STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00388570, IN00389478, IN00392001, IN00396646, and IN00396693. Complaint IN00388570- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00389478 - Unsubstantiated due to lack of evidence. Complaint IN00392001 - Unsubstantiated due to lack of evidence. Complaint IN00396646 - Substantiated. Federal/State deficiencies related to the allegations are cited at F658, F755, and F880. Complaint IN00396693 - Substantiated. Federal/State deficiencies related to the allegations are cited at F603, F609, and F610. Survey dates: December 5, 8, 9, and 13, 2022 Facility number: 000128 Provider number: 155223 AIM number: 100289650 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 18 Medicaid: 46 Other: 29 Total: 93	F 0000	/p> ="" p="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leslie J. Levell	Regional Nurse Consultant	01/23/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 28, 2022.			
F 0603 SS=G Bldg. 00	483.12(a)(1) Free from Involuntary Seclusion §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure a resident's right to be free from involuntary seclusion (separation of a resident from other residents or from the resident's room or confinement to resident's room against the resident's will, or the will of the resident representative) for 4 of 6 residents reviewed for abuse, when staff confined the residents in their room by tethering the door handles to the handrails in the hallway (Residents G, H, J, and K). Using the reasonable person concept, it is likely that this would lead to mental anguish including anger, distrust, and chronic or recurrent fear and anxiety. Findings include: On 12/8/22 at 10:31 a.m., the area Ombudsman	F 0603	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility for residents who reside in the facility to remain free from involuntary seclusion. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**All residents who reside within the facility has the potential to be affected. **What measures will be put into place or what systemic changes will be made**	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reported she had received multiple anonymous phone calls indicating confused and mobile residents, who had been moved and were currently in isolation rooms on the end of the skilled nursing facility (SNF) hallway, had been secluded in their rooms against their will at the direction of the Director of Nursing (DON). Over the weekend of 12/3/22 evening staff members had used a gait belt and a regular belt to tie the doors to the handrail preventing the residents from leaving their rooms. She had received pictures of the tethered doors as proof from a complainant. Complainants indicated they were upset about the treatment of the residents. During an interview on 12/8/22 at 1:32 p.m., Qualified Medication Aide (QMA) 9 indicated she worked primarily on the Skilled Nursing Facility (SNF) unit. There were currently 3 resident rooms at the end of the hallway with residents in isolation. Residents were kept in their rooms and redirected if they tried to come out. Resident G routinely screamed with all care, or just laid in bed and screamed "help" for no reason, but she was able to transfer and move around in her wheelchair independently. QMA 9 indicated she had heard girls on 2nd shift barred the door to Resident G's room, but she did not know staff names. During an interview on 12/8/22 at 2:04 p.m., CNA 13 indicated she routinely worked evening shift on the SNF hallway. There were currently 3 rooms with 5 residents in isolation on the end of the hallway due to COVID-19 who had dementia and keeping the residents in their rooms included a lot of redirection. On 12/2/22 she had observed Residents G, H, J, and K's rooms tied shut with a gait belt and what looked like a thread. Upon observation she approached the nurse and was		**to ensure that the deficient practice does not recur:**Resident G, H, J and K assessed on 12/3/2022 with no negative findings. Physician and POA notification completed and documented in progress notes. DON in-service on abuse policy by regional nurse consultant. Inservice for LPN 17, QMA 18, C.N.A 13, C.N.A 21 and all staff was completed on 12/3/22, 12/8/22 and 1/10/23 to include but not limited to:Types of abuse abuse coordinator notification involuntary seclusionThe Administrator/DON or designee will complete audits of all restraint allegations weekly for four weeks, then bi-weekly for four weeks, then monthly for four months, or until no further corrective action is needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**At monthly QA meeting the results of the audits will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	told she was not sure what it was, but they were told to make sure the residents stayed in their rooms. LPN 17 went and looked, and CNA 13 thought she removed it. It was not okay for the resident doors to be tied. During an interview on 12/8/22 at 3:35 p.m., the DON indicated she did not remember but thought she had been informed of the residents being tied into their rooms by the ADON by phone call on Friday 12/2/22 between 7:00 p.m. to 8:00 p.m. She had been informed a gait belt or something was on wandering residents' doors tying Residents G, H, J, and K into their rooms. Staff were told they were not allowed the tie the doors shut. DON indicated if residents wandered out, they were to be redirected back into their room. The DON indicated she had the ability to view the facility camera per her cellphone and looked at footage of the hallway and could see something but could not make out what was on the doors. She then called staff and told them if the doors were tied, they had to remove the ties immediately. There was no reason for the staff to have tied the doors as they were in the hallway and should have just re-directed as best as they could. During an interview on 12/8/22 at 5:20 p.m., the DON indicated she did not have pictures on her phone of the resident doors being tied shut, she must have just been showed the pictures by the ADON on Friday evening 12/2/22 while still in town at a parade the facility was participating in. The DON indicated upon seeing the pictures she had called the facility and spoke to LPN 17 and QMA 18. On 12/9/22 at 10:30 a.m., the DON provided a typed statement, dated 12/3/22, unsigned, indicated it was a statement from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator. The statement indicated, "Investigation: Per staff statements: CNAs secured doors to [room numbers] for approximately 90 minutes. Staff entered the room every 15 - 20 minutes. Staff was in area of rooms through the time doors were secured. Doors could be opened to approximately 1 foot. Residents did not appear to be in distress during staff visits to room. It was not the intent of staff to cause harm to residents in these rooms, intent was to prevent other residents from infection [COVID-19]. Conclusion: All staff in-serviced on proper protocol of isolation for COVID-19, Abuse, Customer Service, and Administrator notification." Confidential interviews were conducted during the survey indicated the following: a. The employee indicated there were 3 rooms with 5 residents on the SNF unit where residents were residing temporarily due to COVID-19 and need for isolation. She had heard on Friday evening 12/2/22 Residents G, H, J, and K's rooms had been tied shut on evening shift to prevent them from getting out and wandering in the hallway. During the day on Friday there was an extra aide just to provide oversight for the 3 isolation rooms but only 2 staff members on the evening shift, and when busy the aide on this end of the hallway indicated they could not provide oversight for them and put the other residents to bed. When the night shift came to work, they were not comfortable with having the doors tied closed and untied them. Pictures the employee saw showed Residents J and K's door was tied shut with some type of black belt and Resident's G and H's room was tied shut with a white sheet. b. The employee indicated on 12/2/22 at approximately 9:30 p.m., evening CNAs 13 and 21			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were overheard discussing tying the doors shut to Resident G, H, J, and K rooms as the residents had COVID-19 and staff were having a hard time keeping Resident H in her room, she kept coming out and trying to walk per her normal routine. Employee was not comfortable with having the resident doors tied and along with another staff member viewed the doors and untied them. Understanding was day shift had a 3rd aide on the hallway to oversee the isolated residents until 6:00 p.m., and after that aide left CNAs 13 and 21 kept having to put Resident H back into her room so they tied the hallway door shut. Resident H was able to access Residents J and K's room through the connecting bathroom, so their door was tied shut also. Evening staff indicated management knew and had approved of the doors being tied. When the evening staff left the facility the night staff did not know what to do so they took pictures of the situation and sent them to the ADON with text asking if administration had approved of this. The ADON responded to no one had informed her about this. c. Employee indicated on Friday evening 12/2/22 evening CNA's 13 and 21 were overheard talking about tying the doors shut to Resident G, H, J, and K's rooms. Employee indicated this was illegal, so went with another staff member and looked at the doors and found the doors tied with gait belts with a crack in them, "maybe could open 2 inches tops." The evening shift employees said management was aware, but the employee did not believe the Administrator or DON would allow this. The employees who had concerns about the doors being tied shut sent pictures as evidence to the ADON between 10:00 p.m. and 10:30 p.m., as she was usually awake late, and then untied the doors. The employee believed the staff had tied the doors out of frustration as these 4 residents			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had dementia and it was hard dealing with them. The 2 pictures were provided and observed. In the pictures Residents G and H's door was tied tight from the door handle to the railing with a white gait belt. Residents J and K's door was tied tight with a black belt from the door handle and the railing. Neither picture looked as if the doors could have been opened. d. Employee indicated, around 9:30 p.m. had overheard CNAs 13 and 21 discussing Resident H who liked to wander and how they were having a hard time keeping her in her room for isolation, and upper management said to tie her in her room. Employee indicated upper management would never have told staff to do that. Hearing the residents' doors were tied, instantly made the employee mad. What would have happened if a fire broke out, or the residents started fighting? They were all confused residents and had behaviors, like Resident G who threw things. It was not right to tie the residents up. This was abuse. Night CNAs observed the doors and untied them. Care of confused residents with COVID-19 was a little different as doors needed to be closed, but staff could not tie the doors, could not hold the doors shut, or forcefully keep them in there. This was abuse. e. Employee indicated, on 12/2/22 between 9:00 p.m. and 9:30 p.m. it was brought to her attention the doors to Residents G, H, J, and K's rooms were tied closed. They were supposedly the "biggest wanderers." CNAs 13 and 21 indicated upper management was aware of it. Night CNAs went and untied the doors. Pictures of the tied doors had been texted to the ADON. This was abuse. During an interview on 12/8/22 at 5:25 p.m., QMA 18 indicated, he had been passing medications on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the skilled unit the evening of 12/2/22. Residents G, H, J, and K were supposed to be in isolation, but would routinely wander. At 6:00 p.m. a CNA went home and CNAs 13 and 21 were left trying to figure out how to keep the residents in their rooms and finish their work. So, they decided to tie the doors around the doorknobs until they finished their work. QMA 18 indicated he did not believe LPN 17 gave permission for them to tie the doors, but they both knew about the situation and did not say anything to correct it. He did not know how long for sure the doors were tied shut but thought maybe 1 to 1½ hours before the DON called and said to remove the ties. During a phone interview on 12/9/22 at 8:53 a.m., the ADON indicated on Friday evening 12/2/22 she had received a text message from a CNA during the town parade around 7:00 p.m. to 8:00 p.m. The text was 2 pictures of Residents G, H, J, and K's doors tied shut, and she responded she did not know what that was. ADON indicated the staff had no permission to do that and were to remove it immediately. ADON then showed the picture to the DON, and she thought the DON went to the facility to make sure the ties had been removed after the parade. On 12/3/22 the ADON was informed CNA's 13 and 21 were responsible for tying the resident doors closed, they admitted to tying the doors but indicated they had been told to do so by QMA 9. When asked if they knew tying the doors closed was wrong, CNA's 13 and 21 indicated they had questioned this among themselves but were told to do it and had no answer to why they had not notified the ADON, DON, or Administrator. The plan for keeping isolated residents with dementia in their rooms included re-directing them back to their rooms as they cannot wander the hallways.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 12/9/22 at 9:53 a.m., CNA 21 indicated on 12/2/22 she had worked the evening shift with CNA 13 on the SNF hallway. There had been another CNA from day shift who stayed until 6:00 p.m., then it was just the 2 CNAs who were working the floor and could not just sit with the isolated residents. They used PPE and went in about every 15 to 20 minutes to check on the residents. Resident H was the main resident coming out, going back and forth to Resident G's room through the adjoining bathroom, wandered and kept coming out of her room. After the belts were applied to the resident doors, Resident H kept knocking on the door asking if anyone was out there. Even with the belt attached the door to Resident H's room opened inches where she could have taken the belt off if she pushed hard enough. CNA 21 indicated she and CNA 13 went to the nurse's desk and asked how they were going to do work and care for the residents, and QMA 9 told them night and day shift had tied the doors shut with belts. QMA 9 then handed the aides a gait belt and one regular belt, so at that point they assumed it was ok. They did not contact management and get approval. About an hour later the DON called and said the belts had to come off. LPN 17 and QMA 18 knew of the belts as they were sitting at the desk and overheard the discussion. CNA 21 indicated at the time they were under the impression the DON had approved the belts for "medical purposes", but later found out that was not true as the DON was very upset with them. CNA 21 indicated she had been trained on abuse for years to include involuntary seclusion, so knew it was not right. But took the word of another staff and assumed it was okay. She should have called the DON and questioned the situation but trusted the QMA and took her word.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Attempts were made to interview LPN 17 during the survey without a response. On 12/9/22 at 3:20 p.m., DON indicated she had been shown the pictures of the residents' doors being tied shut on Friday evening 12/2/22 by the ADON after the parade around 8:00 p.m. to 8:30 p.m. She did not come to the facility to investigate but called the facility and told them to remove the ties. The DON had the capacity to view video of the hallway to determine how long the ties had been on the doors but did not. She knew the ties were not on the doors at 6:30 p.m. when they left the facility so knew they could not have been on the doors long. When asked if any reasonable person who was alert and oriented had been tied in their room and unable to get out, would you expect them to be upset and angry, the DON indicated "oh yea without a doubt." 1. During the initial tour on 12/5/22 at 11:05 a.m., Resident G's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident was in isolation after being symptomatic and testing positive for COVID-19. The resident's normal routine was to wander daily with another resident. The DON indicated Resident G was not doing well with isolation, she would yell and scream unless someone was in the room with her. Resident G's record was reviewed on 12/9/22 at 10:17 a.m. Diagnoses on Resident G's profile included, but were not limited to schizophrenia, dementia, anxiety disorder, history of falls, and convulsions. A physician's order for Resident G, dated 12/1/22, indicated transmission based contact/droplet isolation every shift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A progress notes for Resident G, dated 12/1/22 at 3:52 a.m., indicated the resident was positive for COVID-19, the family was notified, and the patient was in isolation. A social service notes for Resident G, dated 12/1/22 at 4:55 p.m., indicated resident had a diagnosis of COVID-19 and was in isolation. Resident had exhibited increased behavioral episode today of throwing things at the door and hitting at staff. Resident received an order for Haldol (antipsychotic to treat mental disorders) 0.2 ml (milliliter) and Risperdal (antipsychotic to treat schizophrenia) 0.25 mg (milligram). Resident had a diagnosis of undifferentiated Schizophrenia with Risperdal 0.25 mg twice daily. Resident was able to be redirected and calmed down to where staff could provide care. A progress notes for Resident G, dated 12/1/2022 at 7:04 p.m., indicated resident was extremely agitated this shift. The Physician was notified, and a new order obtained to give the resident Haldol IM (intramuscular). The resident record lacked documentation of behaviors in November 2022, then antipsychotic medications administered 12/1/22 due to increased behaviors after being placed in isolation and the door closed. The resident record lacked documentation the physician or responsible party had been made aware the resident was involuntarily secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident. A quarterly Minimum Data Set (MDS) assessment, completed on 12/2/22, assessed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident G as being unable to complete the BIMS (Brief Interview for Mental Status) assessment as the resident rarely/never understood the questions. She displayed signs and symptoms of delirium to include inattention, and disorganized thinking. Physical, verbal, and other signs of behaviors such as hitting or scratching self, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. There was documentation of rejection of care. Extensive assistance of 2 or more persons (+) physical assist for bed mobility, transfers, dressing, and toilet use. She was a limited assistance of 1 person physical assist for locomotion on and off the unit. Mobility devices included a wheelchair. A care plan for Resident G indicated she was at risk for falls due to a history of falls and dementia. The medical record lacked documentation of a current care plan related to being positive for COVID-19, being placed in isolation, or interventions to address the resident's increased behaviors related to isolation and being prevented from routine wandering. 2. During the initial tour on 12/5/22 at 11:07 a.m., Resident H's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident had been moved from her primary room to cohabitate with another resident in isolation after being symptomatic and testing positive for COVID-19. The resident's normal routine was to wander daily with another resident. When asked how the residents were kept isolated if they liked to wander, the DON and Administrator indicated they did the best they could, but at times the residents were placed in personal protective equipment (PPE), the other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident doorways to the hallway closed, and the residents were allowed to wander at the end of the hallway a bit. Resident H's record was reviewed on 12/9/22 at 10:48 a.m. Diagnoses on Resident H's profile included, but were not limited to, Alzheimer's disease, disorientation, and history of falling. A physician's order for Resident H, dated 5/11/20, indicated up ad lib (as wanted). A physician's order for Resident H, dated 12/2/22, indicated transmission based contact/droplet isolation every shift. A progress notes for Resident H, dated 12/1/22 at 7:00 p.m., indicated resident tested positive for COVID-19 and was immediately isolated to a room by herself, then moved to another room with another COVID-19 positive resident. A progress notes for Resident H, dated 12/3/2022 at 5:42 p.m., indicated resident alert and oriented to self with noted confusion and forgetfulness per usual self. Trying to wander into hallway, redirected with little difficulty. A progress notes for Resident H, dated 12/4/22 at 3:53 a.m., indicated made some attempts to leave room early in shift, however, staff was able to get resident calmed down drew attention away from door, remains under isolation precautions. A progress notes for Resident H, dated 12/4/2022 at 11:11 a.m., indicated resident with noted confusion and forgetfulness per usual self. Trying to wander into hallway, redirected with little difficulty. Resident record lacked documentation the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physician and responsible party had been made aware the resident was involuntarily secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident. An annual MDS assessment, completed on 11/29/22, assessed Resident H as being unable to participate in the BIMS assessment due to rarely/never understood the questions. Resident displayed signs or symptoms of delirium to include inattention and disorganized thinking. No symptoms of behaviors or rejection of care but did wander daily. Resident required extensive assistance of one person physical assist for bed mobility, and transfers. Resident required limited assistance of one person physical assist for walking in the room, and limited assistance of 2+ persons physical assist for walking in the corridor. Supervision and one person physical assist were needed for locomotion on and off the unit. No mobility devices were utilized. A care plan for Resident H, dated 5/12/20, indicated the resident wandered without natural purpose. The goal was for the resident to be safe while wandering in the facility. Interventions included, allow resident to vent, offer snacks and fluids, reassure resident as needed, redirect resident to activity of choice, refer to psychologist as needed, tender loving care, and wanderguard placed with placement and function checks every shift. A care plan for Resident H, dated 12/2/22, indicated the resident tested positive for COVID-19 and was to be placed in transmission based-droplet isolation. The goal for the resident was for the resident to be free from signs and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms of acute respiratory distress and secondary infections such as pneumonia. Interventions included the resident was to remain in her room with all services proved in her room, and to place in a private room if available. Observe for changes in mood and/or psychosocial changes such as increased confusion, changes in sleep patterns, changes in behavior, nervousness, weight loss, or crying episodes. The resident record lacked documentation of interventions to address the resident's behaviors related to isolation and being prevented from routine wandering. 3. During the initial tour on 12/5/22 at 11:16 a.m., Resident J's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident had been moved from her primary room to cohabitate with another resident in isolation after being symptomatic and testing positive for COVID-19. Resident J's record was reviewed on 12/9/22 at 12:20 p.m. Diagnoses on Resident J's profile included, but were not limited to, schizoaffective disorder bipolar type, delusional disorders, major depressive disorder, dementia, history of falling and repeated falls. A physician's order for Resident J, dated 12/1/22, indicated transmission based contact/droplet isolation every shift. A progress notes for Resident J, dated 11/30/22 at 4:40 p.m., indicated the resident was symptomatic and tested positive for COVID-19. The resident was moved to the skilled unit. A social service progress notes for Resident J on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/4/22 at 2:58 p.m., indicated the resident liked to wander with no rational purpose. Resident was currently in isolation due to diagnosis of COVID-19-19. Resident record lacked documentation the physician and responsible party had been made aware the resident was involuntary secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident. A Medicare 5 day MDS assessment complete on 12/5/22, assessed Resident J as not being able to complete a BIMS assessment due to her mental status. The resident displayed signs and symptoms of delirium to include inattention and disorganized thinking, and she wandered daily. Extensive assistance of one person physical assist for bed motility and transfers and walking in the room, she did not walk in the corridor. Supervision and one person physical assist for locomotion on the unit. Supervision and set up help only for locomotion off the unit. Mobility devices included a wheelchair. A care plan for Resident J, dated 8/2/22, indicated the resident exhibited physically aggressive behavior toward peer such as hitting at peers. The goal for the resident was to have no further increased behavioral episodes of hitting at peers. Interventions included explain appropriate behavior, redirect, refer to consulting psychologist, and visit with resident routinely to assess for any further behavioral episodes. A care plan for Resident J, dated 3/19/19, indicated the resident tended to speak unkindly to staff and peers at times, and she had exhibited			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	verbal and physical aggressive behaviors. The goal was for the resident to speak kindly to staff and peers, be easily redirected when she was speaking rudely to staff and peers and have no further aggressive behaviors. Interventions included, allow resident to vent in a private location so that other residents cannot overhear her complaints, attempt redirection when resident was becoming rude with staff and/or peers, explain to resident inappropriate behavior when she was speaking rudely or unkindly to staff and/or peers, notify the physician with concerns, and redirect and explain inappropriate behaviors, and refer to consulting psychologist as indicated. The medical record lacked documentation of a current care plan related to being positive for COVID-19, being placed in isolation, or interventions to address the resident's behaviors related to isolation and being prevented from routine wandering, and how her aggressive behaviors toward others were being monitored with the door closed. 4. During the initial tour on 12/5/22 at 11:11 a.m., Resident K's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident had been moved from her primary room to cohabitate with another resident in isolation after being symptomatic and testing positive for COVID-19. Resident K's record was reviewed on 12/9/22 at 1:55 p.m. Diagnoses on Resident K's profile included, but were not limited to schizoaffective disorder bipolar type, vascular dementia, severe manic episodes, and history of falling. A physician's order, dated 11/28/20, indicated up ad lib.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician's order for Resident K, dated 11/30/22, indicated transmission based contact/droplet isolation every shift. A progress notes for Resident K, dated 11/30/22 at 7:16 a.m., indicated the resident tested positive for COVID-19 and was placed in isolation. A progress notes for Resident K, dated 11/20/22 at 9:45 a.m., indicated the resident was found lying on the floor between the bed and three drawer chest. Abnormal vital signs included temperature 101.5 F (Fahrenheit) (normal 98.6), blood pressure 160/80 (normal less than 120 /80), pulse 102 (normal 60 - 100), and respirations 18 (normal 13 - 19). New orders for x-rays to left foot and toes. A social service progress notes for Resident K, dated 11/30/22 at 5:20 p.m., indicated resident required cues and redirection and wandered with no rational purpose and wander guard in place. A progress notes for Resident K, dated 12/4/22 at 4:11 a.m., indicated the resident did not appear to feel well, had a poor appetite, was cooperative with care, and remained under isolation precautions. A progress notes for Resident K, dated 12/5/2022 at 5:15 p.m., indicated the resident was found on the floor on her back by staff during rounds. Resident record lacked documentation the physician and responsible party had been made aware the resident was involuntary secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A quarterly MDS assessment, completed on 12/2/22, assessed Resident K as not being able to participate in the BIMS assessment as she rarely/never understood. She displayed signs and symptoms of delirium to include inattention, disorganized thinking, and altered level of consciousness. She required extensive assistance of one person physical assist for bed mobility, transfers, locomotion on the unit, toilet use, and personal hygiene. She required limited assistance of 2+ persons physical assist for walking in the room and corridor. Limited assistance of one person physical assist for locomotion off the unit and eating. No history of falls was documented. A care plan for Resident J, dated 5/24/22, indicated the resident had to be redirected to her room and would attempt to go in other rooms at times. The goal was for the resident to be safe while lying in different positions and being redirected. Interventions included encourage resident to lie in proper positioning, redirect resident to own room, and sign in bright color for cue of her room. A care plan for Resident J, dated 3/5/22, indicated she was at risk for falls due to decreased mobility and weakness. The goal for the resident to be free from major injury related to falls. Interventions included assist resident with ADL's (activities of daily living) as needed, decreased mobility and weakness, encourage resident to use call light for assistance from staff. Encourage resident to wear non-skid footwear when out of bed. Due to COVID-19 positive changes in environment will be made. She was in isolation and generally weak at this time with new onset of pain. Resident continued with changes related to COVID-19 positive and was generally weak with temperature.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan for Resident J, dated 12/2/20, indicated resident wandered without natural purpose. The goal was for the resident to be safe wandering in the facility. Interventions included, allow resident to vent, offer snacks and fluids, reassure resident as needed, redirect to activities, refer to psychologist as needed, tender loving care, and wanderguard in place and check placement and function every shift. The medical record lacked documentation of interventions to address the resident's falls and behaviors related to isolation and being prevented from routine wandering, and how her aggressive behaviors toward others were being monitored with the door closed. On 12/9/22 at 10:30 a.m., the DON provided an Abuse Prevention Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to prevent resident abuses, neglect, mistreatment, and misappropriation of property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings ...Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observed, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator ....All incidents will be documented, whether or not abuse occurred, was alleged or suspected ...Staff who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation ...Involuntary			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	seclusion: separation of the resident from other residents or from his or her room or confinement to his or her room [with or without roommates] against the resident's will, or the will of the resident's legal guardian or representative ...Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment ...are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse ..." Using the reasonable person concept, it is likely that residents being restrained in their rooms would lead to the residents having mental anguish including anger, distrust, and chronic or recurrent fear and anxiety. This Federal tag relates to Complaint IN00396693. 3.1-27(a)(4)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure staff reported resident abuse within 2 hours for 4 of 6 residents reviewed for abuse (Residents G, H, J, and K). Findings include: On 12/8/22 at 10:31 a.m., the area Ombudsman reported she had received multiple anonymous phone calls indicating confused and mobile residents, who had been moved and were currently in isolation rooms on the end of the skilled nursing facility (SNF) hallway, had been secluded in their rooms against their will at the direction of the Director of Nursing (DON). Over the weekend of 12/3/22 evening staff members had used a gait belt and a regular belt to tie the doors to the handrail preventing the residents from leaving their rooms. She had received pictures of the tethered doors as proof from a complainant. Complainants indicated they were upset about the treatment of the residents. They indicated no one had investigated the incident or asked them about their knowledge, and no one was being held accountable. A complainant indicated they had spoken to the Social Service Director but did not	F 0609	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility to report to IDOH all alleged allegations of abuse reported to the abuse coordinator. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside within the facility has the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicate they had spoken to the Administrator. During an interview on 12/8/22 at 3:35 p.m., the DON indicated she did not remember but thought she had been informed of the residents being tied into their rooms by the Assistant Director of Nursing (ADON) by phone call on Friday 12/2/22 between 7:00 p.m. to 8:00 p.m. She had been informed a gait belt or something was on wandering residents' doors tying Residents G, H, J, and K into their rooms. Staff were told they were not allowed the tie the doors shut. The DON indicated she had the ability to view the facility camera per her cellphone and looked at footage of the hallway and could see something but could not make out what was on the doors. The DON indicated, she had not informed the Administrator about the situation until the morning of Saturday 12/3/22 and did not remember sending the Administrator the pictures staff had sent. During an interview on 12/8/22 at 3:16 p.m., the Administrator indicated she was not informed until the morning of 12/3/22 by the DON that on the evening of 12/2/22 the resident's doors were tied. Upon questioning staff indicated the resident doors were tied but had the ability to be opened at least a foot. The Administrator indicated she asked staff why they had not called her and received "no good answer." When asked if there was a discussion about reporting the incident as abuse/involuntary seclusion she indicated she had spoken to her boss the Regional Vice President of Operations (RVPO), and the decision was made to not report as residents were supposedly checked every 15 minutes, the doors opened approximately a foot, residents were not reported as being in distress. Social wellbeing assessments were done, and nothing noted out of their normal. The RVPO did		Administrator and DON were educated on reporting guidelines by regional nurse consultant on 12/16/2022. Allegations reported to abuse coordinator will be reported per guidelines. The Administrator/DON or designee will complete audits of abuse allegation for reporting to ISDH weekly for four weeks, then bi-weekly for four weeks, then monthly for four months, or until no further corrective action is needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** At monthly QA meeting the results of the audits will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not consider the situation to be involuntary seclusion. During an interview on 12/13/22 at 12:18 p.m., the Administrator indicated the incident of staff tying the doors to Resident's G, H, J, and K's rooms happened on the evening of Friday 12/2/22. The DON was notified by the Assistance Director of Nursing (ADON) that evening as they were together in town at the parade. The DON then notified the Administrator on 12/3/22, the DON did not indicate why she had not reported earlier. All staff to include the DON were trained at least monthly on abuse and the reporting process, and knew they were required to notify the Administrator immediately of any unusual incident to include abuse. The Administrator indicated she could not understand why none of the staff had called her to question, she would never have okayed the resident doors being tied shut. The Administrator notified her boss the Regional Vice President of Operations (RVPO) and after interviewing the staff, and knowing the ties were supposedly released every 15 minutes, they made the decision not to report as the situation was viewed as a restraint not seclusion of the resident. At the time of the exit survey on 12/13/22, the facility had not reported Residents G, H, J, and K being involuntary secluded (separation of a resident from other residents or from the resident's room or confinement to resident's room against the resident's will, or the will of the resident representative) on 12/2/22. On 12/9/22 at 10:30 a.m., the DON provided an Abuse Prevention Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of this facility to prevent resident abuses, neglect, mistreatment, and misappropriation of property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings ...Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observed, hear about or suspect to the Administrator or an immediate supervisor who will immediately report the allegation to the Administrator ....All incidents will be documented, whether or not abuse occurred, was alleged or suspected ...Staff who are suspected of abuse or misconduct shall immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation ...Involuntary seclusion: separation of the resident from other residents or from his or her room or confinement to his or her room [with or without roommates] against the resident's will, or the will of the resident's legal guardian or representative ...Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment ...are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse ..." This Federal tag relates to Complaint IN00396693. 3.1-28(c) 3.1-28(d)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to assess, document, and conduct a thorough investigation for potential involuntary seclusion of residents by staff Certified Nursing Assistants (CNAs) 13 and 21 for 4 of 6 residents reviewed for abuse (Residents G, H, J, and K). Findings include: On 12/8/22 at 10:31 a.m., the area Ombudsman reported she had received multiple anonymous phone calls indicating confused and mobile residents in isolation rooms on the end of the skilled nursing facility (SNF) hallway had been secluded in their rooms against their will at the direction of the Director of Nursing (DON). Over the weekend of 12/3/22 evening staff members had used a gait belt and a regular belt to tie the doors to the handrail preventing the residents from leaving their rooms. She had received pictures of the tethered doors as proof from a complainant. Complainants indicated they were upset about the treatment of the residents. They indicated no one had investigated the incident or asked them about	F 0610	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility investigate all allegations of abuse. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside within the facility has the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	their knowledge, and no one was being held accountable Confidential interviews were conducted during the survey: a. The employee indicated she had heard on Friday evening 12/2/22 Residents G, H, J, and K's rooms had been tied shut on evening shift to prevent them from getting out and wandering in the hallway. Pictures indicated Residents J and K's door were tied shut with some type of black belt and Resident's G and H's room 45 was tied shut with a white sheet. They indicated they had not been interviewed by management or asked to provide a witness statement. b. The employee indicated on 12/5/22 she had heard Residents G, H, J, and K's rooms had their doors tied shut the prior evening to prevent from wandering out of their room, they did not know details. They indicated they had not been interviewed by management. c. The employee indicated on 12/2/22 at approximately 9:30 p.m., evening CNAs 13 and 21 were overheard discussing tying the doors shut to Resident G, H, J, and K rooms. The employee was not comfortable with having the resident doors tied and along with another staff member viewed the doors and untied them. They indicated had not spoken to a member of management or asked to provide a witness statement. d. Employee indicated on Friday evening 12/2/22 evening CNAs 13 and 21 were overheard talking about tying the doors shut to Resident G, H, J, and K's rooms. Employee indicated this was illegal, so went with another staff member and looked at the doors and found the doors tied with gait belts with a crack in them, "maybe could open		Administrator and DON were educated on investigating allegations of abuse by regional nurse consultant on 12/16/2022. All allegations reported to abuse coordinator will be fully investigated. All persons who witnessed alleged incident will be interviewed. The Administrator/DON or designee will complete audits of all reported allegations to make sure investigation completed weekly for four weeks, then bi-weekly for four weeks, then monthly for four months, or until no further corrective action is needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** At monthly QA meeting the results of the audits will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2" tops." The employee indicated they had not spoken with management or been asked to provide a witness statement. e. Employee indicated, around 9:30 p.m. on 12/2/22, they had overheard CNAs 13 and 21 discussing Resident H who liked to wander and how they were having a hard time keeping her in her room for isolation, and upper management said to tie her in her room. The night shift CNAs observed the doors and untied them. They did not know if family members had been notified but would guess if they had been told at least Residents G and H's family members would have had a fit. She had not been questioned by management about the incident or asked to provide a witness statement. f. Employee indicated, on 12/2/22 between 9:00 p.m. - 9:30 p.m. it was brought to her attention the doors to Residents G, H, J, and K were tied together, they were supposedly the biggest wanderers. Night CNAs went and untied the doors. Pictures of the tied doors had been texted to the ADON. This was abuse and no doubt the CNAs that tied the doors knew better. The employee indicated they had not been interviewed by management or asked to provide a witness statement. On 12/9/22 at 10:30 a.m., the DON provided an undated typed statement, signed by the DON, which indicated, "Regarding incident on 12/2/22, CNAs on duty state doors were able to open 1-2 feet at all times. They were aware this is a violation of resident rights, safety, and possible mental wellbeing. They state at least one staff was always outside the doors and residents were checked on regularly a minimum of every 15 minutes. Once they were told to remove the belts			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restricting the doors, they did as instructed. Writer interviewed residents who have no recollection of incident. Residents assessed for injury and pain, none noted." On 12/9/22 at 10:30 a.m., the DON provided a typed statement, dated 12/3/22, unsigned, indicated it was a statement from the Administrator. The statement indicated, "Investigation: Per staff statements: CNAs secured doors to room 44 and 45 for approximately 90 minutes. Staff entered the room every 15 - 20 minutes. Staff was in area of rooms through the time doors were secured. Doors could be opened to approximately 1 foot. Residents did not appear to be in distress during staff visits to room. It was not the intent of staff to cause harm to residents in these rooms, intent was to prevent other residents from infection [Covid]. Conclusion: All staff in-serviced on proper protocol of isolation for Covid, Abuse, Customer Service, and Administrator notification." Handwritten Witness Statements by the Administrator for LPN 17, QMA 18, CNA 13 and CNA 21, indicated they had been told by the previous shift to secure doors to rooms for Residents G, H, J, and K. Residents were checked by staff every 15 - 20 minutes - staff went into rooms. Staff remained in area of rooms - could see residents through door opening. Residents were not in distress. Employee Disciplinary Action Report for LPN 17, dated and signed by the DON on 12/5/22, indicated the nature of violation was resident health/safety concern. The violation was related to resident's rights, involuntary seclusion as gait belt was used to restrain door and limit access. Doors were able to open 1-2 feet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Employee Disciplinary Action Report for QMA 18, dated and signed by the DON on 12/5/22, indicated nature of violation was resident health/safety concern and other. The violation was related to resident's rights, involuntary seclusion as gait belt was used to secure doors and limit access. Doors were able to open 1 to 2 feet. The form lacked documentation QMA had signed or dated the form to indicate the employee had received disciplinary action. Employee Disciplinary Action Report for CNA 21, dated and signed by the DON and Administrator on 12/5/22, indicated the nature of violation was resident health/safety concern and other with a violation of resident's rights, involuntary seclusion. A gait belt was used to restrain door and limit access. Door was able to open 1-2 feet. Employee Disciplinary Action Report for CNA 13, dated and signed by the DON and Administrator on 12/5/22, indicated the nature of violation was resident health/safety concern and other with a violation of resident's rights, involuntary seclusion. A gait belt was used to restrain door and limit access. Door was able to open 1-2 feet. During a phone interview on 12/9/22 at 8:53 a.m., the ADON indicated on Friday evening 12/2/22 she had received a text message from a CNA during the town parade around 7:00 p.m. to 8:00 p.m. The text was 2 pictures of Residents G, H, J, and K's doors tied shut. ADON then showed the picture to the DON, and she thought the DON went to the facility to make sure the ties had been removed after the parade. This was abuse and had no doubts the CNAs that tied the doors knew better. She was not sure how upper management handled the situation, or if it was it handled			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	correctly. But there should have been an investigation, someone put on leave, and the incident should have been reported. On 12/9/22 at 3:20 p.m., DON indicated she had been shown the pictures of the residents' doors being tied shut on Friday evening 12/2/22 by the ADON after the parade around 8:00 p.m. to 8:30 p.m. She did not come to the facility to investigate but called the facility and told them to remove the ties. The DON had the capacity to view video of the hallway to determine how long the ties had been on the doors but did not. She knew the ties were not on the doors at 6:30 p.m. when they left the facility so knew they could not have been on the doors long. The DON did not notify the Administrator on Friday night 12/2/22 as she did not see this as abuse but considered this a case of staff using a restraint inappropriately. The 4 staff members identified as having been involved and having knowledge of tying the resident doors shut had been counseled but not suspended as the investigation was on-going and still trying to determine if this was considered abuse. When asked if an investigation had been initiated, to include resident physician's and resident representatives' notification, resident assessments for pain or injury and psychosocial wellbeing, she indicated she had notified the physician but had not documented the fact. She had instructed her nurses to notify resident representatives but had no idea if that had been done. During an interview on 12/13/22 at 12:18 p.m., the Administrator indicated the incident of staff tying the doors to Residents G, H, J, and K's rooms happened on the evening of Friday 12/2/22. The DON was notified by the Assistance Director of Nursing (ADON) that evening as they were together in town at the parade. The DON then			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notified the Administrator on 12/3/22. The Administrator notified her boss the Regional Vice President of Operations (RVPO) and after interviewing the staff, and knowing the ties were supposedly released every 15 minutes, they made the decision not to consider the incident as abuse as the situation was viewed as a restraint not seclusion of the resident. The Administrator interviewed the 4 employees (Licensed Practical Nurse (LPN) 17, Qualified Medication Aide (QMA) 18, Certified Nursing Assistant (CNA) 13, and CNA 21) who had been working the unit on the evening in question and she got their statements. The DON and ADON were supposed to have gotten witness statements from other staff members that worked on 12/2/22 and in-serviced all staff on abuse. The 4 staff members involved received written counseling, but they were not suspended. 1. During the initial tour on 12/5/22 at 11:05 a.m., Resident G's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident was in isolation after being symptomatic and testing positive for COVID-19. The resident's normal routine was to wander daily with another resident. The DON indicated Resident G was not doing well with isolation, she would yell and scream unless someone was in the room with her. Resident G's record was reviewed on 12/9/22 at 10:17 a.m. Diagnoses on Resident G's profile included, but were not limited to, schizophrenia, dementia, anxiety disorder, history of falls, and convulsions. The resident record lacked documentation the physician or responsible party had been made aware the resident was involuntarily secluded in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident. The medical record lacked documentation of a current care plan related to being positive for covid, being placed in isolation, or interventions to address the resident's increased behaviors related to isolation and being prevented from routine wandering. 2. During the initial tour on 12/5/22 at 11:07 a.m., Resident H's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident had been moved from her primary room to cohabitate with another resident in isolation after being symptomatic and testing positive for covid. The resident's normal routine was to wander daily with another resident. When asked how the residents were kept isolated if they liked to wander, the DON and Administrator indicated they did the best they could, but at times the residents were placed in personal protective equipment (PPE), the other resident doorways to the hallway closed, and the residents were allowed to wander at the end of the hallway a bit. Resident H's record was reviewed on 12/9/22 at 10:48 a.m. Diagnoses on Resident H's profile included, but were not limited to, Alzheimer's disease, disorientation, and history of falling. Resident record lacked documentation the physician and responsible party had been made aware the resident was involuntarily secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incident. The resident record lacked documentation of interventions to address the resident's behaviors related to isolation and being prevented from routine wandering. 3. During the initial tour on 12/5/22 at 11:16 a.m., Resident J's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident had been moved from her primary room to cohabitate with another resident in isolation after being symptomatic and testing positive for COVID-19. Resident J's record was reviewed on 12/9/22 at 12:20 p.m. Diagnoses on Resident J's profile included, but were not limited to, schizoaffective disorder bipolar type, delusional disorders, major depressive disorder, dementia, history of falling and repeated falls. Resident record lacked documentation the physician and responsible party had been made aware the resident was involuntary secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident. The medical record lacked documentation of a current care plan related to being positive for covid, being placed in isolation, or interventions to address the resident's behaviors related to isolation and being prevented from routine wandering, and how her aggressive behaviors toward others were being monitored with the door closed. 4. During the initial tour on 12/5/22 at 11:11 a.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident K's door was observed to be closed with a red stop sign taped to the door. The DON indicated the resident had been moved from her primary room to cohabitate with another resident in isolation after being symptomatic and testing positive for covid. Resident K's record was reviewed on 12/9/22 at 1:55 p.m. Diagnoses on Resident K's profile included, but were not limited to, schizoaffective disorder bipolar type, vascular dementia, severe manic episodes, and history of falling. Resident record lacked documentation the physician and responsible party had been made aware the resident was involuntary secluded in her room by use of a gait belt to secure the door shut, assessed for injury, or that psychosocial assessments were completed following the incident. The medical record lacked documentation of interventions to address the resident's falls and behaviors related to isolation and being prevented from routine wandering, and how her aggressive behaviors toward others were being monitored with the door closed. On 12/9/22 at 10:30 a.m., the DON provided an Abuse Prevention Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of this facility to prevent resident abuses, neglect, mistreatment, and misappropriation of property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings....All incidents will be documented, whether or not abuse occurred, was alleged or suspected ...Staff who are suspected of abuse or misconduct shall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	immediately (regardless of time left on shift) be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation ...Involuntary seclusion: separation of the resident from other residents or from his or her room or confinement to his or her room [with or without roommates] against the resident's will, or the will of the resident's legal guardian or representative..." This Federal tag relates to Complaint IN00396693. 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure a resident's jejunostomy tube (j-tube) medications were administered correctly and the right medications were given for 1 of 1 resident reviewed for J-tube medication administration (Resident N). Findings include: 1. On 12/13/22 at 10:13 a.m., Resident N record was reviewed. His diagnoses included but were not limited to malignant neoplasm of the stomach (stomach cancer), acquired absence of part of the stomach, artificial openings of gastrointestinal tract (j-tube for assistance with caloric intake and medications), cerebral infarction due to occlusion	F 0658	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the policy of this facility to ensure all residents with feeding tube who reside in the facility to have complete comprehensive care plans and proper medication administration through feeding tubes. **How other residents having the potential to be affected by the same deficient practice will**	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(stroke), hemiplegia and hemiparesis affecting right dominant side (weakness and paralysis), and diabetes mellitus (blood sugar disorder). His physician orders included, but were not limited to: a. Elevate the head of his bed to 30 degrees b. Check j-tube placement two times a day before and after any feeds and before and after any medication administration. c. Flush j-tube every 4 hours with 30 mL (milliliters) of water before and after any feeds and before and after any medication administration. d. Enteral (artificial intestinal opening) feed two times a day continuous tube feeding at 70 mL per hour of Vivonex (nutritional support). e. Hydromorphone Hcl liquid 1 mg (milligram) per mL. Give 4 mL via j-tube every 8 hours for pain. f. Acetaminophen DM (pain relief and cough suppressant) liquid 325-10 mg per 10 mL. Give 30 mL via j-tube three times a day (TID) with a start date of 12/1/22. On 12/9/22 at 1:33 p.m., Resident N's acetaminophen DM was highlighted in pink on the Medication Administration Record (MAR) on the computer because it was late. QMA 9 indicated the medication cart was out of the Tylenol. She indicated it should have been ordered before it was out. She had wanted to give the hydromorphone 4 mL at the same time as the acetaminophen DM. The hydromorphone was due at 2:00 p.m. On 12/9/22 at 1:40 p.m., Qualified Medication Aide (QMA) 9 provided medication for Resident N. She indicated he did not have any acetaminophen DM. When she opened the order, it indicated to give Robitussin Severe Nighttime 12.5-5-325 mg/10 mL liquid. Scheduled TID. She poured the		**be identified and what corrective action(s) will be taken:** All residents with feeding tubes who reside within the facility has the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Resident N was assessed with no negative outcome related deficient practice. QMA 9 and LPN 33 were educated on by Staff Development Nurse on policy to Enteral Feeding and all licensed staff were educated by staff development nurse on 12/16/2022. The DON or designee will complete audits of proper medication administration of 5 residents: 5 times weekly for four weeks, 4 times weekly for four weeks, 3 times weekly for four weeks, 2 times weekly for four weeks, and 1 time weekly for four weeks, or until no further corrective action is needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hydromorphone 4 mL in a medication cup and wrote it in the narcotic binder. She did not ask the nurse to check the j-tube placement. She opened the j-tube access tube, removed the plunger from the Toumey syringe, and poured in 30 mL of water. Without waiting to see if the water would go in by gravity, she poured in the hydromorphone 4 mL, and added another 30 mL of water. After waiting less than one minute and realizing the water medication mixture would not go in by gravity, she attached the plunger to the Toumey syringe and pushed the water and medication into the resident via his j-tube. Using the palm of her other hand, she appeared to be advancing the plunger with some effort. She did not have the nurse come into the room after the hydromorphone was given to check the j-tube placement again. 2. On 12/13/22 at 12:03 p.m., Licensed Practical Nurse (LPN) 33 indicated she needed to provide Resident N's Tylenol. She removed Mucinex Children's from the medication cart and poured 30 mL. The physician's order indicated to give acetaminophen DM, 30 mL, TID. She indicated the medications were the same. The bottle indicated acetaminophen 325 mg for pain, phenylephrine 5 mg as a nasal decongestant, and diphenhydramine 12.5 mg as an antihistamine. She used a Toumey syringe, she checked for the j-tube placement. Then, she poured in 30 mL of water, 30 mL of Mucinex Children's, and 30 mL of water. She let the water medication mixture flow in by gravity. On 12/13/22 at 12:20 p.m., LPN 33 indicated when providing j-tube medication you always check for residual and placement to make sure the j-tube was in the right place and let the water and medications flow in by gravity. Pushing the		**assurance program will be put into place:** At monthly QA meeting the results of the audits will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medications will cause air in the belly. She indicated she checked Resident N for residual by pulling back on the syringe about 5 - 10 cc (cubic centimeters). On 12/13/22 at 12:45 p.m., the Regional Consultant indicated when providing j-tube medications the staff should always check for j-tube patency first, then give crushed medications in tepid water, then flush with 30-50 mL of water. On 12/13/22 at 12:50 p.m., the DON indicated she would not have used the syringe's plunger to push down the medication. Staff should have checked for residual and, at least, auscultate to check for placement. On 12/13 at 12:51 p.m., the Regional Consultant indicated the staff should have auscultated and listened for the whoosh of the air to check placement. Regarding checking for residual, the staff should not be doing it because it pulls the stomach acid out and back in the gut, possibly added bacteria to the gut from the tube or syringe. On 12/13/22 at 2:05 p.m., the Assistant Director of Nursing (ADON) indicated she did not know the medication (Robitussin Severe Nighttime and Mucinex MS) provided to Resident N was different from the medication ordered by the physician (acetaminophen DM). On 12/14/22 at 3:20 p.m., the Director of Clinical Services (DCS) for the pharmacy indicated Resident N's order for acetaminophen DM was an over-the-counter product. She indicated there was a new order for Mucinex MS today on 12/14/22 and older order for Robitussin Liquid Severe. She would need to further investigate.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 12/14/22 at 3:49 p.m., the DCS for the pharmacy indicated the doctor ordered acetaminophen DM liquid. Delsym was the same as the acetaminophen DM, but they did not have it in stock. So, they changed it to Robitussin Liquid Severe as an equivalent. But she indicated they were not the same, they had different ingredients. Dextromethorphan was a cough suppressant, and diphenhydramine was an antihistamine. She would continue to check with the pharmacist to find out how the order got changed. On 12/15/22 at 9:48, the DCS for the pharmacy indicated the pharmacist had made an error and the nurse at the facility did not catch the error. The pharmacy did not have the acetaminophen DM the physician ordered. The pharmacist who filled the order thought he was filling the order with an equivalent medication, but it was a misfill. The correct medication was an over-the-counter medication. Last night, the pharmacy filled the order correctly by sending a bottle of acetaminophen and a bottle of dextromethorphan. On 12/13/22 at 1:35 p.m., the DON provided Resident N's December MAR. It indicated acetaminophen DM was provided TID from 12/1/22 through 12/12/12. On 12/13/22, he only had it twice, and was awaiting his evening dose. On 12/9/22 at 1:40 p.m., QMA 9 opened the acetaminophen DM order, it indicated to give Robitussin Severe Nighttime 12.5-5-325 mg/10 mL liquid. Scheduled TID. It had been the replacement for acetaminophen DM when it ran out. On 12/9/22, the pharmacy provided Mucinex MS Liquid Nighttime Multi-Symptoms Cold medication as a replacement for acetaminophen DM. A current Qualified Medication Aide, "Job			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Description," was provided by the DON, on 12/13/22 at 1:35 p.m. A review of the job description indicated, " ...The qualified Medication Aide (QMA) will administer medications with safety techniques and sound judgment under the supervision of a licensed nurse ...Documents what medications were given for the day on the medication administrator record (MAR) chart ...." A current policy, titled, "Enteral Tube Medication Administration," was provided by the DON, on 12/13/22 at 1:35 p.m. A review of the policy indicated, " ...Verify physician's order. Liquid form of medication, when available is preferred. Right resident; right medication; right dose, right route; right time ...Verify tube placement and flush tube with 30 cc of water. Instill the medications into the enteral tube utilizing the 60 cc piston syringe ...Ensure that all medications have been administered to the resident and that no residual is left. Flush the tube again with a minimum of 30 cc water ...." A current policy, titled, "Medication Administration," was provided by the DON, on 12/13/22 at 1:35 p.m. A review of the policy indicated, " ...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration ...Medication Administration Record will be signed after for each medication administered to the resident ...." This Federal tag relates to Complaint IN00396646. 3.1-35(g)(1) 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were signed out when given for 3 of 12 residents	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	receiving narcotics (Resident T, Resident DD, and Resident EE). Findings include: On 12/9/22 at 12:57 p.m., QMA 23 reviewed the narcotics on the South Med (medication) cart. Four narcotic counts were wrong, she indicated she forgot to write down all four narcotics. a. Resident T's Xanax (treats anxiety) 0.25 mg count was wrong, she added in the narcotic binder that it was given about 30 minutes ago. b. Resident DD's Lyrica 225 mg count was wrong, she indicated she Forgot to write it down. She gave it at noon. c. Resident EE's Lyrica (treats pain) 75 mg was not written down, she corrected it in the narcotic binder. She indicated she gave it about noon. d. Resident EE's Morphine sulfate (pain relief) 15 mg ER (extended release) narcotic count was wrong. She signed it out during the review. On 12/9/22 at 1:08 p.m., QMA 23 indicated the narcotics should have written down right away after the resident swallowed it. On 12/13/22 at 12:56 p.m., the Director of Nursing indicated the narcotics should have been signed out as soon as they are popped out of the medication card. A current Qualified Medication Aide, "Job Description," was provided by the DON, on 12/13/22 at 1:35 p.m. A review of the job description indicated, " ...The qualified Medication Aide (QMA) will administer medications with safety techniques and sound judgment under the supervision of a licensed nurse ...Documents what medications were given for the day on the medication administrator record		**practice:** It is the policy of this facility for residents who reside in the facility to provide accurate pharmaceutical services. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside within the facility has the potential to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Pharmacy made aware of error on 12/15/2022. Resident DD and EE assessment completed with no negative outcomes. Education provided for QMA 23 and all licensed staff on the policies which included Medication Administration Controlled Substances, mediation administration policy along with the Five Rights of Medication Administration by Staff Development Nurse on 12/15/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(MAR) chart ...." A current policy, titled, "Medication Administration," was provided by the DON, on 12/13/22 at 1:35 p.m. A review of the policy indicated, " ...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration ...Medication Administration Record will be signed after for each medication administered to the resident ...." This Federal tag relates to Complaint IN00396646. 3.1-25(a) 3.1-25(b)(1) 3.1-25(b)(3) 3.1-25(c)		The DON or designee will complete audits of medication documentation and auditing that the nurses and QMA's are signing out narcotics correctly of 5 residents: 5 times weekly for four weeks, 4 times weekly for four weeks, 3 times weekly for four weeks, 2 times weekly for four weeks, and 1 time weekly for four weeks, or until no further corrective action is needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** At monthly QA meeting the results of the audits will be reviewed. Any concerns will have been addressed as found. However, any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored weekly by the Administrator until resolution.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure hand washing was completed according to infection control practices for 8 of 18 residents reviewed for medication administration and resident care (Resident N, R, S, Q, U, Z, AA, and FF). Findings include: 1. On 12/9/22 at 2:03 p.m., Qualified Medication Aide (QMA) 9 was observed administering Resident Q's medications. After leaving her room, she did not wash or hand gel before preparing Resident R's medications. On 12/9/22 at 2:07 p.m., QMA 9 was observed	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of this facility to maintain an infection control program to help prevent the development and transmission of communicable diseases and infections. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administering Resident R's medication. After leaving his room, she did not wash or hand gel before preparing Resident S's medications. On 12/9/22 at 3:15 p.m., QMA 18 was observed administering Resident T's medication. After leaving her room, he did not wash or hand gel before preparing Resident FF's medication. On 12/9/22 at 3:20 p.m., QMA 18 was observed administering Resident FF's medication. After leaving her room, he did not wash or hand gel before preparing Resident U's medication. Resident U received her medications at 3:23 p.m. On 12/9/22 at 4:14 p.m., QMA 26 was observed administering Resident Y 's medication. After leaving her room, she did not wash or hand gel before preparing Resident Z 's medication. On 12/9/22 at 4:17 p.m., QMA 26 was observed administering Resident Z's medication. After leaving her room, she did not wash or hand gel before preparing Resident AA's medication. Resident AA received her medications at 4:21 p.m. 2. On 12/13/22 at 12:59 p.m., Certified Nursing Assistant (CNA) 32 was observed leaving Resident N's room carrying two small bags of soiled items. She dropped them off in the trash/soiled room. Without washing or gelling her hands she was observed to hold the handles of Resident Q's wheelchair to take her to her room to be toileted. On 12/13/22 at 1:04 p.m., CNA 32 indicated she should have washed her hands after leaving Resident N's room and disposing of soiled items, before she assisted Resident Q to her room for toileting.		All residents who reside within the facility has the potential to be affected. ¿ What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Root Cause Analysis (RCA) was conducted. As a result of the RCA, facility staff will be educated relative to infection control guidelines, including but not limited to, proper hand hygiene technique and when to perform hand hygiene by 1/10/23. Education provided by Staff Development Nurse on 12/18/2022 for QMA 23, QMA 8, QMA 9, QMA 26, C.NA 32 and all staff educated on the proper handwashing on proper handwashing techniques following policy “Hand Hygiene Guidelines” with emphasis during medication pass.¿ Any staff member that fails to comply with the points of the in-services will be further educated.¿ A member of the IDT will be present during medication pass to observe proper hand hygiene using	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 12/13/22 at 12:26 p.m., Licensed Practical Nurse (LPN) 33 indicated CNA 32 should have washed her hands between resident care events. On 12/13/22 at 12:52 p.m., the Director of Nursing (DON) indicated it was absolutely necessary for staff to, at least, sanitize their hands between residents. There were sanitizing stations throughout the building, and most of the staff had containers of hand gel in their pockets. A current policy, titled, "Hand Hygiene Guidelines," with no date, was provided by the DON, on 12/13/22 at 1:35 p.m. A review of the policy indicated, " ...The scope of this guideline includes all interdisciplinary members, visitors, and individuals that partake in the resident plan of care ...When hands are visibly soiled, exposure to a spore forming organism has been suspected or proven, before and after eating, and after using the restroom hands should be washed with a non-microbial or anti-microbial soap ...When criteria above have not been met it is appropriate to use a waterless alcohol based agent ...." This Federal tag relates to Complaint IN00396646. 3.1-18(b)		a tool named “Hand Washing Observation”.¿ Any noted concerns will be immediately corrected. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,¿i.e., what quality assurance program will be put into place: The IP nurse/DON/designee will complete random visual rounds daily, on scheduled days of work, for 6 weeks, and until continued compliance is maintained, to ensure staff are practicing appropriate Infection Control Practices, including but not limited to, proper performance of hand hygiene, at the proper times. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months, or until 100% compliance is achieved for 3 consecutive months.¿ The QA Committee will¿review, update, and make changes, as necessary, to this plan of correction to ensure substantial compliance for no less than 6 months.¿ The results of these audits will be reviewed in Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Assurance Meeting monthly for 6 months. ="" span="">="" span="">="" span="">="" span="">="" span="">="" span<="" p="">="" span="">="" p="">="" span="">**span="">** **span="">** ="" span="">="" span="">="" span<="" p="">="" span<="" p="">="" p="">="" b="">="" p="">="" b="">="" p="">="" p="">="" p="">="" p="">="" p="">**b="">** **b="">** ="" b="">="" p="">="" p="">="" p="" <="">="" p="">="" span="">="" span="">="" span="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			=”” span=””> =”” span=””> =”” span<=”” p=””> =”” span=””> =”” p=””> =”” span=””> **span=””> span=””> =”” span=””> =”” span=””> =”” span<=”” p=””> =”” span<=”” p=””> =”” span=””> =”” p=””> =”” b=””> =”” p=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> **b=””> b=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” b=””> =”” p=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> **b=””> b=””> =”” b=””	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			="" p=""> ="" p=""> ="" p=""> ="" p=""> ="" b=""> ="" p=""> ="" b=""> ="" p=""> ="" p=""> ="" p=""> ="" b=""> ="" p=""> ="" p=""> ="" b=""> ="" p=""> ="" b=""> ="" p=""> ="" p=""> ="" p=""> ="" b=""> ="" p=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span<="" p=""> ="" p=""> ="" span=""> ="" span=""> ="" span<="" p=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span=""> ="" span<="" p="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			=”” span=””> =”” p=””> =”” span=””> **span=””> span=””> =”” span=””> =”” span=””> =”” span<=”” p=””> =”” span<=”” p=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span<=”” p=””> =”” span=””> =”” p=””> =”” span=””> **span=””> span=””> =”” span=””> =”” span=””> =”” span<=”” p=””> =”” span<=”” p=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span=””> =”” span<=”” p=””> =”” span=””> =”” p=””> =”” span=””> **span=””> span=””> =”” span=””	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			=”” span=””> =”” span<=”” p=””> =”” span<=”” p=””> =”” span=””> =”” span=””> =”” p=””> =”” b=””> =”” p=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> **b=””> b=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” s=””> =”” p=””> =”” b=””> =”” p=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> **b=””> b=””> =”” b=””> =”” p=””> =”” p=””> =”” p=””> =”” p=””> =”” s=”>	