STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 00 B. WING	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF INDIANAPOLIS, THE	3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00450922 and IN00451215. Complaint IN00450922 - No deficiencies related to the allegations are cited. Complaint IN00451215 - Federal/State deficiencies related to the allegations are cited at F550, F761, and F880. Unrelated deficiencies are cited. Survey dates: February 6 and 7, 2025 Facility number: 000537 Provider number: 155409 AIM number: 100267270 Census Bed Type: SNF/NF: 72 Total: 72 Census Payor Type: Medicare: 1 Medicaid: 65 Other: 6 Total: 72 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 10, 2025.	F 0000		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility	F 0550	F550 Resident Rights/Exercise of	02/23/2025

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

Alicia Harris | Administrator | 02/20/2025

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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	failed to ensure resident rights were maintained when a cognitively intact resident was not allowed to sign out for a leave of absence for 1 of 3 residents reviewed for resident's rights. (Resident C) Findings include: During an interview on 2/6/25 at 9:42 a.m., Resident C indicated the staff had told her that she cannot sign out and leave the facility for a leave of absence and they had not let her leave. During an interview on 2/6/25 at 1:09 p.m., the Director of Nursing (DON) indicated Resident C was allowed to sign out and leave the facility with family or friends, but not with her boyfriend. Resident C was not allowed to sign out on her own even though she was cognitively intact. The DON did not think Resident C's rights were violated. The clinical record was reviewed on 2/7/25 at 12:13 p.m. The diagnoses included, but were not limited to, alcohol abuse, psychoactive substance abuse, and bipolar disorder. An Admission Minimum Data Set (MDS) assessment, dated 12/25/24, indicated Resident C was cognitively intact. A current physician's order, dated 12/24/24, indicated Resident C may not go out on a leave of absence. There was no stop date noted. On 2/6/25 at 11:44 a.m., the DON provided a copy of an undated facility policy, titled Your Rights and Protections as a Nursing Home Resident, and indicated this was the current policy used by the facility. A review of the policy indicated residents		Rights It is the intent of this facility to ensure residents rights are maintained by allowing residents cognitively intact to sign-out for a leave of absence. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident C was assessed on 2-17-25 with no signs of psychosocial distress by the SSD/Designee Order received on 2-17-25 that resident may go on LOA, by the DON/Designee 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. Audit of orders for leave of absences completed on 2-20-25, by the DON/Designee, no other residents were found to be affected. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The ADMIN/Designee staff on resident rights with emphasis on	

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	have the right to leave the facility. This citation relates to Complaint IN00451215. 3.1-3(a)		leave of absence for cognitively intact residents was completed on 2-23-25. Any staff that fails to comply with the points of education will be further educated and/or disciplined. 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; and DON/Qualified designee will interview 10 random residents and 10 random staff members on the residents right for leave of absence weekly for 4 weeks, then 5 random residents and staff members weekly for 4 weeks, then 3 random residents and staff members weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Any concerns noted will be addressed immediately at the time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to report an allegation of abuse for 1 of 3 residents reviewed for abuse. Staff did not immediately report to the administrator when staff overheard a female resident tell a male staff member she would report him for hitting her and did not accurately report all known information regarding the allegation of abuse at the time the allegation was reported to the state survey agency. (Resident B, CNA 1, CNA 2, DON, Floor Tech) Findings include: During an interview on 2/6/25 at 10:02 a.m., Resident B indicated a couple of weeks ago, in the morning, she was wheeling down the hall and attempted to pass the Floor Technician (Floor Tech), from behind, as he was buffing the floor. The machine was plugged in and the cord was across the floor, and Resident B was on his left. The Floor Tech stuck out his left arm and hit her right shoulder. Resident B said I'm telling that you hit me. Resident B didn't think the Floor Tech. intended to hit her. Resident B couldn't remember the date this happened, but thought it happened between 1/20/25 and 1/22/25. During an interview on 2/6/25 at 10:16 a.m., the Floor Tech indicated, on the morning of 1/22/25, he was buffing the floor when Resident B wheeled the front wheels of her wheelchair over the power cord to the buffer. He told Resident B to back off the cord and as the Floor Tech pulled the cord out of the wall he touched Resident B's hand. The Floor Tech left work until approximately 1:30 p.m., that day until the Director of Nursing (DON) told	F 0609	p paraid="2231466" paraeid="{566b77a4-0459-4d8d-9bab-1400b9668295}{240}" >F609 Reporting of Alleged Violations It is the intent of this facility to report an allegation of abuse and for staff to report the allegation to the abuse coordinator at the time of the allegation. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident B had Skin assessment completed on 2/9/2025 with no alterations noted. Psycho-social follow up completed by Social Service Director on 2-17-25 with no negative psycho-social noted from alleged 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide skin sweep was completed by the DON/Designee on 2-20-25 on	02/23/2025

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	him he had to leave due to the abuse allegation. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated on 1/22/25 at approximately 6:01 a.m., Resident B reported she was going down the hallway and tried to roll over the cord to the buffer as the Floor Tech was buffing the floor. Resident B said the Floor Tech jerked the cord out of the wall and purposely hit her right upper arm. The Floor Tech said he stuck his arm out, so Resident B didn't get hurt. CNA 1 and CNA 2 heard Resident B tell the floor tech she was going to report him for hitting her. The DON wasn't sure if all of that information should have been included in the initial incident report for the state health department because the corporate office had to approve it before they filed it. During an interview on 11:06 a.m., CNA 1 indicated she never heard Resident B tell anyone she would report them for hitting her. CNA 1 was not aware of any incident that occurred with Resident B and the Floor Tech. This was the first time CNA 1 heard anything about any incident between Resident B and the Floor Tech. During an interview on 2/6/25 at 1:24 p.m., CNA 2 indicated when she was standing in another residents bathroom getting ready to provide morning care when she heard Resident B say she was going to report that someone hit her. CNA 2 didn't leave the other resident's room to check on Resident B nor report what Resident B said. CNA 2 should have reported what Resident B said. The clinical record for Resident B was reviewed, on 2/6/25 at 11:32 a.m. The diagnoses included, but were not limited to, bacteremia, acute respiratory failure, and pulmonary edema		residents with a Bim's of 12 or less. Abuse questionnaires were completed by the SSD/Designee on 2-17-25 for all residents with a Bim's score of 13 or higher. Any concerns for addressed or reported as needed. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. ul class="BulletListStyle1 SCXW126038273 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" The Administrator/Designee completed education with facility staff including Floor Tech, CNA 1, 2 and DON on the Abuse Reporting including ensuring residents were free from abuse on 2-23-25. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 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; and	

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	An admission Minimum Data Set (MDS) assessment, dated 12/18/24, indicated Resident B was cognitively intact and used a wheelchair. On 2/6/25 at 11:42 a.m., the DON provided a copy of a typed document and indicated it was the statements from staff about Resident B's allegation. A review of the document indicated CNA 2 overheard Resident B say that she was going to report him for hitting her. On 2/6/25 at 11:44 a.m., the DON provided a copy of an undated facility policy, titled Abuse Prevention Program, and indicated this was the current policy used by the facility. A review of the policy indicated all employees must promptly report any incident or suspected incident of abuse. On 2/7/25 at 9:20 a.m., the DON provided the reportable incident, dated 1/22/25 at 6:01 a.m., indicated on 1/23/25 the Floor Tech reported to the Administrator that Resident B was going to report him when she tried to pass him this morning, on 1/22/25, as she was going to the pantry, and he was buffing the floors when she tried to pass him and roll her wheelchair over the cord. On 2/7/25 at 2:30 p.m., the facility was unable to provide a policy regarding reporting to the state health department. 3.1-28(c)		The Social Service Director/designee will conduct interviews 10 random residents a week x 4 weeks, then 5 random residents a week x 4 weeks, then 3 random residents once a month x 4 months. The ADMIN will interview 10 random staff members on Abuse reporting weekly x 4 weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Any concerns noted will be addressed immediately at the time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on interview and record review, the facility failed to follow the abuse policy and ensure an	F 0610	p paraid="407376764" paraeid="{6f9a641c-4500-4a84-b7c	02/23/2025

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	alleged perpetrator of abuse was immediately removed from the facility for 1 of 3 residents reviewed for abuse. (Resident B, Floor Tech, CNA 1, CNA 2) Findings include: During an interview on 2/6/25 at 10:02 a.m., Resident B indicated a couple of weeks ago, in the morning, she was wheeling down the hall and attempted to pass the Floor Technician (Floor Tech), from behind, as he was buffing the floor. The machine was plugged in, the cord was across the floor, and Resident B was on his left. The Floor Tech stuck out his left arm and hit her right shoulder. Resident B said I'm telling that you hit me. Resident B didn't think the Floor Tech intended to hit her. Resident B couldn't remember the date this happened, but thought it happened between 1/20/25 and 1/22/25. During an interview on 2/6/25 at 10:16 a.m., the Floor Tech indicated, on the morning of 1/22/25, he was buffing the floor when Resident B wheeled the front wheels of her wheelchair over the power cord to the buffer. He told Resident B to back off the cord and as the Floor Tech pulled the cord out of the wall he touched Resident B's hand. The Floor Tech left work at approximately 1:30 p.m., that day until the Director of Nursing (DON) told him he had to leave due to the abuse allegation. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated CNA 1 and CNA 2 heard Resident B tell the floor tech she was going to report him for hitting her. During an interview 2/6/25 at 11:06 a.m., CNA 1 indicated she never heard Resident B tell anyone she would report them for hitting her. CNA 1 was		5-98f51ae0f796}{123}" >F610 Investigate/Prevent/Correct Alleged Violation It is the policy of this facility to ensure an alleged perpetrator of abuse is immediately removed from the facility. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. perpetrator of abuse was suspended pending investigation on 1-23-25. Resident B was assessed on 1-23-25 by the DON/Designee and with no negative outcome. 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice. A facility wide skin sweep was completed by the	

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	not aware of any incident that occurred with Resident B and the Floor Tech. This was the first time CNA 1 heard anything about any incident between Resident B and the Floor Tech. During an interview on 2/6/25 at 1:24 p.m., CNA 2 indicated she was standing in another residents bathroom getting ready to provide morning care when she heard Resident B say Resident B was going to report that someone hit her. CNA 2 didn't leave the other resident's room to check on Resident B nor report what Resident B said. CNA 2 should have reported what Resident B said. The clinical record for Resident B was reviewed 2/7/25 at 11:32 a.m. The diagnoses included, but were not limited to, bacteremia, acute respiratory failure, and pulmonary edema An admission Minimum Data Set (MDS) assessment, dated 12/18/24, indicated Resident B was cognitively intact and used a wheelchair. On 2/6/25 at 11:42 a.m., the DON provided a copy of a typed document and indicated it was the statements from staff about Resident B's allegation. A review of the document indicated CNA 1 saw the Floor Tech. and Resident B but did not see an inappropriate interaction. CNA 1 overheard Resident B say she was going to report him for hitting her. CNA 2 did not see an inappropriate interaction but overheard Resident B say she was going to report him for hitting her. During an interview on 2/7/25 at 8:06 a.m., the DON indicated, on 1/22/25 at approximately 6:01 a.m. Resident B told the DON that earlier that morning she wheeled down the hallway and tried to roll over the cord to the buffer as the Floor Tech was buffing the floor. Resident B said the		DON/Designee on 2-20-25 on residents with a Bim's of 12 or less. Abuse questionnaires were completed by the SSD/Designee on 2-17-25 for all residents with a Bim's score of 13 or higher. Any concerns for addressed or reported as needed. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The ADMIN or completed education with facility staff on the Abuse Policy on 2-23-25. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. ul class="BulletListStyle1 SCXW261030798 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" 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; and The ADMIN/Designee will audit allegation of abuse and	

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	Floor Tech jerked the cord out of the wall and purposely hit her right upper arm. The DON wasn't sure if all of that information should have been included in the initial incident report for the state health department because the corporate office had to approve it before they filed it. During an interview on 2/7/25 at 8:50 a.m., the Administrator indicated the Floor Tech should have stopped and removed himself from the floor. CNA 2 should have stopped what she was doing and ensured Resident B's safety. The Floor Tech should have been removed from the facility at that time. On 2/6/25 at 11:44 a.m., the DON provided a copy of an undated policy, titled Abuse Prevention Program, and indicated this was the current policy used by the facility. A review of the policy indicated separate the alleged perpetrator and ensure all resident's safety. Staff members who are suspected of abuse shall immediately be barred from any further contact with residents and be suspended from duty. 3.1-28(d)		suspension of the alleged perpetrator daily x 6 months. If the facility is within 95% compliance after months, the monitoring will be stopped. Any concerns noted will be addressed immediately at the time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications were stored in accordance with accepted professional principles for 2 of 3 residents observed for medication administration. An unlabeled medication was not removed from the medication cart and eye drops were not dated when opened. (Resident D, QMA 1, LPN 1) 1. During a medication pass observation on 2/6/25	F 0761	p paraid="1312258184" paraeid="{8aae392b-ac66-4293-983a-7a1d85b57082}{16}" >F761 Label/Store Drugs and Biologicals It is the intent of this facility to store medications in accordance with accepted professional standards, remove medications	02/23/2025

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	at 8:09 a.m., Qualified Medication Aide (QMA) 1 pulled a pill packet out of the medication cart. The packet had the label torn off so there was no resident name, no medication name or strength, and no instructions. Two white round pills with 54/24 on one side of each pill were observed. At that time, QMA 1 indicated the medication packet with the label removed should not have been left in the medication cart because she didn't know who the medication was for, what the medication was, nor the directions. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated the medication packet with the label removed should have been removed from the medication cart. On 2/6/25 at 11:44 a.m., the DON provided a copy of a facility policy, titled Prescription Labels, dated 3/2023, and indicated this was the current policy used by the facility. A review of the policy indicated medication containers having damaged labels are returned to the pharmacy. 2. During a medication pass observation on 2/6/25 at 8:46 a.m., Licensed Practical Nurse (LPN) 1 removed the wrapper and opened a new bottle of Zaditor 0.035% eye drops (antihistamine eye drop used to treat itchy eyes) for Resident D. LPN 1 did not date the newly opened bottle before nor after the eye drops were administered. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated the bottle of Zaditor eye drops should have been dated when the nurse opened it. On 2/7/25 at 2:30 p.m., the facility was unable to provide a policy regarding dating opened medications.		that are unlabeled from the medication carts, and date eye drops when opened. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed Resident D on 2-8-25 and was not affected undated eye drops. Eye drops for resident D destroyed and replaced on 2-11-25, by the DON/Designee. 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. DON/Designee audited medication carts for un-labeled and un-dated medications. Any Medications that were found to not have labels and not have dates were destroyed and replaced on 2-8-25. measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON or completed education with and Qualified Medication	

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	This citation relates to Complaint IN00451215. 3.1-25(j)		Assistances on Medication storage, dating medications when opened and removing any medication unlabeled from the medication carts on 2-8-25. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. ul class="BulletListStyle1 SCXW68741532 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" 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; and The DON/designee will complete an audit of medication carts for unlabeled medications and dating of medications 5 x a week x 4 weeks, then 3 times a week x 4 once a week x 4 months. If the facility is within 95% compliance after months, the monitoring will be stopped. Any concerns noted will be addressed immediately at the time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155409	A. BUILDING 00 B. WING	02/07/2025

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			Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during the administration of eye drops for 1 of 3 residents reviewed for medication administration. (Resident D, LPN 1) Findings include: During a medication pass observation on 2/6/25 at 8:46 a.m., Licensed Practical Nurse (LPN) 1 carried a bottle of Zaditor 0.035% eye drops (antihistamine eye drop used to treat itchy eyes) into Resident D's room. LPN 1 was not observed to be wearing gloves. LPN 1 explained what she was going to administer and took a pair of clean gloves out of a box and donned the gloves while holding the eye drops. LPN 1 was not observed to perform hand hygiene before donning the gloves. LPN 1 ensured Resident D was sitting up in his chair and leaned his head back, gently pulled down the lower right eye lid, and administered one drop into the outer edge of the right eye and applied pressure for three seconds. Then LPN 1 pulled the left lower eye lid down, administered one drop into the outer left eye and applied pressure for three seconds. LPN 1 asked Resident D if he was okay, removed her gloves, and left the room. No hand hygiene was observed. LPN 1 placed the bottle of eye drops back into the	F 0880	p paraid="1752615662" paraeid="{8aae392b-ac66-4293-983a-7a1d85b57082}{204}" >F880 Infection Prevention and Control It is the policy of this facility to maintain infection control during the administration of eye drops. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed resident D on 2-8-25 and no negative outcome related to the cited deficient practice. 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 that currently reside in the facility have the potential to be affected by the alleged deficient	02/23/2025

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	labeled baggy in the top drawer of the medication cart. During an interview on 2/6/25 at 10:32 a.m., the Director of Nursing (DON) indicated the nurse should have washed her hands before she put on gloves to administer Resident D's eye drops. On 2/6/25 at 11:44 a.m., the DON provided a copy of a facility policy, titled Eye Drop Administration, dated 3/2023, and indicated this was the current policy used by the facility. A review of the policy indicated properly wash hands before and after the administration of eye drops. This citation relates to Complaint IN00451215. 3.1-18(b)(1)		practice, therefore this plan of correction applied to all residents that reside in the facility. ul class="BulletListStyle1 SCXW207495430 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON or completed education with nursing staff and Qualified Medication Assistance on hand hygiene during medication administration. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. 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; and DON/Designee will complete Medication administration audits for hand hygiene during medication administration, DON/Designee will audit 10	

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			random nurse/ for 4 weeks, then 5 random nurse/QMA for weekly weeks, then 3 random nurse/QMA weekly x 4 months. If the facility is within 95% compliance after months, the monitoring will be stopped. Any concerns noted will be addressed immediately at the time of audit. The results of the audit will be reviewed, reported and trended for compliance through the facility Quality Assurance and Performance Improvement Committee for a minimum of six months then randomly thereafter until substantial compliance is achieved.	