STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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 a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Complaint IN00435280. Complaint IN00435280 - No deficiencies related to the allegations are cited. Survey dates: June 24, 25, 26, 27, and 28, 2024. Facility number: 011509 Provider number: 155770 AIM number: 200909280 Census Bed Type: SNF/NF: 63 Residential: 9 Total: 72 Census Payor Type: Medicare: 10 Medicaid: 36 Other: 17 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 5, 2024.	F 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is July 23, 2024. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey revisit.**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Eric Will | Administrator | 07/19/2024

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
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure residents were safe from falls with the use of motion sensor alarms, testing of alarms, and prompt attention for 2 of 7 residents reviewed for falls. (Residents 20 and 5) Findings include: 1. During an observation on 6/24/24 at 11:25 a.m., Resident 20 appeared confused and was sitting at the dining table near the staff. The record for Resident 20 was reviewed on 6/25/24 at 1:42 p.m. The resident's diagnoses included, but were not limited to, displaced fracture of the right humerus, fracture of the second lumbar vertebra, unsteadiness on her feet, dementia, abnormalities of her gait and mobility, osteoporosis, and a need for assistance with her personal care. The Admission MDS (Minimum Data Set) assessment, dated 10/24/23, indicated the resident was moderately cognitively impaired. She required supervision or touching assistance for toileting and partial to moderate assistance for showers. The resident had impairment to one side and used a walker. The nurse's note, dated 10/21/23 at 9:10 p.m., indicated the nurse heard yelling upon entering the resident's room with the resident laying on her back. A small amount of blood was on the carpet by the resident's right elbow. The resident's right	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** **It is the policy to ensure safety or supervision of the residents to prevent accidentsWhat corrective action will be accomplished for those residents found to have been affected by the deficient practice.**Resident's #20 & #5 care plans and fall interventions were reviewed and updated as indicated by the DON/designee on July 1, 2024. Both residents motion sensors are functioning properly, checked for proper function by nursing/designee per shift and documented accordingly, and after resident care. Motion sensor batteries are changed per manufacturer recommendations and spare batteries are stored in the resident's rooms and nurse's cart. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**All residents have the potential to be impacted by this deficient practice. An audit was completed by the DON/designee on July 18, 2024, to identify residents that utilize motion sensors. Identified resident's care	07/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	shoulder was popped up with her arm turned outward. The nurse assessed the resident and placed a pillow under the resident's head. 911 and the NP (Nurse Practitioner) were called. Four staff assisted the resident from the floor to a stretcher with careful attention to the right shoulder. The resident was transported to the local hospital. The nurse's note, dated 10/23/23 at 8:00 p.m., indicated the resident arrived back to the facility, and she was admitted back with a diagnosis with a displaced comminuted fracture of the shaft of the right humerus. The fracture was reduced and was splinted in the ER (emergency room), and she had a sling in place. The resident got up twice without ringing her bell for resident safety. A motion sensor alarm was in place, per facility protocol. The resident was still mobile, able to go to bathroom with help due to being unsteady. The IDT (Interdisciplinary team) note, dated 10/24/23 at 2:12 p.m., indicated the fall that occurred on 10/21/23 at night was reviewed. The resident was up ad lib with her walker. The resident was ambulating in her room without her walker and fell. The resident was assessed by the nurse to have a low blood pressure. Several unassisted transfers were attempted during the night and the motion sensor alarm was put in place to remind the resident to ask for staff assistance until she was evaluated by therapy. The care plan was reviewed and updated. The physician's order, dated 10/24/23, indicated staff were to apply a motion sensor alarm every shift for safety with transfers and document if the alarm was functioning properly and to check batteries. The care plan, dated 10/24/23 and last revised on		plans were updated, motion sensors are functioning properly, and checked per shift for proper function by nursing/designee and documented accordingly with spare batteries being available in the residents rooms and nurse's cart. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.**All staff were educated on Incident/Accidents/Falls policy and motion sensors by the DON/Designee by July 23, 2024. Additionally, non-compliance with the Incident/Accident/Falls policy and fall interventions will result in further education/discipline as indicated.**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.**The DON/designee will complete an audit tool to ensure motion sensors are being check for proper function 5 x weekly for 8 weeks, then 3 x weekly for 4 months. Any issues will be immediately corrected. If the facility maintains compliance above 100% at the end of the 6 months; then monitoring can be stopped. The audit tool will be reviewed at the monthly QAPI meeting. The QAPA committee will make additional recommendations as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	1/10/24, indicated the resident was at risk for falls with and without injury related to, muscle weakness, abnormalities of gait and mobility, osteoarthritis, pulmonary hypertension, type 2 diabetes mellitus, and osteoporosis. The interventions, included but were not limited to, Dycem to her wheelchair, encourage or remind the resident to lock wheelchair brakes before attempting to reposition herself in a wheelchair, keep the call bell within reach, encourage her to use the call bell and staff were to answer promptly. Keep the environment free of clutter, keep the room well lit, keep the wheelchair next to the recliner at night, make sure the resident was wearing proper footwear, the motion alarm was to be replaced and new batteries were placed in the alarm with extras placed in the resident's personal medication cabinet, place a motion sensor alarm to remind the resident to ask for staff assistance, and toilet the resident every 2 hours and as needed at night. The nurse's note, dated 11/10/23 at 7:15 p.m., indicated the CNA (Certified Nurse Aide) alerted the nurse that the resident was on the floor. Upon entering the resident's room, the resident was laying supine in front of her end tables, against the wall. The resident indicated she did not hit her head. The resident was able to move all extremities, but her right arm was in a hard cast. The resident was able to move her fingers with no complaints of right arm pain. Upon standing, the resident grimaced in pain. The resident's back was assessed, and a large abrasion was observed to the resident's left middle back. The motion sensor alarm was not turned on. All staff present in the villa were educated on the importance of turning the alarm on when leaving the resident's room. The resident was educated on hitting her call button before getting up.		based on the outcome of the tool. **By what date the systemic changes for each deficient will be completed.**Date:7-23-2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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 nurse's note, dated 11/16/23 at 7:10 p.m., indicated the nurse was called by staff in Villa 2. The resident was found on the floor, next to the dining room table. The resident was lying on her back next to the chair she sat in at supper time. No outer or inner rotation or injuries were observed. The resident could move all extremities. The nurse's note, dated 11/28/23 at 2:40 a.m., indicated the CNA informed the nurse that the resident fell. Upon assessing the resident, sitting on her buttocks in front of her recliner, the resident's legs were up on recliner. The CNA indicated the motion alarm was going off and the resident was trying to transfer herself. The resident had a left knee abrasion. The resident needed to use the toilet. The nurse's note, dated 11/30/23 at 1:51 p.m., indicated a new order from the orthopedic surgeon for a bone stimulator for 20 minutes, once every day and a follow up appointment on 12/28/23 with the orthopedic doctor was received. The nurse's note, dated 1/9/24 at 7:08 p.m., indicated the nurse was called into the resident's room by a CNA. The nurse entered the resident's room, and the resident was sitting on the floor, in front of her recliner chair with the legs of the recliner still elevated. The resident was smiling and sitting on her bottom, holding her hand up, wanting staff to pick her up off the floor. The resident was assessed for injuries with none observed. The nurse's note, dated 1/12/24 at 1:30 a.m., the nurse heard a commotion from the resident's room. When the nurse entered the resident's room, she found the resident on the floor, laying on her back			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	in front of the recliner. A pillow was placed behind the resident's head while the nurse assessed the resident. No injuries were observed, and the resident denied any pain. The IDT note, dated 1/12/24 at 10:41 a.m., indicated the resident's fall was reviewed. The resident was in her room on the floor, near the recliner. The resident had an elevated blood pressure reading. New orders were received. Upon investigation of the fall, the motion sensor alarm was not functioning correctly. The motion sensor alarm was replaced, and new batteries were placed in the alarm with extra batteries being placed in the resident's personal medication cabinet. The nurse's note, dated 2/13/24 at 4:15 a.m., indicated the CNA entered the resident's room after hearing the motion sensor alarm and letting the resident know to wait and the CNA would be right there, returning to find the resident lying on the floor in the resident's bathroom. The CNA notified the nurse of the incident. The nurse entered the resident's bathroom at 4:20 a.m., to find the resident lying on her back on the floor, with her head toward the toilet and both feet toward the door. No injuries were observed, although the resident complained of pain to the posterior head. The resident was transported to the local hospital. The resident still complained of pain to her posterior head, and the resident also complained of pain to her bilateral hips when her legs were moved. The nurse's note, dated 2/15/24 at 1:36 p.m., indicated the resident had a fracture of the L (lumbar)2 vertebrae. The behavior note, dated 2/29/24 at 2:07 a.m., indicated the CNA entered the resident's room			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	and the resident was attempting to ambulate to the toilet, unassisted. The resident was re-educated on the importance of assistance. The nurse's note, dated 4/9/24 at 7:36 a.m., indicated the resident had a steady decline in her transfer. The resident was unable to walk to the bathroom with help. Staff now had to transfer the resident, in a wheelchair, to the bathroom due to the resident's unsteady gait. The nurse's note, dated 4/10/24 at 11:30 a.m., indicated therapy contacted the nurse around 10:30 a.m. this morning to report she found the resident sitting on the floor. The nurse entered Villa 2 to find the resident sitting on the floor with her back against the wall outside the business office. The resident was unable to explain what happened, but she did shake her head no, when she was asked if she hit her head. The resident tended to slouch in her wheelchair due to her lower back fracture. She had been seen using the railing along the wall to pull herself along. The Incident note, dated 5/16/24 at 10:19 p.m., indicated the resident was observed on the floor, on her back, next to her wheelchair, outside of her room. The resident was unable to explain what had happened due to her cognitive issues. The resident denied pain or injury. The current ADL (Activities of Daily Living) tasks indicated the resident required one staff extensive assistance for toileting, transfers, and bed mobility. More assistance may be provided as needed. During an interview on 6/27/24 at 9:15 a.m., CNA 4 indicated the staff would obtain the batteries for the motion sensor alarms from Central Supply			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	CNA 10. CNAs should check the alarms for function before leaving the residents alone in their rooms. The Maintenance Director had taken over checking the motion sensor alarms for function now, but CNAs could check them too. Maintenance would test one motion sensor alarm in the villa in the mornings, occasionally. The central supply room was in Villa 3, which was where the batteries were stored. A red light would come on when the batteries were low on the motion sensor alarm. Staff could also check the function of the alarms by pressing on them to see if they sounded. During an interview on 6/27/24 at 9:20 a.m., QMA (Qualified Medication Aide) 6 indicated all staff checked the alarms every time a resident was laid down. The motion sensor alarm sounded funny or different when the battery was low. Staff put new batteries in the alarms when needed. The resident would try to do self-care and would propel herself along the rails on the wall, while she was in her wheelchair. The resident would let herself slide out of the wheelchair at times. The QMA tried to keep the resident near her or at the dining table. During an interview on 6/27/24 at 9:56 a.m., the DON (Director of Nursing) indicated the nursing staff would replace the motion sensor alarm batteries. The staff would test the alarm for function by setting the resident in place and made sure the alarm would made a beeping sound. The batteries were in Villa 3. If the motion sensor alarm needed new batteries, the staff would contact management and the batteries would be taken to the villa. The DON was contacted when Resident 20 had a fall. She brought the new batteries, for the motion sensor alarm, to the villa. It was the nursing staff's responsibility to make sure the motion sensor alarm was on for the residents.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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 6/28/24 at 8:48 a.m., QMA 7 indicated the resident was declining in health. The resident thought she was independent with her own care, so the CNA went in and out of the resident's room often. When the resident was in the dining room, the resident's door would be kept closed to prevent her from trying to go in their alone. The extra batteries were kept in the medication cart drawer or in the nurse's station desk drawer. During an interview on 6/28/24 at 8:58 a.m., CNA 5 indicated alarms usually gave a warning sound when they were dying. The batteries were kept in the cabinet in the resident's room. If they weren't there, they were found in the medication cart or in Villa 3. The resident had fallen a lot due to sliding out of her chair or she scooted her bottom off of the wheelchair. The alarm went off one time and another resident was being taken care of. The resident was told they would come to her room in a minute to help her. The resident didn't wait for the CNA to return to help her, and she fell. She could usually tell when the resident was antsy and needed help immediately. The resident was hard to understand and flash cards had to be used with pictures to help her communicate what she needed. During an interview on 6/28/24 at 9:25 a.m., the Maintenance Director indicated when the new company took over the facility, he was required to check all rooms with the motion alarms daily. He was provided with a list of residents with motion sensor alarms, and this began last week. During an observation on 6/28/24 at 10:19 a.m., the resident was asleep in her room in a recliner. The motion sensor alarm was placed on the floor,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	pointed toward the resident. 2. The record for Resident 5 was reviewed on 6/26/24 at 8:33 a.m. The diagnoses included, but were not limited to, right sided hemiplegia and hemiparesis following a cerebral infarction, type 2 diabetes mellitus, vascular dementia, muscle weakness, insomnia, cognitive communication deficit, transient cerebral ischemic attack, and joint pain. The care plan, dated 1/31/22 and last revised on 3/11/24, indicated the resident had a potential for falls related to her new environment, cerebral infarction, type 2 diabetes mellitus, impaired cognition and decision making. The interventions, dated 6/7/24, included, but were not limited to, a Dycem was to be placed in the resident's recliner to help prevent her from sliding in the recliner, elevate the resident's footrest while the resident was in the recliner per the resident's preference, a motion sensor alarm was to be placed at bedside every night. 6/18/24 the resident was not to be up in her wheelchair, in her room, unattended. The physician's order, dated 8/22/23, indicated staff were to place a motion sensor alarm at the resident's bedside for safety when the resident was in bed every shift for safety with transfers. The Quarterly MDS assessment, dated 1/24/24, indicated the resident was severely cognitively impaired. The nurse's note, dated 8/22/23 at 6:46 a.m., indicated the resident was found on the floor from an unwitnessed fall. Neurological checks were in place and no injuries were observed. The IDT note, dated 8/22/23 at 9:59 a.m., indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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 fall on 8/22/23 was reviewed. The resident was found on the floor in her room, in front of the resident's bathroom. The resident indicated she was trying to use the bathroom. The resident required assistance with transfers and a call light pendant was not on. A motion sensor alarm was to be placed in the resident's room and utilized at nighttime due to the resident forgetting to call for assistance upon waking. The care plan was reviewed and updated. The nurse's note, dated 9/18/2023 at 7:04 a.m., indicated the resident was setting off the motion sensor alarm multiple times throughout the night. The resident was confused, talking about going to see her boyfriend and about having to take the kids to school. The Incident note, dated 9/19/23 at 4:04 p.m., indicated the nurse heard a noise in the resident's room and the resident had slid out of her recliner. The recliner didn't fold down. No injuries were observed. The IDT note, dated 9/21/23 at 10:16 a.m., indicated the resident's fall on 9/19/23 was reviewed. The resident slid out of her recliner. The resident had involuntary jerking movements. No injuries were observed. The resident was to have a Dycem placed in her recliner to help prevent her from sliding in the recliner. The care plan was to be updated. The nurse's note, dated 12/22/23 at 5:18 a.m., indicated the Villa 6 CNA contacted the nurse in Villa 7 to notify her that the resident was on the floor in her room. This nurse immediately came to Villa 6 to assess the resident. The resident was laying on her back next to her bed with her feet facing the bathroom door. The resident had no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	pain and wanted to stand up. No injuries were observed by the nurse and the CNA stood the resident up and walked her to the bathroom. The resident indicated she was headed to the bathroom because she did not want to have a bowel movement in bed. The motion sensor alarm was in place and that notified the CNA of the incident. The IDT note, dated 12/22/23 at 9:38 a.m., indicated the fall from 12/22/23 was reviewed. The resident needed to use the bathroom and transferred herself out of her bed and fell. The motion sensor alarm went off, alerting staff. The resident was found on the floor and no injuries were observed. Staff were to toilet the resident before being placed in bed. The care plan was updated. The nurse's note, dated 6/17/24 at 7:59 p.m., indicated at 6:15 p.m., the nurse observed the resident on the floor in her room. The resident was positioned laterally on her right hip with her forehead touching the floor. The resident's wheelchair was behind her. The resident's glasses were on her face, and she had non-skid socks on her bilateral feet. The resident was assisted onto her back. The resident complained of pain when the nurse touched the resident's right hip. The NP recommended that the resident be transferred to the hospital for further evaluation. The resident's family visited and requested that the resident not be transferred to the hospital. The resident was assisted by two staff into her bed. The call pendant was within reach, non-skid socks were on, and the motion sensor alarm was on at this time. The resident denied pain and appeared comfortable at this time. The IDT note, dated 6/18/24 at 12:43 p.m.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	indicated the fall on 6/17/24 was reviewed. The resident was sitting in her wheelchair alone in her room. She was observed with increased pelvic thrusting when in her wheelchair. The new intervention was for therapy to screen the resident related to wheelchair positioning and the resident was to not be left in her wheelchair, in her room, unattended. The current ADLs task indicated the resident required one staff assistance for bed mobility, toileting, and transfers due to her hemiparesis. During an interview on 6/28/24 at 9:17 a.m., LPN (Licensed Practical Nurse) 9 indicated she was informed the resident had a fall on the night shift, a few months ago and the alarm wasn't going off. The batteries were not set right in the alarm. When the resident was placed into bed the alarm would be set and this would be tested by pressing on the alarm to check its' function. The alarm would be placed toward the resident or on the outside of the door and not towards the resident. During an observation on 6/28/24 at 10:25 a.m., the resident was sitting asleep in a recliner in the hearth area of Villa 7. The motion sensor alarm was on the floor in the resident's room pointed toward the entry door. The current Safety Alarm Devices policy included, but was not limited to, " ... 4. The personal alarm should sound at the Nurses' station if at all possible. It should be placed per manufacturer's recommendations ... The alarm needs to be checked daily for function ..." 3.1-45(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF GEORGETOWN, THE	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00435280. Complaint IN00435280 - No deficiencies related to the allegations are cited. Survey dates: June 24, 25, 26, 27, and 28, 2024 Facility number: 011509 Residential Census: 9 The Waters of Georgetown was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on July 5, 2024.	R 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged, or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is July 23, 2024. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey revisit.**	