

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2024
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NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00442157.</p> <p>Complaint IN00442157 - Federal/state deficiencies related to the allegations are cited at F684.</p> <p>Survey date: September 24, 2024</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Census Bed Type: SNF/NF: 77 Total: 77</p> <p>Census Payor Type: Medicare: 9 Medicaid: 48 Other: 20 Total: 77</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed September 25, 2024</p>	F 0000	<p>10-3-2024</p> <p>ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204</p> <p>Re: Recertification and State Licensure Survey Chateau Rehabilitation and Healthcare Center 6006 Brandy Chase Cove Fort Wayne, IN 46815-7601</p> <p>Survey Event ID 02HU11</p> <p>Dear Ms. Buroker:</p> <p>On September 24, 2024, a Complaint Survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our formal request for 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.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monique Augustine	Executive Director	10/04/2024

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

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F 0684 SS=D Bldg. 00	<p>483.25 Quality of Care</p> <p>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).</p> <p>Findings include:</p> <p>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.</p> <p>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</p>	F 0684	<p>Please feel free to call me with any further questions at 1 (260) -486-3001.</p> <p>Respectfully submitted,</p> <p>Monique L. Augustine Health Facility Administrator</p> <p>F 684D Quality of Care The facility respectfully requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) What corrective actions will be accomplished for those residents found to have been affected by the practice? ·Resident B had a</p>	10/04/2024

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	<p>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.</p> <p>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.</p> <p>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.</p>		<p><i>comprehensive assessment completed on 9/5/24. An evaluation of the antipsychotic medication and non-pharmacological approaches were reviewed and changes made in the plan of care.</i></p> <p>2.) How will other residents having the potential to be affected by the same practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> <i>-Any resident who receives an antipsychotic medication has the potential to be affected.</i> <i>-An audit was conducted for all residents receiving antipsychotic medications to ensure they remain appropriate.</i> <p>3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.</p> <p><i>Residents currently taking antipsychotic agents will be reevaluated for continued need of therapy and appropriate existing diagnosis by the provider in collaboration with both the IDT team and the consultant pharmacist during monthly behavior meeting.</i></p> <p><i>All residents who are prescribed anti-psychotic agents will be assessed for gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to decrease use of unnecessary</i></p>	

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	<p>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.</p> <p>-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.</p> <p>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.</p> <p>A physician order, dated 8/24/24 at 8:00 p.m., was for Zyprexa 5 mg by mouth at bedtime for schizophrenia [sic].</p> <p>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</p>		<p><i>agents.</i></p> <p><i>Gradual dose reductions must be assessed for appropriateness unless clinically contraindicated. If gradual dose reductions are considered clinically contraindicated, the clear rationale by the provider must be documented in the medical record.</i></p> <p><i>Time frames and duration of attempts to taper any medication must be consistent with accepted standards of practice.</i></p> <p><i>All anti-psychotic regimens must be monitored for side effect development and adequate response to therapy.</i></p> <p><i>The facility staff will be educated on psychotropic medication dose reductions, interventions and monitoring.</i></p> <p>4.) How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place.</p> <p><i>The DON or designee will audit all new residents with psychotropics weekly to determine compliance with the appropriate diagnosis, behavior interventions, and prevention.</i></p> <p><i>The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance is achieved x3 consecutive months.</i></p> <p><i>The QA Committee will identify any trends or patterns and make</i></p>	

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	<p>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.</p> <p>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.</p> <p>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</p>		<p><i>recommendations to revise the plan of correction as indicated.</i></p> <p>5. Date of Correction 10-4-2024</p>	

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	<p>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 9/2/24. She was re-admitted to a rehabilitation room not located on the secured MCU.</p> <p>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.</p> <p>On 9/2/24, Resident B's re-admission orders included, Zyprexa 5 mg by mouth at bedtime for dementia with behavioral disturbance.</p> <p>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.</p> <p>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</p>			

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	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>			

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	<p>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.</p> <p>Progress notes, dated 8/28/24, indicated Resident B was at the facility for 4 days when she became agitated, wanting to help a fellow 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.</p> <p>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</p>			

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	<p>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.</p> <p>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...."</p> <p>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</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2024

FORM APPROVED

OMB NO. 0938-039

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	<p>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..."</p> <p>This Citation refers to Complaint IN00442157.</p> <p>3.1-37</p>			