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	03/27/2025

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 the Investigation of Complaints IN00455500 and IN00456149. Complaint IN00455500 - No deficiencies related to the allegations are cited. Complaint IN00456149 - Federal/State deficiencies related to the allegations are cited at F609, F684, F690, F691, F759, and F842. An unrelated deficiency is cited Survey dates: March 24, 25, 26 and 27, 2025 Facility number: 011509 Provider number: 155770 AIM number: 200909280 Census Bed Type: SNF/NF: 67 Residential: 7 Total: 74 Census Payor Type: Medicare: 11 Medicaid: 51 Other: 5 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 1, 2025.	F 0000	The following Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission to and does not constitute an agreement with alleged deficiencies herein. The Plan of Correction is submitted to meet the requirements established by the state and federal regulations. Due to low scope and severity of the deficiencies cited, the facility respectfully requests the granting of a desk review and paper compliance. Should you require any further information or documentation, please do not hesitate to contact the facility.	
F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
andrew grubb	rdo	04/21/2025

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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Bldg. 00	Based on interview and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated for 1 of 3 residents reviewed for abuse. (Resident P) Findings include: The incident report, dated 3/24/25 at 10:30 a.m., indicated Resident P reported that she felt RN (Registered Nurse) 6 was sexually inappropriate during care. The clinical record for Resident P was reviewed on 3/26/25 at 2:57 p.m. The resident's diagnoses included, but were not limited to, diabetes, anxiety, insomnia and GERD (gastroesophageal reflux disease). The quarterly Minimum Data Set (MDS) assessment, dated 1/31/25, indicated the resident's cognition was intact. During an interview, on 3/24/25 at 3:11 p.m., Resident P indicated RN 6 had come to her room to give her evening medications. RN 6 asked Resident P if she needed something to help her sleep and Resident P told her if she had one prescribed. RN 6 responded "I did not ask you that". RN 6 told Resident P that she loved her, she was beautiful and that she did not think Resident P was crazy. RN 6 rubbed Resident P's left arm and leg and then nuzzled (rub or push against gently with the nose and mouth) her neck. She told RN 6 that what she did made her uncomfortable and then RN 6 left. She reported what had happened to Certified Nurse Aide (CNA) 7, who then reported the incident to Licensed Practical Nurse (LPN) 8. LPN 8 came over and she told her what had happened.	F 0609	It is the policy of this facility to ensure an allegation of abuse is thoroughly investigated. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Adm/designee reported resident P's incident to the Indiana Department of Health on 3/24/25. Investigation was completed on 3/24/25 by SSD, RNC and DON. The SSD/Designee assessed resident P on 3/24/25, 3/25/25, and 3/26/25 with no negative outcome. Resident discharged on 4/1/25 and no longer resides in the facility. 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 that resided in the facility have the potential to be affected by the alleged deficient practice, therefore this plan of correction applied to all residents. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur.	04/22/2025

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	During an interview, on 3/26/25 at 1:14 p.m., CNA 7 indicated RN 6 seemed a little "touchy/feely" when she worked with her. Resident P reported to her that RN 6 rubbed her arms and kissed her on the neck. RN 6 asked Resident P if she wanted a sleeping pill and Resident P responded "if I have one prescribed". RN 6 then said "I did not ask you that". CNA 7 reported the incident to LPN 8. During an interview, on 3/26/25 at 11:18 a.m., LPN 8 indicated CNA 7 reported that RN 6 made Resident P feel uncomfortable by rubbing her hand and telling the resident she loved her. LPN 8 tried to get more information but Resident P was confused. Resident P did not want RN 6 to be her nurse. RN 6 denied the incident and was not suspended per the Director of Nursing (DON). Normally, the facility would suspend the staff member during an investigation. There was a couple of times staff had called and reported an odor of alcohol on RN 6. One time, she assessed the RN and RN 6 had no smell of alcohol. LPN 8 moved LPN 9 to Villa 6 for the rest of the shift. LPN 8 did not interview any other staff or residents in Villa 6 or Villa 7. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled "Abuse Prevention Program" dated 10/22/22. It included, but was not limited to, "It is the policy of this facility to prevent abuse, neglect...Each resident receives care and services in a person-centered environment in which all individuals are treated a human beings...Employees are required to report any incident, allegation or suspicion of potential abuse...to the Administrator or immediate supervisor who will immediately report the allegation to the Administrator...Upon learning of		The RDO/Designee in-serviced the DON/Adm on the Indiana Department of Health reporting guidelines on 4/1/25. Additionally, any staff that fails to comply with the point of this in-service will be further educated and/or disciplined 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 Adm/DON/Designee will review progress notes 5 days weekly for any incident that meets the requirements of reportable criteria was initially reported to the appropriate state agency x 6 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. 4/22/25	

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	the report, the Administrator or in the absence of the Administrator, the person in charge of the facility shall initiate an incident investigation...All incidents will be documented, whether of not abuse occurred, was alleged or suspected...Any...allegation involving abuse...will result in an abuse investigation...The Charge Nurse must complete an incident report and obtain a written, signed and dated statement from the person reporting the incident...Staff members who are suspected of abuse or misconduct shall immediately... be barred from any further contact with residents of the facility and be suspended from duty, pending the outcome of the investigation...." This Citation relates to Complaint IN00456149 3.1-28(c) 3.1-28(d)		=" " p=" ">	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure residents (Resident D, Resident F and Resident G) were monitored for medication side effects and failed to ensure treatments were completed for a resident (Resident L) for 4 of 4 residents reviewed for quality of care. Findings include: 1. The clinical record for Resident D was reviewed on 3/24/25 at 4:48 p.m. The diagnoses included, but were not limited to, diabetes, peripheral vascular disease and systemic lupus. The physician's order, dated 3/21/25, indicated to resident was to receive Eliquis (anticoagulant) 5	F 0684	**F 684** It is the intent of this facility to ensure medications that require side effect monitoring are monitored for side effects to ensure treatments were completed. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed Resident's D, F, L and G on	04/22/2025

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	mg (milligrams) twice a day for DVT (deep vein thrombosis) prevention. The care plan, dated 1/11/24, indicated the resident was at risk for bleeding due to anticoagulant medication use and to observe for signs and symptoms of complications which included blood tinged or frank blood in urine, black tarry stool, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, petechiae, diarrhea, muscle/joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden change in memory, changes in mental status, and significant sudden changes in vision. The physician's order, dated 3/21/25, indicated the resident was to receive Insulin Lispro (short acting insulin) per sliding scale before meals and at bedtime. The care plan, dated 2/10/22, indicated the resident had diabetes and to monitor for signs and symptoms of hypoglycemia and hyperglycemia. The clinical record lacked documentation of monitoring for side effects related to diabetes and anticoagulant use upon readmission on 3/21/25. During the survey period, between 3/24/25 and 3/27/25, Staff Member 10 indicated if a resident was on a blood thinner, nursing staff should monitor every shift for signs and symptoms of bleeding anywhere, bruising, blood clots and black tarry stools and documenting the assessment on the medication administration record (MAR or treatment administration record (TAR). Diabetics should be monitored ever shift for signs and symptoms of hypoglycemia and hyperglycemia and documented on the		4/11/25, no negative outcome related to the cited practice. The DON/Designee notified residents D, F, and G and added monitoring orders for diuretics, blood thinners and insulin on 4/11/25. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. The DON/Designee completed an audit of residents receiving blood thinners, insulin and diuretices and entered monitoring orders in the EHR as indicated on 4/14/25. The DON/Designee completed an audit of residents with wound care treatments and wounds were assessed as indicated. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. The DON/Designee will in-service the nursing staff on medications requiring side effect monitoring, inputting orders for side effect monitoring and completion/documentation of treatments on or before 4/16/25. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.	

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	MAR/TAR. Residents who receive diuretics should be monitored for signs of dehydration and the assessment should be documented on the MAR/TAR. 2. The clinical record for Resident F was reviewed on 3/24/25 at 2:08 p.m. The resident's diagnoses included, but were not limited to, right sided hemiplegia and hemiparesis secondary to cerebral vascular accident, diabetes, hyperlipidemia and hypertensive heart disease. The physician's order, dated 3/7/25, indicated the resident was to receive Warfarin (blood thinner) 5 mg every evening for cerebral vascular accident. The care plan, dated 3/7/25, indicated the resident had the potential for complications related to anticoagulant use and to observe for reactions such as nausea, hemorrhage, fever, rash, bruise easily, angioedema, anaphylaxis and thrombocytopenia. The clinical record lacked documentation for the monitoring of the possible reactions and/or complications. 3. The clinical record for Resident G was reviewed on 3/26/25 at 8:55 a.m. The resident's diagnoses included, but were not limited to hypertension and congestive heart failure. The physician's order, dated 3/12/25, indicated the resident was to receive Lasix (diuretic) 80 mg daily for congestive heart failure. The physician's order, dated 3/21/25, indicated the resident was to receive Lasix 20 mg in the afternoon for edema.		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 monitor orders for appropriate side effect monitoring and completion of treatments. This will be monitored 5 days weekly x 4 weeks, then 3 days weekly x 4 weeks then 1 day weekly for 4 months If the facility is within 95% compliance at the end of 3 months, the monitoring will be stopped. At the monthly QAPI meeting, the monitoring will be reviewed.¿ Any concerns will have been corrected as found.¿ Any patterns will be identified.¿ If necessary, an Action Plan will be written by the committee.¿ Any written Action Plan will be monitored by the Administrator weekly until resolution.¿ By what date the systemic changes for each deficiency will be completed. 4/22/25 ="" p="">	

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	The care plan, dated 3/25/25, indicated the resident was at risk for fluid volume deficit due to diuretic use and to observe for signs and symptoms of dehydration. The clinical record lacked documentation for the monitoring of signs and symptoms of dehydration related to the diuretic use. 4. The clinical record for Resident L was reviewed on 3/27/25 at 10:54 a.m. The resident's diagnosis included, but was not limited to, abdominal wall abscess. The physician's order, dated 2/16/25, indicated to pack the surgical wound next to the stoma with gauze four times a day at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. for a wound infection. The March 2025 treatment administration record indicated the treatment was not completed on the following dates and times: - On 3/01/25 at 12:00 a.m. and 6:00 a.m. - On 3/03/25 at 6:00 p.m. - On 3/04/25 at 6:00 p.m. - On 3/08/25 through 3/12/25 at 6:00 a.m. - On 3/15/25 through 3/16/25 at 6:00 a.m. - On 3/22/25 at 6:00 a.m. This Citation relates to Complaint IN00456149 3.1-37			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure Indwelling catheter care was provided for a resident and failed to ensure urine	F 0690	**F 690** It is the intent of this facility to	04/22/2025

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	output was documented as ordered for 2 of 2 residents reviewed for Indwelling catheters. (Resident K and Resident L) Findings include: 1. The clinical record for Resident K was reviewed on 3/27/25 at 10:20 a.m. The resident's diagnosis included, but was not limited to, urinary retention. The care plan, dated 1/3/25, indicated the resident had an Indwelling catheter and staff were to provide catheter care every shift and document the resident's urine output every shift. The physician's order, dated 1/3/25, indicated to provided catheter care every shift. The physician's order, dated 2/26/25, indicated to record catheter output every shift for monitoring. The March 2025 medication administration (MAR) lacked documented urine output on the following dates and shifts: - On 3/3/25 and 3/4/25, there were no documented urine output on day shifts. - On 3/7/25 and 3/8/25, there were no documented urine output on night shifts. - On 3/10/25, there was no documented urine output on night shift. - On 3/13/25, there was no documented urine output on day shift. - On 3/17/25, there was no documented urine output on night shift. - On 3/18/25 and 3/19/25, there were no documented urine output on day shifts. - On 3/21/25, there was no documented urine output or catheter care on night shift.		ensure in-dwelling catheter care was provided for a resident and to ensure urine output was documented as ordered What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed residents K and L on 4/11/25, no negative outcome related to the cited practice. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. Residents with an indwelling catheter have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents with an indwelling catheter. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. The DON/Designee will in-service the nursing staff on or before 4/16/25 on the following. 1.Catheter Care 1.Following Physician Orders 1.Completion of signing the	

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	During an interview, from 3/24/25 through 3/27/25, Staff Member 10 indicated all physicians' orders should be followed as well as a resident's plan of care. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled "Physician Orders/Following Physician Orders Guideline" dated 2/15/19. It included, but was not limited to, "It is the policy of this facility to follow the orders of the physician...The facility will follow physician orders to provide essential care to the resident...." 2. The clinical record for Resident L was reviewed on 3/27/25 at 10:54 a.m. The resident's diagnosis included, but was not limited to, neuromuscular dysfunction of the bladder. The care plan, dated 2/20/25, indicated the resident had an Indwelling catheter and staff were to document the resident's urine output every shift. Review of the resident's March 2025 treatment administration record (TAR) lacked documentation of the resident's urine output on the following dates and shifts: - On 3/4/25, there was no urine output documented on day shift. - On 3/7/25 and 3/8/25, there were no urine output documented on night shifts. - On 3/10/25 through 3/12/25, there were no urine output documented on night shifts. - On 3/13/25, there was no urine output documented on day shift. This Citation relates to Complaint IN00456149		ETAR/EMAR for urinary output and catheter care as ordered Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined 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. DON/designee will monitor the ETAR/EMAR for catheter care and recording of outputs 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a month x 4 months. If the facility is within 95% compliance at the end of the 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. 4/22/25 ="" p="">	

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F 0691 SS=D Bldg. 00	3.1-41(a)(2) 483.25(f) Colostomy, Urostomy, or Ileostomy Care Based on interview and record review, the facility failed to ensure a resident's (Resident L) ostomy output was documented and care of the ostomy completed, as ordered by the physician for 1 of 1 resident reviewed for ostomy care. Findings include: The clinical record for Resident L was reviewed on 3/27/25 at 10:54 a.m. The resident's diagnosis included, but was not limited to, ostomy status. The care plan, dated 2/20/25, indicated the resident had an ostomy surgical site and staff were to administer the resident's treatments as ordered. The physician's order, dated 2/15/25, indicated to provide ostomy care and record any liquid output every shift. The resident's March 2025 treatment administration record lacked documentation of care provided and the resident's output on the following dates and shifts: - On 3/4/25, there was no output documented on day shift. - On 3/7/25 and 3/8/25, there were no output documented on night shifts. - On 3/10/25 through 3/12/25, there were no output documented on night shifts. - On 3/13/25, there was no output documented on day shift.	F 0691	**F 691** Colostomy, Urostomy or Ileostomy Care It is the policy of this facility to ensure that residents with a ostomy document outputs and provide ostomy care as ordered. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed resident L on 4/11/25, no negative outcome related to the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action will be taken. Residents with an ostomy have the potential to be affected by the alleged deficient practice, therefore, this plan of correction applies to all residents with an ostomy. What measures will be put into place and what system changes	04/22/2025

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	- On 3/21/25, there was no ostomy care completed. This Citation relates to Complaint IN00456149 3.1-47(a)(3)		will be made to ensure that the deficient practice does not recur. The DON/Designee will in-service the nursing staff on or before 4/16/25 on the following. 1.Ostomy Care 1.Following Physician Orders 1.Completion of signing the ETAR/EMAR for urinary output and catheter care as ordered Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined 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. Don/Designee will monitor ostomy care and output documentation 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, and then 1 x weekly for 4 months. If the facility is within 95% compliance at the end of 6 months, monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until	

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

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			resolved. By what date the systemic changes for each deficiency will be completed. 4/22/25 ="" p="">	
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff Based on observation, interview and record review, the facility failed to ensure the facility was adequately staffed to provide adequate care and safety for the residents. This deficient practice had the potential to affect 67 of 67 residents residing in the facility. Findings include: During an interview, between 3/24/25 and 3/27/25, Staff Member 11 indicated there was supposed to be an aide in every Villa but that did not always happen. When Staff Member 11 had two Villas to administer medications, Staff Member 11 would have to flip flop with the aide in Villa 3 which would leave the residents in Villa 1 alone with no staff in the building for approximately two minutes. There had, however been times when Villa 1 had been left unattended for 5 to 10 minutes. "The way the facility staffed the Villas was not safe nor was it fair to the residents." During an interview, between 3/24/25 and 3/27/25, Certified Nurse Aide (CNA) 12 indicated the facility was currently short staffed. She had cared for residents that required assistance of two staff members and frequently had to wait to change residents or put them to bed until another staff	F 0725	="" p=""> **F 725** It is the intent of this facility to ensure each Villa/Unit is staffed to ensure residents receive care and services. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed the residents on 4/14/25, no negative outcome related to the alleged deficient practice. 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 had the potential to be affected by the alleged deficient practice, therefore, this plan of correction applied to all residents that reside in the facility.	04/22/2025

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	member could assist her. For the most part, CNA 12 could complete all tasks assigned, however, when she worked in Villa 5, she was not able to complete her showers. During an interview, between 3/24/25 and 3/27/25, Qualified Medication Aide (QMA) 13 indicated she had worked as the nurse and the aide in a Villa many times. When you have to administer medication, provide resident care and serve all the meals during the 12-hour shift, it was like running around like a chicken with its head cut off and impossible to complete all care tasks, especially showers. During an interview, between 3/24/25 and 3/27/25, Licensed Practical Nurse (LPN) 5 indicated it was hard to complete all of her assigned tasks. LPN 5 sometimes times had to leave her Villa for long periods of time to administer insulin in multiple Villas where there were QMA's working. During an interview, between 3/24/25 and 3/27/25, LPN 10 indicated she has had to work two Villas before due to no nurses available. There had been a lot of QMA's working so the nurses had to leave their Villas to administer insulin in the other Villas. There had been times when LPN 10 would have to go to another Villa to assess a resident and, at times, send the residents out to the hospital. When that happened, your aide was left alone in the Villa for longer periods of time. The current staffing was not safe and was definitely not fair to the residents. During an interview, between 3/24/25 and 3/27/25, CNA 14 indicated she has had to work Villa 7 by herself multiple times which was very difficult. All the residents in the Villa received therapy and they also had heightened needs. There were times		What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. The ADM/DON were educated relative to Sufficient Staffing by the RDO on 4/1/25, including but not limited to provision of sufficient staffing based on resident acuity to meet the needs and preferences of residents. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined 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 ADM/Designee will monitor staffing levels 5 days a week for 4 weeks, , then 3 days a week for 4 weeks, then weekly for 4 months. Any concerns noted in this audit will be addressed and corrected immediately. If the facility is within 95% compliance at the end of the 6 then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any will be written by the QAPI committee. Any written Action Plan will be	

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	when she would be toileting one resident, and she could hear two other residents yelling because they needed to go to the bathroom at the same time. It makes it very hard when you are in a Villa by yourself. Review of the February 2025 and March 2025 as worked staffing sheets indicated the following: - On 2/11/25, there was no nurse in Villa 3 on night shift. - On 2/24/25, there was no nurse in Villa 3 on night shift. - On 3/15/25, there was no aide in Villa 4 on night shift. - On 3/24/25, there was one nurse for Villa 5 and Villa 6 on day shift. - On 3/25/25, there was no nurse in Villa 3 on night shift. - On 3/27/25, there was one nurse for Villa 5 and Villa 6 on day shift. During an observation, on 3/25/25 at 11:22 a.m., Villa 5 was observed without a nurse. CNA 15 indicated RN (Registered Nurse) 16 was currently over in Villa 6 giving medications. The incident report, dated 3/25/25 at 5:30 p.m., indicated a resident from Villa 5 exited the facility, in his wheelchair without supervision. The resident was re-directed back to the Villa by the Director of Rehabilitation. During an interview, on 3/27/25 at 1:55 p.m., CNA 15 indicated right after dinner, RN 16 had to go over to Villa 6 to send a resident out to the hospital since she was covering Villa 5 and Villa 6. CNA 15 was in a room, with the door closed, providing care for a resident. Her pager started going off while she was in the room, so she		monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. 4/22/25	

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	hurried up and completed care on the resident. When she came out of the room, she heard the door alarm sounding. She could not hear the door alarm because she was in a resident's room with the door closed. When she looked out the door, she saw therapy bringing the resident whom had exited back into Villa 5. 3.1-17(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on interview and record review, the facility failed to ensure a resident's (Resident H) scheduled narcotic was administered, as ordered by the physician, for 1 of 3 residents reviewed for medications errors. Findings include: The clinical record for Resident H was reviewed on 3/27/25 at 9:59 a.m. The resident's diagnoses included, but were not limited to, depression, anxiety and age-related osteoporosis. The care plan, dated 3/7/25, indicated the resident was at risk for pain and to administer medications as ordered. The care plan, dated 3/7/25, indicated the resident had an anxiety disorder and to give anti-anxiety medication as ordered by the physician. The physician's order, dated 3/19/25, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 10-325 mg (milligrams) every 6 hours at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. for pain.	F 0759	**759** It is the intent of this facility to ensure residents schedule narcotics are administered as ordered by the physician. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The DON/Designee assessed resident H on 4/11/25, no negative outcome related to the alleged deficient practice, the DON/Designee notified resident H's physician of the missed doses on 4/11/25. 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 with orders for	04/22/2025

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	The physician's order, dated 3/6/25, indicated the resident was to receive Xanax (narcotic anti-anxiety medication), 1 mg every 6 hours at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. for anxiety. Review of the March 2025 medication administration record indicated the resident did not receive the pain medication or the anti-anxiety medication on 3/22/25 at 6:00 a.m. Review of the controlled drug record for March 2025 indicated the that neither the Hydrocodone or Xanax were signed out as administered. During an interview, from 3/24/25 through 3/27/25, Staff Member 10 indicated all physicians' orders should be followed. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled "Physician Orders/Following Physician Orders Guideline" dated 2/15/19. It included, but was not limited to, "Policy...It is the policy of the facility to follow the orders of the physician...." This Citation relates to Complaint IN00456149 3.1-48(c)(1)		medications have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. The DON/Designee will in-service the nursing staff and Qualified Medication Assistances on or before 4/16/25 on the following. 1.Medication Administration 1.Five Right of Medication Administration. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined 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. If the facility is within 95% compliance at the end of the 6 months, then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any Action Plan needed will be written by the QAPI committee. Any	

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			written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. 4/22/25 ="" p="">	
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure unavailable medications were not documented as administered for 1 of 6 residents (Resident E); failed to ensure resident medication administration records accurately reflected the administration of medications for 5 of 6 residents (Resident D, Resident G, Resident H and Resident M); and failed to ensure a resident's (Resident E and Resident L) medication administration record accurately reflected the administration of narcotic pain medication for 2 of 3 reviewed for documentation. Findings include: 1. The clinical record for Resident D was reviewed on 3/24/25 at 4:48 p.m. The resident's diagnosis included, but was not limited to, hypothyroidism. The physician's order, dated 4/18/24, indicated the resident was to receive Levothyroxine Sodium Tablet, 100 mcg (micrograms) daily at 6:00 a.m. The March 2025 medication administration record (MAR) lacked documentation of the	F 0842	**F 842** It is the policy of this facility to ensure unavailable medications were not documented as administered and to ensure resident medication administration records accurately reflected the administration of medications. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident E, D, G, H, M and L's Medications were audited on 4/11/25 for availability as well as their MARS to ensure medications were administered and documented as ordered. How other residents having the potential to be affected by the same deficient practice will be	04/22/2025

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	administration of the medication on 3/6/25, 3/9/25, 3/12/25 and 3/16/25. During an interview, on 3/25/25 at 1:28 p.m., RN (Registered Nurse) 6 indicated the medication administration record should be signed to show a medication was administered. On 3/27/25 at 9:18 a.m., the Regional Nurse Consultant provided a current copy of the document titled "Medication Administration Guideline" dated 1/25/19. It included, but was not limited to, "Policy...Medications are administered as prescribed...The resident's MAR is initialed by the person administering a medication...When PRN medications are administered, the following documentation is provided...Date and time of administration...Signature or initial of person recording administration...." 2. The clinical record for Resident E was reviewed on 3/24/25 at 1:38 a.m. The resident's diagnoses included, but were not limited to, constipation and cellulitis of the right lower extremity. The resident admitted to the facility on 3/21/25 at 5:50 p.m. The March 2025 MAR record indicated the resident received the following medications: - 3/21/25 at 8:00 p.m., Colace (medication for constipation) 100 mg (milligrams) - 3/21/25 at 8:00 p.m., Linezolid (antibiotic) 600 mg - 3/21/25 at 8:00 p.m., Lovenox Injection (blood thinner) 0.4 ml (milliliters) subcutaneously - 3/22/25 at 12:00 a.m., Amoxicillin (antibiotic) 500 mg Review of the pharmacy delivery sheet indicated medications for the resident did not arrive to the facility until 3/22/25 at 7:14 a.m.		identified, and what corrective action will be taken. All MARS were audited on 4/14/25 for medication availability and accurate documentation of administration. What measures will be put into place and what system changes will be made to ensure that the deficient practice does not recur. An in-service will be held on or before 4/16/25 by DON/Designee on the following: Notifying the physician of unavailable medications and following physician orders. 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. DON/designee will monitor medication administration and medication availability 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any	

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	During an interview, on 3/25/25 at 9:20 a.m., the Regional Nurse Consultant indicated there were no medications pulled from the EDK (emergency drug kit) on 3/21/25 for administration. During an interview, on 3/25/25 at 1:28 p.m., RN 6 indicated she worked night shift on 3/21/25. She could not recall if she signed off medications as administered for Resident E. If a medication was not available for administration, the medication should not be signed out as given. The physician's order, dated 3/21/25, indicated the resident was to receive Oxycodone HCl (narcotic pain medication) 10 mg every four hours as needed for pain. The March 2025 controlled drug record indicated the resident received the medication on 3/23/25 at 4:00 a.m. and 3/24/25 at 4:00 a.m. The March 2025 MAR lacked documentation of the administration of the narcotic pain medication. During an interview, on 3/27/25 at 1:55 p.m., Licensed Practical Nurse (LPN) 5 indicated if an as needed narcotic pain was administered, it should be signed off on the controlled drug record and the medication administration record to show the medication was administered. 3. The clinical record for Resident G was reviewed on 3/26/25 at 8:55 a.m. The resident's diagnoses included, but were not limited to, hypothyroidism, chronic obstructive pulmonary disease, gastrostomy status, anxiety and atrial fibrillation. The physician's order, dated 3/12/25, indicated the resident was to receive Levothyroxine Sodium		Action Plan needed will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed. 4/22/25 ="" p ="" p="">	

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	tablet 125 mcg daily at 6:00 a.m. The March 2025 MAR lacked documentation of the administration of the medication on 3/15/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. The physician's order, dated 3/19/25, indicated the resident was to receive Insulin Lispro (fast acting insulin) per sliding scale every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The March 2025 MAR lacked documentation of a blood sugar check or insulin administration on 3/22/25 at 6:00 a.m. and 3/23/25 at 6:00 a.m. The physician's order, dated 3/12/25, indicated the resident was to receive guaifenesin liquid 10 ml (milliliters) every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. The March 2025 MAR lacked documentation of the administration of the medication 3/15/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. The physician's order, dated 3/13/25, indicated the resident was to receive Meropenem (antibiotic) intravenously every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. for 14 doses related to cellulitis. The March 2025 MAR lacked documentation of the administration of the medication on 3/15/25 at 6:00 a.m. 4. The clinical record for Resident H was reviewed on 3/27/25 at 9:59 a.m. The resident's diagnosis included, but was not limited to, hypothyroidism. The physician's order, dated 3/5/25, indicated the resident was to receive Levothyroxine Sodium 137			

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	mcg daily at 6:00 a.m. The March 2025 MAR lacked documentation of the administration of the medication on 3/12/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. 5. The clinical record for Resident L was reviewed on 3/27/25 10:54 a.m. The resident's diagnoses included, but were not limited to, diabetes and cutaneous abscess of the abdominal wall. The physician's order, dated 2/14/25, indicated the resident was to receive Hydrocodone/APAP 7.5/325 mg every six hours as needed. The March 2025 controlled drug record indicated the resident received the narcotic pain medication on the following dates and times: - 3/01/25 at 5:30 p.m. - 3/03/25 at 3:30 a.m. - 3/05/25 at 10:00 p.m. - 3/09/25 at 10:00 p.m. - 3/10/25 at 5:30 p.m. - 3/11/25 at 5:30 p.m. - 3/15/25 at 2:00 p.m. - 3/17/25 at 12:00 a.m. The resident's March 2025 MAR lacked documentation of the administration of the narcotic medication. 6. The clinical record for Resident M was reviewed on 3/27/25 at 11:17 a.m. The resident's diagnosis included, but was not limited to, hypothyroidism. The physician's order, dated 2/7/25, indicated the resident was to receive Levothyroxine Sodium 50 mcg daily at 6:00 a.m.			

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	The March 2025 MAR lacked documentation of the administration of the medication on 3/12/25 at 6:00 a.m. and 3/22/25 at 6:00 a.m. This Citation relates to Complaint IN00456149 3.1-50(a)(2)			