| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155249 | A. Building<br>B. Wing | 09/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Chateau Rehabilitation and Healthcare Center | 6006 Brandy Chase Cove<br>Fort Wayne, IN 46815 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147<br><br>Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment, evaluation and non-pharmacological approaches were identified and implemented, prior to decreasing a resident's anti-psychotic medication prescribed to treat behavior symptoms for 1 of 2 residents reviewed (Resident B).<br><br>Findings include:<br><br>An Indiana reported incident, dated 8/28/24 at 6:01 p.m., indicated Resident B was agitated while walking around in the dining room of the secured memory care unit (MCU), had thrown silverware at staff and then threw herself onto the floor. She was sent to the hospital and treated for a right hip fracture.<br><br>On 9/24/24 at 2:35 P.M., Resident B was observed lying in bed in her room. She was confused but articulate and appeared to enjoy visiting. She indicated she had retired from a state hospital, had spent most of her life caring for children with mental illness and had always been a caregiver. When asked, she denied pain; she indicated some female doctor had cut open her hip and she had a huge wound. She was irritated with the doctor who operated on her because she hadn't spoken directly to her and hadn't come to see her since the surgery. She hadn't sounded angry but indicated she was leaving this place today because all she was doing was lying in bed and that wasn't her. She wasn't getting therapy and was caring for herself so believed she didn't need to be here and could go home.<br><br>On 9/24/24 at 10:24 A.M., Resident B's record was reviewed. Diagnoses included, dementia with behavioral disturbances, anxiety disorder, and severe malnutrition. The resident had been hospitalized , prior to admission, with worsening confusion and fractured left ankle.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A hospital note, dated 8/21/24 at unknown time, indicated the resident was seen for a psychiatric consult. The psychiatric physician indicated he had seen the resident during a previous hospital stay on 6/25/24 for evaluation of confusion and psychosis. At the time, she presented with cognitive impairment, visual hallucinations and paranoid delusions. On 7/30/24, the physician indicated he declared she hadn't the capacity to make decisions. She was tried on a low dose of Risperdal (anti-psychotic) without clear benefit so was started on Zyprexa 5 milligrams (mg) by mouth at bedtime approximately 2 weeks prior. She was hospitalized again on 8/16/24 for confusion, failure to thrive, poor appetite and not eating/drinking. He met with the resident and asked about her previous hallucination and paranoid delusion regarding strangers at home. She indicated nobody had bothered her recently. Psychiatric problems were: Personality disorder from 2013 to present time; major neurocognitive disorder due to multiple etiologies with psychotic and behavioral disturbance from 6/25/24 to present; and major depressive disorder from unknown time to present. Current psychiatric medications were: Pristiq (anti-depressant), Gabapentin (used for chronic pain), Hydroxyzine (sedating anti-histamine), and Zyprexa (an antipsychotic) 5 mg at bedtime.<br><br>-Assessment and Recommendations: Resident presented with cognitive impairment, disorientation, poor memory, confabulation (memory error causing person to create false or distorted memories), reduced executive functioning and impaired judgement. She was, again, determined unable to make decisions about her health care based on cognitive impairment, poor self care and poor insight. She was to continue on Zyprexa 5 mg at bedtime for psychosis. It was recommended she be discharged to a memory care unit for dementia care.<br><br>A nurse note, dated 8/24/24 at 6:18 p.m., indicated the resident had arrived to the facility with her family. She had a fractured left ankle with a boot in place for comfort when weight bearing. She complained of some pain in her shoulders and right arm and had a scabbed area over her left elbow from a previous fall.<br><br>A physician order, dated 8/24/24 at 8:00 p.m., was for Zyprexa 5 mg by mouth at bedtime for schizophrenia [sic].<br><br>A Baseline Care Plan Meeting, dated 8/26/24 at unknown time, indicated a meeting was held with staff. Resident B's daughter attended by phone. Prior to her admission to the facility, she had lived by herself at home using a wheelchair for mobility, but since her hospitalization , her daughter believed she may require long term placement. The resident's goal was to remain in the facility as she was doing well, was adjusting to her roommate, socializing and participating in activities. Her cognitive assessment, indicated she had moderately impaired cognition. The resident smoked but would only do so when her daughter was present. Her medications were reviewed and indicated the resident was prescribed as-needed [sic] antipsychotic medication. According to her family, she could become verbally aggressive with them. There was no documentation of non-pharmaceutical interventions or behavioral health interventions put in place to be used in addition to antipsychotic medications to treat her behaviors. There was no documentation to indicate the need to decrease her antipsychotic medication at the time nor documentation of the daughter's knowledge of the plan to decrease the medication or agreement to do so.<br><br>A Social Service note, dated 8/27/24 at 12:13 p.m., indicated a Gradual Dose Reduction (GDR) meeting was held to discuss the resident's use of anti-psychotic medication (Zyprexa). It was determined the dose should be reduced and a new order was received, per the Psychiatric NP, to decrease the dose of Zyprexa from 5 mg to 2.5 mg at bedtime for 14 days, then discontinue the medication.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A nurse note, dated 8/28/24 at 5:11 p.m., indicated Resident B had been agitated, walking around in the dining room, wearing only socks, carrying a cup of coffee. She kept going back and forth to the beverage cart, attempting to pour a peer some coffee. Staff attempted to re-direct her without success. She was observed to yell at and throw silverware at staff and then threw herself to the floor. The resident immediately complained of pain to her right leg when on the floor. She was transported to the hospital where she was admitted for a fractured right hip. She underwent surgical repair of the hip fracture and returned to the facility on [DATE]. She was readmitted to a rehabilitation room not located on the secured MCU.<br><br>A Medication Administration Record (MAR) dated August 2024 and initiated 8/26/24, indicated behaviors to be tracked for use of antipsychotic medication on each shift was delusions. There were no delusions documented on 8/26, 8/27, or 8/28/2024.<br><br>On 9/2/24, Resident B's re-admission orders included, Zyprexa 5 mg by mouth at bedtime for dementia with behavioral disturbance.<br><br>Behaviors of delusions were tracked on the MAR dated September 2024. On 9/4/24, during the evening shift, the resident had 4 delusions but there no other delusions documented through 9/23/24. The MAR hadn't indicated the resident had other behaviors which were to be monitored.<br><br>A care plan, initiated 9/3/24, indicated the resident was at risk for impaired psychosocial well-being due to impaired cognition, sensory deficits, communication deficits, and displayed episodes of wanting to elope. She had behaviors of believing she was at a resort or country club. She had behaviors of flailing her arms, kicking, pinching, and spitting at staff, throwing herself on the floor while trying to be assisted, throwing dishes and silverware at staff; physical and verbal aggression towards staff; and making false accusations against others. Interventions included: monitor and document episodes of inappropriate behaviors and notify the NP when behaviors persist or won't deescalate; monitor behavior episodes and attempt to determine underlying cause.<br><br>On 9/6/24 at an unknown time, a letter from Resident B's daughter was received by the facility. The letter indicated a request to have no further reductions made in the resident's psychotropic medications due to a history of catastrophic psychiatric reactions in prior attempts at medication reductions.<br><br>A psychiatric NP note, dated 9/10/24 at unknown time, indicated the resident engaged in conversation but was easily distracted. Staff reported an increase in her behaviors of verbal and physical agitation not easily redirected. She was currently prescribed Zyprexa to be increased to target her increased symptoms. Her mental status exam indicated she was frail, underweight, oriented with impaired judgement and insight. She was anxious but had no delusions or hallucinations. The assessment and plan was to continue use of Pristiq for depression and increase the dose of Zyprexa from 5 mg at bedtime to Zyprexa 2.5 mg by mouth 2 times per day and Zyprexa 5 mg by mouth at bedtime.<br><br>Resident B's baseline care plan didn't indicate she was prescribed Zyprexa to treat psychosis, delusions and hallucinations. There was no documentation of indications for withdrawing the antipsychotic medication nor non-pharmaceutical interventions put in place prior to decreasing the dose. There was no documentation to indicate the resident's family member had been notified and approved of the decrease in the use of Zyprexa.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Hospital psychiatrist notes, dated 8/21/24, indicated Zyprexa was necessary to continue treatment for her delusions, hallucinations, and psychosis. The psychiatrist had treated the resident during prior hospital stays in June, July, and August 2024 and was familiar with her mental health needs.<br><br>Progess notes, dated 8/28/24, indicated Resident B was at the facility for 4 days when she became agitated, wanting to help a fell ow peer, and acted out by throwing herself on the floor sustaining a hip fracture. Progress notes, dated 9/2/24 through 9/24/24, indicated Resident B returned to the facility, was placed in a non-secured room, and was prescribed the initial dose of Zyprexa 5 mg by mouth at bedtime. Since return from the hospital, she was reported to have behaviors of verbal and physical aggression towards staff and dose of Zyprexa increased to a total of 10 mg per day-double the initial dose.<br><br>On 9/24/24 at 11:22 A.M., the Director of Nursing (DON), Regional Nurse Consultant (RNC), Social Service Director (SSD) and psychiatric NP were interviewed. The SSD and psychiatric NP indicated they were trying to see if the resident's dose of Zyprexa could be decreased hence the change in dosage. The psychiatric NP indicated information from the hospital had not been available to her prior to the attempted GDR and she had not seen the resident until after her fall and hospitalization . She indicated she had attempted to visit the resident but the resident had been asleep and wouldn't wake up to speak with her. There was no documentation to indicate the resident had been excessively sedated or attempts had been made to visit and evaluate the resident. The RNC indicated the Interdisciplinary team (IDT) hadn't determined the resident's fall had been due to a decrease in her medication however, her behaviors may have escalated due to the decrease in Zyprexa as well as being newly admitted to the facility.<br><br>A current facility policy, titled Medication Management Psychotropic Agents was provided by the Administrator, on 9/24/24 at 11:00 A.M., and stated: The psychotropic medication regimen will be managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being in compliance with federal guidelines .A comprehensive regimen review will ensure the following regarding psychotropic agents .4. Gradual dose reductions must be assessed for appropriateness .5. Time frames and duration of attempts to taper any medication must be consistent with accepted standards of practice<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Standards of Practice for Behavioral/Psychological symptoms of Dementia was retrieved on 9/24/24 from psychiatryonline.org which indicated the following recommendations of the American Psychiatric Association: Patients with dementia should be assessed for the type, frequency, severity, pattern, and timing of symptoms; patients should be assessed for pain and other modifiable contributors to symptoms; patients with dementia with agitation or psychosis should have response to treatment assessed with a quantitative measure; patients should have a documented comprehensive treatment plan with appropriate person-centered nonpharmacological and pharmacological interventions .for patients who have shown a positive response to treatment, decision making about possible tapering of antipsychotic medication should be accompanied by a discussion with the patient (if clinically feasible) as well as with the patient ' s surrogate decision maker (if relevant) with input from family or others involved with the patient. The aim of such a discussion is to elicit their preferences and concerns and to review the initial goals, observed benefits and side effects of antipsychotic treatment, and potential risks of continued exposure to antipsychotic's, as well as past experience with antipsychotic medication trials and tapering attempts; for patients who show adequate response of behavioral/psychological symptoms to treatment with an antipsychotic drug, an attempt to taper and withdraw the drug should be made within 4 months of initiation; for patients with dementia whose antipsychotic medication is being tapered, assessment of symptoms should occur at least monthly during the taper and for at least 4 months after medication discontinuation to identify signs of recurrence and trigger a reassessment of the benefits and risks of antipsychotic treatment .<br><br>This Citation refers to Complaint IN00442157.<br><br>3.1-37 |