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	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Rehabilitation and Healthcare Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation interview, and record review the facility failed to ensure fall interventions were recorded and communicated for 1 of 6 residents reviewed (Resident 67). Findings include: Resident 67's record was reviewed on 8/13/24 at 11:48 AM. Diagnoses included Alzheimer's disease, major depressive disorder, and unilateral primary osteoarthritis, right hip. Resident 67's current quarterly Minimum Data Set (MDS) dated [DATE] indicated his Basic Interview for Mental Status (BIMS) score was not conducted as he was rarely if ever able to make himself understood. The MDS indicated Resident 67 required assistance with activities of daily living and had fallen since admission to the facility. An admission fall risk assessment dated [DATE] indicated Resident 67 had fall risk factors including disorientation, 1-2 falls in the past 3 months, incontinence, decreased muscular coordination, use of medications that had side effects including drowsiness and dizziness, recent medication changes, and diagnoses predisposing a fall risk. A document titled Initial Occurrence Note dated 5/18/24 at 4:43 PM indicated Resident 67 was found lying on the floor after being seen walking toward the garden room. No fall interventions were recorded at the time of the fall. An interdisciplinary team (IDT) note dated 5/20/24 at 5:01 PM indicated an intervention of orienting Resident 67 to surroundings should be added. An IDT note dated 5/21/24 at 12:58 PM indicated an intervention of ensuring non-skid footing was in place. A document titled Initial Occurrence Note dated 6/23/24 at 6:40 AM indicated Resident 67 fell . No description of the fall or interventions added were available for review. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled Initial Occurrence Note dated 6/30/24 at 10:00 AM indicated Resident 67 was standing in the dining room with his hands on the back of a chair when he suddenly fell to the left landing on his left shoulder and arm. An intervention was assisting the Resident 67 to bed and lowering the bed to the floor. An IDT note dated 7/1/24 indicated staff should ensure proper footing when ambulating. A document titled Initial Occurrence Note dated 7/5/24 at 7:53 AM staff heard a noise in the dining room and found Resident 67 on the floor. An IDT note dated 7/8/24 at 4:25 PM indicated staff was educated on keeping the area bright, ensure toileting is completed, and offering snacks at bedtime. A document titled Initial Occurrence Note dated 7/26/24 at 5:00 PM indicated Resident 67 was walking in the dining room when he bent over to pick something up, lost his balance and fell . An IDT note dated 7/29/24 at 10:44 AM indicated staff should assist resident when bending over to pick items up off the floor. A document titled Initial Occurrence Note dated 8/9/24 at 2:30 PM indicated Resident 67 was found sitting on the floor of another resident's room. The intervention initiated was to assist the resident to lie down in his room. An IDT note dated 8/12/24 at 1:36 PM indicated Physical and Occupational therapy were initiated for weakness. During an observation and interview on 8/15/24 at 11:57 AM, Certified Nurse Aide (CNA) 11 indicated staff instructions for care of each resident were found in a book marked ADLS (activities of daily living), located in a cabinet in the pantry area of the dementia unit dining room. The book included printed care plan forms with care plan goal dates of 2022. The Dementia Care Director (DCD) indicated most of the care plans in the book were for residents no longer residing on the unit. She did not know why the book had not been updated. Resident 67's care plan was not found in the book. CNA 11 and the Dementia Care Director were not aware of any other place instructions for care for CNAs were located and accessible to the CNA staff. A document titled Visual Bedside Kardex provided by the Assistant Director of Nursing on 8/15/24 at 12:28 PM indicated Resident 67 had safety precautions including encouraging him to lay in his bed and not in the middle of the floor or sidewalk. A mat to the floor beside the bed while in bed was an additional intervention. No other interventions were listed. Resident 67's current Care plan titled .at risk for impaired safety/injury .indicated the resident had a problem of a risk for falls, with a goal date of 9/16/24. Interventions included the following: 1. Distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, television, book, etc. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Encourage resident to avoid secured doorways to avoid injury when staff are entering and exiting unit; periodically re-evaluate need for secured unit. 3. Keep bed in lowest position 4. Mat to floor at bedside while in bed. 5. Refer to psychiatrist/psychologist/behavior specialist. No additional interventions were listed. During an interview on 3/18/24 at 3:18 PM, the Director of Nursing (DON) indicated a new intervention should be put in place immediately after post fall care (vital signs, assessments, first aid, if applicable) has been provided for a resident who had fallen. Interventions should be passed on verbally in report, added to the care plan and the Kardex (document for CNAs detailing individual care interventions). A current policy, undated, titled Falls Management and Fall Risk provided by the Chief Nursing Officer indicated each resident will have a person-centered fall care plan. The fall care plan should be reviewed at a minimum of quarterly, post fall, annually and with significant changes. The policy indicated the fall care plan should address both prevention of falls as well as when applicable, specific interventions in response to a fall occurrence. The policy indicated staff should implement additional or different interventions. 3.1-45(a)(2)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 46156 Based on record review and interview the facility failed to ensure the qualified/registered dietician was licensed in Indiana. This deficient practice had the potential to affect 70 of 70 residents in the facility who received dietary services. Findings include: The employee records were reviewed on 8/18/24 at 11:40 AM. The employee records indicated Registered Dietician (RD) 6 was hired by the facility on 6/1/2024. Review of the Indiana Professional Licensing Agency website on 8/19/24 at 11:53 AM indicated, effective 7/1/2019, Dieticians would receive licensures instead of certifications through the Medical Licensing Board of Indiana. RD 6's undated resume indicated she provided Dietician coverage for Long Term Care/Rehabilitation facilities as needed remotely through a nationwide dietician staffing service since 4/2024. The RD 6's resume indicated she was a RD/Licensed Dietician/Nutritionist in the states of North Carolina, South Carolina, and Florida. On 8/19/24 at 11:55 AM the Indiana Professional Licensing Agency website, 2024, was used to search for and verify RD 6's license. No current Indiana Registered Dietician license was found for RD 6. In an interview on 8/19/24 at 11:45 AM, the Administrator indicated according to federal regulations the facility's registered dietician must be licensed or certified as a dietitian or nutrition professional by the State in which the services are performed unless the State does not provide certification or licensure. A current policy titled, Food and Nutritional Services, dated 11/2021, provided by the Director of Nursing on 8/19/24 at 12:18 PM, indicated a qualified dietician or other clinically qualified nutrition professional was one who .was licensed or certified as a dietician/nutritional professional in the State their services were performed unless the State does not provide certification or licensure. No current Indiana Registered Dietician license was provided for RD 6 by survey exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review, the facility failed to ensure a shared glucometer was cleaned between uses for 3 of 12 residents reviewed (Resident 19, Resident 29, and Resident 30). Findings include: During a medication pass observation on 8/16/24 at 8:37 AM, Licensed Practical Nurse (LPN) 9 removed a glucometer (handheld device designed to measure blood glucose levels), lancet (small needle designed to poke the skin to produce a drop of blood), a test strip, and an alcohol swab from the top drawer of the medicine cart on the 300-hall of the C-wing. LPN 9 entered the room of Resident 19, cleaned her finger with an alcohol swab, obtained a drop of blood, applied it to the test strip inserted in the glucometer and obtained a reading. After the test, LPN 9 placed the glucometer in the top drawer of the cart, completed her documentation, and proceeded to prepare medications for the next resident who required medicine at that time. The glucometer was not cleaned before or after use. Upon completion of the medication pass observation, the medicine cart for the 300 hall of the C-wing was inspected. The glucometer in the top right drawer was the only glucometer in the cart. LPN 9 indicated that glucometer was used for all the residents on the 300- hall requiring blood glucose monitoring. She indicated it should be cleaned with a disinfectant wipe for 3 minutes before and after each use. She thought another employee had cleaned it earlier and did not give a reason for not cleaning it after use. A document titled Glucometers, provided by the Director of Nursing on 8/16/24 at 12:32 PM indicated Resident 19, Resident 29, and Resident 30 used the glucometer in the 300-hall medication cart. Resident 19's record was reviewed on 8/16/24 at 1:04 PM. Diagnoses included type 2 diabetes without complications, chronic kidney disease, stage 4, and hypothyroidism. Resident 19's current significant change Minimum Data Set (MDS) dated [DATE] indicated her Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). Physician orders dated 5/9/24 indicated Resident 19's blood sugar should be checked twice daily. Resident 29's record was reviewed on 8/16/24 at 12:02 PM. Diagnoses included type 2 diabetes without complications, end stage renal disease, and acute respiratory failure, unspecified whether hypoxia or hypercapnia. Resident 29's current quarterly Minimum Data Set (MDS) dated [DATE] indicated her Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). Physician's orders dated 3/5/22 indicated a glucometer check should be performed twice daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 30's record was reviewed on 8/16/24 at 11:28 AM. Diagnoses included type 2 diabetes mellitus with diabetic neuropathy, end stage renal disease, acute on chronic diastolic (congestive) heart failure. Resident 30's current quarterly Minimum Data Set (MDS) dated [DATE] indicated his Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). Physician orders dated 5/23/24 indicated blood glucose readings were needed to determine need for insulin coverage at mealtimes. In an interview on 8/16/24 at 10:19 AM, the Administrator indicated the glucometer should be cleaned before and after each use to prevent cross contamination. A current policy dated 6/11/24 provided by the Administrator on 8/16/24 at 9:46 AM indicated blood glucometers intended for reuse are cleaned and disinfected between use with a disinfectant. An undated document titled Medical and Commercial Disinfecting wipes provided by the Administrator indicated a wipe must keep the device thoroughly wet for 2 minutes to ensure disinfection. 3.1-18(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure flooring panels were complete and intact for 1 of 24 residents reviewed (Resident 11). Findings include: During an observation on 8/13/24 at 9:51 AM, an approximately 15 inch by 30 inch area of floor paneling was missing in front of the heating unit and near the end of Resident 11's bed. One floor panel was lying loose across a small portion of the uncovered area. Resident 11's record was reviewed on 8/14/24 at 9:49 AM. Diagnoses included multiple sclerosis, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and type 2 diabetes mellitus without complications. Resident 11's current quarterly Minimum Data Set (MDS) dated [DATE] indicated her Basic Interview for Mental Status (BIMS) score was 4 (cognitively impaired). During an observation and interview on 8/13/24 at 12:16 PM, Registered Nurse (RN) 4, and Certified Nurse Aide (CNA) 5 and CNA 6 indicated they were not aware of the floor damage until that observation. CNA 5 indicated it likely just happened since one piece of flooring was lying in the middle of the patch of missing flooring. She was unable to identify where the other missing floor panels were located and indicated the additional damage must have happened at an earlier time. She indicated floor damage should be reported to maintenance immediately. During an observation and interview, on 8/13/24 at 12:18 PM, Maintenance 3 indicated this was the first he heard of floor damage. During an interview on 8/13/24 at 1:34 PM, the Administrator indicated floor damage should be reported through the facility maintenance system as soon as the damage is found. She indicated she was not aware the floor panels were missing until today. A Document titled Point Click Care Dashboard, dated 8/13/24, provided by the Administrator on 8/13/24 at 3:10 PM indicated staff should use an application called tells to generate a work order to notify maintenance staff of any concerns. She indicated this system was the facility's current method of communication regarding maintenance issues and there were no additional facility policies available for review. 3.1-19(a)(4)