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	08/22/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure a resident's personal and medical information were protected from possible observation by other persons in the area during 5 medication administration observations with 5 staff and 11 residents. (Resident F and LPN 4)Findings include:During a medication administration observation on 8-21-25 at 1:16 p.m., a facility computer laptop was observed opened to Resident F's medical administration record, which had the resident's name and medical information visible. The computer was located on top of the medication cart, near the nurses' station and was visible for anyone walking near or by the medication cart. No staff were observed in the area until 1:20 pm. At that time, Licensed Practical Nurse (LPN) 4 returned to the medication cart. In an interview at 1:21 p.m., with LPN 4, she indicated she had been pulled away for care related to another resident and did not take the time to secure the computer.During a review of Resident F's medical record on 8-22-25 at 11:50 a.m., the record indicated she had multiple medical diagnoses and received multiple medications related to her diagnoses.In an interview with the Director of Nursing on 8-21-25 at 3:30 p.m., she indicated she had conducted an in-service (staff education) in the last month, addressing medication administration. She indicated she had educated all staff on the importance of securing all medications when staff were not present and staff were knowledgeable regarding keeping resident personal information secure.On 8-22-25 at 1:15 p.m., the Executive Director provided an undated copy of a policy entitled, Resident Rights. This policy indicated, Residents have a right to a dignified existence.The facility will protect and promote their rights. They have the right of privacy over their personal and clinical records.This citation relates to Intakes 1656340 and 2564836.3.1-3(o)

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure staff members correctly administered medications as ordered for 1 of 4 residents reviewed for accuracy of medication receipt. (Resident E and QMA 5)Findings include:In an interview with the Director of Nursing (DON) on 8-20-25 at 3:40 p.m. She indicated there was a medication error that had occurred since the most recent annual survey at the end of June 2025, and was identified on the day after it occurred. She indicated the staff member did not check the resident's medication administration record (MAR) as that staff member would have found out the pain medicine had been DC'd [discontinued]. I preach to the staff to read and double check those MAR's.A review of the progress notes for 7-16-25, failed to identify any documentation of Resident E receiving a dose of as needed, or PRN pain medication on the evening of 7-16-25. The Controlled Drug Receipt Record/Disposition Form, for Resident E's oxycodone 5 milligrams (mg) indicated Qualified Medication Aide (QMA) 5, administered one dose of this medication on 7-16-25 at 8:30 p.m. The last dose, prior to this dose, was received on 7-15-25 at 8:00 p.m. The form indicated the directions for this medication were to take one capsule orally every four hours as needed for pain for seven days, with the original start date listed as 7-9-25, and the form indicated 30 tablets had been received on 7-10-25, with the first dose received on 7-10-25 at 7:00 p.m. It indicated a total of seven doses had been administered to Resident E, including the last dose on 7-16-25 at 8:30 p.m., given by QMA 5. It indicated 23 doses of this medication were disposed of on 7-18-25, which was conducted by a staff nurse and the Assistant Director of Nursing.A review of the MAR for 7-16-25 failed to identify any documentation of Resident E receiving a dose of as needed, or PRN pain medication on the evening of 7-16-25. The entry for oxycodone 5 mg every four hours as needed for pain, indicated the order began on 7-9-25 and had a discontinue date of 7-16-25 at 11:45 a.m. In an interview on 8-22-25 at 9:10 a.m., with the DON, she indicated the facility's investigation identified QMA 5 had not signed the MAR or made an entry into the progress notes. She indicated the order had been discontinued on 7-16-25, on the same day the facility began staff education related to the facility's most recent annual survey related to medication administration citations. The DON indicated the facility did conduct a 72-hour follow-up on the resident with no complications identified. The DON indicated the discontinued order had been updated in the computer system and reflected on the MAR, but the med had not been pulled from the med cart yet, because the nurses aren't allowed to dispose of meds without the DON or ADON [Assistant Director of Nursing] being present. At the time, [name of QMA 5].had been employed about a month or so. In an interview on 8-22-25 at 1:58 p.m., with the DON, she indicated the facility couldn't find where QMA 5 had notified any of the nurses that he was going to give a prn, and since there were no notes or documentation on the MAR, apparently it was not done. The normal procedure for a prn the QMA's were wanting to give, they were to notify the licensed nurse and then put that in the notes either on the MAR that automatically places it in the progress notes, or they were to make a note in the progress notes about this. The clinical record for Resident E was reviewed on 8-21-25 at 3:28 p.m. His diagnoses included, but were not limited to, lung cancer. On 8-22-25 at 1:15 p.m., the Executive Director provided an undated copy of a document entitled, Qualified Medication Aide Scope of Practice. This document indicated, The following tasks are within the scope of practice for the QMA unless prohibited by the facility policy .11. Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty. This citation relates to Intakes 1656340 and 2564836.3. 1-14(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure a medication that had been discontinued was not administered by facility staff to 1 of 4 residents reviewed for accuracy of medication receipt. (Resident E, QMA 5)Findings include:In an interview with the Director of Nursing (DON) on 8-20-25 at 3:40 p. m. She indicated this was the only medication error that had occurred since the most recent annual survey at the end of June 2025, and was identified on the day after it occurred. She indicated the staff member did not check the resident's medication administration record (MAR) as that staff member would have found out the pain medicine had been DC'd [discontinued]. I preach to the staff to read and double check those MAR's.The clinical record of Resident E was reviewed on 8-21-25 at 3:28 p.m. His diagnoses included, but were not limited to, lung cancer.A review of the progress notes for 7-16-25, failed to identify any documentation of Resident E receiving a dose of as needed, or PRN pain medication on the evening of 7-16-25. The Controlled Drug Receipt Record/Disposition Form, for Resident E's oxycodone 5 milligrams (mg) indicated Qualified Medication Aide (QMA) 5, administered one dose of this medication on 7-16-25 at 8:30 p.m. The last dose, prior to this dose, was received on 7-15-25 at 8:00 p.m. The form indicated the directions for this medication were to take one capsule orally every four hours as needed for pain for seven days, with the original start date listed as 7-9-25, and the form indicated 30 tablets had been received on 7-10-25, with the first dose received on 7-10-25 at 7:00 p.m. It indicated a total of seven doses had been administered to Resident E, including the last dose on 7-16-25 at 8:30 p.m., given by QMA 5. It indicated 23 doses of this medication were disposed of on 7-18-25, which was conducted by a staff nurse and the Assistant Director of Nursing.A review of the MAR for 7-16-25 failed to identify any documentation of Resident E receiving a dose of as needed, or PRN pain medication on the evening of 7-16-25. The entry for oxycodone 5 mg every four hours as needed for pain, indicated the order began on 7-9-25 and had a discontinue date of 7-16-25 at 11:45 a.m. In an interview on 8-22-25 at 9:10 a.m., with the DON, she indicated the facility's investigation identified QMA 5 had not signed the MAR or made an entry into the progress notes. She indicated the order had been discontinued on 7-16-25, on the same day the facility began staff education related to the facility's most recent annual survey related to medication administration citations. The DON indicated the facility did conduct a 72-hour follow-up on the resident with no complications identified. The DON indicated the discontinued order had been updated in the computer system and reflected on the MAR, but the med had not been pulled from the med cart yet, because the nurses aren't allowed to dispose of meds without the DON or ADON [Assistant Director of Nursing] being present. At the time, [name of QMA 5].had been employed about a month or so. This citation relates to Intakes 1656340 and 2564836.3.1-48(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure a medication was stored safely in the absence of staff for 1 of 1 medication during 5 medication administration observations with 5 staff and 11 residents. (Resident F and LPN 4)Findings include: During a medication administration observation on 8-21-25 at 1:16 p.m., a packet of medication, labelled, phenazopyridine 100 mg with one tablet inside and labelled for Resident F was observed lying on top of medication cart, located near the nurses' station. No staff were observed in the area until 1:20 pm. At this time, Licensed Practical Nurse (LPN) 4 returned to the medication cart. In an interview at 1:21 p.m., with LPN 4, she indicated she had been pulled away for care related to another resident and did not take the time to secure the medication into the medication cart in her absence. The medication cart was observed to be locked during this time.In a review of Resident F's medications on 8-22-25 at 11:50 a.m., she was physician ordered to receive phenazopyridine 100 milligrams every 8 hours for bladder spasms. Her medical diagnoses, included but were not limited to neuromuscular bladder dysfunction.In an interview with the Director of Nursing on 8-21-25 at 3:30 p.m., she indicated she had conducted an in-service (staff education) in the last month, addressing medication administration. She indicated she had educated all staff on the importance of securing all medications when staff were not present.This citation relates to Intakes 1656340 and 2564836.3.1-25(m)