

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Chateau Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6006 Brandy Chase Cove 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's physicians were notified of a change in condition and refusal of treatment for 1 of 3 residents reviewed (Resident D). Findings include: A report, dated [DATE], alleged Resident D had been in poor shape one day and was sent to the hospital where he later died. It was alleged staff ignored his condition and assumed he had been drinking alcohol as the cause of his decline. On [DATE] at 1:08 P.M., Resident D's record was reviewed. Diagnoses included end stage renal disease with dependence on dialysis, chronic low back pain, and diabetes. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated a Brief Interview Mental Status (BIMS) score of 9 indicating Resident D had moderately impaired cognition. He had chronic moderate pain which would occasionally cause disruption with his daily activities. He was prescribed opioid medications to manage his pain. Care plans indicated Resident D received kidney dialysis at the facility. He was scheduled for 4 hours of dialysis at 4:00 p.m. on M-W-F. Staff were to perform pre and post dialysis care which was communicated to dialysis staff. Resident D was at risk for side effects related to use of opioids and staff were to observe for and report side effects to the physician. There was no care plan indicating Resident D had current or past issues with substance or alcohol abuse. A nurse progress note, dated [DATE] at 6:57 a.m., indicated Resident D had spoken with Licensed Practical Nurse (LPN) 2. During the conversation, LPN 2 indicated the resident smelled of alcohol. The medical Nurse Practitioner (NP) and Unit Manager were notified. At 12:18 p.m., new orders were given for a drug and alcohol screen to be done. The nurse progress notes nor assessments indicated the drug and alcohol screen had been completed as ordered. There was no follow up documentation completed indicating the residents' condition on 11/3 or [DATE]. A Change in Condition form, dated [DATE] at 8:00 p.m., indicated Resident D refused his scheduled dialysis appointment on [DATE] at 4:00 p.m. The resident was not socializing in his normal manner and had refused his evening medications. He slept most of the evening and would fall asleep while sitting up. The Director of Nursing, NP, Unit Manager and dialysis nurse were aware, and orders given by dialysis. An NP progress note, dated [DATE], indicated Resident D was seen for a chronic care visit. Staff had reported him to have altered level of consciousness and refusing dialysis the day before ([DATE]). He refused dialysis treatment yesterday, telling staff he wasn't feeling well. He was observed sitting on the side of his bed, slow to answer questions, and needed assistance to reposition in bed and lay down. He appeared awake, alert, and slow to respond and his cognition was unable to be assessed. The NP ordered labs to be drawn today including blood alcohol level. Staff were to monitor his condition and report any changes. A Medication Administration Record (MAR), dated [DATE], indicated Resident D's medications, scheduled to be administered on [DATE] at 8:00 p.m., including insulin, blood pressure medication, and pain medications, were not given due to the resident sleeping. There was no documentation of nursing assessment done on the resident due to sleepiness and holding of medications. There was no documentation indicating the NP or dialysis team had been notified of the medications being held due to Resident D's sleepiness. A transfer form, dated [DATE] at 8:40 a.m., indicated Resident D was sent to the hospital due to a very low oxygenation saturation level of 68% (normal >90%). On [DATE] at 2:50 P.M., the Director of Nursing (DON) was interviewed and was asked for results of the drug and alcohol screen ordered on [DATE]. The DON indicated the resident had refused the testing however, it had not been documented in the resident's medical record. When asked if the NP or dialysis team had been notified of the resident's refusal, she indicated the NP and dialysis team should have been notified and notification documented in the resident's medical record. On [DATE] at 10:12 A.M., LPN 2 was interviewed. He indicated on [DATE], Resident D had called him to his room. The resident was out of sorts and smelled of alcohol. He notified the medical NP and got an order for a drug and alcohol screen. He asked the resident if he would take the test and the resident refused. He indicated, thinking he had notified the NP of the refusal but hadn't charted it. LPN 2 indicated, Resident D continued to be out of sorts on [DATE] and stayed in his room most of the day. He was not aware of the resident's condition on 11/5 or [DATE]. When questioned he indicated he wasn't sure if nurses were to notify the dialysis team of a resident's drinking or refusals of drug and/or alcohol tests. On [DATE] at 3:47 P.M., the Nephrologist (kidney doctor) was interviewed. She indicated she had not been notified nor had her staff of the resident's possible intoxication with alcohol on [DATE]. Resident D received dialysis on [DATE] and indicated it would be important for the dialysis team to be made aware of any changes with dialysis patients including possible substance abuse</p>		