

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER Chateau at Moorings Park, The		STREET ADDRESS, CITY, STATE, ZIP CODE 130 Moorings Park Drive Naples, FL 34105	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609</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 record review, and staff interviews, the facility failed to report alleged violations which could constitute abuse or neglect to the State Survey Agency for 1, (Resident #99), of 3 sampled residents. The findings included: Review of the clinical record revealed Resident #99 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including dementia, atrial fibrillation, anxiety, aspiration, muscle weakness, depression, pain, dysphagia, restless leg syndrome, sleep apnea, and hemiplegia. The admission Minimum Data Set (MDS) dated [DATE] documented the resident was dependent for all care and was non-ambulatory. The MDS noted the residents' cognitive skills for daily decision making were intact. On 8/28/25 Resident #99 became unresponsive at the facility and emergency medical services (EMS) was contacted. Review of the nursing progress notes documented on 8/28/25 at 2:27 p.m., Resident #99 was observed unresponsive in his wheelchair sitting in the common area of the unit. His breathing was shallow, and he was returned to bed with the use of a mechanical lift. EMS was notified. Oxygen was applied due to shallow breathing. Resident #99 was sent to the local emergency room (ER) for evaluation. Review of the hospital records revealed EMS had administered Narcan (medication used to reverse an opioid overdose) to Resident #99. Once in the ER a drug screen was completed and documented the resident had tested positive for Fentanyl (a powerful synthetic opioid) that can treat severe pain. Review of the residents medications included: Medications- MiraLAX 17 grams daily, Tylenol 325 milligrams (mg) 2 tablets every 6 hours as needed, aspirin 81 mg daily, amiodarone 200 mg daily, Montelukast 10 mg at HS, Sennosides 8.6 mg one tab at bedtime, Trazodone 50 mg at bedtime, Lidocaine 4% topical patch daily, Plavix 75 mg daily, Pepcid 40 mg at bedtime, Losartan 25 mg daily, metoprolol succinate ER 100 mg twice a day, and Pentoxifylline 400 mg ER three times a day. There were no physician orders for a Fentanyl patch and no orders for opioid medication. On 9/3/25 at 10:30 a.m., in a phone interview with Resident #99's representative said he was contacted by the hospital to report they did a toxicology screen, and his father had tested positive for fentanyl. He said his father never took opioids in his life and had no access to them. He said his father never had access to any opioids and did not know how they got into his system. On 9/3/25 at 10:49 a.m., in an interview, the Assistant Executive Director (AED) said he had a visit by a detective from the local police department telling him the resident had tested positive for Fentanyl, but she had no additional information. He said he contacted the hospital multiple times, but they said they were not able to provide him with any information. We started an internal investigation, but we have not been able to find anything. On 9/3/25 at 11:10 a.m., in an interview the Executive Director provided this writer with a copy of the Investigation, that was a 1/2 sheet of typed paper and said, I think we should discuss this. She said the facility had spoken to the hospital and received no information. The assumption is something could have happened, but it is difficult to make a determination. On 9/3/25 at 11:20 a.m., the AED said, we had one other person in the facility was on a Fentanyl patch that was applied two days prior to the incident. Following this report on Resident #99 we did a full house assessment and no residents had any changes in their status. The Fentanyl patch was on a totally different part of the facility on a different cart, with different staff. Review of the investigation conducted by and provided by the facility documented: 1. 8/28 resident was transferred to the hospital following an unresponsive episode around 2:12 p.m. 2. On 8/29/25 around 3:30 p.m., a detective arrived at the facility to discuss the incident. Reported that the resident tested positive for fentanyl on 8/28, detective reported that the results came back at 5:11 p.m., on 8/28/25, resident left facility before 2:30 p.m. 3. On 8/29 the Director of Nursing (DON) reviewed narcotic disposal and dispense sheets to verify all medications in order. Verified narcotic disposal and procedure is being followed. 4. On 8/29 the DON and nursing team completed a full head to toe assessment on all residents. 5. 8/29 DON completed in-service with education with nursing team throughout the weekend on drug disposal policy. 6. 8/30 DON and Admin met with weekend supervisor and on shift providing additional education. 7. 9/2/25 Detective returned to the facility and met with the clinical team on shift 8/28/25 interviewing them. 8. 8/29 DON completed in-service with education with nursing team throughout the weekend on drug disposal policy. 9. 9/2/25 the Detective returned to the facility and met with the clinical team on shift 8/28/25 interviewing them. On 9/3/25 at 11:75 a.m., in an interview Licensed Practical Nurse (LPN) Staff A said the resident was sitting in the common area and was yelling he wanted to go to bed but the CNA's (certified nursing assistant) were putting other residents to bed. He had therapy and when they came to take him down to the therapy room, he was unresponsive. The CNA's were hoping the therapists would not</p>