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 _____	C 09/15/2022

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

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F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00389258, IN00389460, IN00389533, IN00389595

Complaint IN00389258 - Unsubstantiated, due to lack of evidence.

Complaint IN00389460 - Unsubstantiated, due to lack of evidence.

Complaint IN00389533 - Unsubstantiated, due to lack of evident.

Complaint IN00389595 - Substantiated. Federal/State deficiency related to the allegation is cited at F689

Survey date: September 15, 2022

Facility number: 000153
Provider number: 155249
AIM number: 100266910

Census Bed Type:
SNF/NF: 89
Total: 89

Census Payor Type:
Medicare: 5
Medicaid: 69
Other: 15
Total: 89

This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on September 23,

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

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F 000	Continued From page 1 2022.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to appropriately transfer a resident who required the extensive assistance of two staff members. One staff member transferred the resident from chair to the bed using a bear hug and a short time later the resident was observed lying in bed with her foot/leg in an unnatural position facing the left leg, which resulted in the resident found with a right femur compression fracture for 1 of 3 residents reviewed for accident hazards. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/15/22 at 11:00 A.M. The resident's diagnoses included, but were not limited to, unspecified protein-calorie malnutrition, unspecified dementia with behavioral disturbance, disorder of bone density and structure, abnormal weight loss, and age-related osteoporosis without current pathological fracture. A progress note, dated 8/29/22, indicated the	F 689	Past noncompliance: no plan of correction required.	

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facility staff heard the resident yelling and they opened the resident's door. The staff observed the resident lying in bed, the bedding was off, and her right leg was in an unnatural position with her foot pointed to the left leg. They observed a discoloration (black), resident's right foot was cool to touch, and they were unable to obtain a pedal pulse. The staff notified the NP, DON, resident's sister, and called 911.

An annual Minimum Data Set (MDS) Assessment, dated 8/25/22, indicated the resident required the extensive assistance of two staff members with transferring.

A current care plan, dated 2/11/21, indicated The resident required two staff members physical assistance for transferring.

The employee statements were provided by the Administrator on 9/15/22 at 12 P.M. The statements indicated the following:

On 8/30/22, CNA (Certified Nurse Aide) 2 indicated CNA 3 had asked CNA 2 to assist with putting Resident B to bed. CNA 2 arrived in the resident's room and she was in her chair. CNA 2 indicated she helped put Resident B into bed and CNA 3 finished providing care. CNA 3 asked CNA 2 if Resident B was combative with care, CNA 2 indicated yes and to put the resident's hand on the bedrail when turning her. CNA 2 exited the room.

On 8/30/22, CNA 3 indicated she took Resident B to her room, started to undress her and the resident was being combative. CNA 3 then asked CNA 2 for assistance. CNA 3 indicated CNA 2 picked up Resident B by herself and sat her in the

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bed. Resident B turned herself and laid down herself. CNA 2 instructed CNA 3 how to roll her and where to place her hand. CNA 3 placed her bed in lowest position, pulled up the covers and resident appeared to be falling asleep.

On 8/29/2b2, LPN (licensed Practical Nurse) 4 indicated at 5 PM, Resident B was sat upright in her geri-chair fully clothed. The LPN assisted Resident B with dinner in the dining room. She then brought the resident out of the dining room and sat her beside the fish tank. Resident B's legs were in a sitting position with knees evenly bent.

On 8/30/22, CNA 7 indicated he had assisted with ADL (activities of daily care) approximately at 6:30 P.M. and did not notice anything out of the ordinary. After performing ADL care, CNA 7 transferred the resident to her wheelchair without any complications. The statement did not indicate any other staff assisted with the transfer.

On 9/7/22, QMA (Qualified Medication Assistant) 6 indicated she had observed CNA 2 and CNA 3 enter Resident B's room together. After a few minutes CNA 2 exited the room and shut the door while CNA 3 remained in the room. The resident was not screaming at the time. The QMA went to check on Resident B and observed her leg, she knew something was wrong, and notified LPN 4.

During an interview on 9/15/22 at 11:30 A.M., the Administrator indicated on the evening, of 8/29/22, CNA 2 and CNA 3 had assisted Resident B into bed. CNA 3 asked CNA 2 if the resident was usually combative, CNA 2 indicated yes, but if you help her place her arm on the bedrail she would be able to hold onto the rail. CNA 2 then

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exited the room. CNA 3 had placed her hand on the resident's hip to assist with rolling. The resident did not indicate any sign of injury at the time. CNA 3 continued to provide care and placed the resident's bed in lowest position and exited the room. Staff had heard Resident B screaming and the staff had then went in to check on the resident. The staff indicated the resident was in bed and they observed a fracture/displacement of Resident B's hip. The nurse was then called into the room to assess the resident and then the hospital was called. The Administrator also indicated he thought the pressure placed on the resident's hip during care could have been too much.

During an interview on 9/15/22 at 2:04 P.M., the DON indicated Resident B had fallen a couple days prior to 8/29/22, but the resident had no injuries. On the evening of 8/29/22, CNA 3 and CNA 2 transferred the resident into bed around 7:00 P.M., then CNA 2 exited the room and the resident was in a natural position. CNA 3 provided care and then left the room. At approximately 7:30 P.M. the staff overheard Resident B screaming. CNA 2 and LPN 4 walked into the resident's room and found her in an unnatural position. She had interview multiple staff, but all the stories were different.

During an interview on 9/15/22 at 2:33 P.M., LPN 4 indicated she had assisted Resident B with dinner on 8/29/22 and the resident ate well. After dinner she had sat the resident in her wheelchair by the nursing station and went on a 15-minute break. She had returned from break and went to assist with another resident when she heard Resident B screaming. She went to check on Resident B with CNA 2. She observed the

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resident's gown and blanket off, the resident was holding onto her loose brief and grimacing. She went to reach for the resident's gown and observed the resident's foot was in an abnormal position. The back of the resident's knee was discolored and her foot was cool to touch. She called the NP and was instructed to send the resident to the Emergency Room (ER). She had told the Emergency Medical Services (EMS) that the resident was lying in bed and was found to have her foot/leg in an unnatural position facing the left leg. Resident B had fallen forward out of her wheelchair a couple days prior, but no injuries were noted.

During an interview on 9/15/22 at 2:47 P.M., CNA 2 indicated on the night of 8/29/22, CNA 3 had asked CNA 2 for assistance with Resident B. She had transferred resident by bear hugging her, unsure on time, by herself. CNA 3 had asked her if it was normal for Resident B to be combative, CNA 2 indicated yes, but the resident would help with rolling if you placed her hand onto the side rail. CNA 3 indicated she then left the room, unsure of time. She later heard Resident B yelling, She and QMA 6 entered the room and observed Resident B's legs in a deformed position. She had then asked LPN 4 to observe the resident.

During an interview on 9/15/22 at 4:35 P.M., the Emergency Room Charge Nurse 8 indicated on 8/29/22, Resident B was sent to the hospital due to the resident found in bed with a hip deformity per the facility. The story was inconsistent with the injuries observed.

The physician's note, dated 8/29/22, indicated Resident B had a comminuted intertrochanteric

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right femur fracture with posterior lateral angulation (bone broken into 3+ pieces, compression fracture). The ER Charge Nurse was unable to provide any additional information.

A corrective action form, dated 9/6/22, was provided by the Administrator on 9/15/22 at 12:00 P.M. The formed indicated CNA 2 had failed to provide a safe transfer for Resident B.

During an interview on 9/15/22 at 5:17 P.M., CNA 2 indicated a proper transfer would not include a bear hug. A proper transfer included a gait belt and two staff lifting on each side of the resident.

During an interview on 9/15/22 at 5:17 P.M., QMA 9 indicated a proper transfer for a resident who required extensive- total assistance would require two staff. The resident's wheelchair would be place close to the bed with wheels locked. Each staff would place their arms under the resident's arms on each side and grab the back of their pants and then pivot. The facility did not use gait belts.

During an interview on 9/15/22 at 5:20 P.M., the Administrator and Regional Nurse indicated CNA 2 transferred Resident B by herself and should not have. The proper transfer would have included a 2-person transfer.

An incident report, dated 8/29/22, was provided by the Director of Nursing (DON) on 9/15/22 at 10:00 A.M. The preliminary reports from the hospital indicated Resident B had a right femur fracture. The follow-up report, dated 9/1/22, indicated the investigation was completed. All staff were interviewed, and statements were received. The DON, Administrator and Regional

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Nurse had re-enacted the scenario based on the information gathered and was unable to determine the cause of the injury. The follow-up report, dated 9/3/22, indicated additional information was provided. The information provided indicated injury could have occurred while transferring the resident from the wheelchair to the bed. The NP also provided the facility information which indicated the resident had a diagnosis of osteopenia with a prior fracture from 3/2021. The staff were educated on proper transferring/ activities of daily living care and the resident's care plan was updated.

A policy, titled "Activities of Daily Living," dated 11/1/20, was provided by thee Administrator on 9/16/22 at 5:43 PM. The policy indicated... "this policy is a guideline only. Each resident has his or her own set of circumstances which may require this policy not to be followed. The needs of each resident supersede the policy."

The facility corrected the deficient practice prior to the beinginning of the current survey, on 9/9/2022, after completeding review of all residents, care plans, progress notes; staff education; monitoring; and clinical competency validations.

This Federal tag relates to Complaint IN00389595

3.1-45(a)(2)