|           | T OF DEFICIENCIES                                                               | X1) PROVIDER/SUPPLIER/CLIA            |          |      | NSTRUCTION                                                             | (X3) DATE |            |
|-----------|---------------------------------------------------------------------------------|---------------------------------------|----------|------|------------------------------------------------------------------------|-----------|------------|
| AND PLAN  | OF CORRECTION                                                                   | IDENTIFICATION NUMBER                 | A. BUILD | ING  | 00                                                                     | COMPL     |            |
|           |                                                                                 | 155770                                | B. WING  |      |                                                                        | 03/27/    | 2025       |
| NAME OF P | ROVIDER OR SUPPLIEF                                                             | · · · · · · · · · · · · · · · · · · · |          |      | DDRESS, CITY, STATE, ZIP COD                                           |           |            |
|           |                                                                                 |                                       |          |      | STER BARBARA WAY                                                       |           |            |
| WATERS    | OF GEORGETOV                                                                    | VN, THE                               | G        | EURG | ETOWN, IN 47122                                                        |           |            |
| (X4) ID   | SUMMARY                                                                         | STATEMENT OF DEFICIENCIE              | II       | D    | PROVIDER'S PLAN OF CORRECTION                                          |           | (X5)       |
| PREFIX    | (EACH DEFICIEN                                                                  | ICY MUST BE PRECEDED BY FULL          | PRE      | EFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION |
| TAG       | REGULATORY OF                                                                   | R LSC IDENTIFYING INFORMATION         | Tz       | AG   | DEFICIENCY)                                                            |           | DATE       |
| F 0000    |                                                                                 |                                       |          |      |                                                                        |           |            |
| Dida 00   |                                                                                 |                                       |          |      |                                                                        |           |            |
| Bldg. 00  |                                                                                 |                                       | E 0000   |      | The following Dlan of Correction                                       |           |            |
|           | This visit was for the                                                          | ne Investigation of Complaints        | F 0000   |      | The following Plan of Correction constitutes the facility's written    |           |            |
|           | IN00455500 and IN                                                               |                                       |          |      | allegation of compliance for th                                        |           |            |
|           | 11 100 133300 and 11                                                            | 100 1301 13.                          |          |      | deficiency cited. However,                                             | C         |            |
|           | Complaint IN00455                                                               | 5500 - No deficiencies related to     |          |      | submission of this Plan of                                             |           |            |
|           | the allegations are o                                                           |                                       |          |      | Correction is not an admission                                         | ı to      |            |
|           | -                                                                               |                                       |          |      | and does not constitute an                                             |           |            |
|           | Complaint IN00456                                                               | 5149 - Federal/State deficiencies     |          |      | agreement with alleged                                                 |           |            |
|           | related to the allegations are cited at F609, F684, F690, F691, F759, and F842. |                                       |          |      | deficiencies herein. The Plan                                          | of        |            |
|           |                                                                                 |                                       |          |      | Correction is submitted to mee                                         | et        |            |
|           |                                                                                 |                                       |          |      | the requirements established                                           | ру        |            |
|           | An unrelated deficiency is cited                                                |                                       |          |      | the state and federal regulatio                                        | ns.       |            |
|           | Cumiori dotosi Mom                                                              | ah 24 25 26 and 27 2025               |          |      | Due to law seems and sevenity                                          |           |            |
|           | Survey dates: Marc                                                              | ch 24, 25, 26 and 27, 2025            |          |      | Due to low scope and severity the deficiencies cited, the facil        |           |            |
|           | Facility number: 01                                                             | 1509                                  |          |      | respectfully requests the grant                                        | -         |            |
|           | Provider number: 1                                                              |                                       |          |      | of a desk review and paper                                             | iiig      |            |
|           | AIM number: 2009                                                                |                                       |          |      | compliance. Should you require                                         | ·e        |            |
|           |                                                                                 |                                       |          |      | any further information or                                             |           |            |
|           | Census Bed Type:                                                                |                                       |          |      | documentation, please do not                                           |           |            |
|           | SNF/NF: 67                                                                      |                                       |          |      | hesitate to contact the facility.                                      |           |            |
|           | Residential: 7                                                                  |                                       |          |      |                                                                        |           |            |
|           | Total: 74                                                                       |                                       |          |      |                                                                        |           |            |
|           | С В Т                                                                           |                                       |          |      |                                                                        |           |            |
|           | Census Payor Type<br>Medicare: 11                                               |                                       |          |      |                                                                        |           |            |
|           | Medicaid: 51                                                                    |                                       |          |      |                                                                        |           |            |
|           | Other: 5                                                                        |                                       |          |      |                                                                        |           |            |
|           | Total: 67                                                                       |                                       |          |      |                                                                        |           |            |
|           | 10001007                                                                        |                                       |          |      |                                                                        |           |            |
|           | These deficiencies                                                              | reflect State Findings cited in       |          |      |                                                                        |           |            |
|           | accordance with 41                                                              |                                       |          |      |                                                                        |           |            |
|           |                                                                                 |                                       |          |      |                                                                        |           |            |
|           | Quality review com                                                              | npleted on April 1, 2025.             |          |      |                                                                        |           |            |
| E 0600    | 400 40/1 \/5\/?\/\$\                                                            | (D)(-)(4)(4)                          |          |      |                                                                        |           |            |
| F 0609    | 483.12(b)(5)(i)(A)                                                              |                                       |          |      |                                                                        |           |            |
| SS=D      | Reporting of Alleg                                                              | jeu violations                        |          |      |                                                                        |           |            |
| LABORATOR | Y DIRECTOR'S OR PRO                                                             | VIDER/SUPPLIER REPRESENTATIVE'S SI    | GNATURE  |      | TITLE                                                                  |           | (X6) DATE  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

andrew grubb

rdo

04/21/2025

Any defiency statement 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 disclodays 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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                    | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE |       |         | SURVEY                                                              |        |            |
|------------------------------------------------------|----------------------------------------------------|--------------------------------------------|-------|---------|---------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                      | IDENTIFICATION NUMBER                      | A. BU | JILDING | 00                                                                  | COMPL  | ETED       |
|                                                      |                                                    | 155770                                     | B. W  | ING     |                                                                     | 03/27/ | /2025      |
|                                                      |                                                    |                                            |       | CTREET  | A DDDEGG CITY CT A TE ZID COD                                       |        |            |
| NAME OF P                                            | ROVIDER OR SUPPLIER                                | 2                                          |       |         | ADDRESS, CITY, STATE, ZIP COD<br>ISTER BARBARA WAY                  |        |            |
| \\\\\\                                               |                                                    | /NI THE                                    |       |         |                                                                     |        |            |
| WATERS                                               | OF GEORGETOW                                       | VN, THE                                    |       | GEUR    | GETOWN, IN 47122                                                    |        |            |
| (X4) ID                                              | SUMMARY                                            | STATEMENT OF DEFICIENCIE                   |       | ID      | PROVIDER'S PLAN OF CORRECTION                                       |        | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                                     | CY MUST BE PRECEDED BY FULL                |       | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                  | REGULATORY OR                                      | R LSC IDENTIFYING INFORMATION              |       | TAG     | DEFICIENCY)                                                         |        | DATE       |
| Bldg. 00                                             |                                                    |                                            |       |         |                                                                     |        |            |
|                                                      | Based on interview                                 | and record review, the facility            | F 0   | 609     | It is the policy of this facility to                                |        | 04/22/2025 |
|                                                      |                                                    | allegation of abuse was                    |       |         | ensure an allegation of abuse                                       | is     |            |
|                                                      | thoroughly investig                                | ated for 1 of 3 residents                  |       |         | thoroughly investigated.                                            |        |            |
|                                                      | reviewed for abuse.                                | (Resident P)                               |       |         |                                                                     |        |            |
|                                                      |                                                    |                                            |       |         | What corrective action will be                                      |        |            |
|                                                      | Findings include:                                  |                                            |       |         | accomplished for those reside                                       | nts    |            |
|                                                      |                                                    |                                            |       |         | found to have been affected b                                       | y the  |            |
|                                                      | The incident report,                               | dated 3/24/25 at 10:30 a.m.,               |       |         | deficient practice.                                                 |        |            |
|                                                      | indicated Resident I                               | P reported that she felt RN                |       |         |                                                                     |        |            |
|                                                      | (Registered Nurse)                                 | 6 was sexually inappropriate               |       |         | The Adm/designee reported                                           |        |            |
|                                                      | during care.                                       |                                            |       |         | resident P's incident to the Inc                                    | liana  |            |
|                                                      |                                                    |                                            |       |         | Department of Health on 3/24                                        | /25.   |            |
|                                                      | The clinical record for Resident P was reviewed on |                                            |       |         | Investigation was completed of                                      | on     |            |
|                                                      | 3/26/25 at 2:57 p.m. The resident's diagnoses      |                                            |       |         | 3/24/25 by SSD, RNC and DC                                          | N.     |            |
|                                                      | included, but were r                               | not limited to, diabetes,                  |       |         | The SSD/Designee assessed                                           |        |            |
|                                                      | anxiety, insomnia a                                | nd GERD (gastroesophageal                  |       |         | resident P on 3/24/25, 3/25/25                                      | 5,     |            |
|                                                      | reflux disease).                                   |                                            |       |         | and 3/26/25 with no negative                                        |        |            |
|                                                      |                                                    |                                            |       |         | outcome. Resident discharged                                        | d on   |            |
|                                                      | The quarterly Minir                                | num Data Set (MDS)                         |       |         | 4/1/25 and no longer resides i                                      | n the  |            |
|                                                      | assessment, dated 1                                | /31/25, indicated the resident's           |       |         | facility.                                                           |        |            |
|                                                      | cognition was intact                               | t.                                         |       |         |                                                                     |        |            |
|                                                      |                                                    |                                            |       |         | How other residents having th                                       | е      |            |
|                                                      | _                                                  | y, on 3/24/25 at 3:11 p.m.,                |       |         | potential to be affected by the                                     |        |            |
|                                                      | Resident P indicated                               | d RN 6 had come to her room                |       |         | same deficient practice will be                                     | ;      |            |
|                                                      | to give her evening                                | medications. RN 6 asked                    |       |         | identified, and what corrective                                     | . !    |            |
|                                                      |                                                    | eeded something to help her                |       |         | action will be taken.                                               |        |            |
|                                                      | sleep and Resident                                 | P told her if she had one                  |       |         |                                                                     |        |            |
|                                                      | prescribed. RN 6 re                                | sponded "I did not ask you                 |       |         | All residents that resided in the                                   | е      |            |
|                                                      | that". RN 6 told Res                               | sident P that she loved her, she           |       |         | facility have the potential to be                                   | ÷      |            |
|                                                      |                                                    | nat she did not think Resident             |       |         | affected by the alleged deficie                                     | nt     |            |
|                                                      | P was crazy. RN 6 i                                | rubbed Resident P's left arm and           |       |         | practice, therefore this plan of                                    |        |            |
|                                                      | -                                                  | d (rub or push against gently              |       |         | correction applied to all                                           | ļ      |            |
|                                                      |                                                    | nouth) her neck. She told RN 6             |       |         | residents.                                                          | ļ      |            |
|                                                      |                                                    | ade her uncomfortable and                  |       |         |                                                                     | ļ      |            |
|                                                      |                                                    | reported what had happened                 |       |         | What measures will be put into                                      | ၁      |            |
|                                                      |                                                    | Aide (CNA) 7, who then                     |       |         | place and what system chang                                         | es     |            |
|                                                      | reported the inciden                               | nt to Licensed Practical Nurse             |       |         | will be made to ensure that the                                     | e      |            |
|                                                      | (LPN) 8. LPN 8 car                                 | ne over and she told her what              |       |         | deficient practice does not rec                                     | ur.    |            |
|                                                      | had happened.                                      |                                            |       |         |                                                                     |        |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETED  B. WING 03/27/2025                                                                                                             |  |              | ETED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                       |                    |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------|
|                                                                                                          | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                     |  | 1002 SI      | ADDRESS, CITY, STATE, ZIP COD<br>ISTER BARBARA WAY<br>GETOWN, IN 47122                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                       |                    |
| (X4) ID<br>PREFIX                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL                                                                                                                                             |  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ATE                                                                                                   | (X5)<br>COMPLETION |
| TAG                                                                                                      | During an interview 7 indicated RN 6 sewhen she worked wher that RN 6 rubbe the neck. RN 6 asked sleeping pill and Redone prescribed". RN that". CNA 7 reported Touring an interview 8 indicated CNA 7 Resident P feel unchand and telling the tried to get more into confused. Resident nurse. RN 6 denied suspended per the I Normally, the facility member during an incouple of times staff odor of alcohol on the RN and RN 6 himoved LPN 9 to Vi LPN 8 did not intervised the residents in Villa 6.  On 3/27/25 at 9:18 Consultant provided document titled "Ald dated 10/22/22. It is "It is the policy of the neglectEach residing a person-centered individuals are treat beingsEmployees incident, allegation abuseto the Admis supervisor who will standard to the supervisor who will supervi | a.m., the Regional Nurse d a current copy of the buse Prevention Program" neluded, but was not limited to, his facility to prevent abuse, ent receives care and services d environment in which all |  | TAG          | The RDO/Designee in-service DON/Adm on the Indiana Department of Health reporting guidelines on 4/1/25. Addition any staff that fails to comply with the point of this in-service will further educated and/or discipas indicated.  How the corrective action will monitored to ensure the deficipractice will not recur, i.e what quality assurance program with put into place.  The Adm/DON/Designee will review progress notes 5 days weekly for any incident that must the requirements of reportable criteria was initially reported to appropriate state agency x 6 months. If the facility is within 95% compliance at the end of 6 months, then monitoring car stopped. Results of the monitor will be reviewed at the month QAPI meeting. Any concerns have been addressed. However any patterns will be identified. Action Plan needed will be wroby the QAPI committee. Any written Action Plan will be monitored by the Administration weekly until resolved.  By what date the systemic changes for each deficiency were completed. | ed the  g ally, vith be blined  be ient it ll be  leets be the n f the be oring y will ver, Any itten | DATE               |

|                            | T OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                                                                                                      | ľ í           |         | ONSTRUCTION                                                                                                                                                                                                                                                                                                                                 | (X3) DATE       |            |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|------------|
| AND PLAN (                 | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | IDENTIFICATION NUMBER 155770                                                                                                                                                                                                                                                                                                                                    | A. BU<br>B. W | JILDING | 00                                                                                                                                                                                                                                                                                                                                          | COMPL<br>03/27/ |            |
|                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 133770                                                                                                                                                                                                                                                                                                                                                          | B. W          | _       |                                                                                                                                                                                                                                                                                                                                             | 03/21/          | 2023       |
|                            | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                 |               | 1002 SI | ADDRESS, CITY, STATE, ZIP COD<br>ISTER BARBARA WAY<br>GETOWN, IN 47122                                                                                                                                                                                                                                                                      |                 |            |
| (X4) ID                    | SUMMARY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STATEMENT OF DEFICIENCIE                                                                                                                                                                                                                                                                                                                                        | 1             | ID      |                                                                                                                                                                                                                                                                                                                                             |                 | (X5)       |
| PREFIX                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                     |               | PREFIX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                     |                 | COMPLETION |
| TAG                        | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                     |               | TAG     | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                                                                                                                                                                                                                                                                                            | IIE.            | DATE       |
|                            | the report, the Admithe Administrator, to facility shall initiate incidents will be do abuse occurred, was suspectedAnyal result in an abuse in Nurse must complet obtain a written, sig the person reporting who are suspected of immediately be based with residents of the from duty, pending investigation"  This Citation relates 3.1-28(c) 3.1-28(d)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | inistrator or in the absence of the person in charge of the e an incident investigationAll cumented, whether of not s alleged or legation involving abusewill evestigationThe Charge te an incident report and med and dated statement from the incidentStaff members of abuse or misconduct shall arred from any further contact the facility and be suspended |               |         | ="" p="">                                                                                                                                                                                                                                                                                                                                   |                 |            |
| F 0684<br>SS=E<br>Bldg. 00 | 483.25<br>Quality of Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                 |               |         |                                                                                                                                                                                                                                                                                                                                             |                 |            |
|                            | failed to ensure resident G) we side effects and faile completed for a resiresidents reviewed for a residents reviewed for a resident for a r | rd for Resident D was reviewed<br>o.m. The diagnoses included,<br>I to, diabetes, peripheral                                                                                                                                                                                                                                                                    | F 00          | 584     | F 684  It is the intent of this facility to ensure medications that requiside effect monitoring are monitored for side effects to ensure treatments were completed.  What corrective action will be accomplished for those reside found to have been affected by deficient practice.  The DON/Designee assessed Resident's D, F, L and G on | ents<br>y the   | 04/22/2025 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Z6N611

Facility ID: 011509

If continuation sheet Page 4 of 22

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                   | (X2) MULTIPLE CONSTRUCTION       |                                  |                                    | (X3) DATE SURVEY                                                       |        |            |
|------------------------------------------------------|---------------------------------------------------|----------------------------------|----------------------------------|------------------------------------|------------------------------------------------------------------------|--------|------------|
| AND PLAN                                             | OF CORRECTION                                     | IDENTIFICATION NUMBER            | A. BU                            | JILDING                            | 00                                                                     | COMPL  | ETED       |
|                                                      |                                                   | 155770                           | B. W                             | NG                                 |                                                                        | 03/27/ | /2025      |
|                                                      |                                                   |                                  |                                  | ·                                  |                                                                        |        |            |
| NAME OF I                                            | PROVIDER OR SUPPLIEF                              | ₹                                |                                  |                                    | ADDRESS, CITY, STATE, ZIP COD                                          |        |            |
|                                                      |                                                   |                                  |                                  |                                    | ISTER BARBARA WAY                                                      |        |            |
| WATERS                                               | S OF GEORGETOV                                    | VN, THE                          |                                  | GEORG                              | GETOWN, IN 47122                                                       |        |            |
| (X4) ID                                              | SUMMARY                                           | STATEMENT OF DEFICIENCIE         |                                  | ID                                 | PROVIDER'S PLAN OF CORRECTION                                          |        | (X5)       |
| PREFIX                                               | (EACH DEFICIEN                                    | ICY MUST BE PRECEDED BY FULL     |                                  | PREFIX                             | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE     | COMPLETION |
| TAG                                                  | REGULATORY OF                                     | R LSC IDENTIFYING INFORMATION    |                                  | TAG                                | DEFICIENCY)                                                            | 1.5    | DATE       |
|                                                      | mg (milligrams) tw                                | ice a day for DVT (deep vein     |                                  |                                    | 4/11/25, no negative outcome                                           |        |            |
|                                                      | thrombosis) preven                                | tion.                            |                                  |                                    | related to the cited practice. T                                       | he     |            |
|                                                      |                                                   |                                  |                                  |                                    | DON/Designee notified reside                                           | nts    |            |
|                                                      | The care plan, dated                              | d 1/11/24, indicated the         |                                  |                                    | D, F, and G and added monito                                           | ring   |            |
|                                                      | resident was at risk for bleeding due to          |                                  |                                  |                                    | orders for diuretics, blood thin                                       | ners   |            |
|                                                      | anticoagulant medication use and to observe for   |                                  |                                  |                                    | and insulin on 4/11/25.                                                |        |            |
|                                                      | signs and symptoms of complications which         |                                  |                                  |                                    |                                                                        |        |            |
|                                                      | included blood ting                               | ed or frank blood in urine,      |                                  |                                    | How other residents having th                                          | е      |            |
|                                                      | black tarry stool, dark or bright red blood in    |                                  |                                  |                                    | potential to be affected by the                                        |        |            |
|                                                      | stools, sudden severe headaches, nausea,          |                                  |                                  |                                    | same deficient practice will be                                        |        |            |
|                                                      | vomiting, petechiae, diarrhea, muscle/joint pain, |                                  |                                  |                                    | identified, and what corrective                                        |        |            |
|                                                      | lethargy, bruising, blurred vision, shortness of  |                                  |                                  |                                    | action will be taken.                                                  |        |            |
|                                                      | breath, loss of appetite, sudden change in        |                                  |                                  |                                    |                                                                        |        |            |
|                                                      | memory, changes in mental status, and significant |                                  |                                  |                                    | The DON/Designee completed                                             | d an   |            |
|                                                      | sudden changes in vision.                         |                                  |                                  |                                    | audit of residents receiving blo                                       | ood    |            |
|                                                      |                                                   |                                  |                                  |                                    | thinners, insulin and diuretices                                       |        |            |
|                                                      | The physician's ord                               | er, dated 3/21/25, indicated the |                                  |                                    | and entered monitoring orders                                          |        |            |
|                                                      | resident was to rece                              | eive Insulin Lispro (short       | the EHR as indicated on 4/14/25. |                                    |                                                                        |        |            |
|                                                      | acting insulin) per s                             | sliding scale before meals and   | The DON/Designee completed an    |                                    |                                                                        |        |            |
|                                                      | at bedtime.                                       |                                  |                                  | audit of residents with wound care |                                                                        |        |            |
|                                                      |                                                   |                                  |                                  |                                    | treatments and wounds were                                             |        |            |
|                                                      | _                                                 | d 2/10/22, indicated the         |                                  |                                    | assessed as indicated.                                                 |        |            |
|                                                      |                                                   | es and to monitor for signs and  |                                  |                                    |                                                                        |        |            |
|                                                      | symptoms of hypog                                 | glycemia and hyperglycemia.      |                                  |                                    | What measures will be put into                                         | )      |            |
|                                                      |                                                   |                                  |                                  |                                    | place and what system chang                                            |        |            |
|                                                      |                                                   | lacked documentation of          |                                  |                                    | will be made to ensure that the                                        |        |            |
|                                                      | _                                                 | effects related to diabetes and  |                                  |                                    | deficient practice does not rec                                        | ur.    |            |
|                                                      | anticoagulant use u                               | pon readmission on 3/21/25.      |                                  |                                    |                                                                        |        |            |
|                                                      |                                                   |                                  |                                  |                                    | The DON/Designee will in-ser                                           | vice   |            |
|                                                      |                                                   | period, between 3/24/25 and      |                                  |                                    | the nursing staff on medication                                        |        |            |
|                                                      | · ·                                               | ber 10 indicated if a resident   |                                  |                                    | requiring side effect monitoring                                       | -      |            |
|                                                      |                                                   | ner, nursing staff should        |                                  |                                    | inputting orders for side effect                                       |        |            |
|                                                      |                                                   | for signs and symptoms of        |                                  |                                    | monitoring and                                                         |        |            |
|                                                      |                                                   | , bruising, blood clots and      |                                  |                                    | completion/documentation of                                            |        |            |
|                                                      | black tarry stools as                             |                                  |                                  |                                    | treatments on or before 4/16/2                                         | _      |            |
|                                                      | assessment on the medication administration       |                                  |                                  |                                    | Additionally, any staff member                                         |        |            |
|                                                      | `                                                 | atment administration record     |                                  |                                    | that fails to comply with the po                                       |        |            |
|                                                      |                                                   | hould be monitored ever shift    |                                  |                                    | of this in-service will be further                                     |        |            |
|                                                      |                                                   | toms of hypoglycemia and         |                                  |                                    | educated and/or disciplined as                                         | 3      |            |
|                                                      | hyperglycemia and                                 | documented on the                |                                  |                                    | indicated.                                                             |        |            |

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Event ID:

Z6N611

Facility ID: 011509

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| STATEMEN  | T OF DEFICIENCIES                                                                                     | X1) PROVIDER/SUPPLIER/CLIA                               | (X2) MU | JLTIPLE CO | ONSTRUCTION                                                                           | (X3) DATE S | SURVEY     |
|-----------|-------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------|------------|---------------------------------------------------------------------------------------|-------------|------------|
| AND PLAN  | OF CORRECTION                                                                                         | IDENTIFICATION NUMBER                                    | A. BU   | JILDING    | 00                                                                                    | COMPL       | ETED       |
|           |                                                                                                       | 155770                                                   | B. WI   | NG         |                                                                                       | 03/27/      | 2025       |
| NAME OF B | AD CLUBED OD CLUBELIED                                                                                |                                                          |         | STREET A   | ADDRESS, CITY, STATE, ZIP COD                                                         | <u> </u>    |            |
| NAME OF P | PROVIDER OR SUPPLIER                                                                                  | 3                                                        |         |            | ISTER BARBARA WAY                                                                     |             |            |
|           | OF GEORGETOW                                                                                          |                                                          |         | GEORG      | GETOWN, IN 47122                                                                      |             |            |
| (X4) ID   |                                                                                                       | STATEMENT OF DEFICIENCIE                                 |         | ID         | PROVIDER'S PLAN OF CORRECTION                                                         |             | (X5)       |
| PREFIX    | `                                                                                                     | CY MUST BE PRECEDED BY FULL                              |         | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE          | COMPLETION |
| TAG       |                                                                                                       | a LSC IDENTIFYING INFORMATION  nts who receive diuretics |         | TAG        | Daniela.ve.i                                                                          |             | DATE       |
|           |                                                                                                       | d for signs of dehydration and                           |         |            | How the corrective action will                                                        | he          |            |
|           | the assessment should be documented on the                                                            |                                                          |         |            | monitored to ensure the defici                                                        |             |            |
|           | MAR/TAR.                                                                                              |                                                          |         |            | practice will not recur, i.e wha                                                      |             |            |
|           |                                                                                                       |                                                          |         |            | quality assurance program wil                                                         |             |            |
|           | 2. The clinical recor                                                                                 | rd for Resident F was reviewed                           |         |            | put into place.                                                                       |             |            |
|           | •                                                                                                     | o.m. The resident's diagnoses                            |         |            |                                                                                       |             |            |
|           |                                                                                                       | not limited to, right sided                              |         |            | The DON/Designee will monite                                                          |             |            |
|           |                                                                                                       | niparesis secondary to cerebral                          |         |            | orders for appropriate side eff                                                       | ect         |            |
|           |                                                                                                       | liabetes, hyperlipidemia and                             |         |            | monitoring and completion of                                                          | .           |            |
|           | hypertensive heart of                                                                                 | lisease.                                                 |         |            | treatments. This will be monit                                                        |             |            |
|           | The physician's order, dated 3/7/25, indicated the resident was to receive Warfarin (blood thinner) 5 |                                                          |         |            | 5 days weekly x 4 weeks, ther days weekly x 4 weeks then 1                            |             |            |
|           |                                                                                                       |                                                          |         |            | weekly for 4 months If the faci                                                       | •           |            |
|           |                                                                                                       | for cerebral vascular accident.                          |         |            | is within 95% compliance at the                                                       | -           |            |
|           | ing every evening is                                                                                  | or coreorar vascular accident.                           |         |            | end of 3 months, the monitoring                                                       |             |            |
|           | The care plan, dated                                                                                  | d 3/7/25, indicated the resident                         |         |            | will be stopped.                                                                      | .9          |            |
|           | -                                                                                                     | r complications related to                               |         |            |                                                                                       |             |            |
|           | -                                                                                                     | nd to observe for reactions                              |         |            | At the monthly QAPI meeting                                                           | , the       |            |
|           | such as nausea, hen                                                                                   | norrhage, fever, rash, bruise                            |         |            | monitoring will be reviewed.                                                          | Any         |            |
|           | easily, angioedema,                                                                                   | anaphylaxis and                                          |         |            | concerns will have been corre                                                         | cted        |            |
|           | thrombocytopenia.                                                                                     |                                                          |         |            | as found.¿ Any patterns will b                                                        |             |            |
|           |                                                                                                       |                                                          |         |            | identified.¿ If necessary, an A                                                       | ction       |            |
|           |                                                                                                       | lacked documentation for the                             |         |            | Plan will be written by the                                                           |             |            |
|           |                                                                                                       | ossible reactions and/or                                 |         |            | committee.¿ Any written Actio                                                         | n           |            |
|           | complications.                                                                                        |                                                          |         |            | Plan will be monitored by the                                                         |             |            |
|           | 3 The clinical room                                                                                   | rd for Resident G was reviewed                           |         |            | Administrator weekly until                                                            |             |            |
|           |                                                                                                       | a.m. The resident's diagnoses                            |         |            | resolution.¿                                                                          |             |            |
|           |                                                                                                       | not limited to hypertension and                          |         |            | By what date the systemic                                                             |             |            |
|           | congestive heart fai                                                                                  |                                                          |         |            | changes for each deficiency w                                                         | /ill        |            |
|           | <i>6</i> <b>1</b>                                                                                     |                                                          |         |            | be completed.                                                                         |             |            |
|           | The physician's ord                                                                                   | er, dated 3/12/25, indicated the                         |         |            | '                                                                                     |             |            |
|           |                                                                                                       | ive Lasix (diuretic) 80 mg daily                         |         |            | 4/22/25                                                                               |             |            |
|           | for congestive heart                                                                                  | failure.                                                 |         |            | ="" p="">                                                                             |             |            |
|           |                                                                                                       | 1 . 10/04/07 1                                           |         |            |                                                                                       |             |            |
|           |                                                                                                       | er, dated 3/21/25, indicated the                         |         |            |                                                                                       |             |            |
|           |                                                                                                       | eive Lasix 20 mg in the                                  |         |            |                                                                                       |             |            |
|           | afternoon for edema                                                                                   | 4.                                                       |         |            |                                                                                       |             |            |
|           |                                                                                                       |                                                          |         |            | I                                                                                     |             |            |

|                            | of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (155770)                                                                                                                                                 | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                                              | ONSTRUCTION  00                                                                                                | (X3) DATE SURVEY COMPLETED 03/27/2025 |  |  |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------|--|--|
|                            | PROVIDER OR SUPPLIER S OF GEORGETOWN, THE                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP COD<br>1002 SISTER BARBARA WAY<br>GEORGETOWN, IN 47122 |                                                                                                                |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION                                                                                                      | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE                  |  |  |
|                            | 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.<br>- On 3/03/25 at 6:00 p.m.<br>- On 3/04/25 at 6:00 p.m.<br>- On 3/08/25 through 3/12/25 at 6:00 a.m.<br>- On 3/15/25 through 3/16/25 at 6:00 a.m.<br>- On 3/22/25 at 6:00 a.m. |                                                                                         |                                                                                                                |                                       |  |  |
|                            | This Citation relates to Complaint IN00456149                                                                                                                                                                             |                                                                                         |                                                                                                                |                                       |  |  |
|                            | 3.1-37                                                                                                                                                                                                                    |                                                                                         |                                                                                                                |                                       |  |  |
| F 0690<br>SS=D<br>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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| A BILIDING   QQ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                      |          |                                                                        |       |            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------|---------------------------------------------|----------------------|----------|------------------------------------------------------------------------|-------|------------|
| NAME OF PROVIDER OR SUPPLIER  WATERS OF GEORGETOWN, THE  ONLY ID SUMMARY STATEMENT OF DEFICIENCIE (IACH IDERCITYCE MICE IN EPRICIDED BY PELL)  PREFIX (HACH IDERCITYCH MICE IN EPRICIDED BY PELL)  REGULATORY OR SEE IDENTIFYING NEORMATION TAO REGULATORY OR SEE IDENTIFYING NEORMATION TO BE A COMPLETION DATE  OUtput was documented as ordered for 2 of 2 residents reviewed for Indivedling catheters. (Resident K and Resident L)  I. The clinical record for Resident K was reviewed on 3/27/25 at 10:20 a.m. The residents' diagnosis included, but was not limited to, urinary retention. deficient practice.  The care plan, dated 1/3/25, indicated the resident had an Indivelling catheter and staff were to provide catheter care every shift and document the resident's mino output every shift.  The physician's order, dated 2/3/25, indicated to provided catheter care every shift.  The physician's order, dated 2/26/25, indicated to provided catheter care every shift.  The physician's order, dated 2/26/25, indicated to provided catheter care every shift.  The physician's order, dated 2/26/25, indicated to provided catheter care every shift.  The physician's order, dated 2/26/25, indicated to provided catheter care every shift.  The physician's order, dated 2/26/25, indicated to record catheter output every shift for monitoring, dates and shifts:  - On 3/725 and 3/4/25, there were no documented urine output on night shift.  - On 3/10/25, there was no documented urine output on day shift.  - On 3/10/25, there was no documented urine output on day shift.  - On 3/18/25, there was no documented urine output on day shift.  - On 3/18/25, there was no documented urine output on day shift.  - On 3/18/25, there was no documented urine output on day shift.  - On 3/18/25, there was no documented urine output on adjets this.  - On 3/18/25, there was no documented urine output or catheter care on night shift.                                                                                                                                             | AND PLAN                                             | OF CORRECTION                                       | IDENTIFICATION NUMBER                       | A. B                 | UILDING  | 00                                                                     | COMPL | ETED       |
| NAME OF PROVIDER OR SCIPPLER  WATERS OF GEORGETOWN, THE  SIMMARY STATIMENT OF DEPICIENCE:  (PACID DEPICENCY MLST BE PRECEDED BY RELL TAG  Output was documented as ordered for 2 of 2 residents reviewed for Indivelling catheters.  (Resident K and Resident I.)  Findings include.  I. The clinical record for Resident K was reviewed on 3/27/25 at 10/20 a.m. The residents faignosis included, but was not limited to, urinary retention.  The care plan, dated 1/3/25, indicated the resident had an Indiwelling catheter and staff were to provide catheter care every shift.  The physician's order, dated 1/3/25, indicated to provided eatheter care every shift.  The physician's order, dated 2/26/25, indicated to record eatheter output every shift.  The physician's order, dated 2/26/25, indicated to record eatheter output every shift for monitoring.  The March 2025 medication administration (MAR) lacked documented urine output on hight shifts.  - On 3/3/25 and 3/4/25, there were no documented urine output on hight shift.  - On 3/1/3/25, there was no documented urine output on hight shift.  - On 3/1/3/25, there was no documented urine output on night shift.  - On 3/1/25, there was no documented urine output or anight shift.  - On 3/1/25, there was no documented urine output or output on hight shift.  - On 3/1/25, there was no documented urine output or anight shift.  - On 3/1/25, there was no documented urine output or onight shift.  - On 3/1/25, there was no documented urine output or night shift.  - On 3/1/25, there was no documented urine output or night shift.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                      |                                                     | 155770                                      | B. W                 | ING      | 03/27/2025                                                             |       |            |
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| WATERS OF GEORGETOWN, THE   GEORGETOWN, IN 47122                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NAME OF P                                            | PROVIDER OR SUPPLIER                                | 8                                           |                      |          |                                                                        |       |            |
| REGIL ATORY OR LSc IDENTIFYING INFORMATION TAG  THE REGILATORY OR LSc IDENTIFYING INFORMATION REGILATORY OR LSc IDENTIFYING INFORMATION TAG  THE REGILATORY OR LSc IDENTIFYING INFORMATION REGILATORY OR LSC IDENTIFY OR STATEMATION REGILATORY OR LSC IDENTIFY OR STATEMATION REGILATORY OR LSC IDENTIFY OR STATEMATION REGILATORY | WATERS                                               | OF GEORGETOW                                        | VN, THE                                     | GEORGETOWN, IN 47122 |          |                                                                        |       |            |
| TAG  RECULATORY OR ISC IDENTIFYING INFORMATION  RECULATORY OR ISC IDENTIFYING INFORMATION  (Resident K and Resident L)  Findings include:  I. The clinical record for Resident K was reviewed on 3/27/25 at 10:20 a.m. The residents finded 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.  The physician's order, dated 2/26/25, indicated to record catheter output every shift.  The March 2025 medication administration (MAR) lacked documented urine output on high shift.  - On 3/13/25 and 3/4/25, there were no documented urine output on night shift.  - On 3/10/25, there was no documented urine output on day shifts.  - On 3/17/25 and 3/19/25, there were no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on day shifts.  - On 3/17/25, there was no documented urine output on day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.                                                                        | (X4) ID                                              | SUMMARY                                             | STATEMENT OF DEFICIENCIE                    |                      | ID       | PROVIDER'S PLAN OF CORRECTION                                          |       | (X5)       |
| TAG  RECULATORY OR ISC IDENTIFYING INFORMATION  RECULATORY OR ISC IDENTIFYING INFORMATION  (Resident K and Resident L)  Findings include:  I. The clinical record for Resident K was reviewed on 3/27/25 at 10:20 a.m. The residents finded 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.  The physician's order, dated 2/26/25, indicated to record catheter output every shift.  The March 2025 medication administration (MAR) lacked documented urine output on high shift.  - On 3/13/25 and 3/4/25, there were no documented urine output on night shift.  - On 3/10/25, there was no documented urine output on day shifts.  - On 3/17/25 and 3/19/25, there were no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on might shift.  - On 3/17/25, there was no documented urine output on day shifts.  - On 3/17/25, there was no documented urine output on day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.  - On 3/17/25, there was no documented urine output or day shifts.                                                                        | PREFIX                                               | (EACH DEFICIEN                                      | CY MUST BE PRECEDED BY FULL                 |                      | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE    | COMPLETION |
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| 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 might shift.  On 3/10/25, there was no documented urine output on day shift.  On 3/17/25, there was no documented urine output on alght shift.  On 3/17/25, there was no documented urine output on might shift.  On 3/18/25 and 3/19/25, there were no documented urine output on day shift.  On 3/18/25, there was no documented urine output on day shift.  On 3/18/25, there was no documented urine output on day shift.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.  On 3/18/25, there was no documented urine output on day shifts.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      | provided catheter ca                                | are every shift.                            |                      |          | potential to be affected by the                                        |       |            |
| 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 night shift On 3/17/25, there was no documented urine output on night shift On 3/17/25, there was no documented urine output on night 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 on day shifts On 3/21/25, there was no documented urine output or catheter care on night shift.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                     |                                             |                      |          | same deficient practice will be                                        |       |            |
| 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 3/10/25, there was no documented urine output on night shift. On 3/13/25, there was no documented urine output on night shift. On 3/13/25, there was no documented urine output on night shift. On 3/13/25, there was no documented urine output on night shift. On 3/13/25, there was no documented urine output on night shift. On 3/18/25 and 3/19/25, there were no documented urine output on night shift. On 3/18/25 and 3/19/25, there were 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 3/18/25 and 3/19/25, there were no documented urine output on day shifts. On 3/12/25, there was no documented urine output or catheter care on night shift.  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 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                      | The physician's ord                                 | er, dated 2/26/25, indicated to             |                      |          | identified, and what corrective                                        |       |            |
| 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 3/10/25, there was no documented urine output on night shift.  On 3/13/25, there was no documented urine output on night shift.  On 3/17/25, there was no documented urine output on night shift.  On 3/17/25, there was no documented urine output on night shift.  On 3/17/25, there was no documented urine output on night 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 3/12/25, there was no documented urine output on night shift.  Con 3/12/25, there was no documented urine output or catheter care on night shift.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                      | record catheter outp                                | out every shift for monitoring.             |                      |          | action will be taken.                                                  |       |            |
| 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 3/10/25, there was no documented urine output on night shift.  On 3/13/25, there was no documented urine output on night shift.  On 3/17/25, there was no documented urine output on night shift.  On 3/17/25, there was no documented urine output on night shift.  On 3/17/25, there was no documented urine output on night 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 3/12/25, there was no documented urine output on night shift.  Con 3/12/25, there was no documented urine output or catheter care on night shift.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                      | Th - M1- 2025                                       | - didi                                      |                      |          | Desidents with an instruction                                          |       |            |
| 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 3/17/25, 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 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.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                      |                                                     | · · · · · · · · · · · · · · · · · · ·       |                      |          | _                                                                      |       |            |
| practice, therefore, this plan of correction applies to all residents with an indwelling catheter.  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 3/17/25, 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 day shifts.  On 3/21/25, there was no documented urine output or catheter care on night shift.  1. Catheter Care output or Physician Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                     | urme output on the following                |                      |          | T =                                                                    |       |            |
| - 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 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.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                      | uates and shifts:                                   |                                             |                      |          |                                                                        |       |            |
| 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 3/17/25, 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 on day shifts.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                      | On 3/3/25 and 2/4                                   | /25 there were no documented                |                      |          | · ·                                                                    |       |            |
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| 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.  Uhat 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 on hight shift.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                      |                                                     |                                             |                      |          | with an indweiling catheter.                                           |       |            |
| - 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.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  - On 3/21/25, there was no documented urine output or catheter care on night shift.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                     |                                             |                      |          | What measures will be nut into                                         | , l   |            |
| 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.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      |                                                     |                                             |                      |          | •                                                                      |       |            |
| - 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.  1. Catheter Care on 1. Following Physician Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                      |                                                     |                                             |                      |          | 1 .                                                                    |       |            |
| 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.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                      |                                                     |                                             |                      |          |                                                                        | _     |            |
| - 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.  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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                      |                                                     |                                             |                      |          | denoient practice does not led                                         | ui.   |            |
| 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.  the nursing staff on or before 4/16/25 on the following.  1.Catheter Care 1.Following Physician Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      |                                                     |                                             |                      |          | The DON/Designed will in ser                                           | vice  |            |
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| documented urine output on day shifts.  - On 3/21/25, there was no documented urine output or catheter care on night shift.  1. Catheter Care 1. Following Physician Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                      |                                                     |                                             |                      |          | _                                                                      |       |            |
| - On 3/21/25, there was no documented urine output or catheter care on night shift.  1.Catheter Care 1.Following Physician Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                      |                                                     |                                             |                      |          | 7, 10,20 on the following.                                             |       |            |
| output or catheter care on night shift.  1.Following Physician Orders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                      |                                                     | -                                           |                      |          | 1 Catheter Care                                                        |       |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                      |                                                     |                                             |                      |          |                                                                        | .     |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                      | carpar of oumore of                                 | are on inghe onite.                         |                      |          | 1.Completion of signing the                                            | ~     |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                    |                                                                      |                      | (X3) DATE SURVEY                                                                                        |              |
|------------------------------------------------------|-----------------------|----------------------------------------------------------------|----------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------------|--------------|
| AND PLAN                                             | OF CORRECTION         | IDENTIFICATION NUMBER                                          | A. B                                                                 | UILDING              | 00                                                                                                      | COMPLETED    |
|                                                      |                       | 155770                                                         | B. W                                                                 | ING                  |                                                                                                         | 03/27/2025   |
|                                                      |                       |                                                                |                                                                      | STREET A             | ADDRESS, CITY, STATE, ZIP COD                                                                           |              |
| NAME OF P                                            | PROVIDER OR SUPPLIER  | 8                                                              |                                                                      |                      | ISTER BARBARA WAY                                                                                       |              |
| WATERS                                               | OF GEORGETOW          | VN, THE                                                        |                                                                      | GEORGETOWN, IN 47122 |                                                                                                         |              |
| (X4) ID                                              | SUMMARY               | STATEMENT OF DEFICIENCIE                                       |                                                                      | ID                   | PROVIDER'S PLAN OF CORRECTION                                                                           | (X5)         |
| PREFIX                                               | `                     | CY MUST BE PRECEDED BY FULL                                    |                                                                      | PREFIX               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE           |
| TAG                                                  |                       | LSC IDENTIFYING INFORMATION                                    |                                                                      | TAG                  | DEFICIENCY)                                                                                             | DATE         |
|                                                      |                       | y, from 3/24/25 through 3/27/25,                               |                                                                      |                      | ETAR/EMAR for urinary outpu                                                                             | ıt           |
|                                                      |                       | dicated all physicians' orders as well as a resident's plan of |                                                                      |                      | and catheter care as ordered                                                                            |              |
|                                                      | care.                 | as well as a resident's plan of                                |                                                                      |                      | Additionally, any staff that fails                                                                      | s to         |
|                                                      | care.                 |                                                                | Additionally, any staff that fails to comply with the points of this |                      |                                                                                                         |              |
|                                                      | On 3/27/25 at 9:18 :  | a.m., the Regional Nurse                                       |                                                                      |                      | in-service will be further                                                                              |              |
|                                                      |                       | d a current copy of the                                        |                                                                      |                      | educated/disciplined as indica                                                                          | ted          |
|                                                      | -                     | sysician Orders/Following                                      |                                                                      |                      | addition, also plinted as males                                                                         |              |
|                                                      |                       | uideline" dated 2/15/19. It                                    |                                                                      |                      | How the corrective action will                                                                          | be           |
|                                                      | -                     | ot limited to, "It is the policy                               |                                                                      |                      | monitored to ensure the defici                                                                          |              |
|                                                      |                       | llow the orders of the                                         |                                                                      |                      | practice will not recur, i.e wha                                                                        |              |
| physicianThe facility will follow physician          |                       |                                                                |                                                                      |                      | quality assurance program wil                                                                           |              |
| orders to provide essential care to the resident"    |                       |                                                                |                                                                      | put into place.      |                                                                                                         |              |
|                                                      |                       |                                                                |                                                                      |                      |                                                                                                         |              |
|                                                      | 2. The clinical recor | rd for Resident L was reviewed                                 |                                                                      |                      | DON/designee will monitor the                                                                           | e            |
|                                                      | on 3/27/25 at 10:54   | a.m. The resident's diagnosis                                  | ETAR/EMAR for catheter care and                                      |                      |                                                                                                         | e and        |
|                                                      |                       | ot limited to, neuromuscular                                   | recording of outputs 5 times a                                       |                      |                                                                                                         |              |
|                                                      | dysfunction of the b  | bladder.                                                       |                                                                      |                      | week x 4 weeks, then 3 times                                                                            | а            |
|                                                      |                       |                                                                |                                                                      |                      | week x 4 weeks, then once a                                                                             |              |
|                                                      | -                     | d 2/20/25, indicated the                                       |                                                                      |                      | month x 4 months. If the facilit within 95% compliance at the                                           | -            |
|                                                      |                       | welling catheter and staff were                                |                                                                      |                      |                                                                                                         |              |
|                                                      |                       | ident's urine output every                                     |                                                                      |                      | of the 6 months, then monitori                                                                          | ng           |
|                                                      | shift.                |                                                                |                                                                      |                      | can be stopped.                                                                                         |              |
|                                                      | D: £41: 4             |                                                                |                                                                      |                      | Results of the monitoring will                                                                          |              |
|                                                      | administration reco   | ent's March 2025 treatment                                     |                                                                      |                      | reviewed at the monthly QAPI                                                                            |              |
|                                                      |                       | ne resident's urine output on                                  |                                                                      |                      | meeting. Any concerns will ha been addressed. However, ar                                               |              |
|                                                      | the following dates   | -                                                              |                                                                      |                      | patterns will be identified. Any                                                                        | •            |
|                                                      | the following dates   | una bilitts.                                                   |                                                                      |                      | Action Plan needed will be write                                                                        |              |
|                                                      | - On 3/4/25, there w  | vas no urine output                                            |                                                                      |                      | by the QAPI committee. Any                                                                              |              |
|                                                      | documented on day     | -                                                              |                                                                      |                      | written Action Plan will be                                                                             |              |
|                                                      | -                     | /25, there were no urine output                                |                                                                      |                      | monitored by the Administrato                                                                           | r            |
|                                                      | documented on nigl    | _                                                              |                                                                      |                      | weekly until resolved.                                                                                  |              |
|                                                      | _                     | gh 3/12/25, there were no urine                                |                                                                      |                      | <b>1</b>                                                                                                |              |
|                                                      | output documented     |                                                                |                                                                      |                      | By what date the systemic                                                                               |              |
|                                                      | -                     | was no urine output                                            |                                                                      |                      | changes for each deficiency w                                                                           | <i>r</i> ill |
|                                                      | documented on day     | shift.                                                         |                                                                      |                      | be completed.                                                                                           |              |
|                                                      |                       |                                                                |                                                                      |                      |                                                                                                         |              |
|                                                      | This Citation relates | s to Complaint IN00456149                                      |                                                                      |                      | 4/22/25                                                                                                 |              |
|                                                      |                       |                                                                |                                                                      |                      | ="" p="">                                                                                               |              |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                                                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING 00 COMPLETED  B. WING 03/27/202                                                                                      |      |                     | ED                                                                                                                                                                                                  |        |                            |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------------|
|                                                                                                          | PROVIDER OR SUPPLIER                                                                  |                                                                                                                                                                             |      | 1002 SI             | ADDRESS, CITY, STATE, ZIP COD<br>ISTER BARBARA WAY<br>GETOWN, IN 47122                                                                                                                              |        |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                 | (EACH DEFICIEN<br>REGULATORY OR                                                       | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION                                                                                            |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                                                                                      | TE (   | (X5)<br>COMPLETION<br>DATE |
| F 0691<br>SS=D<br>Bldg. 00                                                                               | Based on interview                                                                    | omy, or Ileostomy Care                                                                                                                                                      | F 06 | 591                 | F 691                                                                                                                                                                                               |        | 04/22/2025                 |
|                                                                                                          | output was docume                                                                     | sident's (Resident L) ostomy nted and care of the ostomy ed by the physician for 1 of 1 or ostomy care.                                                                     |      |                     | Colostomy, Urostomy or Ileostomy Care  It is the policy of this facility to ensure that residents with a                                                                                            |        |                            |
|                                                                                                          | Findings include:                                                                     |                                                                                                                                                                             |      |                     | ostomy document outputs and provide ostomy care as ordere                                                                                                                                           |        |                            |
|                                                                                                          | 3/27/25 at 10:54 a.r. included, but was not the care plan, dated resident had an osto | for Resident L was reviewed on m. The resident's diagnosis of limited to, ostomy status.  1 2/20/25, indicated the omy surgical site and staff the resident's treatments as |      |                     | What corrective action will be accomplished for those reside found to have been affected by deficient practice.  The DON/Designee assessed                                                          | y the  |                            |
|                                                                                                          |                                                                                       | er, dated 2/15/25, indicated to e and record any liquid output                                                                                                              |      |                     | resident L on 4/11/25, no negal outcome related to the alleged deficient practice.  How other residents having the potential to be affected by the                                                  | ı      |                            |
|                                                                                                          |                                                                                       | rd lacked documentation of<br>the resident's output on the                                                                                                                  |      |                     | same deficient practice will be identified, and what corrective action will be taken.  Residents with an ostomy have                                                                                |        |                            |
|                                                                                                          | day shift On 3/7/25 and 3/8 documented on nigl - On 3/10/25 throug documented on nigl | sh 3/12/25, there were no output                                                                                                                                            |      |                     | the potential to be affected by alleged deficient practice, therefore, this plan of correctic applies to all residents with an ostomy.  What measures will be put into place and what system change | the on |                            |

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Event ID:

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Facility ID: 011509

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2025 FORM APPROVED OMB NO. 0938-039

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155770 |                           | A. BUILDING  B. WING                                                             | 00                                                                                  | COMPLETED 03/27/2025                                                                                                                                                                                                                                                              |                                        |  |  |  |
|------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--|--|--|
|                                                      | PROVIDER OR SUPPLIER      |                                                                                  | STREET ADDRESS, CITY, STATE, ZIP COD  1002 SISTER BARBARA WAY  GEORGETOWN, IN 47122 |                                                                                                                                                                                                                                                                                   |                                        |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIEN            | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                                                                                                                                                     | (X5) COMPLETION DATE                   |  |  |  |
|                                                      |                           | was no ostomy care completed. s to Complaint IN00456149                          |                                                                                     | will be made to ensure that the deficient practice does not recommend. The DON/Designee will in-serve the pursing staff on or before                                                                                                                                              | cur.                                   |  |  |  |
|                                                      | 3.1- <del>4</del> 7(a)(3) |                                                                                  |                                                                                     | the nursing staff on or before 4/16/25 on the following.  1.Ostomy Care  1.Following Physician Order  1.Completion of signing the ETAR/EMAR for urinary output and catheter care as ordered                                                                                       |                                        |  |  |  |
|                                                      |                           |                                                                                  |                                                                                     | Additionally, any staff that fails comply with the points of this in-service will be further educated/disciplined as indicated.                                                                                                                                                   |                                        |  |  |  |
|                                                      |                           |                                                                                  |                                                                                     | How the corrective action will monitored to ensure the defici practice will not recur, i.e wha quality assurance program will put into place.                                                                                                                                     | ent<br>t                               |  |  |  |
|                                                      |                           |                                                                                  |                                                                                     | Don/Designee will monitor ost care and output documentation x weekly for 4 weeks, then 3 x weekly for 4 weeks, and then weekly for 4 months. If the fact is within 95% compliance at the end of 6 months, monitoring of be stopped. Results of the monitoring will be reviewed at | on 5<br>C<br>1 x<br>Sility<br>ne<br>an |  |  |  |
|                                                      |                           |                                                                                  |                                                                                     | monthly QAPI meeting. Any concerns will have been addressed. However, any pat will be identified. Any Action F needed will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until                                               | Plan<br>QAPI                           |  |  |  |

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| CENTERS FOR | R MEDICARE & MEDIC    | AID SERVICES                      |                      |                                                  | OMB NO. 0938-039 |  |  |
|-------------|-----------------------|-----------------------------------|----------------------|--------------------------------------------------|------------------|--|--|
| STATEMEN    | IT OF DEFICIENCIES    | X1) PROVIDER/SUPPLIER/CLIA        | (X2) MULTIPLE C      | ONSTRUCTION                                      | (X3) DATE SURVEY |  |  |
| AND PLAN    | OF CORRECTION         | IDENTIFICATION NUMBER             | A. BUILDING          | 00                                               | COMPLETED        |  |  |
|             |                       | 155770                            | B. WING              | <del>_</del>                                     | 03/27/2025       |  |  |
|             |                       |                                   |                      |                                                  |                  |  |  |
| NAME OF F   | ROVIDER OR SUPPLIER   | t                                 |                      | ADDRESS, CITY, STATE, ZIP COD                    |                  |  |  |
| \\\\ TED6   |                       | A. T. E                           |                      | SISTER BARBARA WAY                               |                  |  |  |
| WATERS      | OF GEORGETOW          | VN, THE                           | GEORGETOWN, IN 47122 |                                                  |                  |  |  |
| (X4) ID     | SUMMARY               | STATEMENT OF DEFICIENCIE          | ID                   | PROVIDER'S PLAN OF CORRECTION                    | (X5)             |  |  |
| PREFIX      | (EACH DEFICIEN        | CY MUST BE PRECEDED BY FULL       | PREFIX               | (EACH CORRECTIVE ACTION SHOULD BE                | COMPLETION       |  |  |
| TAG         | REGULATORY OR         | R LSC IDENTIFYING INFORMATION     | TAG                  | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | DATE             |  |  |
|             |                       |                                   |                      | resolved.                                        |                  |  |  |
|             |                       |                                   |                      |                                                  |                  |  |  |
|             |                       |                                   |                      | By what date the systemic                        |                  |  |  |
|             |                       |                                   |                      | changes for each deficiency v                    | vill             |  |  |
|             |                       |                                   |                      | be completed.                                    |                  |  |  |
|             |                       |                                   |                      | · '                                              |                  |  |  |
|             |                       |                                   |                      | 4/22/25                                          |                  |  |  |
|             |                       |                                   |                      | ="" p="">                                        |                  |  |  |
|             |                       |                                   |                      | · .                                              |                  |  |  |
| F 0725      | 483.35(a)(1)(2)       |                                   |                      |                                                  |                  |  |  |
| SS=F        | Sufficient Nursing    | Staff                             |                      |                                                  |                  |  |  |
| Bldg. 00    |                       |                                   |                      |                                                  |                  |  |  |
|             | Based on observation  | on, interview and record          | F 0725               | ="" p=""> <b>F 725</b>                           | 04/22/2025       |  |  |
|             | review, the facility  | failed to ensure the facility was |                      |                                                  |                  |  |  |
|             | adequately staffed t  | o provide adequate care and       |                      | It is the intent of this facility to             |                  |  |  |
|             | safety for the reside | ents. This deficient practice     |                      | ensure each Villa/Unit is staffe                 | ed to            |  |  |
|             | had the potential to  | affect 67 of 67 residents         |                      | ensure residents receive care                    | and              |  |  |
|             | residing in the facil | ity.                              |                      | services.                                        |                  |  |  |
|             | Findings include:     |                                   |                      | What corrective action will be                   |                  |  |  |
|             | 8                     |                                   |                      | accomplished for those reside                    |                  |  |  |
|             | During an interview   | y, between 3/24/25 and 3/27/25,   |                      | found to have been affected b                    |                  |  |  |
|             | -                     | dicated there was supposed to     |                      | deficient practice.                              | ,,               |  |  |
|             |                       | Villa but that did not always     |                      |                                                  |                  |  |  |
|             | •                     | f Member 11 had two Villas to     |                      | The DON/Designee assessed                        | I the            |  |  |
|             | administer medicati   | ions, Staff Member 11 would       |                      | residents on 4/14/25, no nega                    |                  |  |  |
|             | have to flip flop wit | th the aide in Villa 3 which      |                      | outcome related to the alleged                   |                  |  |  |
|             |                       | idents in Villa 1 alone with no   |                      | deficient practice.                              |                  |  |  |
|             | staff in the building | for approximately two             |                      | · ·                                              |                  |  |  |
|             | _                     | , however been times when         |                      | How other residents having th                    | ne               |  |  |
|             |                       | t unattended for 5 to 10          |                      | potential to be affected by the                  |                  |  |  |
|             |                       | the facility staffed the Villas   |                      | same deficient practice will be                  |                  |  |  |
|             | -                     | is it fair to the residents."     |                      | identified, and what corrective                  | l l              |  |  |
|             |                       |                                   |                      | action will be taken.                            |                  |  |  |
|             | During an interview   | y, between 3/24/25 and 3/27/25,   |                      |                                                  |                  |  |  |
|             | -                     | le (CNA) 12 indicated the         |                      | All residents had the potential                  | to               |  |  |
|             |                       | ly short staffed. She had cared   |                      | be affected by the alleged def                   |                  |  |  |
|             |                       | quired assistance of two staff    |                      | practice, therefore, this plan of                |                  |  |  |
|             | members and freque    | ently had to wait to change       |                      | correction applied to all reside                 |                  |  |  |

residents or put them to bed until another staff

that reside in the facility.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         | (X3) DATE SURVEY  COMPLETED  03/27/2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                               |  |  |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP COD<br>1002 SISTER BARBARA WAY<br>GEORGETOWN, IN 47122 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                                                                                 | (EACH DEFICIEN<br>REGULATORY OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                 | (X5) COMPLETION DATE                                                          |  |  |
|                                                                                                          | 12 could complete a<br>when she worked in<br>complete her shows                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         | What measures will be put integrated place and what system chang will be made to ensure that the deficient practice does not reconstructed.                                                                                                                                                                                                                                                                                                                                                                   | ges<br>ne                                                                     |  |  |
|                                                                                                          | Qualified Medicationshe had worked as to many times. When medication, provided meals during the 12 around like a chicked impossible to compositionshowers.  During an interview Licensed Practical Inhard to complete all sometimes times had periods of time to a Villas where there we use the provided provided the provided provided provided the provided pro | r, between 3/24/25 and 3/27/25, on Aide (QMA) 13 indicated the nurse and the aide in a Villa you have to administer the resident care and serve all the shour shift, it was like running on with its head cut off and lete all care tasks, especially r, between 3/24/25 and 3/27/25, Nurse (LPN) 5 indicated it was shof her assigned tasks. LPN 5 d to leave her Villa for long dminister insulin in multiple were QMA's working.          |                                                                                         | The ADM/DON were educate relative to Sufficient Staffing by RDO on 4/1/25, including but limited to provision of sufficient staffing based on resident act to meet the needs and preferences of residents. Additionally, any staff member that fails to comply with the profit of this in-service will be further educated and/or disciplined a indicated. How the corrective action will monitored to ensure the deficiency practice will not recur, i.e what quality assurance program with put into place. | by the not not uity  er coints er s be ient                                   |  |  |
|                                                                                                          | before due to no nu a lot of QMA's wor their Villas to admi There had been tim go to another Villa times, send the resid When that happened the Villa for longer staffing was not saft the residents.  During an interview CNA 14 indicated sherself multiple tim the residents in the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | rses available. There had been king so the nurses had to leave nister insulin in the other Villas. es when LPN 10 would have to to assess a resident and, at dents out to the hospital. d, your aide was left alone in periods of time. The current e and was definitely not fair to v, between 3/24/25 and 3/27/25, he has had to work Villa 7 by es which was very difficult. All Villa received therapy and tened needs. There were times |                                                                                         | The ADM/Designee will monistaffing levels 5 days a week weeks, then 3 days a week weeks, then weekly for 4 mor Any concerns noted in this auxill be addressed and correct immediately. If the facility is weekly compliance at the end of then monitoring can be stop Results of the monitoring will reviewed at the monthly QAP meeting. Any concerns will be been addressed. However, all patterns will be identified. Any be written by the QAPI command any written Action Plan will be                   | for 4 for 4 for 4 nths. udit eed vithin f the oped. be I ave ny y will ittee. |  |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                                                                                                     | A. BU                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                  |                     | (X3) DATE SURVEY COMPLETED 03/27/2025                                                                         |    |                            |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------|----|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE                                                   |                                                                                                                     |                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 |                     |                                                                                                               |    |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                 | (EACH DEFICIEN                                                                                                      | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION                                                                                                                   |                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|                                                                                                          | could hear two other<br>they needed to go to                                                                        | toileting one resident, and she<br>er residents yelling because<br>to the bathroom at the same                                                                                                              |                                                                                   |                     | monitored by the Administrato weekly until resolved.                                                          | r  |                            |
|                                                                                                          | by yourself.                                                                                                        | ry hard when you are in a Villa                                                                                                                                                                             |                                                                                   |                     | By what date the systemic changes for each deficiency will be completed.                                      |    |                            |
|                                                                                                          | worked staffing she                                                                                                 | uary 2025 and March 2025 as eets indicated the following:                                                                                                                                                   |                                                                                   |                     | 4/22/25                                                                                                       |    |                            |
|                                                                                                          | shift.                                                                                                              | was no nurse in Villa 3 on night was no nurse in Villa 3 on night                                                                                                                                           |                                                                                   |                     |                                                                                                               |    |                            |
|                                                                                                          | shift On 3/24/25, there Villa 6 on day shift                                                                        | was no aide in Villa 4 on night was one nurse for Villa 5 and . was no nurse in Villa 3 on night                                                                                                            |                                                                                   |                     |                                                                                                               |    |                            |
|                                                                                                          | shift.                                                                                                              | was one nurse for Villa 5 and                                                                                                                                                                               |                                                                                   |                     |                                                                                                               |    |                            |
|                                                                                                          | Villa 5 was observe                                                                                                 | ion, on 3/25/25 at 11:22 a.m., and without a nurse. CNA 15 stered Nurse) 16 was currently and medications.                                                                                                  |                                                                                   |                     |                                                                                                               |    |                            |
|                                                                                                          | indicated a resident<br>in his wheelchair w                                                                         | dated 3/25/25 at 5:30 p.m., from Villa 5 exited the facility, ithout supervision. The exted back to the Villa by the itation.                                                                               |                                                                                   |                     |                                                                                                               |    |                            |
|                                                                                                          | 15 indicated right a<br>over to Villa 6 to se<br>hospital since she v<br>CNA 15 was in a ro<br>providing care for a | or, on 3/27/25 at 1:55 p.m., CNA fter dinner, RN 16 had to go and a resident out to the vas covering Villa 5 and Villa 6. soom, with the door closed, a resident. Her pager started was in the room, so she |                                                                                   |                     |                                                                                                               |    |                            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                     | (X2) MULTIPLE CONSTRUCTION (X3)                            |      | (X3) DATE | X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------|------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER         |                                                     | A. BUILDING <u>00</u>                                      |      | COMPL     | COMPLETED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |            |
| 155770                                               |                                                     | B. WING 03/27/20                                           |      |           | /2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |            |
|                                                      |                                                     |                                                            |      | STREET A  | ADDRESS, CITY, STATE, ZIP COD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |            |
| NAME OF P                                            | ROVIDER OR SUPPLIER                                 |                                                            |      |           | ISTER BARBARA WAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |         |            |
| WATERS OF GEORGETOWN, THE                            |                                                     |                                                            |      |           | GETOWN, IN 47122                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |            |
| (X4) ID                                              | SUMMARY STATEMENT OF DEFICIENCIE                    |                                                            | ID   |           | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         | (X5)       |
| PREFIX                                               | *                                                   | CY MUST BE PRECEDED BY FULL                                |      | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | ΓE      | COMPLETION |
| TAG                                                  |                                                     | LSC IDENTIFYING INFORMATION                                |      | TAG       | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         | DATE       |
|                                                      | •                                                   | pleted care on the resident.                               |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     | of the room, she heard the                                 |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     | g. She could not hear the door                             |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     | was in a resident's room with ten she looked out the door, |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     | nging the resident whom had                                |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | exited back into Vil                                |                                                            |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | cated back into vii                                 | ia 5.                                                      |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | 3.1-17(a)                                           |                                                            |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
| F 0759                                               | 483.45(f)(1)                                        |                                                            |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
| SS=D                                                 | ( / (  /                                            | n Error Rts 5 Pront or More                                |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
| Bldg. 00                                             |                                                     |                                                            |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | Based on interview                                  | and record review, the facility                            | F 07 | 759       | 759                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         | 04/22/2025 |
|                                                      | failed to ensure a resident's (Resident H)          |                                                            |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | scheduled narcotic was administered, as ordered     |                                                            |      |           | It is the intent of this facility to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |            |
|                                                      | by the physician, for 1 of 3 residents reviewed for |                                                            |      |           | ensure residents schedule                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |            |
|                                                      | medications errors.                                 |                                                            |      |           | narcotics are administered as                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |            |
|                                                      |                                                     |                                                            |      |           | ordered by the physician.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |            |
|                                                      | Findings include:                                   |                                                            |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     |                                                            |      |           | What corrective action will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |            |
|                                                      |                                                     | for Resident H was reviewed                                |      |           | accomplished for those reside                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |            |
|                                                      |                                                     | .m. The resident's diagnoses                               |      |           | found to have been affected by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | tne tne |            |
|                                                      | anxiety and age-rela                                | not limited to, depression,                                |      |           | deficient practice.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |            |
|                                                      | anxiety and age-rea                                 | ned osteoporosis.                                          |      |           | The DON/Designee assessed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |            |
|                                                      | The care plan dated                                 | 1 3/7/25, indicated the resident                           |      |           | resident H on 4/11/25, no nega                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ativo   |            |
|                                                      | •                                                   | and to administer medications                              |      |           | outcome related to the alleged                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |            |
|                                                      | as ordered.                                         |                                                            |      |           | deficient practice, the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |            |
|                                                      |                                                     |                                                            |      |           | DON/Designee notified resider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | nt      |            |
|                                                      | The care plan, dated                                | 1 3/7/25, indicated the resident                           |      |           | H's physician of the missed do                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |            |
|                                                      | -                                                   | rder and to give anti-anxiety                              |      |           | on 4/11/25.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |            |
|                                                      | -                                                   | ed by the physician.                                       |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     |                                                            |      |           | How other residents having the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Э       |            |
|                                                      |                                                     | er, dated 3/19/25, indicated the                           |      |           | potential to be affected by the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | resident was to rece                                |                                                            |      |           | same deficient practice will be                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | -                                                   | aminophen (narcotic pain                                   |      |           | identified, and what corrective                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      |                                                     | mg (milligrams) every 6 hours                              |      |           | action will be taken.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |            |
|                                                      | -                                                   | p.m., 6:00 p.m. and 12:00 a.m. for                         |      |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |            |
|                                                      | pain.                                               |                                                            |      |           | All residents with orders for                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Z6N611

Facility ID: 011509

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/27/2025 155770 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1002 SISTER BARBARA WAY WATERS OF GEORGETOWN, THE GEORGETOWN, IN 47122 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE medications have the potential to The physician's order, dated 3/6/25, indicated the be affected by the same alleged resident was to receive Xanax (narcotic deficient practice. Therefore, this anti-anxiety medication), 1 mg every 6 hours at plan of correction applies to all 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. for residents of the facility. anxiety. What measures will be put into Review of the March 2025 medication place and what system changes administration record indicated the resident did will be made to ensure that the not receive the pain medication or the anti-anxiety deficient practice does not recur. medication on 3/22/25 at 6:00 a.m. The DON/Designee will in-service Review of the controlled drug record for March the nursing staff and Qualified 2025 indicated the that neither the Hydrocodone Medication Assistances on or or Xanax were signed out as administered. before 4/16/25 on the following. During an interview, from 3/24/25 through 3/27/25, 1.Medication Administration Staff Member 10 indicated all physicians' orders 1. Five Right of Medication should be followed. Administration. Additionally, any staff that fails to On 3/27/25 at 9:18 a.m., the Regional Nurse comply with the points of this Consultant provided a current copy of the in-service will be further document titled "Physician Orders/Following educated/disciplined as indicated. Physician Orders Guideline" dated 2/15/19. It included, but was not limited to, "Policy...It is the How the corrective action will be policy of the facility to follow the orders of the monitored to ensure the deficient physician...." practice will not recur. i.e what quality assurance program will be This Citation relates to Complaint IN00456149 put into place. 3.1-48(c)(1)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

FORM CMS-2567(02-99) Previous Versions Obsolete

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| JENTERS FOR                                          | R MEDICARE & MEDIC.                                                                                                                                                                                                                                                                                                                                     | AID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | OMB NO. 0938-039    |  |
|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ONSTRUCTION           | (X3) DATE SURVEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     |  |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770  |                                                                                                                                                                                                                                                                                                                                                         | IDENTIFICATION NUMBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | A. BUILDING <u>00</u> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | COMPLETED           |  |
|                                                      |                                                                                                                                                                                                                                                                                                                                                         | B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       | 03/27/2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |  |
|                                                      | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1002 \$               | ADDRESS, CITY, STATE, ZIP COD<br>SISTER BARBARA WAY<br>GETOWN, IN 47122                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |  |
| (X4) ID                                              | SUMMARY                                                                                                                                                                                                                                                                                                                                                 | STATEMENT OF DEFICIENCIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID                    | PROVIDER'S PLAN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X5)                |  |
| PREFIX                                               | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                          | CY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | PREFIX                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | COMPLETION          |  |
| TAG                                                  | REGULATORY OR                                                                                                                                                                                                                                                                                                                                           | LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TAG                   | DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | DATE                |  |
| F 0842<br>SS=E                                       | 483.20(f)(5), 483.7<br>Resident Records                                                                                                                                                                                                                                                                                                                 | 70(i)(1)-(5)<br>- Identifiable Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                       | written Action Plan will be monitored by the Administrator weekly until resolved.  By what date the systemic changes for each deficiency whe completed.  4/22/25  ="" p="">                                                                                                                                                                                                                                                                                                                                                                         |                     |  |
| Bldg. 00                                             | failed to ensure una documented as adm (Resident E); failed administration record administration of m (Resident D, Reside M); and failed to en and Resident L) me accurately reflected pain medication for documentation.  Findings include:  1. The clinical record on 3/24/25 at 4:48 princluded, but was not resident was to recertablet, 100 mcg (m | and record review, the facility vailable medications were not inistered for 1 of 6 residents to ensure resident medication rds accurately reflected the edications for 5 of 6 residents and G. Resident H and Resident sure a resident's (Resident E dication administration record the administration of narcotic 2 of 3 reviewed for  and for Resident D was reviewed a.m. The resident's diagnosis of limited to, hypothyroidism.  The resident's diagnosis of limited to, hypothyroidism. | F 0842                | It is the policy of this facility to ensure unavailable medication were not documented as administered and to ensure resident medication administration administration of medications.  What corrective action will be accomplished for those resider found to have been affected by deficient practice.  Resident E, D, G, H, M and L's Medications were audited on 4/11/25 for availability as well their MARS to ensure medications were administered and documented as ordered.  How other residents having the potential to be affected by the | nts y the s as ions |  |

(MAR) lacked documentation of the

same deficient practice will be

| CENTERS FO                                           | R MEDICARE & MEDIC    | CAID SERVICES                     |              |                                                                     | OMB NO. 0938-039 |
|------------------------------------------------------|-----------------------|-----------------------------------|--------------|---------------------------------------------------------------------|------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE C                   | CONSTRUCTION | (X3) DATE SURVEY                                                    |                  |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER         |                       | A. BUILDING                       | 00           | COMPLETED                                                           |                  |
|                                                      |                       | 155770                            | B. WING      | <u> </u>                                                            | 03/27/2025       |
|                                                      |                       |                                   |              |                                                                     |                  |
| NAME OF                                              | PROVIDER OR SUPPLIEF  | 3                                 |              | ADDRESS, CITY, STATE, ZIP COD                                       |                  |
| TWINE OF                                             | I KO VIDEK OK SOITEEL |                                   | 1002 \$      | SISTER BARBARA WAY                                                  |                  |
| WATER:                                               | S OF GEORGETOV        | VN, THE                           | GEOR         | RGETOWN, IN 47122                                                   |                  |
| (V4) ID                                              | CUMMADY               | STATEMENT OF DEFICIENCIE          | ID           |                                                                     | (V5)             |
| (X4) ID                                              |                       |                                   |              | PROVIDER'S PLAN OF CORRECTION                                       | (X5)             |
| PREFIX                                               | `                     | ICY MUST BE PRECEDED BY FULL      | PREFIX       | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA |                  |
| TAG                                                  | +                     | R LSC IDENTIFYING INFORMATION     | TAG          | DEFICIENCY)                                                         | DATE             |
|                                                      |                       | ne medication on 3/6/25, 3/9/25,  |              | identified, and what corrective                                     | e                |
|                                                      | 3/12/25 and 3/16/2:   | 5.                                |              | action will be taken.                                               |                  |
|                                                      |                       |                                   |              |                                                                     |                  |
|                                                      | During an interview   | v, on 3/25/25 at 1:28 p.m., RN    |              | All MARS were audited on 4/                                         | 14/25            |
|                                                      | (Registered Nurse)    | 6 indicated the medication        |              | for medication availability and                                     | i                |
|                                                      | administration reco   | rd should be signed to show a     |              | accurate documentation of                                           |                  |
|                                                      | medication was adr    | ninistered.                       |              | administration.                                                     |                  |
|                                                      |                       |                                   |              |                                                                     |                  |
|                                                      | On 3/27/25 at 9:18    | a.m., the Regional Nurse          |              | What measures will be put int                                       | to               |
|                                                      | Consultant provide    | d a current copy of the           |              | place and what system chang                                         | ges              |
|                                                      | document titled "M    | edication Administration          |              | will be made to ensure that th                                      | ie               |
|                                                      | Guideline" dated 1/   | 25/19. It included, but was not   |              | deficient practice does not red                                     | cur.             |
|                                                      | limited to, "Policy   | Medications are administered      |              | · ·                                                                 |                  |
|                                                      |                       | resident's MAR is initialed by    |              | An in-service will be held on o                                     | or               |
|                                                      | •                     | tering a medicationWhen           |              | before 4/16/25 by DON/Desig                                         |                  |
|                                                      | _                     | re administered, the following    |              | on the following:                                                   | J.100            |
|                                                      |                       | rovidedDate and time of           |              | Notifying the physician of                                          |                  |
|                                                      | _                     | gnature or initial of person      |              | unavailable medications and                                         |                  |
|                                                      | recording administr   | -                                 |              | following physician orders.                                         |                  |
|                                                      | recording administr   |                                   |              | How the corrective action will                                      | he               |
|                                                      | 2 The clinical reco   | rd for Resident E was reviewed    |              | monitored to ensure the defic                                       |                  |
|                                                      |                       | a.m. The resident's diagnoses     |              |                                                                     |                  |
|                                                      |                       | _                                 |              | practice will not recur, i.e wha                                    | l l              |
|                                                      |                       | not limited to, constipation and  |              | quality assurance program wi                                        | ii be            |
|                                                      |                       | at lower extremity. The resident  |              | put into place.                                                     |                  |
|                                                      | admitted to the faci  | lity on 3/21/25 at 5:50 p.m.      |              | BON//                                                               |                  |
|                                                      | TI M. 1 20273         | (A.D. 12.12.4.13.                 |              | DON/designee will monitor                                           |                  |
|                                                      |                       | AR record indicated the           |              | medication administration and                                       |                  |
|                                                      | resident received th  | e following medications:          |              | medication availability 5 times                                     |                  |
|                                                      |                       |                                   |              | week x 4 weeks, then 3 times                                        | l l              |
|                                                      |                       | m., Colace (medication for        |              | week x 4 weeks, then one time                                       | l l              |
|                                                      | constipation) 100 n   |                                   |              | week x 4 months. If the facility                                    | -                |
|                                                      | _                     | m., Linezolid (antibiotic) 600 mg |              | within 95% compliance at the                                        | end              |
|                                                      | _                     | m., Lovenox Injection (blood      |              | of the 6 months; then monitor                                       | ring             |
|                                                      | thinner) 0.4 ml (mi   | lliliters) subcutaneously         |              | can be stopped                                                      |                  |
|                                                      | - 3/22/25 at 12:00 a  | .m., Amoxicillin (antibiotic) 500 |              |                                                                     |                  |
|                                                      | mg                    | •                                 |              | Results of the monitoring will                                      | be               |
|                                                      |                       |                                   |              | reviewed at the monthly QAP                                         | l l              |
|                                                      | Review of the phar    | macy delivery sheet indicated     |              | meeting. Any concerns will ha                                       | l l              |
|                                                      | _                     | resident did not arrive to the    |              | heen addressed. However, as                                         |                  |

facility until 3/22/25 at 7:14 a.m.

patterns will be identified. Any

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | A. BUILDING <u>00</u> COMPLET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |       |                                                                                   | (X3) DATE SURVEY COMPLETED 03/27/2025                                                                                                                                                                                                           |            |  |  |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|--|
| 100770                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | В. W. | _                                                                                 |                                                                                                                                                                                                                                                 | 00/21/2020 |  |  |
| NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       | STREET ADDRESS, CITY, STATE, ZIP COD 1002 SISTER BARBARA WAY GEORGETOWN, IN 47122 |                                                                                                                                                                                                                                                 |            |  |  |
| (X4) ID                                                                                                  | SUMMARY STATEMENT OF DEFICIENCIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       | ID                                                                                | DROVIDED'S DI AN OF CORRECTION                                                                                                                                                                                                                  | (X5)       |  |  |
| PREFIX                                                                                                   | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | NCY MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |       | PREFIX                                                                            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                                                                                                                                  | COMPLETION |  |  |
| TAG                                                                                                      | REGULATORY O                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | R LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |       | TAG                                                                               | DEFICIENCY)                                                                                                                                                                                                                                     | DATE       |  |  |
| TAG                                                                                                      | During an interview Regional Nurse Co no medications pul drug kit) on 3/21/2  During an interview indicated she work could not recall if sadministered for Renot available for adshould not be signed. The physician's orderesident was to recepain medication) Inneeded for pain.  The March 2025 of the resident received 4:00 a.m. and 3/24/2. The March 2025 Method administration of the administration of the medication administration and medication was administration was administration was administration was administration and medication was administration of the medication was administration of the medication was administration of the medication was administration was administration of the medication was administration was administration of the medication was administration of the med | w, on 3/25/25 at 9:20 a.m., the insultant indicated there were led from the EDK (emergency 5 for administration.  w, on 3/25/25 at 1:28 p.m., RN 6 ed night shift on 3/21/25. She she signed off medications as esident E. If a medication was laministration, the medication ed out as given.  der, dated 3/21/25, indicated the eive Oxycodone HCl (narcotic 0 mg every four hours as  ontrolled drug record indicated ed the medication on 3/23/25 at 4:00 a.m.  IAR lacked documentation of of the narcotic pain medication.  w, on 3/27/25 at 1:55 p.m.,  Nurse (LPN) 5 indicated if an as in was administered, it should be controlled drug record and innistration record to show the |       | TAG                                                                               | Action Plan needed will be wriby the QAPI committee. Any written Action Plan will be monitored by the Administrato weekly until resolved.  By what date the systemic changes for each deficiency who is completed.  4/22/25 ="" p = "" p = "" > | r          |  |  |
|                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | der, dated 3/12/25, indicated the eive Levothyroxine Sodium                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |       |                                                                                   |                                                                                                                                                                                                                                                 |            |  |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155770 |                                              | A. BU                                                                                                                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |                                                                                                                       | (X3) DATE SURVEY COMPLETED 03/27/2025 |                            |
|-------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE                                                      |                                              |                                                                                                                          |                                                  | 1002 SI             | ADDRESS, CITY, STATE, ZIP COD<br>STER BARBARA WAY<br>SETOWN, IN 47122                                                 |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                    | (EACH DEFICIEN<br>REGULATORY OR              | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION                                         |                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE                                   | (X5)<br>COMPLETION<br>DATE |
|                                                                                                             |                                              | AR lacked documentation of f the medication on 3/15/25 at                                                                |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             | resident was to rece<br>insulin) per sliding | er, dated 3/19/25, indicated the ive Insulin Lispro (fast acting scale every 6 hours at 12:00 00 p.m. and 6:00 p.m.      |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             | blood sugar check of                         | AR lacked documentation of a per insulin administration on and 3/23/25 at 6:00 a.m.                                      |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             | resident was to rece                         | er, dated 3/12/25, indicated the ive guaifenesin liquid 10 ml hours at 12:00 a.m., 6:00 a.m., p.m.                       |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             |                                              | AR lacked documentation of of the medication 3/15/25 at 25 at 6:00 a.m.                                                  |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             | resident was to rece<br>intravenously every  | er, dated 3/13/25, indicated the ive Meropenem (antibiotic) 6 hours at 12:00 a.m., 6:00 d 6:00 p.m. for 14 doses related |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             |                                              | AR lacked documentation of of the medication on 3/15/25 at                                                               |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             | on 3/27/25 at 9:59 a                         | rd for Resident H was reviewedm. The resident's diagnosis ot limited to, hypothyroidism.                                 |                                                  |                     |                                                                                                                       |                                       |                            |
|                                                                                                             |                                              | er, dated 3/5/25, indicated the ive Levothyroxine Sodium 137                                                             |                                                  |                     |                                                                                                                       |                                       |                            |

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Event ID:

Z6N611

Facility ID: 011509

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | r í                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | UILDING | nstruction<br><u>00</u> | (X3) DATE<br>COMPI<br>03/27                                                                                          | ETED      |                            |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------|----------------------------------------------------------------------------------------------------------------------|-----------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         | 1002 SI                 | DDRESS, CITY, STATE, ZIP COD<br>STER BARBARA WAY<br>SETOWN, IN 47122                                                 |           |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                                 | (EACH DEFICIEN<br>REGULATORY OF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B:<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | 3<br>NATE | (X5)<br>COMPLETION<br>DATE |
|                                                                                                          | the administration of 6:00 a.m. and 3/22/5 10:54 a. included, but were cutaneous abscess of The physician's ord resident was to rece 7.5/325 mg every si The March 2025 co the resident receive on the following da - 3/01/25 at 5:30 p. 3/03/25 at 10:00 p. 3/09/25 at 10:00 p. 3/10/25 at 5:30 p. 3/11/25 at 5:30 p. 3/11/25 at 5:30 p. 3/11/25 at 5:30 p. 3/11/25 at 12:00 a The resident's March documentation of the arcotic medication 6. The clinical recoon 3/27/25 at 11:17 included, but was not the physician's ord | AR lacked documentation of of the medication on 3/12/25 at 25 at 6:00 a.m.  rd for Resident L was reviewed m. The resident's diagnoses not limited to, diabetes and of the abdominal wall.  er, dated 2/14/25, indicated the give Hydrocodone/APAP ix hours as needed.  ontrolled drug record indicated d the narcotic pain medication tes and times:  m. m. o.m.  o.m.  ch. 2025 MAR lacked ne administration of the administration of the diam. The resident's diagnosis ot limited to, hypothyroidism.  er, dated 2/7/25, indicated the give Levothyroxine Sodium 50 |         |                         |                                                                                                                      |           |                            |
|                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |         |                         |                                                                                                                      |           |                            |

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Event ID:

Z6N611

Facility ID: 011509

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2025 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155770 |                                            |                                                                                                       | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |         |                                                                       | (X3) DATE SURVEY COMPLETED 03/27/2025 |            |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------|-----------------------------------------------------------------------|---------------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER WATERS OF GEORGETOWN, THE                                                   |                                            |                                                                                                       |                                                  | 1002 SI | ADDRESS, CITY, STATE, ZIP COD<br>STER BARBARA WAY<br>SETOWN, IN 47122 |                                       |            |
| (X4) ID                                                                                                  | SUMMARY                                    | STATEMENT OF DEFICIENCIE                                                                              |                                                  | ID      | PROVIDER'S PLAN OF CORRECTION                                         |                                       | (X5)       |
| PREFIX                                                                                                   | (EACH DEFICIEN                             | CY MUST BE PRECEDED BY FULL                                                                           | PREFIX                                           |         | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA   | TE                                    | COMPLETION |
| TAG                                                                                                      | REGULATORY OR                              | LSC IDENTIFYING INFORMATION                                                                           |                                                  | TAG     | DEFICIENCY)                                                           |                                       | DATE       |
|                                                                                                          | the administration of 6:00 a.m. and 3/22/2 | AR lacked documentation of of the medication on 3/12/25 at 25 at 6:00 a.m.  s to Complaint IN00456149 |                                                  |         |                                                                       |                                       |            |

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