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	05/18/2023

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

(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 IN00406632 and IN00408095. Complaint IN00406632 - Federal/state deficiencies related to the allegations are cited at F804. Complaint IN00408095 - Federal/state deficiencies related to the allegations are cited at F677. Unrelated deficiencies are cited. Survey dates: May 17 and 18, 2023 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 2 Medicaid: 74 Other: 11 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed May 22, 2023	F 0000	5-30-23 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis Indiana 46204 RE : Complaint survey: Survey Event ID Y9G411 Chateau Nursing and Rehabilitation 6006 Brandy Chase Cove Fort Wayne IN 46815 Dear Ms Buroker: On May 18, 2023 a complaint survey ID Y9G411 was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request 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 of 6-9-23. Please feel free to call me with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Vasil	Executive Director	05/30/2023

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.

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	05/18/2023

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

(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
			any further questions at 1-260-486-3001. Respectfully submitted, Cathy Vasil Executive Director	
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.			

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	05/18/2023

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

(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
	§483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to ensure grievances were resolved in a timely manner for 3 of 3 months reviewed. Finding include: On 5/18/23 at 11:06 P.M., the Resident Council President was interviewed. During the interview, she indicated there had been several unresolved concerns during the past few months. Grievances included, long call light response times, not getting showers as scheduled or requested, housekeeping services, and dietary services. She indicated, it took on average, 45 minutes to an hour to get a call light answered. Food served on room trays were cold, portions were not consistent between residents and at times, there wasn't enough food. They had a food committee meeting once a month however, nothing changed. The kitchen was supposed to use hot plates on the room trays to try and keep the food warm but hadn't used them consistently because there weren't enough of them for all residents to use. She indicated the departments completed a Resident Council Follow Up Form for each grievance. The form listed the action taken however, issues were not resolved and continued month after month. Resident Council meeting minutes reviewed included the following concerns:	F 0565	**F-565 Resident/Family Group and Response** **The facility respectively 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 counsel minutes reviewed. Areas of concern forwarded to responsible department head for resolution. **2. How the facility identified other residents:** All resident that reside in the facility have the	06/09/2023

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	05/18/2023

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

(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
	-3/13/23: Issues with getting showers as scheduled; inconsistent ice water passes; poor job of housekeeping cleaning rooms; and dietary concerns including small portions and appropriate temps were to be addressed at the food committee meeting. -4/10/23: Resident's were not satisfied with the follow ups received. Concerns for this month included: Lack of showers even when asked; call light wait time too long when toileting needed, especially on 3rd shift; toilet bowls and rooms not being cleaned; dietary not serving proper temp of food, and too small portions. -5/8/23: Resident's were not satisfied with the follow up received. Concerns for this month included: call light response time slow; ice water not being passed; and dietary serving too small of portions. On 5/18/23 at 11:25 A.M., the Activities Director who conducts the Resident Council meetings was interviewed. Residents had voiced issues brought to the meetings hadn't been addressed and resolved and the same issues continued month after month. Following Resident Council meetings, she would give the grievances to the individual departments for follow-up which they returned to her prior to the next meeting. 3.1-3(l)		potential to be affected by delinquent practice. **3. Measures put into place/ System changes:** Responsible department heads educated on the expectations for resolution of concerns brought forth in resident counsel. Education provided to nursing staff related to call light response expectation, passing of fresh ice water and the provision of scheduled showers. Education provided to dietary staff on palatable food temperatures and utilization of hot plates and proper portion sizes. Education provided to housekeeping staff related to expectations of room cleanliness. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive Director or designee. Identified areas of concern will immediately be reviewed after resident counsel and addressed within 72 hours post council meeting. Call light response, ice water distribution, shower completion and food palatability audits will be reviewed during scheduled morning IDT meetings and monthly during Quality Assurance. Audits will continue for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise 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	05/18/2023

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

(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
			plan of correction as indicated. 5. **Date of Compliance: 6/9/2023**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provide assistance with toileting and incontinent care for 1 of 3 residents reviewed (Resident E). Findings include: On 5/17/23 at 12:04 P.M., Resident E's record was reviewed. Diagnoses included morbid obesity, diabetes, muscle weakness, and need for assistance with personal care. A quarterly MDS (Minimum Data Set) assessment, dated 4/18/23, indicated the resident had no cognitive impairment, no behaviors, and no rejection of care. He was frequently incontinet of bowel. He was non-ambulatory and required extensive assistance from 1 staff member for toileting and transfers. Care plans indicated the following: -Resident E had a self care deficit and needed assistance with his activities of daily living (ADL). The goal was for the resident to be clean, dry, and well-groomed. Interventions were to transfer with assistance of 1 person and provide one person physical assist with toileting.	F 0677	**F-677 ADL PROVIDED FOR DEPENDENT RESIDENTS** **The facility respectively 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 E offered and accepted incontinence care as needed/indicated. Care plans reviewed and updated as required	06/09/2023

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	05/18/2023

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

(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
	-Potential for impaired skin integrity. The goal was to have no skin breakdown. Interventions included: provide pericare (washing of genital and rectal areas). On 5/17/23 at 1:24 P.M., Resident E was interviewed by phone. He indicated he wasn't feeling well with recent stomach issues. On 5/5/23, he had several bouts of diarrhea and alleged staff refused to assist him with getting cleaned up or emptying his urinal. He indicated he felt "abandoned" by staff. A nurse progress note, dated 5/5/23 at 6:59 a.m., indicated the resident had been lying in bed without a brief on. He had a bowel movement in bed and requested the staff clean him up. The nurse indicated in the note the resident was capable of walking to the bathroom and toilet self. On 5/18/23 at 11:58 A.M., CNA 9 (Certified Nurse Aide) was interviewed. She indicated ADL care provided to the residents, including showers, was charted in the computer every shift. On 5/18/23 at 12:52 P.M., CNA 8 was interviewed. She indicated during the week, she would care for Resident E. He would put on his light and she would go assist him with care. He required much encouragement to care for himself. When he first admitted to the facility, CNA 8 indicated he was not able to walk but was able to get himself into his wheelchair from bed with supervision and transfer himself on and off the toilet. He wasn't wanting to do things for himself now and she wasn't sure if he was just being "lazy" or if there was something physically wrong. On 5/18/23 at 3:02 P.M., the MDS nurse provided a current copy of the resident's Kardex		to meet resident ADL care needs. **2. How the facility identified other residents:** Any residents that is dependent for ADLs and incontinent of bowel and bladder have the potential to be affected by deficient practice. **3. Measures put into place/ System changes:** Facility staff educated on components of F677 ADL provided for dependent residents. Education provided on the proper procedure for incontinence care for residents. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit 5 random residents for incontinence care completion 3 times weekly. Audits will be reviewed monthly during Quality Assurance. Audits will continue for 6 months and or until 100% compliance is achieved for 3 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: 6/9/2023**	

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	05/18/2023

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

(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
	(information to CNA's on how to care for the resident). The Kardex indicated Resident E required extensive assistance from 1 person for transfers and toileting, was non-ambulatory, and frequently incontinent of bowel. An Occupational Therapy (OT) Discharge Summary form indicated the resident had received OT services from 4/5/23-5/10/23. At the start of therapy, he was dependent on staff for assistance with toileting and pericare. On 4/27/23, he continued to be dependent on staff for toileting and pericare. On 5/10/23, he was discharged from OT services but continued to need partial to moderate assistance with toileting and pericare. On 5/18/23 at 4:18 P.M., the Director of Nursing (DON) provided a print out of the 24 hour CNA care provided to Resident E from the past 30 days. On 5/4/23 at 9:59 p.m., the resident was provided limited assistance of 1 with toileting. There was no documentation for care provided on the night shift from 5/4-5/5/23. On 5/5/23 at 1:59 p.m., Resident E was provided with extensive assistance of 1 with toileting. CNA's were to chart in the computer, every shift, the ADL care provided to residents. This Federal tag relates to Complaint IN00408095. 3.1-38(a)(3)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that			

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	05/18/2023

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

(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
	conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food at a palatable temperature for 4 of 6 residents interviewed for food temperatures (Resident L, Resident F, Resident N, and Resident H). Findings include: On 5/17/23 and 5/18/23, interviewable residents, identified by the facility, indicated the following concerns with meals: -Resident L, indicated the food was "ok" but at times cold depending on when staff passed the room trays. They could ask staff to warm up the food but indicated they were tired of asking them to do so. -Resident F indicated they preferred to eat all meals in their room and received a room tray. The food was always cold. They had filed a grievance and dietary was supposed to use hot plates to keep the food warm. The kitchen had used these for awhile which had helped but were back to not having them and food was cold. -Resident N was observed lying in bed with a tray in front of them. The tray had an uneaten hamburger on it. The resident was munching on a bag of doritoes. They indicated the food was not good, was always cold, and portions were not consistent from person to person. Staff would warm up food if requested but they no longer asked because it "wasn't worth it". The facility	F 0804	**F-804 Nutritive Value/Appear, Palatable /Prefer Temp** **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:** Residents were reminded about the ability to ask for alternate meal or replacement meal when dissatisfied with quality or temperature of food. Alternate menu and Monthly menu provided to all residents. **2. How the facility identified other residents:** All residents	06/09/2023

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	05/18/2023

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

(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
	offered alternatives such as a hamburger, hot dog, or grilled cheese but was tired of the same food. They indicated the facility was aware of the ongoing issues with food temperatures and choices. Residents were told room trays were served first before the dining room so the food would be warm, however, passing of the hall trays was dependent on staff who would not always pass them immediately and the food would get cold. The indicated they hadn't paid attention to the use of hot plates but pointed to their plate and the absence of one. -Resident H indicated food served on room trays were cold, portions were not consistent between residents and at times, there wasn't enough food. They had a food committee meeting once a month however, nothing changed from month to month. The kitchen was supposed to use hot plates on the room trays to try and keep the food warm but hadn't used them consistently because there weren't enough of them for all residents to use. Confidential staff interviews indicated: -Staff 2 indicated hot plates were "never used" on room trays. -Staff 4 indicated it was "hit or miss" whether room trays had a hot plate or not. -Staff 6 indicated all residents didn't get a hot plate because the kitchen hadn't enough of them to use. They would warm up the food if requested by the resident. On 5/18/23 at 12:48 P.M., staff were observed collecting room trays from residents who resided on halls C2 and C3. There were 6 room trays without a hot plate and 3 with a hot plate. On 5/18/23 at 1:08 P.M., the Dietary Manager was interviewed. Food temperatures were checked		have the potential to affected by deficient practice. **3. Measures put into place/ System changes:** Facility staff and dining staff educated on components of F 804 Nutritive Value/Appear, Palatable /Prefer temp. Quote obtained for hot plates and order in progress. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Administrator/designee who will audit 5 residents' satisfaction with meal service for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 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 6-9-23**	

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	05/18/2023

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

(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
	prior to room tray carts going out and were at correct temperatures however, floor staff were responsible for passing the trays and she wasn't sure how long it took them to do so. She indicated, she had approximately 40-45 hot plates in the kitchen but nursing staff hadn't always returned the hot plates when trays were collected so were short of plates at times. She indicated she was going to order more hot plates. This Federal tag relates to Complaint IN00406632. 3.1-21(a)(2)			