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	02/18/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure treatments to pressure injuries were completed as ordered for 2 of 4 residents reviewed with pressure injuries (Resident D and Resident E). Findings include:1. On 2/17/26 at 10:15 A.M., Resident D's record was reviewed. Diagnoses included paraplegia and pressure related wounds. An in-house wound Nurse Practitioner (NP) progress note, dated 12/31/25, indicated Resident D was seen for chronic wounds. The resident had a wound to her left ischium. The wound, located on the left ischium (lower back part of hip bone), was unstageable and measured 20 centimeters (cm) x 16 cm x 1 cm with 50% epithelial tissue, 20% granulation, and 30% slough with a moderate amount of bloody, serous drainage. The wound had improved with a decrease in wound size and wound drainage. There was no odor. Orders were to clean the wound and apply Calcium Alginate with Santyl (removes dead tissue in a wound) to the base of the wound and secure with a bordered dressing. The wound treatment was to be done 3 times per day. A Treatment Administration Record (TAR), dated January 2026, indicated on 1/1/26 through 1/5/26, Santyl was applied to the left buttock wound topically every morning. The left ischium was treated with Santyl and Calcium alginate and covered with a bordered gauze every day shift. The NP note didn't indicate there was a wound on Resident D's left buttock. The TAR had not indicated dressings to the ischium had been completed 3 times per day as ordered on 12/31/25. A Wound Clinic progress note, dated 1/5/26, indicated Resident D had 2 wounds. A wound to her left buttock, and a wound to her sacrum. The progress note did not indicate measurements of the 2 wounds but provided treatment orders for the wounds as follows: -Left buttock wound: wash wound with baby soap and water, pat dry. Place Santyl nickel thick and cover with gelling fiber Ag (silver), ABD pad, kerlix and tape. Change dressing daily.-Sacral wound: wash wound with baby soap and water, pat dry and cover with gelling fiber Ag, ABD pad, kerlix and tape. Change dressing daily (Santyl was not ordered for this wound). A TAR, dated January 2026, indicated on 1/6/26 through 1/11/26, Santyl was applied to the left buttock wound topically every morning. The left ischium was treated with Santyl, covered with Calcium alginate and a bordered gauze every day shift. The TAR had not indicated treatment was provided as ordered by the wound clinic on 1/5/26. On 1/8/26, an NP note indicated the area to the sacrum was 20 cm x 16 cm x 1 cm. The NP note didn't indicate there was a wound on Resident D's left buttock. In an interview, on 2/17/26 at 10:40 AM, LPN 2 indicated the measured area indicated in the NP note included the left buttock. 2. On 2/18/26 at 10:53 A.M., Resident E's record was reviewed. Diagnoses included chronic sacral wound and diabetes. A wound clinic note, dated 1/7/26, indicated Resident E had been seen for a stage 4 pressure injury of the sacral region with chronic osteomyelitis (bone infection) of the coccyx. The wound measured 2.2 cm x1 cm x 0.1 cm. Orders for wound care included to follow up with the wound clinic in 2 weeks; wash the wound with baby soap and water, and pat dry. Staff were to place Endoform AM (antimicrobial) and cover with Superabsorber with border. The dressing was to be changed every other day. Information regarding Endoform dressing was retrieved from the manufacturer's website, www.aroa.com, on 2/18/26. Endoform (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressings were used to treat acute and chronic wounds. The dressings helped to protect against infection and helped to build new tissue/skin. Endoform antimicrobial (AM) could last from 1 to 7 days in the wound and dressings were to be changed as ordered by the physician. Endoform AM had been shown in studies to heal and close a wound significantly faster than collagen with silver alone. A Treatment Administration Record (TAR), dated January 2026, indicated between 1/1/26 through 1/31/26, Resident E's sacral wound was treated with collagen with silver, cut to size and placed in the wound bed on Monday, Wednesday, and Friday. Every day, staff were to place Vashe soaked gauze in the wound and cover with a bordered gauze. When using collagen, staff were to place the collagen first then the Vashe soaked gauze over it every day shift. The TAR did not indicate treatment was provided as ordered by the wound clinic on 1/7/26. A Wound NP note, dated 1/24/26, indicated the wound measurements were 2.2cm x 1 cm x 0.1 cm. On 2/17/26 at 2:02 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed. The ADON indicated resident's with wounds may be seen by the facility in-house wound NP, the wound clinic or both depending on the resident's choice. She indicated the wound NP could not visit the resident during the same week they were seen at the wound clinic. The DON indicated orders for wound care were to be followed as ordered, either by the wound NP or wound clinic. The ADON indicated orders from the wound clinic should be placed on the TAR and completed as ordered. On the NP's next visit, they could decide if they wanted to change the treatment ordered by the wound clinic and staff would be expected to follow those orders when written. On 2/18/26 at 9:50 A.M., the Administrator indicated staff should have followed treatment orders as written by the wound NP or by the wound clinic when the orders were given. She indicated staff had missed changing the wound treatments as ordered. A current facility policy, titled Wound Care, was provided by the Administrator on 2/18/26 at 10:07 A.M. The policy indicated wound care was to be done as ordered by the physician. This Citation relates to Intake 2736099. 3.1-40

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure necessary assessments and monitoring of catheter care were completed for 1 of 4 residents resulting in hospitalization for sepsis (Resident D). Findings include:A report, dated 2/4/26, alleged Resident D had not been assessed or provided assistance with catheterization of her Indiana pouch (internal urinary reservoir after removal of the bladder) when she became acutely ill. Resident D was hospitalized for profound urinary retention, acute kidney injury, electrolyte imbalance, and sepsis. Information obtained on 2/17/26 from www.medicine.iu.edu, Indiana University where the Indiana pouch was developed, indicated the pouch was a continent urinary reservoir. It was created out of the colon and fashioned into a pouch with an opening through the skin called a urostomy. The pouch could hold up to 600 milliliters of fluid and required routine self-catheterization through the opening of the skin, every 4-6 hours to empty out urine. Routine care included preventing and monitoring for infection of the urine such as strong-smelling, cloudy, dark urine, foul odor, little output, or changes in mental status. On 2/17/26 at 10:15 A.M., Resident D's record was reviewed. Diagnoses included paraplegia, Indiana pouch, pressure related wounds, and chronic pain syndrome treated with routine pain medications. A care plan, dated 6/9/25, indicated Resident D required some assistance with her activities of daily living (ADL) due to paraplegia, muscle wasting, and intermittent catheterization. An intervention, dated 8/25/25, indicated the resident required straight catheterization of her Indiana pouch every 4 hours. The care plan indicated the resident was competent to catheterize herself. Staff were to offer her assistance with catheterization, every 4 hours, especially at night, and document urine output. Staff were to observe for signs and symptoms of urinary tract infection (UTI) such as pain, burning, abnormal urine color, frequency, and mental status changes. A physician order, dated 8/6/25, was to straight catheterize the Indiana pouch at the right iliac crest every 4 hours. Resident D may self-catheterize. Staff were to continue to offer assistance, especially at night. A Treatment Administration Record (TAR), dated January 2026, indicated on 1/11/26 at 8:00 a.m. and 12:00 p.m., the catheterization was not done and there was no output recorded. The nurse's initials and number indicated to refer to progress notes for further information. There were no progress notes written on 1/11/26 between 8:00 a.m. and 12:00 p.m. to indicate why the catheterization was not done or why no output recorded. A progress note, dated 1/11/26 at 3:56 p.m., indicated Resident D had been lethargic during the day. The nurse went to Resident D's room to change her dressings and observed the resident's abdomen to be distended. The resident complained of pain in her swollen abdomen. The nurse tried to help Resident D catheterize her pouch but was unsuccessful. The on-call Nurse Practitioner (NP) was notified and orders received to send the resident to the ER for mental status change, distended abdomen, inability to catheterize, and wound changes. Hospital records, dated 1/11/26, indicated Resident D was seen in the emergency room for abdominal pain. The resident indicated she started having abdominal pain around lunchtime and her appetite had been decreased over the past few days. The resident indicated she self-catheterized her Indiana pouch but hadn't gotten out any urine on 1/11/26. She indicated she hadn't been able to remove any urine since last night. The resident's abdomen was distended. After gentle dilation of the urostomy, a catheter was placed into the pouch where a profound amount of urine was removed. The resident had 2 liters of urine with large amounts of mucous and blood drained from the pouch. Blood work done in the ER indicated a highly elevated white blood count (WBC) of 34.4 (Reference Range: 3.4 - 10.5) indicating infection. A urine sample taken was positive for blood, white blood cells, and bacteria. Her blood sodium level was low at 124 (Reference Range: 134 - 146) and kidney function tests (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were elevated with a creatinine level of 1.16 (Reference Range: 0.60 - 1.10). The resident was admitted to the hospital for leukocytosis (elevated WBC), acute kidney injury, urinary retention and hyponatremia (low sodium). On 2/17/26 at 11:15 A.M., Resident D's family member was interviewed. They indicated while the resident usually was able to self-catheterize her Indiana pouch, with any changes in condition, she would require staff's assistance. They indicated Resident D had been having lethargy since changes in her pain medication a few days before being hospitalized . On 2/17/26 at 2:02 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed. The DON indicated she was not aware the resident had not been catheterized either by the resident or the nurse on 1/11/26 at 8:00 a.m. or 12:00 p.m. There should have been documentation in the TAR or progress notes related to why the catheterization wasn't done. The ADON indicated she had specifically written in the care plan for staff to offer assistance with catheterization every 4 hours as scheduled. The ADON indicated staff had been instructed to always ask regardless of how many times the resident refused the offer of assistance. A current facility policy, provided on 2/18/26 at 10:07 A.M., and titled Indiana Pouch (Continent Urinary Diversion) Management Policy indicated: Residents with an Indiana pouch could perform self-catheterization and pouch emptying when they demonstrated the ability and desire to do so. The facility would support the resident's independence while ensuring appropriate monitoring; the resident's ability to perform self-care would be assessed with any change in condition; and nursing staff would monitor changes in continence, signs of infection or complications. This Citation relates to Intake 2736099 3.1-41(a)(2)