STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Rushville Skilled Nursing Facility, The	612 E 11th St Rushville, IN 46173

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 2. During an interview with Resident B on 6/24/25 at 12:32 p.m., they indicated the resident had to wait up to 30 minutes for the call light to be answered. The resident indicated they had a cell phone and timed how long they had to wait. Resident B indicated because they had to wait 30 minutes, it caused them to be incontinent of bowel and bladder. The resident indicated it was embarrassing to have the Certified Nurse Aides (CNAs) clean them up when this happened. The resident indicated they could not get out of bed by themselves due to frequent falls. Resident B indicated the weekends were when it happened the most. The resident did report this to the staff at the time it happened. Review of the Record of Resident B, on 6/25/25 at 1:20 p.m., indicated the diagnoses included, but were not limited to, weakness, lack of coordination, osteoarthritis, congestive heart failure, and repeated falls. The Quarterly MDS assessment, dated 5/13/25, indicated the resident was cognitively intact for daily decision making. The resident was consistent and reasonable. The resident had no behaviors. The resident utilized a wheelchair for mobility. The resident required substantial to maximal assistance with toileting and transfers. The resident rights policy was provided by the Administrator on 6/26/26 at 1:20 p.m. The policy indicated all residents would have their well-being and self-esteem and self-worth enhanced during all care service interactions. The staff were to treat each resident with respect and dignity. This citation relates to Complaints IN00456924 and IN00458111. 3.1-3(t) Based on interview and record review, the facility failed to promote dignity for a resident when requesting pain medication (Resident G), and failed to answer a call light timely, resulting in a resident being incontinent of bowel and bladder (Resident B) for 2 of 2 residents reviewed for dignity. Findings include: 1. The clinical record for Resident G was reviewed on 6/25/25 at 9:44 a.m. The diagnoses included, but were not limited to, presence of left artificial knee joint, pain in the left knee, and muscle weakness. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 5/9/25, indicated Resident G was cognitively intact and used opioid medication. During an interview with Resident G on 6/25/25 at 12:27 p.m., Resident G indicated on third shift, the night after she returned from the hospital on 6/20/25, she had an issue with Qualified Medication Aide (QMA) 4 when asking for pain medication. Resident G indicated she called out for a pain pill because her leg was hurting. Resident G indicated she told QMA 4 she needed pain medication and QMA 4 said, oh, you really need a pain pill? Resident G indicated QMA 4 brought the pain pill back to her, and QMA 4 said, Here! Here is your pain pill, is that all you are here for is pain medicine? Resident G indicated QMA 4 then said, I don't know what else I can do for you, I'm out of here. Resident G indicated QMA 4 speaking to her in that manner hurt her feelings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The clinical record for Resident 12 was reviewed on 6/26/25 at 11:25 a.m. The diagnoses included, but were not limited to, type 1 diabetes mellitus. She was admitted to the facility on [DATE]. The physician's orders indicated to administer ten units of insulin lispro (fast-acting insulin) injection solution 100 UNIT/ML (units per milliliter) with meals, effective 6/15/25; 15 units twice daily, effective 3/7/25; and sliding scale for blood sugar readings as follows, effective 6/15/25: 151 - 200 = two units; 201 - 250 = four units; 251 - 300 = six units; 301 - 350 = ten units; 351 - 400 = 12 units, subcutaneously three times a day, and to call the physician if blood sugar reading was below 60 or above 400. The 5/14/25 physician's order indicated to set up an appointment with Resident 12's endocrinologist. This order was revised on 6/2/25 to include the specific endocrinologist. The 6/11/25 nursing progress note indicated, Called and left a message with endocrinology [name of endocrinologist] through [name of provider network] to set up a follow up apt [appointment]. There were no progress notes prior to or after the above 6/11/25 nursing progress note to indicate an endocrinology appointment was scheduled after the 5/14/25 order to do so. An interview was conducted with Resident 12 on 6/27/25 at 11:38 a.m. She indicated she would like to see an endocrinologist, because of her diabetes. No one at the facility said anything to her about having an appointment scheduled. An interview was conducted with the NP (Nurse Practitioner) on 6/27/25 at 12:04 p.m. She indicated Resident 12's need for an endocrinology appointment stemmed from her having a lot of specialists upon admission, so she (NP) was trying to cover all the bases. Resident 12 was very brittle with her diabetes, so the NP thought they should get endocrinology back on board. The NP would have left the information regarding Resident 12's need for an endocrinology appointment with the DON or ADON (Assistant Director of Nursing). They had prior issues with appointments not being scheduled and orders not being followed through upon, so they agreed orders would be given directly to one of the two of them. An interview was conducted with the DON on 6/27/25 at 11:10 a.m. She indicated they had just scheduled Resident 12's endocrinology appointment yesterday, 6/26/25. The Guidelines For Resident Appointments Outside The Facility were provided by the DON on 6/27/25 at 11:50 a.m. It indicated, While the facility has in-house physician visits to residents per policy and State/Federal regulatory mandates, there are times when the resident may need to be seen outside of the facility by a provider that does not physically travel to the nursing home. This includes but is not limited to such services as: .Doctor Appointments (such as a follow up from a surgery or a consult .) Upon receiving a physician's order for a situation or event that will require the resident to need transport services, the nurse who processes the order will notify the staff member who coordinates transport orders so that appropriate transport can be scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00460358. 3.1-37(a) Based on interview and record review, the facility failed to provide wound dressings as ordered (Resident C) and failed to timely schedule and follow-up on an endocrinology appointment (Resident 12) for 2 of 2 residents reviewed for quality of care. Findings include: 1. The clinical record for Resident C was reviewed on 6/25/25 at 9:42 a.m. The diagnoses included, but were not limited to, anxiety disorder, osteoarthritis, and neuromuscular dysfunction of the bladder. The Annual Minimum Data Set (MDS) assessment, dated 6/5/25, indicated Resident C was cognitively intact and had moisture-associated skin damage (MASD). A weekly wound evaluation, dated 6/3/25, indicated Resident C had erythema intertrigo (red, inflamed skin found in skin folds due to moisture, friction, and lack of ventilation) to the distal rectum. The current treatment indicated to cleanse with 0.125% Dakins solution (a diluted antiseptic solution, used for cleaning and disinfecting wounds) and pack with Dakins moistened gauze and border foam twice daily and as needed. The June 2025 Treatment Administration Record (TAR) indicated an order, dated 6/3/25, to cleanse the distal rectum with Dakins 0.125% solution and pack the wound with Dakins 0.125% moistened gauze and cover with border foam two times a day for wound care. The treatment times were 5:00 a.m. (0500) and 8:00 p.m. (2000). The June 2025 TAR indicated the following days and times that the wound dressings were omitted: -Friday, 6/6/25 at 2000, -Saturday, 6/7/25 at 2000, -Sunday, 6/8/25 at 2000, -Tuesday, 6/10/25 at 0500, -Wednesday, 6/11/25 at 0500 and 2000, -Friday, 6/13/25 at 2000, -Saturday, 6/14/25 at 0500, -Monday, 6/16/25 at 2000, -Tuesday, 6/17/25 at 0500, -Saturday, 6/21/25 at 0500 and 2000, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Sunday, 6/22/25 at 0500, and -Monday, 6/23/25 at 0500. The plan of care for Resident C, dated 5/15/25, indicated the resident had an alteration in skin integrity with potential for worsening due to impaired healing due to diabetes and incontinence. The interventions included, but were not limited to, providing treatment as per MD (Medical Doctor) order. During an interview with the Director of Nursing (DON) on 6/26/25 at 10:22 a.m., she indicated some missed dressing changes were due to having a Qualified Medication Aide (QMA) working down a hall where there was not a nurse scheduled. The QMA was to notify a nurse of any dressing changes due so they could be completed. The DON indicated either the QMA did not notify the nurse that a dressing down her hall needed to be changed, or the nurse did it and did not document it since it was not one of her scheduled residents for the shift. During an interview with Resident C on 6/26/25 at 11:30 a.m., he indicated occasionally the staff would miss doing the treatments to his bottom twice a day. The Following Physician's orders policy was provided by the Administrator on 6/26/25 at 1:20 p.m. It indicated, .it is the policy of the facility to follow the orders of the physician .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to have a Registered Nurse (RN) on duty at the facility for 5 of 30 days reviewed for RN coverage. This had the potential to affect 43 of 43 residents that reside in the facility. Findings include: Review of the schedules provided by the Director of Nursing (DON), on 6/25/25 at 12:44 p.m., indicated the facility did not have RN coverage, 8 hours a day, on 1/7/25, 1/21/25, 1/22/25, 1/25/25, and 1/26/25. During an interview with the DON on 6/25/25 at 12:44 p.m., she indicated the facility did not have RN coverage on 1/7/25, 1/21/25, 1/22/25, 1/25/25 and 1/26/25. The DON indicated there was no resident care and/or assessments not completed due to no RN in the building on those dates. The DON indicated there was no negative outcome for residents on these dates due to no RN coverage. During an interview conducted with the Administrator on 6/26/25 at 1:33 p.m., she indicated the facility did not have a policy on sufficient nurse staffing. The facilities expectation was to have RN coverage for 8 consecutive hours a day, 7 days a week. This citation relates to Complaint IN00460358. 3.1-17(b)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 2. On 6-23-25 at 7:46 p.m., during a medication administration observation, QMA 2 was observed to prepare five (5) oral medications for Resident 99. Those medications and their physician instructions included the following: - atorvastatin 40 milligrams (mg) at bedtime for elevated blood fats. - tab-a-vite one tablet once daily for unspecified vitamin deficiency. - hydroxyurea 500 mg twice daily on Monday, Wednesday and Friday and once daily on Tuesday, Thursday, Saturday and Sunday for gout: wear gloves when handling or crushing; do not crush. - furosemide 40 mg twice daily for congestive heart failure. - metoprolol succinate extended-release 50 mg twice daily for high blood pressure. QMA 2 was observed to touch each medication with his bare hands during the preparation of the medications. When queried about touching the hydroxyurea with his bare hands and the labeled instructions, he responded, I guess I didn't see that. When queried regarding touching each pill with bare hands, he indicated that he should not have done that and would now need to replace the medications. On 6-27-25 at 10:20 a.m., the Administrator provided a copy of a document, dated February of 2017, entitled Tips For Safe Medication Administration. This document indicated, Follow good infection control practices . Cleanse hands when contact is made with a medication .Never touch any of the medication with fingers . Accurately dispense medications to residents .Punch medications directly into cup and never into your hands . On 6-27-25 at 10:20 a.m., the Administrator provided a copy of a document dated, February of 2017, entitled Medication Administration. It indicated its purpose was to administer all medications safely and appropriately . Read and follow any special instructions written on labels. 3.1-18(b)(1)(A) Based on observation, interview, and record review, the facility failed to adhere to infection control standards of storing respiratory equipment in a clean plastic bag when not in use (Resident 14), ensure an indwelling urinary catheter drainage bag and tubing were free from contact with the floor (Resident 14), and utilize appropriate handling of medication (Resident 99) for 2 of 7 residents reviewed for infection control standards. Findings include: 1. The clinical record for Resident 14 was reviewed on 6/25/2025 at 1:30 p.m. The diagnoses included, but were not limited to, urinary tract infection and chronic obstructive pulmonary disease. An admission Minimum Data Set assessment, dated 6/10/2025, indicated Resident 14 was cognitively intact, needed substantial/maximal assistance with toilet hygiene and transfers, and utilized an indwelling urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A respiratory care plan, initiated on 4/23/2025 and revised on 4/23/2025, indicated to utilize CPAP (Continuous Positive Airway Pressure) device as directed. A urinary care plan, initiated on 6/11/2025 and revised on 6/12/2025, indicated Resident 14 was at risk for developing urinary tract infections. An intervention was listed as providing catheter care and position catheter tubing to facilitate drainage. A physician order, dated 6/3/2025, indicated Resident 14 to utilize a CPAP device. A physician order, dated 6/3/2025, indicated Resident 14 to utilize an indwelling urinary catheter. During an observation on 6/24/2025 at 11:50 a.m., a CPAP mask was noted to be lying on Resident 14's bedside table in Resident 14's private room. No plastic storage bag for respiratory equipment was visible in the room. During an observation on 6/24/2025 at 12:04 p.m., Resident 14 was noted to be propelling himself back to his room in his wheelchair. Resident 14's urinary catheter drainage bag and tubing were noted to be contacting the ground. During an observation and interview on 6/24/2025 at 12:14 p.m., Resident 14 was in his room. He indicated that he utilized a CPAP at nighttime and when he naps, but he doesn't have anything to store it in. He stated the staff have not helped him clean it since he had been here, but the staff do fill up the water reservoir when he forgets to. Resident 14 was sitting in his wheelchair at this time. Resident 14's urinary catheter drainage bag was contacting the ground. During an observation and interview on 6/24/2025 at 12:22, Resident 14 was sitting in his room in his wheelchair. Qualified Medication Aide (QMA) 2 came in to reposition Resident 14's catheter drainage bag. QMA 2 indicated that Resident 14's urinary catheter bag and tubing were contacting the floor, the drainage bag and tubing should not be contacting the ground, and it should have been positioned in the back to ensure it was free of the ground. Resident 14's CPAP mask continued to be laying on the bedside table without a storage bag. During an interview on 6/26/2025 at 1:34 p.m., the Administrator indicated it was the expectation of the facility to have urinary catheter drainage bags and tubing free of contact with the floor. A policy entitled Continuous Positive Airway Pressure (CPAP), was provided by the Administrator on 6/25/2025 at 12:50 p.m. The policy indicated .When the CPAP machine is not in use the face mask is stored in a plastic bag at the beside .