include the wound contained dead tissue. Treatment was to continue with with cleansing the heels with wound cleanser daily followed by application of Skin Prep to base of wounds and heels left open to air. Preventative treatments and recommendations were unchanged: staff were to apply moisturizer to resident's skin daily but not massage over bony prominences; the resident was to wear proper fitting footwear to prevent/minimize unwanted pressure and friction; and moisture barrier creams were to be applied after thorough skin care for each incontinent episode. The resident remained at increased risk of skin breakdown and recommendations remained to continue with			

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	04/25/2025

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
	moderate assistance with adl's as needed; application of emollients daily; skin kept clean and dry; barrier cream as necessary; and avoidance of pressure on bony prominence by adhering to turning protocols and floating heels. A physician order, dated 1/9/25, was for Triad Hydrophilic wound dress external paste (wound dressing) to be applied to buttocks topically every shift for redness. A Treatment Administration Record (TAR), dated January 2025, indicated by nurse initials, Triad Hydrophilic wound dressing was applied, as ordered, from 1/9/25 until 1/21/25. A change in condition form (SBAR), dated 1/11/25 at 8:11 a.m., indicated the resident had increased urinary incontinence and complained of burning and pain with urination. The form indicated the resident had no skin impairment. An order was received to obtain a urinalysis and culture to check for infection. A urine sample was collected on 1/11/25 and received by the lab on 1/14/25. The medical NP reviewed the results on 1/17/25 and ordered an antibiotic-Levofloxacin 500 milligrams (mg) by mouth, 1 time per day for urinary tract infection. A weekly skin observation form, dated 1/15/25 at 10:27 a.m., indicated Resident P's skin was observed to be warm and dry with good skin turgor. She had skin concerns to her right and left heels which were not new. The form indicated the resident had stage 2 pressure injuries to both heels but hadn't indicated measurements or description of the wounds. A Wound NP skin and wound note, dated 1/16/25 at 6:40 p.m., indicated Resident P was seen for			

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	04/25/2025

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
	skin and wound consultation. The resident's blisters to her right and left heels were flattened and firm to touch. Wound assessment indicated the right heel remained a stage 2 pressure injury measuring 5 cm by 4 cm and covered with 100% epithelial tissue. The left heel remained a stage 2 pressure injury measuring 3 cm by 3 cm and covered with 100% epithelial tissue. Treatment was to continue with with cleansing the heels with wound cleanser daily followed by application of Skin Prep to base of wounds and heels left open to air. Preventative treatments and recommendations were unchanged: staff were to apply moisturizer to resident's skin daily but not massage over bony prominences; the resident was to wear proper fitting footwear to prevent/minimize unwanted pressure and friction; and moisture barrier creams were to be applied after thorough skin care for each incontinent episode. The resident remained at increased risk of skin breakdown and recommendations remained to continue with moderate assistance with adl's as needed; application of emollients daily; skin kept clean and dry; barrier cream as necessary; and avoidance of pressure on bony prominence by adhering to turning protocols and floating heels. The progress note hadn't indicated condition of the resident's bottom; if there was new or continued redness to the area as reported on 1/9/25. A Pressure assessment form, dated 1/16/25 at 6:59 a.m., indicated the type of assessment was a weekly status report and not a new skin concern. The resident had a pressure injury to her coccyx, acquired in-house. There was no drainage or signs of infection and the wound bed and skin around the wound bed were intact. The wound			

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	04/25/2025

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
	had well defined edges and shape and the form was marked as unchanged in status. There were no measurements of the wound completed. A physician order, dated 1/16/25 at 11:00 p.m., was for Calmoseptine cream (Moisture barrier that prevents and Helps heal skin irritations from urine, diarrhea, perspiration or wound drainage) to be applied, every shift and as needed, for an open area on the coccyx. The resident was to be turned side to side with pillows to hold the resident in place and turned side to side every 2 hours. A TAR, dated January 2025, indicated by nurse initials, Calmoseptine cream had been applied as ordered on 1/16/25 through 1/21/25. There was no further documentation of the coccyx wound in the medical record. The care plan was not updated to indicate Resident P had developed a open pressure injury to her coccyx or the interventions put into place to prevent worsening of the wound until the day of discharge. A Discharge Instruction form, dated 1/21/25 at 9:55 a.m., indicated the resident was being discharged to another facility on 1/21/25 at 10:30 a.m. She was to be transported to the receiving facility by the receiving facilities transportation van. Her skin condition on discharge, indicated Resident P had a pressure injury to her right and left heels. The form hadn't indicated wound measurements, stage of wounds, nor treatments for the wounds. There were no other forms or notes to indicate the resident had any other wounds or open areas. A Discharge/Transfer/LOA note, dated 1/21/25 at 11:55 a.m., indicated the resident was being discharged to another facility on 1/21/25 at 11:00			

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	04/25/2025

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
	a.m. Records from the receiving facility, were reviewed on 4/23/25 at 2:25 P.M., and indicated Resident P arrived to the receiving facility via their transportation van and nursing summary completed on 1/21/25 at 10:25 a.m. A nurse note, dated 1/21/25 at 12:45 p.m., indicated the resident was alert and oriented to self, president, year and knew she was at a new facility but unsure of the name. She was wheelchair bound and had heel protector boots with her sent from the transferring facility. Skin assessments were completed and indicated the follow wounds were identified: -1/21/25 at 2:56 p.m., right heel wound, black in color, measured 4.8 cm by 3.7 cm. -1/21/25 at 2:59 p.m., left heel wound, black in color, measured 3.3 cm by 2.9 cm. -1/21/25 at 3:02 p.m., an extensive, large and deep wound was observed to the coccyx area. The wound was unstageable and covered with 100% slough with surrounding tissue colored black, blue, and red. The wound had a strong foul odor and measured 5 cm by 3.6 cm and depth was unable to be determined due to slough covering the wound. The family was present and observed the wounds and were shocked at the extensive wounds on her heels and had no knowledge she had a wound on her bottom. The medical NP reviewed the wound assessment and pictures of the wounds and ordered treatment with Dakins solution (anti-septic containing diluted bleach), packing the wound followed by application of 4 x 4 dressing which was to be completed daily and as needed. On 1/23/25, in collaboration between the receiving facility's Medical Director and medical NP, a full assessment was completed which indicated the			

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	04/25/2025

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
	resident had been admitted to the facility with wounds. She was experiencing increased lethargy. New orders were given to administer Rocephin (antibiotic) intramuscularly STAT, start an IV for fluids, obtain labs, and STAT chest x-ray. A medical NP note, dated 1/23/25 at 8:35 p.m., indicated the resident had wounds which were suspected to have underlying infection. A medical NP note, dated 1/27/25 at 9:08 a.m., indicated the resident was lethargic and not speaking. Her coccyx wound was open and seeping foul, green/brown drainage. She had been on Rocephin and Bactrim (antibiotic). Her prognosis was guarded. Her coccyx wound was infected and she was referred to the wound clinic and was being followed by the facility wound NP. She was at high risk of decline and sepsis. A nurse note, dated 1/27/25 at 4:05 p.m., indicated the resident had passed away. On 4/23/25 at 9:56 A.M., Registered Nurse (RN) 5 from the sending facility was interviewed. She indicated Resident P had been prescribed Triad paste for her coccyx and at some point, had been changed to Calmoseptine but was unable to remember dates changed. When asked, she indicated a wound could be viewed through Triad paste and the resident's coccyx was observed daily. She was not aware of an open area being on the resident's coccyx. On 4/23/25 at 4:02 P.M., the Administrator from the sending facilitywas interviewed. She indicated, Resident P did not have an open wound on her bottom. When questioned about the order gotten on 1/16/25 for Calmoseptine, she repeated there was no open area and the nurse who			

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	04/25/2025

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
	obtained the order, was no longer employed at the facility. On 4/24/25 at 10:17 A.M., the wound NP from the sending facility was interviewed. She indicated she had last viewed Resident P's bottom/sacral/coccyx area on 1/9/25 after being told of redness on the residents bottom. She and the Unit Manager (UM) observed the residents bottom and saw no redness. She ordered Triad Hydrophilic wound dress external paste (wound dressing) to be applied to buttocks topically every shift for redness and protection. She indicated she had not been notified an open area had been found on the resident's coccyx on 1/16/25 or a new order had been given for Calmoseptine. When asked, the wound NP indicated Triad paste was white and non-transparent. The paste had to be removed with wound cleanser and re-applied. When asked if a wound could be viewed through the paste, she indicated absolutely not. Calmoseptine was pink in color and was required to be removed with wound cleanser and re-applied. Manufacturer's instructions for Calmoseptine indicated to use the cream around wounds and to not use the cream on deep wounds as a moisture barrier. Manufacturer's instructions Triad indicated the wound dressing be used for open wound with light exudate (drainage) and as a debriding (removal of dead skin) agent. There were no other pressure assessment forms or pressure tracking available for review. On 4/24/25 at 10:50 A.M., Certified Nurse Aide (CNA) 2 from the sending facility was interviewed.			

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	04/25/2025

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
	She indicated she provided care to Resident P during the day shift, Monday through Thursdays. When asked what kind of care the resident required, CNA 2 indicated it was "all hands on care" and she required assistance of 2 staff for transfers due to weakness and wounds on her heels. She indicated the resident used to have a pink cream applied to her bottom but hadn't been used recently prior to her discharge. When asked, she indicated she cared for the resident on 1/13, 1/14, 1/15, and 1/16/25 and 1/20 and 1/21/25. She had not seen any pink cream on the resident's bottom while providing incontinent care on those days. She indicated she toileted the resident approximately every hour and a half because the resident felt she had to go. On 1/21/25, she had another CNA assist her to transfer the resident onto the shower chair after breakfast, and she provided the resident's shower prior to her discharge. She indicated she saw some "slight" redness on her bottom but no open sores. On 4/24/25 at 12:35 P.M., the Director of Nursing (DON) and Unit Manager (UM) at the receiving facility were interviewed. They indicated Resident P arrived to their facility on 1/21/25 at 10:25 a.m. via their facility transport van. She arrived in a transport wheelchair which appeared small and was immediately transferred to a different wheelchair. She had been groggy but interacted with family present. She was in the wheelchair until after lunch and then put to bed. Skin assessments were completed at the times provided in their records. The UM indicated surprise when she assessed the wound on her coccyx because she nor the DON had been made aware of the wound prior to admission. The wound was extensive and deep. It was located on her coccyx right above the crack of her buttocks which was very dry. There was no barrier cream or			

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	04/25/2025

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
	paste observed on her buttocks or wound. The wound was black and covered with eschar (dead skin) and had a foul odor. The eschar appeared sunken and was not flush with the surrounding skin. When asked, the UM indicated the coccyx wound was not hidden in skin folds and had been immediately observed and smelled upon removal of her brief. Pictures of the wound on her coccyx and right and left heels were taken in addition to an area of redness and swelling on her left earlobe and all areas measured and documented. The medical NP, present in the facility, reviewed the pictures of the wounds and gave orders for Dakins solution, pack the wound and cover with a dressing. Both indicated the resident had increased lethargy, abnormal labs, and worsening of the wounds. She passed away on 1/27/25. Manufacturer's instructions for Dakins solution indicated to use on wounds with light to moderate drainage as a debriding agent. On 4/24/25 at 1:41 P.M., the Medical NP at the receiving facility was interviewed. She indicated she had not been aware of any diagnosis or condition the resident had which would have caused her skin breakdown. She observed pictures of the wounds, spoke with the resident and her family and ordered treatment to the wound on 1/21/25 and completed a full assessment with the Medical Director on 1/23/25. A current policy, titled "Skin and Wound Management" was provided by the DON on 4/24/25 at 11:57 A.M. indicated:"Risk Assessment: Assess the resident on admission (within eight hours)...Inspect the skin on a daily basis when performing or assisting with personal care or ADL's...Identify any signs of developing pressure injuries (i.e., non-blanchable redness)...Inspect			

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	04/25/2025

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
	pressure points (sacrum, heels, buttocks, coccyx, etc)...Monitoring: Evaluate, report and document potential changes in the skin; Review the interventions for effectiveness on an ongoing basis...Assessment and Recognition...the nurse shall describe and document/report the following...pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; pain assessment; mobility status; current treatments including support surfaces; and all active diagnoses...the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing...dressings, and application of topical agents...." The Immediate Jeopardy that began on 1/21/25 was removed and the deficient practice corrected on 4/25/25 when the facility re-educated all licensed nurses on facility policies for Pressure ulcers/Skin breakdown, clinical protocol, prevention, assessment and wound staging, but will remain at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy. This Citation relates to Complaints IN00457597, IN00457901 and IN00457935. 3.1-40			