STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00448858 and IN00452280. Complaint IN00448858 - No deficiencies related to the allegations are cited. Complaint IN00452280 - No deficiencies related to the allegations are cited. Survey dates: January 27, 28, 29, 30, and 31, 2025 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 1 Medicaid: 56 Other: 2 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 5, 2025.	F 0000	I would like to request desk review/Paper Compliance for this survey.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property Based on observation, interview, and record review, the facility failed to ensure a cognitively	F 0557	Neither signing nor submission of this plan of correction shall	02/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Thomas	Executive Director	02/16/2025

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.

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	impaired resident was provided services to maintain a dignified existence related to available clothing for 1 of 3 residents reviewed for activities of daily living. (Resident 47) Finding includes: During an observation on 1/27/25 at 10:52 a.m., Resident 47 wore a gray long sleeve shirt and lounge pants as he walked out of his room. During an observation on 1/28/25 at 10:09 a.m., the resident wore gray long sleeve shirt and white/black plaid/checkered lounge pants, unchanged from the previous day, as he participated in an activity in the dining area. During an interview on 1/28/25 at 10:51 a.m., the resident tugged on his shirt and indicated that he did not have a change of clothing. The resident opened his drawer, which contained a blue polo Special Olympics shirt with his name on it. The resident opened his closet, which contained a tote with a button-up dress shirt. No other clothing items were observed in the resident's room. Resident 47's clinical record was reviewed on 1/28/25 at 3:03 p.m. Diagnoses included dementia, cerebral infarction, and mild intellectual disabilities. An annual Minimum Data Set (MDS) assessment, dated 12/4/24, indicated the resident had moderate cognitive impairment. The resident required partial assistance from staff for toileting, lower body dressing, and personal hygiene. The resident required supervision from staff for upper body dressing. The resident had frequent urinary and bowel incontinence.		constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 47 was provided with several changes of clothing from the laundry department. Additionally, all of his inventory items were located and returned to his room. 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 had the potential to be affected. An audit was conducted of all residents and no other residents were found to be without adequate clothing. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All new residents will have their clothing inventoried and taken to the laundry department to be labeled with their name within the first week of arrival. New clothing purchases that are reported to the	

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	A current care plan, dated 11/29/24, indicated the resident required assistance and/or monitoring with morning care, evening care, and elimination. Interventions included, morning cares to include bathing and dressing (11/29/24), and evening cares to include bathing and dressing (11/29/24). A current care plan, dated 12/5/24, indicated the resident was unable to make daily decisions without cues and supervision. Interventions included, encourage resident to self-evaluate decisions made (12/5/24). A current care plan, dated 12/5/24, indicated the resident had absence of personal contact with sisters as they live out of town. Interventions included, Provide opportunity for resident to express feelings (12/5/24) A current care plan, dated 12/6/24, indicated the resident required assistance from staff with activities of daily living (ADL's) related to dementia and intellectual disability. Interventions included, provide assistance with dressing, grooming, and hygiene as needed (12/6/24). A Nurse's note, dated 11/27/24 at 3:40 p.m., indicated Resident 47 arrived at the facility from another nursing facility, and had brought belongings with him. The belongings were placed in his room. Review of Resident 47's inventory log, dated 12/6/24, indicated the following clothing items: 15 blouses/shirts, 1 pair of shorts, 1 slacks/trousers, 1 sweat/lounge top, 1 sweater/blazer, 2 undershirts, 1 pair of jeans, and a jean jacket. During an observation on 1/29/25 at 9:46 a.m., the resident wore a gray long sleeve shirt and		facility will also be taken to the laundry department for labeling as soon after purchase as possible. An inservice was conducted will all staff to review the grievance process for reporting missing clothing The Social services Director for the 100/200 halls and the Memory Care Support specialist for the 200/300 halls or their designee will complete a clothing inventory sheet upon admission. Quarterly during the residents' care conference the MCSS and Social Services director will ask the resident or their representative if they feel they have adequate clothing. All issues will be addressed and a care plan meeting will be convened with the resident and the residents representatives to address the issue. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool "Resident clothing" weekly for 4 weeks, monthly for 6 months and	

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	white/black plaid/checkered lounge pants, unchanged from the previous observations, as he sat at a table in the dining area. During an interview on 1/29/25 at 3:47 p.m., CNA 4 indicated Resident 47 needed supervision to limited assistance from staff for activities of daily living. The resident was continent most of the time. He dressed himself and she believed that he had adequate clothing available. Staff was required to report to a nurse if a resident was without adequate clothing/personal items. During an interview on 1/29/25 at 3:47 p.m., CNA 5 indicated Resident 47 needed supervision to limited assistance from staff for activities of daily living. The resident was continent most of the time. He dressed himself and she believed that he had adequate clothing available. Staff was required to report to a nurse if a resident was without adequate clothing/personal items. During an observation on 1/30/25 at 9:46 a.m., the resident wore a gray long sleeve shirt and white/black plaid/checkered lounge pants, unchanged from the previous observations, as he participated in an activity in the dining area. During an interview on 1/30/25 at 11:31 a.m., CNA 6 indicated the resident lacked the ability to follow directions and often needed cued or a demonstration of the task to be completed. She gave the resident a shower on 1/27/25. The clothing that the resident had been wearing this week was obtained from the boutique due to the resident not having any clothing available at the time of his 1/27/25 shower. He lacked an adequate amount of clothing in his room and she had discussed this with another aide previously. He had plenty of clothing when he first arrived to the		quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	

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	facility. His clothing had been missing prior to the resident's room change. She went to the boutique and to the lost and found in laundry when she needed clothing for the resident. She confirmed the closet was empty. A drawer had two rolled up items and one shoe. A second dresser drawer lacked any clothing. During an interview on 1/30/25 at 1:48 p.m., the SSD indicated the laundry staff labeled clothing when residents admitted to the facility. The standard policy was to send clothing items for labeling on the day of admission. She had a boutique in her office of donated clothing. Items selected from the boutique were required to go straight to laundry to be labeled with the resident's name. Three to five outfits could have been obtained at one time from the boutique. During an interview on 1/30/25 at 1:48 p.m., the Memory Care Support Specialist indicated that she was not aware of the resident's lack of clothing. Staff were required to inform her when residents lacked clothing. Multiple outfits should have been obtained from the boutique during the resident's clothing shortage. She did not think that the resident came with very much clothing when he admitted. She worked on the resident's unit Monday-Friday from 9 a.m.-5 p.m. She observed the resident in the same clothing the week of 1/27/25. She was aware the resident normally wore the same outfit for 2-3 days . During an interview on 1/31/25 at 1:25 p.m., Laundry Aide 11 indicated the resident received facility laundry services. A current facility policy, revised 4/18, titled "Resident's Personal Laundry", provided by the SSD on 1/30/25 at 2:13 p.m., indicated the			

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	following: "Policy...Staff will wash resident's personal laundry on a regular basis... Procedure...Once laundry is gathered... should be taken to the laundry room, sorted, washed, dried, folded or hung, and returned to the apartment timely... The clean, folded, or hung garments shall be returned along with the laundry container/bag to the resident's apartment. If assistance is required, staff shall assist with putting clothing in resident's closet and drawers...." 3.1-9(a) 3.1-9(b) 3.1-9(f)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff Based on interview and record review, the facility failed to ensure nursing staff followed the five rights of medication administration (right resident, right medication, right dose, right time, and right route) to prevent a medication error for 1 of 5 residents reviewed for unnecessary medications. (Resident 8) Finding includes: Resident 8's clinical record was reviewed on 1/28/25 at 2:46 p.m. Diagnoses included peripheral vascular disease and a non-pressure chronic ulcer of an unspecified lower leg. A physician's order, dated 12/9/24, included hydrocodone-acetaminophen (narcotic pain reliever) 10-325 milligrams (mg) - give one tablet by mouth every six hours for pain. This medication was scheduled to be administered at the following times: 5:00 a.m., 11:00 a.m., 5:00 p.m., 11:00 p.m. The order was discontinued on 1/9/25.	F 0726	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 8 had no negative effects and is participating per his baseline. Resident was monitored per MD order. LPN received 1:1 education per DNS.	02/24/2025

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	A current physician order, dated 1/9/25, included hydrocodone-acetaminophen 10-325 mg- give one tablet by mouth every four hours for pain. This medication was scheduled to be administered at the following times: 3:30 a.m., 7:30 a.m., 11;30 a.m., 3:30 p.m., 7:30 p.m., and 11:30 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 1/17/25, indicated the resident was cognitively intact. Opioids were received during the assessment period. A current care plan, dated 5/10/24, indicated the resident was at risk for pain related to peripheral vascular disease. Interventions included, administer medications as ordered. A Nurse's note, dated 1/11/25 at 5:18 a.m., indicated the resident received and additional dose of hydrocodone 10-325 mg in error. Vital signs were within normal limits. The resident was alert and oriented and monitored frequently. A Nurse's note, dated 1/11/25 at 5:46 p.m., indicated the provider ordered to observe the resident for 4 hours and to hold the next dose of hydrocodone. A Nurse's note, dated 1/11/25 at 2:03 p.m., indicated the resident was resting in his bed with even and non-labored respirations and no shortness of breath. The resident took medications per order. Review of the January 2025 MAR indicated Resident 8 received the scheduled dose of hydrocodone-acetaminophen on 1/11/25 at 3:30 a.m. The doses scheduled on 1/11/25 at 7:30 a.m., 11:30 a.m. and 3:30 p.m. were held. The dose		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 have the potential to be affected by the alleged practice. No others residents were affected, A Medication error report was completed per policy with follow up per Medical Directors orders. All nurses were in-serviced by the DNS/Designee by 2/14/25 on mediation pass and 5 rights related medication administration. An audit was completed by the DNS of Medications administered by LPN 9 and no concerns were identified what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All nurses have been in-serviced by the DNS/Designee by 2/14/25 on mediation pass and 5 rights related medication administration. The SDC will complete medication skills validations with all nurses. All newly hired nurses will have medication pass skills validation completed upon hire. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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	scheduled on 1/11/25 at 7:30 p.m. was left blank. Review of the resident's narcotic count sheet indicated a dose of hydrocodone-acetaminophen 10-325 mg was administered in error on 1/11/25 at 5:00 a.m. by LPN 9. The previous dose scheduled on 1/11/25 at 3:30 a.m. was administered at 4:00 a.m. by LPN 9. During an interview on 1/31/25 at 9:20 a.m., the DON indicated LPN 9 had administered a dose of hydrocodone-acetaminophen 10-325 mg in error on 1/11/25. LPN 9 had administered the additional dose of medication based on her memory rather than looking at the new order prior to the medication administration. The previous order of the same medication had been due at 5:00 a.m., but the order had been changed and was not scheduled at that time. The physician and family were notified by LPN 9 of the medication error. Staff were not permitted to pass medications based on memory, nor without verification of the physician's order for the medication. During an interview on 1/31/25 at 9:45 a.m., the DON indicated LPN 9 administered the additional dose of medication on 1/11/25 at 5:00 a.m. If the nursing staff charted by exception, they would not have charted anything in the clinical record unless abnormalities were found, when a resident received a medication in error. During an interview on 1/31/25 at 10:10 a.m., LPN 9 indicated she had administered an additional dose of the resident's hydrocodone-acetaminophen 10-325 mg in error on 1/11/25 by accident. She automatically got out the dose that had previously been ordered to administer at 5:00 a.m. (no longer ordered at that time) and administered it to the resident. The Medication Administration		quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. CQI tool identified as Medication pass will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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	Record (MAR) had not triggered her to administer the dose at 5:00 a.m., as the next dose was not due until 7:30 a.m. She was in a hurry because she had assisted another staff member on another unit with medication administration and had her own medication cart as well. She felt she had adequate time to complete her tasks, but she rushed and it was her fault. The facility required staff to check the five rights prior to administration of medications. She had notified the provider and the on-call nurse manager, assessed the resident, and obtained vitals. The provider gave her orders to monitor the resident for sedation for four hours, and to hold the next dose of hydrocodone-acetaminophen 10-325 mg scheduled for 1/11/25 at 7:30 a.m. The on-call nurse instructed her to continue the resident's assessments. This occurred at the end of her shift and she had reported the medication error all of the above mentioned orders to RN 10 during morning report, at the end of her shift around 6:00 a.m. on 1/11/25. During an interview on 1/31/25 at 10:28 a.m., the DON indicated additional doses were held because the order to hold the hydrocodone-acetaminophen for the next dose had been entered and timed to hold until 11:00 p.m. During an interview on 1/31/25 at 11:03 a.m., RN 10 indicated she provided care for the resident on 1/11/25 after he had the medication error on the previous shift. LPN 9 had given her report at the shift change and made her aware of the resident's medication error and the need for continued observation for sedation. She was uncertain of the specific length of time the resident needed observed on her shift. LPN 9 had explained the hydrocodone was on hold and the orders had			

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	been placed in the computer. She was unaware the medication was ordered to be held only for the next dose. She was unaware of any other reason the resident's hydrocodone-acetaminophen 10-325 mg was held for additional doses. A current facility policy, revised 11/2018, titled "Medication Errors," provided by the Corporate Nurse Consultant on 1/31/25 at 12:26 p.m., indicated the following: "POLICY... It is the policy of this provider to ensure resident residing in the facility are free from medication errors...." 3.1-14(i)			
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, record review, and interview, the facility failed to post the daily facility census number and actual hours worked of licensed and unlicensed nursing staff directly responsible for resident care per shift daily. Finding includes: During an observation and record review, on 1/28/25 at 11:43 a.m., the "Nursing Staffing Data" was posted from 1/28/25- 2/3/25 on the wall outside the Business Office and indicated the following: On 1/28/25, the total number of licensed and unlicensed staff were 2 Registered Nurses (RN), 2 Licensed Practical Nurses (LPN), 2 Qualified Medication Aides (QMA) and 15 Certified Nursing Assistants (CNA). The form lacked a shift to shift breakdown. The form lacked a census number.	F 0732	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the “Statement of Deficiencies”. This plan of correction is provided as evidence of the facility’s desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. The nursing staffing data is now posted with all required information. how other residents having the potential to be affected by the	02/24/2025

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	On 1/29/25, the total number of licensed and unlicensed staff were 2 RNs, 2 LPNs, 2 QMAs and 15 CNAs. The form lacked a shift to shift breakdown. On 1/30/25, the total number of licensed and unlicensed staff were 2 RNs, 1 LPN, 3 QMAs and 15 CNAs. The form lacked a shift to shift breakdown. On 1/31/25, the total number of licensed and unlicensed staff were 1 RN, 4 LPNs, 1 QMA and 15 CNAs. The form lacked a shift to shift breakdown. During an interview, at the time of the observation, the Administrator indicated he completed staffing weekly, as it was easier to keep track of that way. The previous 4 weeks remained in the plastic holder behind the current posting. During an observation and record review, on 1/31/25 at 11:00 a.m., of the "Nursing Staffing Data," the census number column remained blank for 1/29/25, 1/30/25, and 1/31/25. During an interview, on 1/31/25 at 11:25 a.m., the Administrator indicated the Director of Nursing filled out the direct care staffing numbers on the "Nursing Staffing Data" form. He indicated he did not see a shift to shift breakdown on the form. During an interview, on 1/31/25 at 11:30 a.m., the DON indicated she filled out the forms with the nursing staffing information for a 24-hour time frame and not shift to shift. She indicated some of the previous dates were missing a census number. A facility policy, last revised 7/23, titled, "Posted Nurse Staffing Data and Retention Requirements,"		same deficient practice will be identified and what corrective action(s) will be taken; All residents had the potential to be affected however no residents were affected. The Executive Director was educated by DNS/Designee related to posting the staffing data each date and to ensure census and shift breakdown are included. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A new staff posting report was developed detailing the scheduled hours by shift and the actual hours worked per shift and the total for the day. The ED/designee will ensure the staff data is accurate and posted daily. 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 ED/designee will complete posted staffing QA tool weekly x4 weeks, monthly x6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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	provided by the Administrator on 1/31/25 at 12:35 p.m., indicated the following: "...The facility must post the following information at the beginning of each shift...c. Resident census. d. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses, licensed practical nurses, certified nursing aides..."		developed.	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure food was prepared and served under safe and sanitary conditions for 1 of 3 units observed during dining (Cottage Unit). This had the potential to affect 21 of 21 residents who were served meals on the Cottage Unit. Findings include: During a Cottage Unit dining observation on 1/27/25 from 11:43 a.m. through 12:03 p.m. the following was observed: CNA 13 handled Resident 45's sloppy Joe sandwich with her bare hands while she assisted the resident with his meal in the dining room. CNA 13 handled Resident 46's breaded tenderloin sandwich with her bare hands while she set up the residents food for the resident to eat in the dining room. CNA 13 grasped three of Resident 45's cups from the top, touching the rim of each cup, at the dining room table. During an interview on 1/30/25 at 12:08 p.m., the	F 0812	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents had any ill effects from this deficient practice. An inservice was conducted for C.N.A 13 on proper food handling by the Culinary Manager and Director of Nursing. 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	02/24/2025

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	155038	A. BUILDING 00 B. WING	01/31/2025

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	Memory Care Support Specialist indicated that the residents' cups should have been handled at the bottom of the cup. It was not proper technique to touch the rim of the cup. The proper procedure to assist a resident with a sandwich depended on a resident's abilities. Staff should have assisted residents' with their condiments and then placed the top bun on the sandwich using a fork or spoon. Staff should have never used their hands. During an interview on 1/30/25 at 12:10 p.m., CNA 6 indicated cups were required to be handled from the bottom, avoiding the rim. After she applied condiments, she flipped the top bun onto the sandwich. She held up her hands and demonstrated she used her hands to place the top bun on the sandwich. During an interview on 1/30/25 at 12:26 p.m., CNA 13 indicated that cups should not have been touched by staff around the rims. The top bun of a sandwich should have been placed using silverware or gloves. She had touched the above mentioned sandwiches and cups because it was a habit. Perhaps she was rushed and just forgot to do the proper technique. A current facility policy, dated 1/24, titled "Hand Hygiene in the Dining Room", provided by the MDS Coordinator on 1/30/25 at 2:22 p.m., indicated the following: "Do Not Touch Food With Your Hands (Gloved or Ungloved)... Always use utensils when touching food... Avoid Touching Food Contact Surfaces of Dishware... (cup rims, surfaces of silverware....)" 3.1-21(i)(3)		residents on the cottage had the potential to be affected, however no residents were affected. An inservice was conducted by the Culinary Manager and Director of Nursing, for all staff responsible for serving resident meals. The education outlined the proper serving techniques to maintain a safe sanitary meal service. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; An inservice was conducted by the Culinary Manager and Director of Nursing, for all staff responsible for serving resident meals. The education outlined the proper serving techniques to maintain a safe sanitary meal service. 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; Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool meal observation daily for 7 days, weekly for 4 weeks, monthly for 6	

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			months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up.	