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	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Rehabilitation and Healthcare Center	6006 Brandy Chase Cove Fort Wayne, IN 46815

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure safe and sanitary food storage and serving practices for 3 of 3 observations. Food prepared in the kitchen was consumed by 90 of 90 residents who lived in the facility. Findings include: During a continuous observation on, 7/22/25 from 09:15 AM-10:15 AM, the following was observed:A dining room pantry had about a cupful of colorful O shaped cereal in an open tray below the cereal dispensers. A second tray contained about a cupful of tan O shaped cereal underneath the dispensers. There was no label on the trays.The dry food storage had an open bag of white granules visible in a bulk sized bag labeled salt. There was no label on the bagThe walk-in freezer had an ice cream tub with the lid partially covering the ice cream. There was no open date on the ice cream tub.In the B Hall pantry, a container of berry fruit juice expired on 7/6/25. The ice scoop was in the ice of the unit ice machine. A broken hook was observed next to the scoop.In The Garden Unit refrigerator, a container of thickener liquid was open, without a lid or cover. In an interview, on 7/22/25 at 09:20 AM, the Dietary Manager indicated the salt should be sealed and dated.In an interview, on 7/22/25 at 09:40 AM, the Dietary Manager indicated the hook for the ice scoop was broken. She indicated the resident and the resident's family wouldn't be happy if we threw away the expired berry juice.During a continuous observation, on 7/23/25 from 10:35 AM to 11:30 AM, the following was observed:Two about cup full of tan flakes, colorful and tan O shaped cereal was found under the dispensers in the dining room pantry. Two paper towel holders in the kitchen had paper towel rolls on top of the holder. Moisture drops on the paper towel rolls were observed after tearing paper off the roll.The wall behind the sink had a missing tile opening, exposing the wall. The tile was sitting on the sink behind the hot water tap.Stacked serving items had moisture in 3 trays, 3 warming lids, and one plate in approximately 3 observations of each item during lunch service. Staff continued to use trays and lids. When the moisture on the plate was addressed by surveyor, the [NAME] removed the moist plate.In an interview, on 7/23/25 at 10:45 AM, the Dietary Manager indicated the missing tile at sink had been entered into maintenance software program. She indicated Housekeeping had not been putting the paper towels in the holders.An observation on 7/28/25 at 12:58 PM, in the dining room pantry, about two cup full of tan flakes, colorful and tan O shaped cereal was found under the dispensers.In an interview, on 7/28/25 at 1:00 PM, [NAME] 5 indicated 90 of 90 residents residing in the facility ate food provided by the kitchen.A current policy undated, provided by the Administrator, indicated opened bulk foods should be sealed or in a sealable container. All foods should be covered. All foods will be checked to assure food will be consumed by use-by date or discarded.A current policy undated, provided by the Administrator, indicated dishes should be air dried on dish racks. Dishes are inspected for complete dryness before being nested. 3.1-21(i)(3)

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record reviewed, the facility failed to maintain clean, intact ceiling tiles in 4 of 6 hallways where residents reside. Findings include: During an observation, on 7/24/25 10:18 AM, a ceiling tile outside room [ROOM NUMBER] had a round brown stain approximately 15 inches in diameter. A ceiling tile outside room [ROOM NUMBER] had 2 irregularly shaped brown stains, about 7 inches in diameter and 5 inches in diameter. Ceiling tiles outside room [ROOM NUMBER] were stained with approximately a 15 inch diameter round brown stain, a 20 inch round brown stain and a 6 inch round brown stain. A ceiling tile outside room [ROOM NUMBER] had an approximately 12 inch round stain and a crack about 14 inches long. A long brown stain was observed above the countertop of the 300 hall end of the nurses station covering the entire length of 2 ceiling tiles. A large crack the width of ceiling tile was observed outside medical records office in a common hallway. 2 ceiling tiles outside the activity room had stains approximately 6 inches in diameter and 4 inches in diameter. A large brown stain, about 8 inches by 4 inches was observed on the ceiling tile outside the social services office. A large brown stain was observed in a ceiling tile above the aquarium near the B-wing nurses station about 12 inches by 24 inches. Outside room [ROOM NUMBER] a ceiling tile had dark brown stains about 12 inches by 4 inches. A brown stain about 5 inches in diameter was observed on a ceiling tile outside room [ROOM NUMBER]. Outside room [ROOM NUMBER] a large crack about 7 inches long was observed on a ceiling tile. Ceiling tiles outside room [ROOM NUMBER] had large grey stains approximately 8 inches by 5 inches, 12 inches by 8 inches and 12 inches by 4 inches. A brown stain about 8 inches by about 6 inches was observed on a ceiling tile outside room [ROOM NUMBER]. A large crack about 6 inches long was observed in a ceiling tile outside room [ROOM NUMBER]. A ceiling tile outside room [ROOM NUMBER] around a return air vent had five cracks on each side of the tile from about 4 inches to about 12 inches in length.Documents titled Touch Up Paint schedule, Deep Clean Schedule, and printout of maintenance work orders for the last 30 days, provided by the Administrator 7/25/25 at 9:25 AM, did not include any current plan for replacement of soiled or damaged ceiling tiles.During an interview, on 07/25/25 at 2:04 PM, the Administrator indicated ceiling tiles should be intact and free of stains. She indicated she would initiate tile replacement for damaged tiles.A document titled Ceiling Tile Replacements, provided by the Administrator on 7/25/25 at 2:27 PM, indicated ceiling tiles for the hall including rooms 114 through 129 were scheduled to be replaced by 7/25/25.During an observation, on 7/28/25 at 9:40 AM, observations of ceiling tiles throughout the facility remained unchanged.During an interview, on 7/28/25 at 1:45 PM, the Regional Director of Operations indicated some ceiling tiles had been replaced in April, 2025, but other pressing financial matters had slowed the process of tile replacement.During a review of facility quality assurance and performance improvement plans with the Administrator on 07/28/25 at 1:26 PM, a performance improvement plan for ceiling tile replacement was not available for review.3.1-19(a)(4)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to ensure that 1 of 5 residents reviewed received insulin as ordered. (Resident 83) Findings include:Resident 83's record was reviewed on 7/23/2025 at 9:46 AM. Diagnoses included Diabetes mellitus type 2, hemiplegia or hemiparesis, anxiety, and cerebrovascular accident (stroke).A review of Resident 83's current quarterly MDS indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated the resident received insulin 7 days a week. In an interview, on 7/25/25 at 11:05 AM, Resident 83 indicated the staff had missed insulin doses because Resident 83 did not go out to the nurse's station to receive the doses.A review of the Medication Administration Record, or MAR, dated June 2025 on 7/28/25 at 9:30 AM, indicated there was missing documentation for blood glucose measurements on 6/4/25 at 10:00 PM, 6/10/25 at 11:30 AM, and on 6/26/25 at 11:30 AM. A review of physician orders, dated 2/28/25 at 7:30 AM, indicated blood glucose was to be checked and entered into the record before meals. A review of physician orders, dated 5/21/25 at 10:00 PM indicated blood glucose was to be checked and entered into the record at bedtime (scheduled at 10:00 PM). A new order placed (discontinuing the previous order) on 6/20/25 at 9:35 AM indicated a new sliding scale order was to check blood sugar more than 2 hours (8:00 PM) after the last dose of Novolog and give the listed sliding scale amounts.A review of physician orders, dated 6/25/25 at 2:40 PM, indicated to give Novolog 15 units when blood glucose was between 111-149 before meals. A review of the Medication Administration Record (MAR), dated June 2025, indicated the following insulin administration documentation was missing from the record:Lantus 52 units subcutaneous administrations on 6/4/25 at 8:00 AM, 6/28/25 at 8:00 PM, and 6/30/25 at 8:00 PM.Routine Novolog 25 units subcutaneous before meals on 6/3/25 at 11:30 AM, 6/4/25 at 7:30 AM, and 6/10/25 at 11:30 AM.Novolog Sliding Scale subcutaneous coverage with meals and at bedtime on 6/3/25 at 11:30 for no additional coverage, 6/4/25 at 8:00 AM for 2 units, 6/4/25 at 10:00 PM for an unknown amount of units, 6/10/25 at 11:30 AM for an unknown amount of units, and 6/27/25 at 4:00 PM for 15 units.A review of progress notes, on 7/28/25 at 10:35 AM, indicated Resident 83 had refused doses of Novolog insulin on 6/5/25 at 11:30, 6/17/25 at bedtime, and 6/30/25 at bedtime.The June 2025 MAR was missing documentation on 6/5/25, 6/17/25, and 6/30/25. Refusals were to be indicated with a code 2 and the staff identifier on the MAR.In an interview, on 7/28/25 at 10:51 AM, LPN 2 indicated when a medication was refused, a call should be placed to the provider, documented in electronic health record, and in the medication administration record, with a code # for refused, and the NP notified. There should not be missing information on the MAR.A current policy titled Documentation of Medication Administration, dated 11/2022, provided by the Administrator, indicated documentation must include a reason why medication was withheld, not administered, or refused. 16.2-3.1-37(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the physician of abnormal catheter assessment findings in 1 of 3 residents reviewed (Resident 12).Findings include:During an observation, on 07/23/2025 at 10:56 AM, Resident 12 was seated near the nurses station in a Broda chair. Her catheter tubing contained yellow cloudy fluid with sediment. During an observation, on 07/24/2025 at 1:19 PM, Resident 12 was seated in a Broda chair near the nurses station. Catheter tubing had whitish sediment covering more than half of the tubing. Some light yellow, cloudy fluid was observed in the tubing. During an observation, on 07/25/2025 at 9:10 AM, Resident 12's urine was light yellow and very cloudy with large amounts of sediment. Resident 12's record was reviewed on 07/25/2025 at 11:46 AM. Diagnoses included chronic kidney disease and Kennedy ulcer of the coccyx. During an interview, on 07/25/2025 at 9:11 AM, Registered Nurse (RN) 5 indicated abnormal urine assessments could include dark or discolored urine, cloudiness or sediment. She indicated upon discovering such findings nurses should check for orders to flush the catheter or contact the provider to report assessments. She indicated physician's orders should be followed. She indicated the color and clarity of Resident 12's urine in catheter tubing was normal for her. She indicated she did not know if this condition was documented. Resident 12's current Significant Change in Status Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident 12 had a Basic Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment). The MDS indicated Resident 12 used an indwelling catheter. A current physician's order, dated 3/18/25, indicated staff should irrigate Resident 12's catheter with 30 milliliters (ml) normal saline every six hours as needed for clogging or sediment. A current physician's order, dated 3/12/25, indicated Resident 12's indwelling catheter and urine should be monitored for color, clarity and patency every shift. The order indicated the physician should be notified of abnormal findings. A current care plan titled chronic conditions with risk for discomfort indicated Resident 12 had a problem of risk for decline due to chronic kidney disease, stage 2 with a goal date of 12/9/25. The care plan indicated Resident 12's catheter should be flushed as needed. There was no documentation in the care plan cloudy urine was normal for the resident. A review of medication and treatment administration records, dated July 2025, did not include any signed administration of a catheter flush. No abnormal urine assessments were recorded on the administration record. A review of July 2025 progress notes did not include any abnormal urine assessments or physician notifications of abnormal assessments. During an interview, on 07/25/2025 at 9:34 AM, the Director of Nursing (DON) indicated normal urine would appear clear, light yellow with no sediment or cloudiness. She indicated abnormal findings should be reported to the nurse practitioner. She indicated Resident 12 always had cloudiness and sediment in her urine. She indicated a nurse would know this because it would be passed on in report. She indicated she didn't know if this was documented anywhere a nurse could readily access the information. A current policy, titled Physician's Services and Orders, dated 12/1/23 indicated all physician orders should be followed as prescribed and if not followed, the reason should be recorded in the resident's medical record during that shift. 3.1-41(a)(2)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure trauma informed care was provided for 2 of 3 residents reviewed (Resident 11 and Resident 17).Findings include: 1. In an attempted interview, on 7/23/25 at 11:10 AM, Resident 11 was observed rubbing their hands together. Resident 11 avoided eye contact when greeted. Resident 11 turned their head away when spoken to.Resident 11's record was reviewed on 7/28/25 at 10:27 AM. Diagnoses included major depression, insomnia, nicotine dependence and anorexia nervosa.Resident 11's Annual Minimum Data Set, (MDS) dated [DATE], indicated the resident's Brief Interview for Mental Status (BIMS) score was 15 (no cognitive loss). Resident 11's Preadmission Screening and Resident Review, (PASRR) dated 10/5/20, indicated the resident had attempted suicide in the past. The PASRR indicated pain was a trigger for increased depression. The PASRR indicated Resident 11 had a substance disorder related to alcohol abuse or dependency.A physician order, dated 4/4/25, indicated Resident 11 could be administered 45 milliliters of rum at bedtime as needed for prophylaxis.Resident 11's care plan, dated 8/1/23, indicated the resident had a history of alcohol abuse. The target goal was to have minimal risk for complications and maintain the highest level of wellbeing by 12/5/24. An intervention included providing a safe environment if the resident displayed symptoms of substance abuse.Resident 11's care plan, dated 8/1/23, indicated the resident was at risk for impaired psychosocial wellbeing. The target goal was to follow the recommendations through 12/5/24. Interventions included encouragement of socializing with others and the implementation of the PASRR recommendations.Resident 11's care plan, dated 8/1/23, indicated the resident had a diagnosis of anorexia nervosa. The target goal was meeting needs, honoring preferences, following PASRR recommendations and remaining free of psychosocial complications through 12/5/24. An intervention included avoiding any discussions related to diets and losing weight.Resident 11's care plan did not indicate the resident had a history of attempted suicide.Resident 11's care plan did not indicate pain was a trigger for increased depression.Resident 11's care plan summary for direct care staff (Kardex) indicated a trauma trigger to avoid speaking about diets or weight loss.Resident 11's Kardex did not indicate pain was a trigger for increased depression.Resident 11's Kardex did not indicate the resident had a history of attempted suicide.In an interview, on 7/28/25 at 11:56 AM, the Social Service Director (SSD) indicated each resident was screened for trauma upon admission. The SSD indicated trauma was assessed with either a Psychosocial Assessment or an Abuse and Neglect Screening. The SSD indicated the trauma screening results were added to each resident's care plan according to their PASRR recommendations.On 7/28/25 at 12:11 PM, a Psychosocial Assessment was not documented in Resident 11's record. An Abuse and Neglect Screening was not documented in Resident 11's record.In an interview, on 7/28/25 at 1:55 PM, the Director of Nursing (DON) indicated Resident 11's record did not include a Psychosocial Assessment. The DON indicated Resident 11's record did not include an Abuse and Neglect Screening. The DON indicated each resident should be screened for a history of trauma upon admission.2. On 7/22/25 at 9:40 AM, Resident 17 was observed propelling their wheelchair in the hall. Resident 17 introduced themselves. Resident 17 was smiling and spoke highly of staff members, addressing them by name.In an interview, on 7/23/25 at 11:20 PM, Licensed Practical Nurse (LPN) 4 indicated Resident 17 had a very bad day yesterday. LPN 4 indicated Resident 17 was out with their mom today.Resident 17's record was reviewed on 7/28/25 at 5:57 AM. Diagnoses included cerebral palsy, down syndrome, depression, bipolar disorder, affective mood disorder and impulse disorder.Resident 17's Annual MDS, dated [DATE], indicated their BIMS score was 12 (minimal cognitive impairment). The MDS indicated Resident 17 had depression, bipolar disorder, affective mood disorder, impulse disorder, cerebral palsy, down syndrome and unspecified (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lack of physiological development in childhood. The MDS indicated Resident 17 did not have anxiety. The MDS indicated Resident 17 had not displayed any disruptive behaviors.Resident 17's PASRR, dated 1/3/25, indicated the resident had a diagnosis of intellectual disability. The PASRR indicated Resident 17 had experienced seeing and hearing things that were not real. The PASRR indicated Resident 17's BIMS score was 7.A Psychosocial Assessment, dated 7/29/24, indicated Resident 17 had increased anxiety. Stressful triggers were rapid movement or contact.A Psychosocial Assessment, dated 8/5/24, indicated Resident 17 had a physical altercation with another resident. Resident 17 became agitated due to their mom not being able to take them home. Stressful triggers were rapid movement or contact.An Abuse and Neglect Screening, dated 7/22/25, indicated Resident 17 had a moderate problem with aggressive and agitated behavior. Resident 17 had a moderate problem with abuse or neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior. Resident 17 had a moderate problem of psychotic symptoms such as delusions, hallucinations, misinterpretation of events or intentions of others. Resident 17 had a moderate problem with denial of mental health and psychosocial issues.Resident 17's care plan, dated 7/26/24, indicated the resident was at risk for psychosocial impairment. The care plan indicated Resident 17 displayed episodes of verbal aggression, physical aggression, repetitive questions, repetitive demands and repetitive calls to their mom. The target goals were to be free from psychosocial complications and to follow the PASRR recommendations through 7/6/25. An identified trigger was Resident 17's mom not answering the phone. Interventions included providing simple and structured activities, administering medications as ordered, providing simple and direct communication and following the PASRR recommendations.Resident 17's care plan did not indicate they had a history of delusions or hallucinations.Resident 17's care plan did not indicate triggers were rapid movement or contact.Resident 17's Medication Administration Record, dated 7/1/25 through 7/31/25, indicated the resident had been administered an antipsychotic medication (haloperidol) injection on 7/14/25 at 4:56 PM.Resident 17's Medication Administration Record, dated 7/1/25 through 7/31/25, indicated the resident had been administered an injection of haloperidol on 7/22/25 at 3:16 PM.A progress note, dated 6/25/25 at 5:40 PM, indicated Resident 17 had been disruptive in the dining room. Resident 17 told staff they did not know why they were upset, then the resident said they had an appointment tomorrow.A progress note, dated 6/25/25 at 6:18 PM, indicated Resident 17 had been swearing and attempting to hit staff members. When the resident was asked why they were upset, the resident said they don't know and then said they have an appointment in the morning.A progress note, dated 7/14/25 at 4:44 PM, indicated Resident 17 had an injection of haloperidol administered due to screaming, swearing, kicking the medication cart, throwing items and grabbing items from the nurse station.A progress note, dated 7/20/25 at 8:59 PM, indicated Resident 17 had been agitated and broke their glasses.A progress note, dated 7/21/25 at 9:53 AM, indicated Resident 17 had been in the lobby yelling and demanding to go to their 2:30 PM medical appointment immediately.A progress note, dated 7/21/25 at 7:30 PM, indicated Resident 17 had been yelling loudly and said they hated the doctor. Resident 17 calmed down after numerous attempts to calm the resident.A progress note, dated 7/22/25 at 8:38 AM, indicated Resident 17's mom had reported the rod in the resident's leg had separated from the bone. Resident 17 was scheduled to have more tests and was referred to the wound clinic.A progress note dated 7/22/25 at 1:10 PM, indicated Resident 17 had been agitated and had bitten a staff member. 3 attempts to redirect the resident were not successful.A progress note, dated 7/22/25 at 4:19 PM, indicated Resident 17's mom was going to transport the resident to an appointment on 7/23/25.Resident 17's Kardex indicated PASRR recommendations should be followed. The Kardex indicated attempts should be made to determine the underlying cause for the behaviors. The Kardex did not indicate Resident 17 had a history of delusions or hallucinations.In an interview, on 7/28/25 at 1:55 PM, the DON indicated Resident 17 could possibly be triggered by upcoming medical appointments. The DON indicated Resident 17 could possibly have medical trauma.A current facility policy, titled Trauma Informed Care, dated 1/26/23, indicated the (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility must identify triggers that could possibly re-traumatize residents. The policy indicated residents would be assessed for trauma by observation, interview and the use of screening tools.A current facility policy, titled Behavior Policy, dated 12/26/24, indicated behavioral documentation should be specific. The policy indicated documentation should include the time, duration and frequency of the behaviors. The policy indicated observations of possible triggers for specific behaviors should be included in the documentation.3.1-42(a)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were stored and adequately labeled for 1 of 1 medication room observed and 2 of 5 residents reviewed (Resident 3 and Resident 71) Findings include: During an observation, on [DATE] at 10:57 AM, the B wing medication room was observed. In a drawer was an open bag of 30 insulin syringes. The bag had no label to indicate when the pharmacy had sent them to the building and had no expiration date. A separate drawer held three staple removal kits. Two kits had no label to indicate when the facility received the kits and had no expiration date on the kit. One kit had an expiration date of 2-28-25. In a storage container under the shelf, two catheter irrigation kits were observed to be without expiration dates, and no labeling to indicate when the kits had been sent to the facility. In an interview, on [DATE] at 11:24 AM, Registered Nurse (RN)10 indicated she reviewed the medication room each Friday for expired and unlabeled supplies, and pharmacy double checked the room for the audit about every other month. During an observation, on [DATE] at 11:34 AM, Resident 3's Nitroglycerin tablets 0.3mg were open with no open date noted on the label. The date filled on the pharmacy label was [DATE]. In the top drawer, were 2 clear cups with 3 unidentified pills in the top cup and 4 unidentified pills in the bottom cup. the bottom cup was labeled with Resident 71's room number. In an interview, on [DATE] at 11:40 AM, QMA 11 indicated the medications were not set up by him, and the medications should have been discarded. He indicated the nurse on shift prior to his indicated the resident had already left the building for an appointment, so the nurse was unable to administer the medications she had set up. An undated policy titled Medication labeling and storage provided by the Administrator on [DATE] at 2:54 PM indicated under Medication Labeling 5. medications that were opened or accessed would be dated and discarded with 30 days of opening . and 11. Medications would not be transferred between containers . 3.1-25 (j)(m)

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure a mechanically altered diet was served as ordered for 1 of 12 residents reviewed (Resident 31).Findings include: During a dining observation on the dementia unit, on 07/23/2025 at 12:01 PM, Resident 31 reached into an unattended meal tray cart, partially pulled out a tray, lifted the plate cover, pulled out a bratwurst sausage on a bun and began to eat. The bratwurst was whole and not chopped or ground. Registered Nurse (RN) 10 approached Resident 31 read the tray card, assisted him to the table and placed the remaining items on the tray on the table in front of Resident 31. During an interview, at on 07/23/25 at 12:03 PM, RN 10 indicated the tray served to Resident 31 was prepared for another resident. She indicated it was not an issue because both residents were on the same diet.During an observation, on 07/23/25 at 12:04 PM, RN 10 pulled the tray prepared for Resident 31. The tray contained a bun filled with ground bratwurst. The tray card with Resident 31's name indicated Resident 31 should receive a mechanical soft diet with ground meat.During an interview, on 7/23/25 at 12:05 PM, RN 10 indicated the tray cart should not have been unattended and accessible to Resident 31. She indicated Resident 31's tray card should have been checked prior to serving the tray, and Resident 31 should have received ground meat as ordered.Resident 31's record was reviewed on 07/28/2025 11:26 AM. Diagnoses included dementia and dysphagia. Resident 31's current annual Minimum Data Set assessment, dated 4/13/25, the a Basic Interview for Mental status was not conducted due to Resident 31's inability to make himself understood. The MDS indicated Resident 31 received a mechanically altered diet. A physician's order, dated 8/22/24, indicated Resident 31 should receive a regular diet, double portions with mechanical soft texture. A physician's order, dated 5/22/25, indicated Resident 31's food should be served in individual bowls. Food should given to Resident 31,one bowl at a time. A current care plan titled at nutritional risk indicated Resident 31 was at risk for malnutrition due to dementia and dysphagia and received a mechanical soft textured diet. The care plan had a goal date of 10/12/25. Interventions included serving Resident 31's diet as ordered and providing assistance as needed. A nurses note, dated 07/23/25 at 1:25 PM, indicated Resident 31 ate a hot dog that was not ground up (belonging to another resident) off of the hall cart. A current policy titled Select Menus, undated, indicated nursing staff should check the tray card for to ensure the correct meal is delivered to the correct resident. 3.1-21(a)(3)