STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155556	A. BUILDING 00 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00451017. Complaint IN00451017 - No deficiencies related to the allegations are cited. Survey dates: March 11, 12, 13, 14, 17 and 18, 2025. Facility number: 000505 Provider number: 155556 AIM number: 100266350 Census Bed Type: SNF: 18 SNF/NF: 70 Total: 88 Census Payor Type: Medicare: 8 Medicaid: 50 Other: 30 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 24, 2025.	F 0000		
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints Based on observation, interview and record review, the facility failed to ensure the need for a bed and chair alarm was re-evaluated and on-going monitoring was documented for 1 of 1	F 0604	It is the policy of the facility to ensure that all residents with personal body alarms have the proper assessments completed,	04/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Waymire	Administrator	04/17/2025

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	resident reviewed for physical restraints. (Resident 49) Findings include: During an observation, on 3/13/25 at 9:49 a.m., Resident 49 had a bed alarm and a chair alarm. The clinical record for Resident 49 was reviewed on 3/13/25 at 9:48 a.m. The diagnoses included, but were not limited to, dementia, cognitive communication deficit, mild cognitive impairment, and abnormalities of mobility. A physician's order, with a start date of 7/1/23, indicated to use a bed sensor alarm while the resident was in bed every shift for falls. A physician's order, with a start date of 3/29/24, indicated to place a chair sensor in the resident's chair while she was in her room every shift for falls. A fall risk review assessment, dated 1/14/25, indicated the resident did not have a history of falling within the past 3 months. The last documented fall in the Electronic Health Record (EHR) was 9/17/24. There was no documentation in the EHR about monitoring or reevaluating the bed or chair alarms. There was no documentation to indicate the family agreed to the use of the alarms prior to placement and there was no documentation the Interdisciplinary Team (IDT) team reviewed the sensors quarterly. A current care plan, with a revision date of 3/13/25, indicated the resident's family preferred		consent and ongoing monitoring 1. Resident #49's family was contacted on 04-10-2025 and educated on use of alarms and they chose to have the alarms removed. Care Plan was updated to reflect the same. 2. An audit was completed on all personal alarm devices on 04-10-2025 to ensure all residents with personal alarms have the proper assessments completed, consents obtained, and monitoring in place by the DON/Designee and IDT. 3. At an in-service held by the DON/Designee on 04-10-2025 for all clinical staff the following was reviewed: 1.Safety Alarm Devices Policy and Procedure Additionally, any staff who fail to comply with the points of the in-service will be further educated and/or disciplined as indicated. 4. The DON/Designee will audit all resident with personal alarms 4x a week for 4 weeks, then 3x a week for 4 weeks, then weekly for 4 months to ensure proper assessments completed, consent obtained, and daily function testing. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped.	

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	the resident utilized sensor alarms despite education per staff. This was added on 3/13/25 after asking about the bed alarm. During an interview, on 3/14/25 at 8:58 a.m., the Executive Director (ED) indicated there should have been documentation to indicate the family was educated and gave permission for the use of the alarms. During an interview, on 3/17/25 at 11:18 a.m., the Director of Nursing (DON) indicated there should have been documentation to show the family was verbally education on the use of alarms. During an interview, on 3/18/25 at 10:05 a.m., the DON indicated the care plan was revised, on 3/13/25, about the family's preference on the use of sensor alarms. It was not documented until 3/13/25. During an interview, on 3/18/25 at 1:58 p.m., the DON indicated the re-evaluation, and monitoring was not completed due to the family was insistent on the use of the alarms. During an exit conference, on 3/18/25 at 4:36 p.m., the facility indicated they had no additional information to provide. A current facility policy, titled "GUIDELINES FOR SAFETY ALARM DEVICES," dated 2023 and received from the DON on 3/18/25 at 8:39 a.m., indicated "...The resident's family/representative must be informed of and agree to the placement of an alarm...Alarms must be removed...If the resident has not had a fall or attempted fall in 30 days...The alarms need to be reviewed at least quarterly by the IDT for appropriateness and efficacy for fall prevention...."		At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	

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F 0623 SS=E Bldg. 00	2.1-3(w) 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on interview and record review, the facility failed to ensure the Office of the State Long-Term Care Ombudsman was given notification of the resident's transfer and discharge to the hospital for 4 of 4 residents reviewed for transfer and discharge. (Resident 2, 12, 74 and 237) Findings include: 1. The clinical record for Resident 2 was reviewed on 3/11/25 at 4:16 p.m. The diagnoses included, but were not limited to, fever, respiratory infection, and hallucinations/delusions. The resident was transferred out of the facility and to the hospital on 12/27/24 for fever and respiratory infection and 1/24/25 for new/worsening hallucinations/delusions. The facility was unable to provide notification to the Ombudsman of the transfer. 2. The clinical record for Resident 12 was reviewed on 3/11/25 at 4:11 p.m. The diagnoses included, but were not limited to, dementia, type 2 diabetes, and muscle weakness. The resident was transferred out of the facility and to the hospital due to hallucinations and aggressive behavior on 12/31/24. She was admitted to the hospital for a urinary tract infection and cellulitis of the left lower extremity.3. The clinical record for Resident 74 was reviewed on 3/13/25 at 1:21 p.m. The diagnoses included,	F 0623	It is the policy of this building to ensure that all resident's transfers and discharges are documented with the area Ombudsman. 1. In accordance with the regulation criteria for discharge, the discharges of residents 2, 12, 74, and 237 have been communicated to the area Ombudsman by Social Service Designee on 03-14-2025. 2. A full audit for the proceeding 30 days have been executed and notifications have been sent to the state's ombudsman by Social Service Designee 03-14-2025. 3. SSD and SS Director were in-serviced by the Administrator/Designee on 04-10-2025 on the regulatory process for proper discharge and notification of Ombudsman. Any staff who fail to comply with the points of the in-service will be further educated and/or disciplined as indicated. 4. SSD/Designee will audit any discharges and/or transfers at the morning IDT (Interdisciplinary Team) meetings 5 times weekly for proper notification to area Ombudsman, this monitoring tool will be utilized for five times a	04/16/2025

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	but were not limited to, dementia, unsteadiness on feet, and paroxysmal vertigo. A progress note, dated 11/9/24, indicated Resident 74 was sent to the Emergency Room for evaluation after a fall. A hospital document, dated 11/11/24, indicated Resident 74 was being discharged from the hospital to return to the long-term care facility. There was no documentation the Ombudsman was notified regarding Resident 74's discharge from the facility on 11/9/24 found in the clinical record. 4. The clinical record for Resident 237 was reviewed on 3/13/25 at 2:07 p.m. The diagnoses included, but were not limited to, repeated falls, unsteadiness on feet, and osteoarthritis. A progress note, dated 1/18/25, indicated Resident 237 was discharged from the facility and transferred to the hospital after a fall. A facility incident form, with a follow-up date of 1/20/25, indicated Resident 237 was still in the hospital and the plan was to return to the facility upon discharge from the hospital. There was no documentation the Ombudsman was notified regarding Resident 237's discharge from the facility on 1/18/25 found in the clinical record. During an interview, on 3/14/25 at 2:43 p.m., the Executive Director (ED) indicated the facility notified the Ombudsman of the resident's discharges using an online portal and there was no way to prove the notification to the		week x 4 weeks, then 3 time a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	Ombudsman was sent. An email dated 3/19/25 at 7:50 a.m., from State Long-Term Care Ombudsman 5, indicated the facility had not reported any discharges since July of 2024. A document, titled "Family of Social Service Administration," dated as last updated October 2024, indicated "...Dear Nursing Home Administrator: As you know, CMS requires nursing facilities to notify the Long-Term Care (LTC) Ombudsman of the majority of residents' transfers and discharges...When a resident is transferred on an emergency basis to an acute care facility and expected to return, the SLTCO must be notified. Information from facilities regarding emergency transfers should be provided in a monthly list to the SLTCO, which should include residents' names, dates of transfer, facilities to which residents were transferred, and reasons for the transfers. Please make sure your facility's name is included on the monthly list...." A document, titled "Guidelines for LTC Facilities-in Working with and Coordinating with the Ombudsman," dated 10/30/24 and received from the ED on 3/18/25 at 3:29 p.m., indicated "...The facility will report required information to their Ombudsman as dictated by the individual state and also by federal requirements in a timely manner. This includes the federal notification requirement of reporting (sending a copy) of a notice of discharge when any resident is discharged or transferred from a facility--30 days prior to the discharge or transfer--or if this is not possible then notification must be timely and include a copy of the discharge/transfer. This notification process should meet state/federal requirements and should be discussed and agreed			

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	upon (and documented) by both the facility and their Ombudsman. This further includes when a facility resident is sent to a hospital and then while hospitalized the facility initiates the resident's discharge from the facility. This also includes emergency discharges or transfers that meet the criteria of an emergency discharge or transfer...." 3.1-12(a)(6)(A)(iv)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure care plan meetings were held quarterly and timely upon admission for 2 of 2 residents reviewed for care plan meetings. (Resident 12 and 30) Findings include: 1. The clinical record for Resident 12 was reviewed on 3/11/24 at 4:16 p.m. The diagnoses included, but were not limited to, type 2 diabetes, dementia, and muscle weakness. A care plan note was documented for September 2024 and March 2025. There were no notes found to show a care plan meeting had been held after September and prior to March. During an interview, on 3/13/25 at 9:57 a.m., the Social Service Designee indicated she was not able to find documentation for a care plan meeting between 9/24 and 3/25. She indicated care plan meetings were to be completed quarterly. 2. During an interview, on 3/12/25 at 9:30 a.m., Resident 30 indicated she did not have a care plan	F 0657	It is the policy of this facility to ensure care plan meetings are held quarterly and upon admission. 1. A care plan meeting was completed for Resident 12 on 04-07-2025and resident 30 on 03-26-2025. 2. The SSD/Designee completed an audit of care plan meetings. Any resident identified during the audit will have a care plan meeting scheduled by the SSD/Designee and will be completed by 04-15-2025. 3. The ADM/Designee in-serviced the IDT on the care plan meeting process for resident's quarterly, upon admission and as needed on 04-10-2025.. Additionally, any staff member that fails to comply with the points of this in-service will be further education and/or disciplined as indicated 4. The SSD/Designee will audit 10 random residents, new	04/16/2025

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	meeting until 3/11/25. The clinical record for Resident 30 was reviewed on 3/17/25 at 3:43 p.m. The diagnoses included, but were not limited to, displaced comminuted fracture of the left humerus, pneumonitis, and chronic obstructive pulmonary disease. The resident was admitted to the facility on 1/25/25. During an interview, on 03/13/25 at 10:04 a.m., the Social Service Designee indicated she thought the resident had a care plan meeting in February after she was admitted to the facility. There was no documentation to indicate a care plan meeting had been held in February. During an interview, on 3/18/25 at 1:14 p.m., the Director of Nursing indicated the facility was unable to provide documentation related to the care plan meetings and they were not completed. A current facility policy, titled "Baseline Care Plan Assessment/Comprehensive Care Plans," dated as revised 9/13/24 and received from the Director of Nursing on 3/18/25 at 9:52 a.m., indicated "...Upon completion of the full Comprehensive MDS...the facility will schedule an initial Care Plan Conference...The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum...." 3.1-35(a) 3.1-35(d)(2)(b)		admissions and re-admissions weekly for care plan meetings x 4 weeks, then 5 random residents, new admissions and re-admissions weekly x 4 weeks, then 3 random residents, ne admissions and re-admissions monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents			

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	Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) care were assisted to the bathroom timely, and staff followed a physician's order related to footwear during a transfer for 2 of 2 dependent residents reviewed for ADL care. (Resident 187) Findings include: 1. During an observation, on 3/12/25 at 9:31 a.m., Qualified Medication Aide (QMA) 17 answered the call light for Resident 187. The family had pushed the call light and asked QMA 17 if they could take the resident to the bathroom. QMA 17 indicated they would, but they would have to wait for another aide to be available since the resident was a 2 person assist, and the other aide was busy. During an observation, on 3/12/25 at 10:28 a.m., QMA 17 and another staff member went into the room to take Resident 187 to the bathroom. Resident 187 waited 57 minutes to be taken to the bathroom. During an interview, on 3/12/25 at 10:45 a.m., QMA 17 indicated the resident had soiled her incontinence brief. She was unable to take the resident to the bathroom before because there was not another staff member available to help take her. The clinical record for Resident 187 was reviewed on 3/14/25 at 10:13 a.m. The diagnoses included, but were not limited to, dementia, senile degeneration of the brain, hypertension, and history of falling.	F 0677	It is the intent of the facility to ensure dependent residents are assisted to the bathroom timely and with proper footwear according to doctors' orders. 1. Resident 187 was assessed on 03-14--2025 and no negative outcomes were found related to this alleged deficiency by the DON/Designee. Resident 237 no longer resides in the facility. 2. All residents have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility. 3. DON/Designee in-serviced nursing staff on assisting residents to the bathroom timely and following physician orders related to proper footwear during transfers on 04-10-2025. The SSD/Designee will interview 10 random residents/family members for timely transfers to bathroom and if resident was wearing proper footwear weekly x 4 weeks, then 5 random residents/family members weekly x 4 weeks, the 3 random residents/family members monthly x 4 months.	04/16/2025

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	A current care plan, dated as revised on 3/2/25, indicated Resident 187 required help with ADL care. Staff were to assist the resident with toileting as needed. A current care plan, dated as revised on 3/2/25, indicated the resident was incontinent of bowel and bladder. The goal was to have Resident 187 remain clean, dry and odor free and to assist the resident to the bathroom as needed. A facility bowel and bladder incontinence screen, dated 2/28/25, indicated the resident did void appropriately without incontinence. Resident 187 was sometimes aware of the need to use the toilet. A facility functional abilities and goals assessment, dated 3/13/25, indicated the resident was a substantial/maximal assist when it came to toileting and was dependent with toilet transfers. During an interview, on 3/12/25 at 10:10 a.m., QMA 17 indicated the "Terrace Hall" needed more staffing. It could take longer than they wanted to get their work done some days. During an interview, on 3/12/25 at 10:15 a.m., QMA 17 indicated there were not always enough staff. They would get behind on their work a lot and could not work as fast as they would like to. During an exit conference, on 3/18/25 at 4:36 p.m., the facility indicated they had no additional information to provide. 2. The clinical record for Resident 237 was reviewed on 3/13/25 at 2:07 p.m. The diagnoses included, but were not limited to, abnormalities of gait and mobility, unsteadiness on feet, and			

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	repeated falls. A nursing progress note, dated 11/19/24, indicated the nurse spoke to the resident's podiatrist and explained the resident was non-compliant with her non-weight bearing order and it was causing her distress. The podiatrist gave an order to discontinue the non-weight bearing status due to noncompliance, to ensure the resident always had on shoes while she was out of bed, and to monitor the placement of the resident's feet during transfers. A physician's order, dated 11/19/24, indicated Resident 237 was to always wear shoes when out of bed every shift. A facility document, dated 1/18/25, indicated Resident 237 was being assisted to the restroom by a staff member and fell. A nursing progress note, dated 1/18/25, indicated the nurse entered Resident 237's room to assess her after a fall. Resident 237 was sitting on the floor and was wearing non-skid socks. A SBAR (Situation, Background, Assessment and Recommendation) summary, dated 1/18/25, indicated the nurse found Resident 237 sitting on the bathroom floor with non-skid socks on. An Interdisciplinary Team note, dated 1/20/25, indicated Resident 237 experienced a fall on 1/18/25 at 6:42 a.m. The resident was wearing non-slip socks, and her walker was in the bathroom with her. During an interview, on 3/18/25 at 2:35 p.m., the Director of Nursing (DON) indicated a staff member took Resident 237 to the restroom. The			

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	resident was wearing non-skid socks and slipped in urine, which resulted in a fall. The resident had been stubbing her big toe and was non-compliant with the podiatrists' non weight bearing order. An order was placed for the resident to always have shoes on when out of bed. The DON indicated the resident always wanted her shoes on and should have been wearing her shoes at the time of her transfer and fall. A facility document, titled "Guidelines for Physician Orders--(Following Physician Orders)," dated 6/18/23 and received from the DON on 3/17/25 at 1:59 p.m., indicated "...the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission...The facility must have orders from the physician...routine care to maintain or improve the resident's functional abilities...." A facility assessment, titled "The Waters of Tipton SKILLED NURSING FACILITY Facility Assessment Tool," completed on 7/10/24 and received upon entrance, indicated "...The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies...." A current facility policy, titled "Your Rights and Protections as a Nursing Home Resident," undated and received from the Executive Director upon entrance, indicated "...As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need...." 3.1-38(a)(2)(C)			

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	155556	A. BUILDING 00 B. WING	03/18/2025

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview and record review, the facility failed to ensure residents with catheters had physician's orders in place for 3 of 4 residents reviewed for catheters. (Resident 59, 56 and 10) Findings include: 1. During an observation, on 3/11/25 at 12:03 p.m., Resident 59 was observed sitting in his recliner. A catheter bag was noted to be draining to gravity. The clinical record for Resident 59 was reviewed on 3/13/25 at 11:01 a.m. The diagnoses included, but were not limited to, fall, acute kidney failure, and hypertension. The resident did not have a physician's order for an indwelling catheter. During an interview, on 3/13/25 at 11:12 a.m., LPN 6 indicated a resident needed to have a physician's order for a catheter. She indicated Resident 59 did not have an order for the catheter. 2. During an observation, on 3/11/25 at 11:00 a.m., Resident 56 was sitting on his recliner. A urinary catheter was attached to the side of the recliner. The clinical record for Resident 56 was reviewed on 3/13/25 at 8:08 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, untreatable urinary retention, and paraplegia. A care plan, dated 4/23/24, indicated Resident 56 required the use of a suprapubic catheter for	F 0690	It is the policy of this facility to ensure any resident with a catheter has a proper physician orders. 1. Resident 59, 56, and 10s physician order were obtained for catheters by the DON/Designee on 04-13-2025. Resident #59 discharged home on 03-19-2025. 2. The DON/Designee completed an audit of all residents with catheters on 04-01-2025 to ensure all orders were in place. 3. The DON/Designee in-serviced nursing staff on the Catheter policy and physician orders policy, on 04-10-2025. Additionally, any staff member that fails to comply with the points of this in-service will further education and/or disciplined as indicated. 4. The DON/designee will audit physician orders to ensure that residents with catheters, new admissions and re-admissions have an appropriate order in place 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any	04/16/2025

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	untreatable urinary retention and chronic obstruction. A physician's order, dated 9/11/24, indicated catheter care was to be completed every shift. A physician's order, dated 11/12/24, indicated Resident 56 required enhanced barrier precautions for an indwelling catheter. A physician's order for the indwelling catheter which included the type and size of the catheter and the indication for use could not be found in the record. During an interview, on 3/17/24 at 1:13 p.m., the Director of Nursing (DON) indicated the physician's order for Resident 56's catheter was not completed after his last readmission. 3. During an observation, on 3/13/25 at 8:21 a.m., Resident 10 was in the dining room for breakfast. A urinary catheter bag was attached to the underside of his wheelchair. The clinical record for Resident 10 was reviewed on 3/14/25 at 9:12 a.m. The diagnoses included, but were not limited to, chronic kidney disease, obstructive and reflux uropathy, and muscle wasting. A care plan, dated 1/16/25, indicated Resident 10 required the use of a suprapubic catheter due to obstructive and reflux uropathy. A physician's order, dated 3/10/25, indicated catheter care was to be completed every shift. A current physician's order for the catheter which included the type and size of the catheter and the		needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved	

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	indication for use could not be found in the record. Resident 10's last catheter order was discontinued on 10/11/24. During an interview, on 3/17/25 at 10:17 a.m., the DON indicated she was unsure why the catheter order was not currently active. Resident 10 was readmitted into the facility from the hospital and the unit manager was responsible for ensuring physician's orders were placed when a resident returned to the facility from a discharge. A current facility policy, titled "Catheters," undated and provided from the Clinical Support Nurse on 3/14/25 at 1:30 p.m., indicated "...Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and facility protocol and procedure with adherence to infection prevention and control techniques...." A current facility policy, titled "GUIDELINES FOR PHYSICIAN ORDERS-(FOLLOWING PHYSICIAN ORDERS)," dated 6/18/23 and received from the Director of Nursing on 3/17/25 at 1:59 p.m., indicated "...The facility must have orders from the physician...for...Routine care to maintain or improved the resident's functional abilities...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to label an oxygen line with the date it was put into use, to store an oxygen line in a bag when not in use, to ensure	F 0695	It is the policy and practice of this facility to ensure residents who need respiratory care have respiratory orders, tubing stored	04/16/2025

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	oxygen orders were in place, and to discard a nebulizer mask and tubing which was no longer in use for 3 of 3 residents reviewed for respiratory care. (Resident 59, 140 and 71) Findings include: 1. During an observation, on 3/12/25 at 10:12 a.m., Resident 59 had an oxygen concentrator with the oxygen line and nasal cannula attached. The line was found to be missing the date it was initiated. During an interview, on 3/12/25 at 10:22 a.m., LPN 6 was observed to write a date on the tubing for 3/12/25. She indicated the line should have been changed on the night shift but was not documented and she would have to call the nurse and check. During an observation, on 3/13/25 at 10:26 a.m., the oxygen line for Resident 59 was observed to be wrapped up and laying on top of the oxygen concentrator and not in a bag. The line was dated for 3/12/25. During an interview, on 3/13/25 at 10:29 a.m., QMA 3 indicated the line was to be stored in a bag and the line was not stored correctly. He thought the nurse had obtained a bag yesterday. 2. During an observation, on 3/12/25, Resident 140 was observed receiving oxygen via a nasal cannula. The clinical record for Resident 140 was reviewed on 3/12/25 at 11:26 a.m. The diagnoses included, but were not limited to, major depressive disorder, atrial fibrillation (heart rhythm disorder), and obstructive sleep apnea.		and dated appropriately, and discontinued items removed from room. 1 Resident 59, 140, and 71's rooms were reviewed to ensure proper equipment in place, stored appropriately, and any unnecessary items removed by the DON/Designee. 2. Facility wide audits were completed 04-15-2025 by the DON/Designee to ensure residents with oxygen/nebulizers have their items stored and labeled properly, and any unnecessary equipment was removed. 3. All nursing staff were educated by the Director of Nursing on the policies "Oxygen administration" and on storage of tubing and CPAP and BiPAP masks on 04-10-2025. Additionally, any staff member that fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 4. The Director of Nursing or designee will audit residents with oxygen and a CPAP/BiPap and verify tubing is dated and stored in plastic bag while not in use and that resident have physician orders 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will complete 20 random room rounds to verify resident do not have equipment	

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	The resident did not have an order for oxygen use at the time of the record review. During an interview, on 3/12/25 at 11:18 a.m., the Executive Director indicated residents should have orders for the use of oxygen. 3. During an observation, on 3/11/25 at 10:12 a.m., Resident 71 was in her room and had complaints about being short of breath. A nebulizer mask was noted to be unbagged and laying on the resident's bedside table. A nebulizer mouthpiece was noted to be unbagged and laying on top of the nebulizer machine. During an interview, on 3/11/25 at 10:14 a.m., LPN 6 indicated the nebulizer equipment was not stored correctly. The resident did not use the equipment, but she would get a bag for storage. The clinical record for Resident 71 was reviewed on 3/13/25 at 11:47 a.m. The diagnoses included, but were not limited to, pancreatic cancer, diabetes mellitus, and myasthenia gravis (an auto-immune disorder). A nursing progress note, dated 3/11/25 at 3:38 a.m., indicated the resident was short of breath and a nebulizer treatment was given per the order. A current order for nebulizer treatments was not found in the record. During an interview, on 3/17/25 at 3:37 p.m., the Director of Nursing indicated the policy titled "Oxygen Therapy" covered nebulizer equipment. A current facility policy, titled "Oxygen Therapy," undated and received from the Director of Nursing on 3/17/25 3:37 p.m., indicated "...Discard		that is not in use in the room weekly x 4 weeks, then 10 random rooms weekly x 4 week, then 10 random rooms monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve.	

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	disposable masks, cannulas, and tubing after use...." A current facility policy, titled "Oxygen Administration," undated and received from the Director of Nursing on 3/17/25 at 3:37 p.m., indicated "...It is the policy of this facility to provide oxygen to resident as needed and as ordered by their attending physicians...Orders are to be noted in the M.A.R....Tubing must be changed weekly and must be labeled with date, time, and initials of the individual who changed the tubing...." 3.1-47(a)(6)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, interview and record review, the facility failed to ensure a sufficient number of staff were available to provide residents nursing care and other related services to the residents. (Resident 187, 56, 34, 20, 73, 30 and 66) This deficient practice had the potential to affect 88 of 88 residents. Findings include: A Payroll Based Journal (PBJ) for the 1st quarter of 2025 indicated the facility scored a 1-star staffing rating. 1. During an observation, on 3/12/25 at 9:31 a.m., Qualified Medication Aide (QMA) 17 answered the call light for Resident 187. The family had pushed the call light and asked QMA 17 if they could take the resident to the bathroom. QMA 17 indicated they would, but they would have to wait for another aide to be available since the resident	F 0725	It is the policy of this facility to provide sufficient staffing in order to provide nursing care and other related services to our residents. 1. The DON/Designee assessed residents 187, 56, 34, 20, 73, 30 and 66 and no negative outcome related to the alleged deficient practice. 2. All residents have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility 3. The ADM/DON were educated relative to Sufficient Staffing by the RDO on 04-14-2025, including but not limited to provision of sufficient staffing based on resident acuity to meet the needs and preferences of residents.	04/16/2025

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	was a 2 person assist, and the other aide was busy. During an interview, on 3/12/25 at 10:10 a.m., QMA 17 indicated this hall was staffed fine but Terrace Hall needs more staffing. It can take longer than they want to get their work done on some days. During an interview, on 3/12/25 at 10:15 a.m., QMA 17 indicated there were not always enough staff. They get behind on their work a lot and they were not as fast as they would like to be. During an observation, on 3/12/25 at 10:28 a.m., QMA 17 and another staff member went in to take Resident 187 to the bathroom. It took 57 minutes for Resident 187 to be taken to the bathroom. During an interview, QMA 17 indicated the resident had soiled her brief. She was very wet and they could not get to her for a while because there was not another staff member available to help take her to the bathroom. 2. The resident council meeting minutes were reviewed on 3/13/25 at 10:32 a.m., and indicated: a. March 2024, the old business indicated the food was still cold. b. December 2024, the old business indicated the call light response time had improved but there was still room for improvement. The second shift call light time could be better. c. January 2025, the new business indicated the serving time of the food could be better and they needed more nursing staff. During a meeting with the resident council, on		Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. ADM/Designee will monitor staffing levels are sufficient to meet the needs of the resdients 5 days a week for 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved	

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	3/13/25 at 1:56 p.m., the 2 residents in attendance indicated the facility did not have enough staff, it took a long time for the staff to answer call lights, room trays were passed out late, and the food was usually cold. 3. During an observation and interview, on 3/14/25 at 1:09 p.m., Kitchen Manager 16 took a temperature of a room tray which was about to be delivered. The chili dog temperature was 110 degrees and the corn was 85 degrees. Kitchen Manager 16 indicated both item should temp at 145 degrees. During an interview, on 3/14/25 at 1:30 p.m., an anonymous staff member indicated there was not enough staff to help pass out the room trays. Staff felt bad since the residents always complained about cold food. Passing out meal trays was the most stressful part of the day and leadership rarely helped pass trays. 4. A facility concern form, titled "I WOULD LIKE TO KNOW," dated 2/11/25, indicated a family member was asking why the resident was wearing the same clothes from day to day, her mothers lenses on her glasses were always dusty, the rooms were always dirty, and the floors in her room were always sticky. 5. During an interview, on 3/11/25 at 11:16 a.m., Resident 56 indicated staffing was shorthanded on all shifts. A quarterly Minimum Data Set (MDS) assessment, dated 2/10/25, indicated Resident 56 was cognitively intact. 6. During an interview, on 3/11/25 at 12:05 p.m., Resident 34 indicated there were not enough staff,			

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	there were long wait times for call lights, and sometimes the staff did not return after answering the light. An annual MDS assessment, dated 1/5/25, indicated Resident 34 was cognitively intact. 7. During an interview, on 3/11/25 at 11:50 a.m., Resident 20 indicated the staff needed more help, especially on the weekends. A Quarterly MDS assessment, dated 2/10/25, indicated Resident 20 was cognitively intact. 8. During an interview, on 3/11/25 at 3:39 p.m., Resident 73 indicated the facility was short staffed. A quarterly MDS assessment, dated 9/24/24, indicated Resident 73 was cognitively intact. 9. During an interview, on 3/12/25 at 9:29 a.m., Resident 30 indicated it took a long time for the call lights to be answered on the evening shift. A quarterly MDS assessment, dated 2/4/25, indicated Resident 30 was cognitively intact. 10. During an interview, on 3/12/25 at 9:47 a.m., Resident 66 indicated the facility was grossly understaffed. An annual MDS assessment, dated 2/12/25, indicated Resident 66 was cognitively intact. During an interview, on 3/11/25 at 10:27 a.m., an anonymous staff member indicated it could be challenging to get work done and staff felt rushed. During an interview, on 3/11/25 at 10:55 a.m., an			

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	anonymous family member indicated there was not enough staff and even the staff complained about how short staffed the facility was. During an interview, on 3/12/25 at 9:53 a.m., an anonymous family member indicated there were not enough aides. The call light times were very long and there were not enough aides on the halls. They smelled bowel movement in the room when they came in to see their family member. Staff would come answer a call light, say they would be back, and they did not come back. During an interview, on 3/14/25 at 8:39 a.m., an anonymous staff member indicated they could use more staff on the the "heavier halls", in memory care, and during mealtimes. The residents who received room trays rarely were checked on during their meal. Call lights would go off for long period of times. During an exit conference, on 3/18/25 at 4:36 p.m., the facility staff indicated they had no additional information to provide. A current facility policy, titled "Serving Food and Beverages," dated 2017 and received from the Director of Nursing (DON) on 3/18/25 at 8:40 a.m., indicated "...Foods shall be served at the following temperatures to ensure a safe and appetizing dining experience: Meat, Casseroles-135 to 170 degrees. Vegetables-135-170 degrees...." A facility assessment, titled "The Waters of Tipton SKILLED NURSING FACILITY Facility Assessment Tool," completed on 7/10/24 and received upon entrance, indicated "...The purpose of the assessment is to determine what resources are necessary to care for residents competently			

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	during both day-to-day operations and emergencies...." A current facility policy, titled "Your Rights and Protections as a Nursing Home Resident," undated and received from the Executive Director upon entrance, indicated "...As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need...." 3.1-17(a)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to ensure Registered Nurse coverage was provided for at least 8 consecutive hours in a 24-hour day for 1 of 14 days reviewed for RN coverage. (3/2/25) Findings include: The Payroll Based Journal (PBJ) was reviewed and indicated the facility received a 1-star staffing rating for the first quarter of 2025. The daily nursing staff schedule, dated 3/2/25, indicated there was not a Registered Nurse (RN) in the facility for 8 consecutive hours that day. During an interview, on 3/18/25 at 2:06 p.m., the Director of Nursing (DON) indicated the facility did not currently have a staffing scheduler, so she had been responsible for the nursing schedule. She indicated there was not a Registered Nurse scheduled to be in the facility for any shift on the date of 3/2/25. The weekend option RN who normally worked was on vacation and when the	F 0727	IT is the policy of the facility to ensure RN coverage is provided for at least 8 hours per day, 7 days per week. 1. No residents were identified for this alleged deficient practice. 2. All residents have the potential to be affected by the alleged cited practice, therefore, this plan of correction applies to all residents that reside in the facility. 3. The Administrator educated the facility Nurse Administration Team (DON, ADON, and Scheduler) on the policy “Registered Nurse Coverage” on 04-14-2025.. Additionally, any employee who fails to meet the points of the in-service will be further educated and/or disciplined as indicated. 4. **The daily schedule will be reviewed, during morning meeting to ensure facility staffing is sufficient to meet**	04/16/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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	open shift was filled, it was overlooked. There should be an RN in the building covering at least an 8-hour shift in a 24-hour period. A current facility policy, titled "Registered Nurse Coverage," undated and received from the DON on 3/18/25 at 3:55 p.m., indicated "...it is the policy of the facility to provide the services of an RN for at least 8 consecutive hours per 24 hour day, 7 days a week...The person responsible for the nursing schedule will write the schedule to ensure that at least 8 consecutive hours of RN services are scheduled each 24 hour day, 7 days per week...If there is the potential for a 24 hour period at which time there would not be an RN to provide services for an 8 hour consecutive period in any given 24 hour period, the Director of Nursing and the Administrator will be immediately informed so that incentives can be put into place to provide the required consecutive 8 hours of RN services for that specified 24 hour period....". 3.1-17(b)(3)		**residents needs 5 times per week x 4 weeks, weekly x 4 weeks then monthly x 4 months, ensure RN coverage is conducted 7 days each week (8 consecutive hours)** If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on interview and record review, the facility failed to ensure the pharmacy received a medication authorization and a resident did not have to provide their personal home supply until the medication was authorized for 1 of 1 resident reviewed for pharmacy services (Resident 71) and failed to ensure narcotic count sheets were signed by the in-coming and out-going staff for 4 of 4 narcotic log books reviewed. Findings include: 1. During an interview, on 3/11/25 at 10:26 a.m.,	F 0755	It is the policy of this facility to ensure medication authorizations are obtained timely for resident medication, and to ensure narcotic count sheets are signed by the in-coming and out-going staff. 1. No residents were identified regarding the narcotic shift to shift count. Resident 71 no longer resides at facility. 2. The DON/Designee completed a medication audit to verify residents' medications are	04/16/2025

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	Resident 71 indicated she was not getting her Creon (a medication which replenished enzymes for digestion of food) and it was to be given with meals. A care plan, dated 2/25/25, indicated the resident was at risk for weight loss, pain, fatigue and other complications related to a cancer diagnosis and to administer medications as ordered. The clinical record for Resident 71 was reviewed on 3/13/25 at 11:47 a.m. The diagnoses included, but were not limited to, pancreatic cancer, diabetes mellitus, and myasthenia gravis (an auto-immune disorder). A physician's order, dated 2/20/25, indicated to give 2 capsules of pancrelipase (Creon) delayed release particles 36000-114000 units by mouth with meals for pancreatic cancer. A physician's order, dated 2/20/25, indicated to give 1 capsule of pancrelipase delayed release particles 36000-114000 units by mouth twice a day for pancreatic cancer. The medication must be given with a snack. a. The Medication and Treatment Record (MAR/TAR) indicated, on 3/7/25 at 12:00 p.m. and 5:00 p.m., indicated to see the nurses' notes. There was no documentation found in the nursing notes to indicate why the medication was not given. The resident meal intake record indicated the resident had eaten 51-75 percent of her mid-day meal and 76-100 percent of her evening meal. There was no physician's order which indicated to		available on 03-21-2025.. Any concerns were immediately addressed. The DON/Designee completed narcotic count with the shift nurse on 04-10-2025. 3. The Regional Nurse Consultant in-serviced the Director of Nursing on medication authorizations on 04-14-2025.. The DON/Designee in-serviced the nursing staff and qualified medications assistances and on procedure for medications authorization and what to do when medications are not available on 04-10-2025. The DON/Designee in-serviced the nursing staff and qualified medication assistance on narcotic shift to shift count on 04-10-2025. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. DON/Designee will review all medication orders to ensure medication availability as well as audit controlled medication count records are signed by on-coming and out-going nurses/QMA's 5 times a week x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 4 months, the monitoring will be stopped. During the monthly QAPI	

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	hold the medication if the resident was not eating. b. The MAR/TAR indicated, on 3/7/25 at 8:00 p.m., the medication was refused. There was no documentation found in the nursing notes to indicate why the medication was refused. c. The MAR/TAR indicated, on 3/8/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., the medication was refused. There was no documentation found in the nursing notes to indicate why the medication was refused. The resident meal intake record indicated the resident had eaten 76-100 percent of all three meals. There was no physician's order which indicated to hold the medication if the resident was not eating. d. The MAR/TAR indicated, on 3/8/25 at 10:00 a.m. and 8:00 p.m., the medication was refused. There was no documentation found in the nursing notes to indicate why the medication was refused. e. The MAR/TAR indicated, on 3/9/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., the medication was refused. There was no documentation found in the nursing notes to indicate why the medication was refused. The resident meal intake record indicated the resident had eaten 76-100 percent of her morning and afternoon meals and 21-50 percent of her evening meal.		meeting, monitoring will be reviewed, and any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	There was no physician's order which indicated to hold the medication if the resident was not eating. f. The MAR/TAR indicated, on 3/9/25 at 10:00 a.m., the medication was refused. There was no documentation found in the nursing notes to indicate why the medication was refused. g. The MAR/TAR indicated, on 3/10/25 at 8:00 a.m., 12:00 p.m., and 5:00 p.m., indicated to see the nurses' notes. There was no documentation found in the nursing notes to indicate why the medication was not given. The resident meal intake record indicated the resident had eaten 76-100 percent of her morning and afternoon meal and 51-75 percent of her evening meal. There was no physician's order which indicated to hold the medication if the resident was not eating. h. The MAR/TAR indicated, on 3/11/25 at 8:00 a.m., and 12:00 p.m., indicated to see the nurses' notes. There was no documentation found in the nursing notes to indicate why the medication was not given. The resident meal intake record indicated the resident had eaten 76-100 percent of her morning meal and there was no documentation (blank) to show what she had eaten for her afternoon meal. There was no physician's order which indicated to hold the medication if the resident was not eating.			

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i. The MAR/TAR indicated, on 3/11/25 at 10:00 a.m., indicated to see the nurses' notes.

A nursing progress note, dated 3/11/25, indicated the Creon was not available, the physician was currently in and was made aware of the delay of delivery. The resident's caregiver was in and would check if the resident had any personal supply at home, she could bring in.

A physician's note addendum, dated 3/11/25, indicated the resident had not been getting her Creon for the past several days due to a recent illness. She had not had any adverse effects at this time. The Creon will be resumed as soon as she recovered from her pneumonia.

During an interview, on 3/13/25 at 2:38 p.m., Resident 71 indicated she had never refused her medication. She knew she needed to take the medication, so she did not refuse it. She had worked hard to get the medication.

During a telephone interview, on 3/13/25 at 2:15 p.m., Pharmacy Staff 10 indicated the resident participated in Medicare Part A (insurance) and an authorization for the medication was needed depending on the cost of the medication and if the cost was outside of the facility designated threshold. The medication was filled on 3/11/25 and a 12-day supply was covered by the insurance. The medication authorization was approved by the Executive Director on 3/11/25.

During a telephone interview, on 3/13/25 at 2:22 p.m., Pharmacy Staff 11 indicated on 2/20/25 the medication was originally ordered but it was not filled and sent to the facility as the medication required authorization. The authorization was

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	originally sent out around 2/22/25. The facility was emailed again on 3/5/25 with no response. Another email was sent on 3/11/25 and the medication was approved. The medication was sent out and delivered on 3/12/25. During an interview, on 3/13/25 at 2:38 p.m., Resident 71's friend indicated the first batch of medication was the resident's supply which was brought to the facility and the facility used all of the medication. For the past three days, the pharmacy was supposed to send the medication, but they did not, so more medication was supplied to the facility by the resident. During an interview, on 3/17/25 at 1:50 p.m., the Director of Nursing indicated the facility did not know where the authorization was sent (emailed), but the facility knew when the resident came the medication was expensive and the facility would have to pay for it. During a telephone interview, on 3/17/25 at 2:42 p.m., Pharmacy Staff 12 indicated an authorization for the medication was sent to the facility using a group email for the facility, on 2/20/25. The request for authorization was sent again to the same email address on 2/21, 2/22, 3/5, 3/6, 3/7, 3/10 and 3/11/25. The pharmacy did not receive a response from the Executive Director until 3/11/25 and the medication was authorized on that date. During an interview, on 3/18/25 at 10:07 a.m., Physician 9 indicated, around 2/18/25 (he was not sure of the exact date), Resident 71 was on an antibiotic and not eating much so he verbally told the nurse to hold the medication if the resident was not eating, as the medication was for absorption of food. He gave a verbal (order) and was not sure if the order was written but he			

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	expected the staff to "do the right thing". 2. During an observation, on 3/15/25 at 10:05 a.m., the following was observed: a. The Aviary "NARCOTIC SHIFT-TO-SHIFT COUNT" sheet indicated the following: On 3/1/25, the on-coming nurse did not sign the narcotic log for the night shift. On 3/2/25, the off-going night nurse did not sign the narcotic logs sheet. On 3/3/25, the on-coming nurse did not sign the narcotic log sheet for the day shift or the off-going sheet for the evening shift. On 3/8/25, the on-coming nurse did not sign the narcotic log sheet for the evening shift or the off-going sheet for the night shift. On 3/10/25, the on-coming nurse did not sign the narcotic log for the day shift or the off-going sheet for the evening shift. On 3/10/25, the on-coming nurse did not sign the narcotic log for the evening shift and the on-coming nurse did not sign the log when she took the cart for the night shift. The night shift nurse did not sign the log when she left her shift. b. The Meadow "NARCOTIC SHIFT-TO-SHIFT COUNT" sheet indicated the following: On 3/3/25, the on-coming evening shift nurse did not sign the log sheet when she took the cart and failed to sign the log sheet when she left her shift. On 3/6/25, the on-coming night shift nurse did not sign the log sheet when she took the cart and failed to sign the log sheet when she left her shift. On 3/7/25, the on-coming nurse did not sign the log sheet when she took the cart and failed to sign off when she left her shift. On 3/9/25, the on-coming evening shift nurse failed to sign the log sheet when she took the cart and failed to sign off on the log sheet when she			

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	left her shift. c. The Garden "NARCOTIC SHIFT-TO-SHIFT COUNT" sheet indicated the following: On 3/10/25, the on-coming nurse failed to sign the log sheet when she took the cart and failed to sign off on the log sheet when she left her shift. d. The South Terrace "NARCOTIC SHIFT-TO-SHIFT COUNT" sheet. On 3/3/25, the off-going nurse failed to sign the log sheet when she surrendered the cart. On 3/4/25, the on-coming nurse failed to sign the log when she took the cart and failed to sign the log sheet when she surrendered the cart. On 3/6/25, the on-coming nurse failed to sign the log when she took the cart and failed to sign the log when she surrendered the cart. Between 3/9/25 to 3/13/25, there were 4 of 12 missing signatures for the off-going nurse and 2 of 12 missing signatures for the on-coming nurse. During an interview, on 3/11/25 at 12:30 p.m., LPN 5 indicated staff were supposed to sign off the narcotic sheets at the beginning and end of their shift. During an interview, on 3/17/25 at 10:14 a.m., QMA 20 indicated the narcotic count sheet was to be signed off from shift to shift after counting the narcotics. A current facility policy, titled "Pharmacy Services," dated 3/2023 and received from Corporate Support Nurse 1 indicated "...agrees to perform the following pharmaceutical services...Accurately dispensing prescriptions based on authorized prescriber orders...." A current facility policy, titled "CONTROLLED			

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	SUBSTANCES," dated 3/2023 and received from Corporate Support Nurse 1 on 3/13/25 at 2:31 p.m., indicated "...Both nurses will count the number of packages of controlled substance that are being reconciled during the shift/shift count and document on the Shift controlled Substance Count Sheet...." 3.1-25(a) 3.1-25(e)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure monitoring for potential side effects of psychotropic medications were in place for 1 of 5 residents reviewed for unnecessary medications. (Resident 73) Findings include: The clinical record for Resident 73 was reviewed on 3/17/25 at 2:08 p.m. The diagnoses included, but were not limited to, delusional disorder, visual hallucinations, depression, and neurocognitive disorder with Lewy Bodies. 1. A physician's order, dated 3/12/25, indicated Resident 73 was to take Depakote Sprinkles (a medication commonly used for bipolar disorder symptoms), two times a day, for delusional disorder. A physician's order, dated 3/10/25, indicated Resident 73 was to take haloperidol (an antipsychotic medication), as needed (PRN), for delusions and agitation. A physician's order, dated 3/10/25, indicated	F 0758	It is the policy for the facility to ensure monitoring is in place for side effects of psychotropic medications. 1. DON assessed resident 73 on 04-03-2025 with no negative outcomes. The DON/Designee obtained an order and enter into the EMR for side effect monitoring and behavior monitoring on 04-03-2025. 2. Facility wide audit was completed on 04-11-2025 to ensure any resident receiving a psychotropic medication had side effect monitoring order and behavior monitoring orders, any concerns were immediately addressed. 3. The DON/Designee in-serviced the nursing staff on side effect monitoring and behavior monitoring orders when residents for residents with orders for psychotropic medications on 04-10-2025.. Additionally, any staff	04/16/2025

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	Resident 73 was to take Risperdal (an antipsychotic medication), two times a day, for delusional disorder. A physician's order, dated 8/24/24 and discontinued on 10/30/24, indicated Resident 73 was to take quetiapine (an antipsychotic medication), two times a day, for delusional disorder. A care plan, dated as last revised on 8/19/24, indicated Resident 73 had a diagnosis of delusional disorder and visual hallucinations. The care plan did not include the use of psychotropic medications or instructions to monitor potential side effects of the medications. 2. A physician's order, dated 12/10/24, indicated Resident 73 was to take lorazepam (an antianxiety medication), in the evening, for anxiety. The care plan did not include the need for, the use of, or instructions to monitor for potential side effects of the antianxiety medication. 3. A physician's order, dated 8/24/24, indicated Resident 73 was to take citalopram (an antidepressant medication), once a day, for depression. A care plan, dated as last revised on 8/19/24, indicated the resident was prescribed a psychoactive medication to treat the diagnosis of depression. Instructions were to observe for possible side effects of the medication as indicated on the Medication Administration Record (MAR). The MAR did not include observations for possible side effects of the citalopram.		member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. The DON/Designee will review 10 random residents, new admissions, and re-admissions receiving psychotropic medications for side effect monitoring and behavior monitoring weekly x 4 weeks, then 5 random residents, new admissions and re-admissions weekly x 4 weeks, then 3 random residents, new admissions, and re-admissions monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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The electronic health record (EHR) did not include any active physician's orders for behavior monitoring related to Resident 73's mental health diagnoses.

The EHR did not include any active physician's orders to observe for new and/or worsening side effects of psychotropic medications.

During an interview, on 3/17/25 at 10:17 a.m., the Director of Nursing (DON) indicated Resident 73 was readmitted into the facility and the orders for behavior and side effect monitoring had not been reordered. The unit manager was responsible for ensuring orders were placed back into the EHR when a resident returned from a discharge.

During an interview, on 3/18/25 at 9:07 a.m., the Clinical Minimum Data Set (MDS) nurse indicated Resident 73's orders for behavior monitoring and the monitoring of the psychotropic medication use was discontinued on 10/30/24 when the resident was discharged to the hospital. The orders were not placed back into the EHR when the resident returned to the facility on 11/1/24.

A facility document, titled "Guidelines for Physician Orders--(Following Physician Orders)," dated 6/18/23 and received from the DON on 3/17/25 at 1:59 p.m., indicated "...At the time of admission the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. Two nurses will review admission and readmission orders to serve as a "double check" for the accuracy of the orders...The facility must have orders from the physician upon admission for...drugs...routine

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	155556	A. BUILDING 00 B. WING	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF TIPTON SKILLED NURSING FACILITY, THE	300 FAIRGROUNDS RD TIPTON, IN 46072

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	care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan...Orders that accompany the resident on admission or readmission will be clarified by the physician through action of the nurse who will contact the physician for clarification upon the resident's admission...." A current facility policy, titled "Baseline Care Plan Assessment/Comprehensive Care Plans," dated as last revised 9/13/24 and received from the DON on 3/18/25 at 9:52 a.m., indicated "...The Comprehensive Care Plan will further expand on the resident's risks...and interventions...that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental, and psychosocial needs. These needs will be defined from observation, interviews, clinical medical record review. The Physician Orders...MAR's, TAR's are extensions of the Plan of Care. The facility Interdisciplinary team...will discuss and develop quantifiable objectives along with appropriate interventions to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable for the resident...." 3.1-48(a)(3) 3.1-48(a)(5)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview and record review, the facility failed to ensure food was served at palatable and appetizing temperatures for 1 of 1 room tray observed. (the terrace unit)	F 0804	It is the intent of this facility to ensure food is served at a palatable and appetizing temperature. 1. No resident was identified for	04/16/2025

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	Findings include: During an interview, on 3/12/25 at 9:48 a.m., Resident 66 indicated the food was sometimes served cold. During an interview, on 3/12/25 at 11:13 a.m., Resident 10 indicated the food was served cold. During an observation and interview, on 3/14/25 at 1:09 p.m., Kitchen Manager 16 took a temperature of a room tray which was about to be delivered on the Terrace unit. The chili dog temperature was 110 degrees, and the corn was 85 degrees. Kitchen Manager 16 indicated both items should have temped at 145 degrees. The resident council meeting minutes were reviewed on 3/13/25 at 10:32 a.m., and indicated: a. March 2024, the old business indicated the food was still cold. b. January 2025, the new business indicated the serving time of the food could be better and they needed more nursing staff. During a meeting with the resident council, on 3/13/25 at 1:56 p.m., the 2 residents in attendance indicated the facility did not have enough staff, it took a long time for the staff to answer call lights, room trays were passed out late, and the food was usually cold. During an interview, on 3/14/25 at 1:30 p.m., an anonymous staff member indicated there was not enough staff to help pass out room trays. The staff felt bad since the residents always complained about cold food. Passing out meal trays was the most stressful part of the day and leadership rarely helped with passing trays.		the alleged deficiency. 2. All residents who reside in the facility have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. 3. The Dietary Manager/Designee in-serviced dietary staff on monitoring food temperature on 03-14-2025. The Adm/Designee in-serviced staff on assisting with meal service and passing meal trays on 04-10-2025.. Additionally, any staff member that fails to comply with the points of this in- service will be further educated and/or disciplined as indicated. 4. The Dietary Manager/Designee will audit hallway meal room tray temperatures on random hallways and random meal times 10 times a week x 4 weeks, then 5 random meal room trays on random meal times weekly x 4 weeks, then 3 random meal trays on random meal times monthly 4 months. If the facility is 95% compliance at the end of 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by QAPI committee. Any written	

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	During an interview, on 3/14/25 at 8:39 a.m., an anonymous staff member indicated they could use more staff in the "heavier halls", in memory care, and during mealtimes. The residents who received room trays rarely were checked on during their meal. A current facility policy, titled "Serving Food and Beverages," dated 2017 and received from the Director of Nursing (DON) on 3/18/25 at 8:40 a.m., indicated "...Foods shall be served at the following temperatures to ensure a safe and appetizing dining experience: Meat, Casseroles-135 to 170 degrees. Vegetables-135-170 degrees...." 3.1-21(a)(2)		Action Plan will be monitored by the Administrator weekly until resolved.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to ensure staff used adequate testing equipment, such as a working thermometer, to ensure adequate washing of the dishware in the high temperature dishwasher. This deficient practice had the potential to affect 88 of 88 residents who received food from the kitchen. Findings include: During an observation and interview, on 3/11/25 at 9:50 a.m., the wash cycle thermometer on the dishwasher was not working. Cook 21 indicated the dishwasher was a high temperature dishwasher. She was not sure why the thermometer gauge was not working or what they were using to gauge the temperature. During an observation and interview, on 3/11/25	F 0812	It is the policy of this facility to ensure staff use adequate testing equipment, working thermometers, and ensure adequate washing of the dishware in the high temperature dishwasher. 1. The DON/Designee assessed all residents on 04-09-2025 and no negative outcome related to the alleged cited deficient practice. Vanco dietary equipment supplier repaired the wash cycle thermometer on the dish machine on 04-08-2025. 2. All residents have the potential to be affected by this alleged deficient practice, therefore, this plan of correction applies to all residents that reside in the facility.	04/16/2025

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	at 9:50 a.m., Cook 23 was running the dishes through the dishwasher. He indicated he was not sure why the thermometer was not working and was not sure how the temperature was gauged before washing the dishes. During an interview, on 3/11/25 at 10:23 a.m., Maintenance 24 indicated the gauge had been broken. He was not sure how they were gauging the temperature. During an interview, on 3/11/25 at 10:33 a.m., Kitchen Manager 16 indicated she was not sure how they were gauging the temperature before washing the dishes. The staff were observed to continue to run/wash the dishes through the dishwasher with the broken temperature gauge. During an interview, on 3/11/25 at 2:31 p.m., Dietary Support 25 indicated the staff should have obtained a temperature with a thermometer before washing the dishes. An owner's manual, titled "MODEL CMA-180 Installation and Operation Rev 2.07," dated as revised February 2007 and received from the Director of Nursing on 3/18/25 at 9:34 a.m., indicated "...Adjust the temperature by removing the panel in front of the respective heater and turning the adjustment post. Wash temp. 155 degrees Fahrenheit. Rinse. 180 degrees Fahrenheit...." 3.1-21(i)(3)		3. The Dietary Manager/Designee in-serviced the dietary staff on monitoring temperature of the dish machine and who to notify when not working on 03-14-2025. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. The dietary manage/designee will monitor the dish machine temperature and temp log and functioning of the dish machine thermometer 5 days a week for four weeks, 3 days a week for four weeks, then weekly for 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview and record review, the facility failed to ensure catheter bags were not touching the floor, dental staff were not wearing Personal Protective Equipment (PPE) in the hallway, and hand hygiene was performed before and after tasks for 2 of 2 residents and 2 of 2 staff members randomly observed for infection control. (Resident 43, 56, Dental Staff 8 and LPN 5) Findings include: 1. During an observation, on 3/12/25 at 10:04 a.m., Resident 43 was in the hallway in his wheelchair. He had a catheter bag, and it was lying on the ground. A CNA walked past him and said hi. She did not notice his catheter bag lying on the ground. During an observation, on 3/12/25 at 10:09 a.m., a nurse walked by the resident in the hallway and said hi. She did not notice his catheter bag lying on the ground. During an observation, on 3/12/25 at 11:13 a.m., Resident 43 was in the hallway. The catheter bag was still lying on the ground. During an observation, on 3/12/25 at 11:14 a.m., an activity staff member took the resident from the hallway and wheeled him to the dining room. The catheter bag made an audible sliding sound as it was dragging on the ground. The activity staff did not fix the placement of the catheter bag. The clinical record for Resident 43 was reviewed on 3/13/25 at 8:33 a.m. The diagnoses included, but were not limited to, stage 4 chronic kidney disease, functional urinary incontinence, and diabetes.	F 0880	It is the policy of facility to maintain infection control measures of handwashing and hand-hygiene during medication pass administration, catheter bags are positions appropriately, and no one is wearing PPE in hallways. 1. DON/Designee assessed resident 43 and 56 on 03-20-2025 with no negative outcomes. 2. Residents who reside in the facility have the potential to be affected by this finding. Therefore, this plan of correction applies to all residents that reside in the facility. 3. The DON/Designee in-serviced staff on placement of catheter bags to ensure on the floor, Medication Administration and Hand Hygiene , catheter infection control, and PPE on 04-10-2025 Administrator/Designee educated dental vendor on 04-07-2025 regarding wearing PPE in hallway. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 4. The DON/Designee will audit 6 random nurses on random shifts for hand hygiene during medication administration and blood sugar monitoring weekly x 4 weeks, then 4 random nurses on random shift weekly x 4 weeks, then 3 random nurses on random shifts monthly x 4 months. The DON/Designee will audit catheter placement 5 times a	04/16/2025

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	A physician's order, dated 10/22/24, indicated the resident had a urinary catheter. During an interview, on 3/12/25 at 11:18 a.m., the Executive Director (ED) indicated catheter bags should not be touching the ground. During an interview, on 3/12/25 at 11:24 a.m., Clinical Support 2 indicated she would fix the placement of the catheter. 2. During an observation, on 3/11/25 at 11:00 a.m., Resident 56 was sitting in his recliner with his catheter drainage bag touching the floor. During an observation, on 3/13/25 at 8:25 a.m., Resident 56 was sitting in his recliner with his catheter drainage bag touching the floor. During an observation, on 3/13/25 at 8:27 a.m., Resident 56's catheter drainage bag touched the floor. The clinical record for Resident 56 was reviewed on 3/13/25 at 8:08 a.m. The diagnoses included, but were not limited to, chronic kidney disease stage 3, obstructive and reflux uropathy, and paraplegia. A care plan, dated as last revised on 4/23/24, indicated Resident 56 required the use of a suprapubic catheter. A physician's order, dated 9/11/24, indicated Resident 56 was to receive catheter care every shift and the catheter drainage bag was to be below the waist and covered. During an interview, on 3/13/25 at 8:27 a.m., the ED observed Resident 56's catheter drainage bag		week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will audit for staff and vendors wearing PPE in the hallway 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then 3 times a month x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	touching the floor and indicated catheter bags should not be touching the floor.3. During an observation, on 3/11/25 at 12:26 p.m., Dental Staff 8 was observed in the common area hallway, on the second floor. She was in Personal Protective Equipment and pushing a cart. She was wearing a gown which was tied in the back and a mask. She indicated she was to always wear PPE as far as she was aware, and she entered each room wearing the same gown. During an interview, on 3/11/25 at 1:13 p.m., Corporate Support Nurse 1 indicated dental staff did not enter the residents' rooms. The staff should bring residents to her. 4. During an observation, on 3/11/25 at 12:28 p.m., LPN 5 was observed to enter the restroom for Resident 34, briefly, and retrieve a pair of gloves. She assisted the resident to remove the paper from a straw, then donned gloves to perform a blood sugar test. She was not observed to wash her hands with soap and water or use an alcohol-based hand rub prior to donning gloves. When she had completed the testing, she removed her gloves and discarded the gloves and the testing strip into the trash and left the room. She was not observed to perform hand hygiene after removing her gloves or upon leaving the room. She returned to her medication cart. During an interview, on 3/11/25 at 12:36 p.m., LPN 5 indicated she did not perform hand hygiene because she wanted to wait until she returned to the cart to dispose of the lancet. During an interview, on 3/17/25 at 10:23 a.m., the Director of Nursing indicated hand hygiene was to be performed before and after glove use.A current facility policy, titled "Catheters," undated			

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	and received from the Clinical Support Nurse on 3/14/25 at 1:30 p.m., indicated "...Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and facility protocol and procedure with adherence to infection prevention and control techniques...." A current facility policy, titled "Hand Hygiene," undated and received from Corporate Support Nurse on 3/17/25 at 10:40 a.m., indicated "...If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Some of these situations included...before putting on and taking off gloves...." A current facility policy, titled "GUIDELINES FOR INFECTION CONTROL/ISOLATION," dated as reviewed 2/2023 and received from the Director of Nursing on 3/17/25 at 1:48 p.m., did not cover walking in halls/common areas in PPE. "Donning and Doffing PPE: Proper Wearing, Removal and Disposal" (reviewed October 3, 2022) was retrieved on 3/19/25 from the Centers of Disease Control (CDC) website. The guidance included the need to "...Remove PPE before entering any non-clinical areas...." A current facility document, titled "Guidelines for Infection Prevention and Control," dated 8/17/23 and received from the ED upon entrance on 3/11/25, indicated "...The INFECTION PREVENTION AND CONTROL PROGRAM is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections...." 3.1-18(b)(1)(B)			

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	3.1-18(b)(4) 3.1-18(l)			