STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	1500 Grant St Huntington, IN 46750

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the high-temperature dishwasher functioned at a level to maintain proper sanitization requirements. This deficient practice had the potential to impact 58 of 58 residents who received meals from the facility kitchen. Findings include:During the initial kitchen tour, on 7/21/25 at 9:30 a.m., the following concerns regarding inaccurate high temperature dishwashing were observed:The high temperature dishwashers washing temperature was 126 degrees Fahrenheit (F) instead of the requirement of 160 degrees F or higher.During an interview, on 7/21/25 at 9:50 a.m., the Dietary Manager indicated the thermostat was replaced on Friday. Even though the wash temperature was below the indicated temperature, she felt it was safe to use as she was pouring sanitizing chemical into the dishwasher. She poured a small cup of pink chemical sanitizer into the dishwasher before running the machine. After it ran, she tested the water with a chemical strip that indicated improper sanitization was completed.On 7/21/25 at 9:57 a.m., the Maintenance Director indicated he replaced the thermostat on Friday 7/19/25. He thought the thermostat was preset and did not run the dishwasher to verify the dishwasher reached the appropriate temperature.A current facility policy, dated 2017, titled, Dishwashing: Machine, provided by the administrator, on 7/25/25 at 4:24 p.m., indicated the following: .2. Check to ensure that the wash and rinse cycles are achieving proper temperature per manufacture guidelines. If a chemical sanitizer is used, check the concentration using the correct strip. Refer to the guidelines on the dish machine log for acceptable temperatures for hot water temperature, or the proper sanitizing concentration, do not proceed to wash dishes. Corrective action must be taken.3.1-21(i)(3)

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	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to promote residents' rights to make choices regarding taking leave of absence within the local community and failed to assess residents for their ability to make such determinations before restricting leave of absence for 2 of 2 residents reviewed for self-determination. (Residents 1 and 34). During a Resident Council group interview, on 7/24/25 at 1:33 p.m., Resident 34 indicated she had concerns and questions about why she and another resident were no longer allowed to leave the facility property on their motorized scooters.During an interview with the Administrator on 7/24/25 at 2:15 p.m., she indicated there was an incident with a resident on a motorized scooter. The resident(s) had done something they should not have and caused an incident. The incident happened before the Administrator was employed by the facility. She did not know more about what happened.During an interview with the Social Services Director (SSD) on 7/24/25 at 2:47 p.m., she indicated motorized scooters were owned by Residents 1 and 34. There were two incidents where Resident 1 went to a nearby Dairy Queen and a gas station. The sidewalks were uneven, and she almost tipped over. Resident 1 was educated about not taking the scooter to unsafe areas. The SSD received calls from people in the community saying the residents on the scooters were almost hit by cars. Both Resident 1 and 34 were cognitively intact. The SSD lacked documentation about the incidents and/or interviews with community members.During an interview with the DON on 7/24/25 at 3:02 p.m., she indicated she did not have documentation of where or when the incidents on the motorized scooters occurred. Both residents were cognitively intact.A review of Resident Council minutes, provided by the Activities Director (AD) on 7/28/25 at 11:04 a.m., indicated both Resident 1 and 34 were educated on 6/4/25 about the safety of going to the gas station or leaving the property without supervision. Education was again provided on 7/2/25 about safety and motorized scooters and the importance of safety in the community. Effective 7/2/25, motorized scooters were no longer allowed off of the facility property.Resident 1's clinical record was reviewed on 7/23/25 at 4:02 p.m. Diagnoses included type 2 diabetes mellitus, anxiety disorder, hypertension, overactive bladder, osteoarthritis, GERD, and muscle weakness.A quarterly Minimum Data Set (MDS) assessment, dated 7/10/25, indicated the resident was cognitively intact and used a wheelchair due to impairment on one side of both her upper and lower extremities.A current care plan, dated 7/2/25, indicated the resident had been educated on motorized wheelchair not to be used on the road(s). She was educated that she could go outside but not leave the property without supervision. Interventions included: Educate (the resident) on the importance of maintaining a safe environment free of potential fall hazards, let the resident know the facility can transport to where she wanted to go, or family could be contacted to transport the resident if needed.A Social Services note, dated 6/4/25, provided by the SSD on 7/25/25 at 4:02 p.m., indicated the following: .(Resident 1) was educated on motorized wheelchair not for on- the-road use. Resident (1) educated that she may go outside but not leave property without supervision in case battery may die or uneven sidewalks, safety, uneven road surface. Resident agreed and verbalized understanding.During an interview with Resident 1 on 7/25/25 at 9:32 a.m., she indicated she was unable to leave the facility property anymore on her motorized scooter. The resident had trouble with the sidewalk on one occasion and got stuck. She did not remember when it happened, but it had been awhile. Local police helped her get unstuck. She did not ride the scooter on the roads, but crossed the road to go to Dairy Queen. She was asked to sign a form provided by the SSD, who told her she could no longer leave the property. Resident 1 was told she would have to have supervision in order to leave the property on her scooter.Resident 34's clinical record was reviewed on 7/28/25 at 9:38 a.m. Diagnoses included hypertension, hypernatremia (high sodium levels), COPD, and anemia.A quarterly MDS assessment, dated 5/19/24, indicated Resident 34 was cognitively intact and used a wheelchair for mobility.A current care plan, dated 7/2/25, indicated the resident had been educated on motorized wheelchair not to be used on the road(s). She was (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educated that she could go outside but not leave the property without supervision. Interventions included: Educate on the importance of maintaining a safe environment free of potential fall hazards, let the resident know the facility can transport to where she wants to go, or family can be contacted to transport the resident if needed.During an interview with Resident 34, on 7/25/25 at 3:05 p.m., she indicated the reason she bought the motorized scooter was so she could leave the premises and go to nearby restaurants or stores. She was her own person and made her own health decisions. She took a class about how to operate the motorized scooter and was given instructions to sign in and out of the facility whenever she left the property. She did not remember when, but at some point, she was told she could no longer take her scooter off the property because it was not allowed by the State. She only left the premises one time, got stuck on an uneven section of sidewalk, and a bystander helped her get the scooter off of the uneven sidewalk. She once got stuck just outside the facility, on the premises, and had to wait for an indeterminate amount of time until someone helped her get unstuck. She had never tipped the scooter. She was recently told taking her scooter off the premises was a liability and she was no longer allowed to go off the property. She was provided with information about the restriction and signed the agreement, but she was too mad to know what she actually signed.A Social Services note, dated 6/4/25, provided by the SSD on 7/25/25 at 4:02 p.m., indicated the following: .(Resident 34) was educated on motorized wheelchair is not made for road use. Resident (34) educated that she may go outside but not leave property in case battery may die or uneven sidewalks, unsafe and uneven road surface. Resident agreed and verbalized understanding.A current facility policy, titled Guidelines for the Use of Motorized Vehicles in the Facility, provided by the Administrator on 7/28/25 at 3:16 p.m., indicated the following: .It is the intent of the facility to promote each resident's quality of life to the optimal level to include independence with mobility. Residents who are cognitively intact and who have a documented medical reason to support the use of a motorized vehicle (such as a wheel chair, scooter, or cart) will be allowed to use the vehicle as long as they 1) adhere to the related safe guards that are in place in the facility.Procedure: 2) Residents who desire to use a motorized vehicle will be assessed by therapy for safe operation ability of the device. This assessment will be done prior to the first time the resident uses the device upon admission, re-admission, when there is a change of condition in the resident, and following any incident related to the resident's use of the device. The resident will have the use of the device placed on hold if there are any safety concerns as a result of any assessment.7) When outside, the vehicle should be kept on the sidewalk.18) At any time and for any reason if the physician, therapist, DON, or Administrator feels that the resident's operating capacity poses a safety risk to the resident or others, the Administrator will remove the vehicle from the resident's possess until a decision can be made.related to the use of the vehicle going forward.3.1-3(a)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review the facility failed to assess residents for self-administration of medications for 3 of 3 residents reviewed for self-administration of medication. (Resident 8, Resident 12, and Resident 42)Findings Include: 1.During an observation and interview with Resident 12, on 7/21/25 at 10:51 a.m., the resident indicated his morning medications were left with him each day because he did not like to take his medications before he ate breakfast. On his bedside table was a medication cup which contained one medium round peach pill, one medium round beige pill, one small round pink pill, and half of a small oblong white pill. Nurses left his morning medications with him daily because they were aware he waited for breakfast to be served before he took the pills. During an observation, on 7/23/25 at 9:05 a.m., Resident 12's medications were sitting on his bedside table in a medication cup. The medication cup contained one oblong white pill, one medium round peach pill, one medium round dark pink/purple pill, and half of a small oblong white pill. Resident 12 indicated he had just finished breakfast and had not yet taken his pills. He could not identify the pills or what condition(s) they treated. During an interview with LPN 6, on 7/23/25 at 9:10 a.m., she indicated Resident 12 was not care-planned to self-administer medications. He did not like to take his medications before breakfast. Since he was alert and oriented, she felt comfortable leaving his pills with him. Resident 12's clinical record was reviewed on 7/23/25 at 9:25 a.m. Diagnoses included type 2 diabetes mellitus, major depressive disorder, benign prostatic hyperplasia, and cardiomyopathy. Current physician's orders included nicotine transdermal patch 24-hour apply 14 milligrams (mg) transdermal one time a day for tobacco use, metoprolol tartrate 25 mg 0.5 tablet by mouth two times a day for hypertension (hold for heart rate less than 60 beats per minute, hydralazine hydrochloride 50 mg give one tablet by mouth two times a day for hypertension, lisinopril 5 mg give one tablet by mouth one time a day for hypertension, fluoxetine hydrochloride 60 mg give one tablet by mouth one time a day for depression, and clopidogrel bisulfate 75 mg give one tablet by mouth one time a day for heart attack/stroke prophylaxis. A quarterly Minimum Data Set (MDS) assessment, dated 7/3/25, indicated Resident 12 was cognitively intact, with no hallucinations, delusions, or behaviors, had impairment to his lower extremities bilaterally, used a manual wheelchair, required partial to moderate assistance for activities of daily living, and substantial/maximum assistance for lying to sitting and transfers to shower. The clinical record lacked a physician's order to self-administer medication and self-administration of medication assessment. During an interview with the DON on 7/23/25 at 3:37 p.m., she indicated staff are not supposed to leave medications in residents' rooms. None of the residents in the facility were to self-administer medications and the facility policy says not leave medications in residents' rooms. 2. During an observation, on 7/22/25 at 10:57 a.m., a medication administration cup, containing eight pills, sat beside a plastic cup of water, on Resident 49's table. The medications were, one grey and yellow capsule, one pink tinge, round pill, two small, round, white pills, one medium, round, white pill, (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one large, red, gel capsule, one large, oblong, white pill, and one large, oblong, pink-tinge pill. During an interview, on 7/22/25 at 11:16 a.m., Resident 49 indicated he had gotten side-tracked and had forgotten to take his medication. He self-propelled his wheelchair to the table, picked up the medication administration cup, and emptied the cup of medications into his mouth. After taking a drink from the plastic cup of water, which sat by the medication administration cup, he swallowed the pills. He was unsure of what medications he had taken, except there was a water pill and an eye pill, but he did not know which pills those were. He took whatever medications the staff gave him. During an observation, on 7/23/25 at 10:27 a.m., Resident 49 sat in his recliner. Across the room, a medication administration cup which contained medication, sat beside a plastic cup of water, on Resident 49's table. During an interview, on 7/23/25 at 3:37 p.m., the DON indicated medications were not to be left in any resident rooms by staff. The facility had a policy which addressed not leaving medications in rooms. There were no residents at the facility who self-administered their medications. During an observation on 7/25/25 at 10:18 a.m., Resident 49 was sleeping in his recliner. Across the room, a medication administration cup containing ten pills sat beside a plastic cup of water on Resident 49's table. The medications included one pink and tan capsule, one small, pink, round pill, two small, round, white pills, one medium, round, white pill, one large, red, gel capsule, one large, oblong, white pill, and one large, oblong, pink-tinge pill, one small, oval, off-white pill, one medium, round pink pill. During an observation, on 7/25/25 at 12:07 p.m., Resident 49 was sitting in his wheelchair in his room. The medication administration cup, with medications, remained sitting on the table. Resident 49's clinical record was reviewed on 7/25/24 at 4:05 p.m. Diagnoses included hypertension (high blood pressure), diabetes (high blood sugar), and atrial fibrillation (fast, irregular heartbeat). A quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated Resident 49's cognitive status was moderately impaired. The clinical record lacked a physician's order to self-administer medication and a self-administration of medication assessment. 3. During observation, on 7/25/25 at 10:24 a.m., Resident 8 was asleep in her bed. A medication administration cup, containing nine pills, sat beside a plastic cup of water, on Resident 8's bedside table. The bedside table was across the room, in front of Resident 8's recliner. The medications were, one small, red gel capsule, one small, green, gel capsule, one yellow oval pill, one large maroon capsule, two small, round, white pills, one medium, round, white pill, one white oval pill, 1/2 of a white oval pill, and one Trelegy inhaler. During an interview, on 7/25/2025 at 2:30 p.m., Resident 8 indicated the facility staff would leave medications in her room for her to take when she woke up. She did not know what medications she took. She took whatever medication the staff brought to her. Resident 8's clinical record was reviewed on 7/25/24 at 11:36 a.m. Diagnoses included bipolar disorder, dysphagia (difficulty swallowing), and cognitive communication deficit. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) assessment, dated 6/29/25, indicated Resident 8's cognitive status was moderately impaired. The record lacked a physician's order to self-administer medication and a self-administration of medication assessment. During an interview, on 7/28/2025 at 12:51 p.m., LPN 6 indicated she left medications in both Resident 42 and Resident 8's rooms. Both residents were alert and oriented and they liked their medications available for when they were ready to take them. Resident 42 liked his medications to be placed on the table under the TV, and he took his medications after he ate breakfast. Resident 8 took her medications around breakfast time. Resident 8 sometimes needed an extra reminder due to illness or confusion. She went back to check all the medications left in the resident's rooms were taken. A current facility policy, dated March 2023, titled Medication Administration, provided by the DON on 7/22/25 at 3:31 p.m., indicated the following: Purpose: To administer all medications safely and appropriately.Procedure: 17. Remain with the resident to ensure that the medication is swallowed. 3.1-11(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure the resident and the resident's representative were notified in writing of the transfer/discharge appeal rights and the bed hold policy when a resident was transferred to the hospital for 1 of 3 residents reviewed for hospitalization (Resident 58). Finding includes:Resident 58's clinical record was reviewed on 7/28/25 at 12:09 p.m. His diagnoses included type 2 diabetes with other diabetic kidney complications, paroxysmal atrial fibrillation (rapid irregular heart rhythm), abnormal findings on diagnostic imaging of heart and circulation, and cerebral infarction (stroke) due to occlusion or stenosis of the small artery. A progress note, dated 4/25/25 at 10:30 a.m., indicated the facility spoke with the resident's representative to send the resident to the hospital after the latest labs indicated the resident's hemoglobin continued to decrease. Emergency Medical Services would take the resident to the local hospital. The resident's representative indicated the family would transport the resident to the regional hospital. An e-Interact SBAR (Situation, Background, Assessment, Recommendation) summary for providers note, dated 4/25/25 at 3:40 p.m., indicated the resident was sent to the hospital. The clinical record lacked indication the resident and the resident's representative were notified of the transfer/discharge appeal rights and bed hold policy in writing for the resident's transfer to the hospital. During an interview, on 7/28/25 at 12:59 p.m., LPN 6 indicated, when a resident was transferred, a face sheet was sent, the code status was sent, a medication list was sent, and a bed hold form was sent. She was uncertain of what else was sent and indicated she was going to ask the ADON. During an interview, on 7/28/25 at 1:02 p.m., LPN 6 and the ADON indicated all the required paperwork such as the bed hold and the transfer/discharge forms were now on a pathway on the computer and popped up to complete when a resident was transferred or discharged . During an interview on 7/28/25 at 1:25 p.m., the DON indicated the required forms for transfer/discharge and bed hold were on the computer and popped up when a resident was transferred or discharged . When Resident 58 was transferred, paper copies were used. She indicated the resident's transfer to the hospital had been unusual. The resident's clinical record did not contain the transfer/discharge appeal rights or the bed hold policy provided to the resident and/or the resident representative with the resident's transfer to the hospital. A current facility policy, dated 1/1/17, provided by the DON on 7/28/25 at 2:22 p.m., titled Transfer and Discharge Policy and Procedure, indicated the following: .Before a facility transfers a resident to a hospital or a therapeutic leave, the nursing facility will provide information to the resident/responsible party that specifies the duration of the bed-hold policy and the facility's policies regarding bed-holds.Emergency Transfer:.Explain transfer and reason to the resident and/or representative if applicable send the original State Transfer/Discharge/Bedhold notice with the resident and/or representative or person(s) responsible for care. Place the facility copy in the health record. 3.1-12(a)(6)(A)(i)3.1-12(a)(6)(A)(ii)3.1-12(a)(6)(A)(iii)3.1-12(a)(25)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review, the facility failed to ensure vision services were provided for 1 of 3 residents reviewed for ancillary services. (Resident 33) Finding Includes:During an interview, on 7/21/25 at 10:00 a.m., Resident 33 indicated he had not been seen by the facility's eye doctor. He spoke with the Social Service Director two weeks ago and she was to schedule an eye appointment at the local supermarket. He had not heard anything regarding an appointment. He was blind in his left eye and had poor vision in right eye.Resident 33's clinical record was reviewed on 7/25/25 at 1:59 p.m. Diagnoses included benign prostatic hyperplasia (enlarged prostate), neuropathy (nerve damage), major depressive disorder, and anxiety. Current orders included Resident 33 may receive services including eye care, audiology, podiatry, and dental. (9/19/24). A quarterly Minimum Data Set (MDS) assessment, dated 4/27/25, indicated Resident 33's cognitive status was moderately impaired. He required corrective lenses and his vision was adequate. A current care plan for being at risk for dental, vision, hearing and podiatry issues, dated 1/1/25, indicated Resident 33 asked to be put on the list to be seen by ancillary services, and it would be his choice if he would be seen when ancillary providers were in the building. The goal included Resident 33 would be encouraged to participate in ancillary services quarterly while ancillary providers were in the facility if he allowed them to treat him. A physician progress note, dated 12/23/24, indicated Resident 33 needed an eye doctor appointment scheduled for visual disturbances. A physician progress note, dated 2/17/25, indicated Resident 33 complained of worsening vision and required an eye exam. A follow up was needed to check if Resident 33 was on the list to be seen by the eye doctor during next visit to the facility. A physician progress note, dated 7/7/25, indicated Resident 33 would like an eye exam. A 9/29/24 document, scanned into Resident 33's electronic record, had the wrong last name entered on it. The first name and date of birth were accurate. The form was signed by Resident 33 and indicated that he wanted audiology, eye care, and podiatry ancillary services. A 7/15/25 document, scanned into Resident 33's electronic record, was signed by Resident 33 and indicated that he wanted audiology, eye care, and podiatry ancillary services. During an interview, on 7/28/25 at 10:44 a.m., Resident 33 indicated he felt that his vision in his right eye had worsened and was blurrier than it had been. He wanted to see an eye doctor as soon as possible. During an interview, on 07/28/2025 at 11:42 a.m., the Social Services Director (SSD) indicated she was unable to locate documentation regarding an eye appointment for Resident 33. She recalled discussing an eye appointment with Resident 33 approximately two weeks ago. She reached out to the optometry company via email on 7/14/25 and questioned why Resident 33 had not been seen by their provider. They indicated that Resident 33 was not on their caseload. She had Resident 33 sign a release for ancillary services on 7/15/25. She informed Resident 33 he could be seen in-house during the optometrist's next visit, or he could be seen in the community. She felt Resident 33 opted to wait to be seen by the facility optometrist, so no appointment was scheduled. She was not aware the physician notes indicated the need for an eye exam. She was not aware Resident 33's initial optometry election form had the wrong last name on it. She confirmed the forms had matching first names and date of birth s. She verified the form was in her handwriting and she may have made a mistake. She did not feel optometry services were delayed on her behalf as she acted promptly when finding out Resident 33 wanted to see an eye doctor but did feel the facility optometry services did not see him timely. She verified that both ancillary services documents indicated Resident 33 wanted to receive ancillary services for audiology, eye care, and podiatry. During an interview, on 7/28/2025 at 3:19 p.m., the DON indicated there was a female resident admitted within the same time frame of Resident 33, who had the last name that was listed on Resident 33's initial ancillary services authorization document. The initial consent form was filled out in error. She and the ADON reviewed physician progress notes and anything that occurred within a 24-hour basis. The practitioner did not inform staff of Resident 33 needing an eye exam. She felt the ancillary services provider did not notify the management team of having an unidentifiable resident on (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their facility list. She did not feel that there was a delay in vision services due to Resident 33 had not been vocal about wanting to see an eye doctor. During an interview, on 7/28/2025 at 3:29 p.m., the Administrator indicated the ancillary services provider should have informed the facility of the inability to locate an unidentified resident. If the facility staff had been notified of the wrong name on the initial ancillary services form, the staff would have identified the problem, and it would not have caused a delay of vision services During an interview, on 7/28/2025 at 3:36 p.m., Resident 33 indicated he was frustrated because he was informed earlier in the day that he had an eye doctor appointment at the local supermarket at 1:30 pm. The facility transported him and when he arrived it was noted the eye doctor office did not open until 2:00 p.m. He waited until 2:00 p.m. and then was informed by the local supermarket's vision department staff that the eye doctor was not in until Thursday. The facility transport took him to a local office of an optometry chain. No eye appointments were available at that provider. He did not receive any eye care services today. During an interview, on 7/28/25 at 3:43 p.m., the SSD indicated that she had transportation take Resident 33 to the supermarket's optometry office at 1:30 p.m. for an eye appointment. She had not actually called that office to set up an appointment because she knew they took walk-ins. Resident 33 was on the transportation log to take to the supermarket's optometrist on Thursday, however the optometrist's staff indicated to the facility staff that Thursdays were first come, first serve, so Resident 33 may not be seen on that day either. An eye appointment was made for Monday, August 4 at 3:40 p.m. An admission Agreement, updated 2/6/23, provided by the Administrator on 7/28/25 at 12:48 p.m., indicated the following .ANCILLARY SUPPLIES AND SERVICES: Resident may utilize a variety of ancillary supplies and services during his or her stay in the facility. ancillary supplies and services or supplies and services indirectly related to residents stay in the facility and include, but are not limited to,.certain support services, certain medical equipment, and transportation. 3.1-39(a)

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	155059	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Huntington Skilled Nursing Facility, The	1500 Grant St Huntington, IN 46750

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to develop and implement effective interventions for and monitoring of behavior expressions of known wandering and physical aggression for 1 of 1 residents reviewed for dementia care. (Resident 53)Findings include:Resident 53's clinical record was reviewed on 7/25/25 at 9:38 a.m. Diagnoses included dementia with other behavioral disturbance(s), major depressive disorder, anxiety disorder, need for assistance with personal care, and insomnia.Current physician's orders included sertraline hydrochloride (HCL) 25 milligrams (mg) one tablet by mouth daily for depression, donepezil HCl 10 mg one tablet by mouth at bedtime for dementia, check function of WanderGuard (a wearable device used to monitor residents who are at risk for elopement) to left ankle every shift for elopement risk, behavior monitoring each shift for depressive mood, anxiety, resident to resident altercations, agitation, and non-compliance/aggressive physical contact, and may admit to a secured unit related to diagnosis of Alzheimer's/dementia.A quarterly Minimum Data Set (MDS) assessment, dated 7/8/25, indicated Resident 53 was severely cognitively impaired, had difficulty focusing attention and was easily distracted, had disorganized thinking, incoherent (rambling or irrelevant) conversation, was unpredictable, and wandered daily.A current care plan, initiated 6/30/25, indicated the resident was at risk for elopement from the facility based on the elopement risk assessment and secondary to confusion, disorientation, and other cognitive deficits affecting decision making and general awareness. Interventions included: Assess for unmet needs that might be masked by wandering behavior (i.e., pain, hunger, thirst, toileting, positional needs, companionship, etc.), assess the resident for wandering and elopement risks upon admission, quarterly, and in the event of a significant change in condition, divert attention to safe and meaningful activities, meet needs as determined by assessment, notify the physician or social worker of changes in mood, behavior, or cognition as necessary, provide therapeutic interventions to distract from wandering, and WanderGuard placed on left ankle.A current care plan, initiated 12/13/23, indicated Resident 53 was at risk for elopement due to a diagnosis of dementia. Interventions included: Personalized - I like to be left alone, I like to wander around, I like to be offered food and drinks (9/20/24), if the resident leaves the building, goes into a peer's room, or becomes aggressive, redirect (the resident) by limiting the number of staff who redirect the resident, if another person is needed for safety, the second person should remain out of sight, in the background, or behind the primary caregiver. Do not overwhelm the resident (12/13/23).A current care plan, initiated 8/10/24, indicated the resident was aware that, according to his diagnoses, depression, and cognitive status, he might be at risk for occasional episodes of physical and/or verbal aggression, aggressive physical contact with staff and other residents, inappropriate sexual talk and touch with staff and other residents, wandering hallways, elopement, exit seeking, non-compliance with care and medications, and made false accusations. Interventions included: Allow the resident to vent, refer to psychiatric nurse practitioner if needed, offer the resident his favorite snack, and redirect him to a quiet area to self-regulate.A current care plan, initiated 1/1/25, indicated the resident had episodes of wandering, as evidenced by roaming the halls all day, forgetting where his room was, and wandering into the rooms of other residents. Interventions included: Attempt to redirect the resident from wandering activity, and provide the resident with food, drink, offer toileting, walk with the resident, and offer other activities.A current care plan, initiated 8/9/24, indicated Resident 53 had a depressive mood, anxiety, agitation, and aggressive physical contact. He was at risk for resident-to-resident aggressive physical contact due to his diagnoses and history of aggression. Interventions included: Listen to concerns and follow up on (these) promptly as needed, and provide support and encouragement as needed.A Wandering Risk Scale assessment, dated 7/5/25, indicated the following: The resident was able to follow instructions, was ambulatory, could not communicate, had a history of wandering, medical diagnoses (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of dementia/cognitive impairment, and was a high risk to wander.A review of Resident 53's census indicated from 3/30/22 to 8/19/24, he resided on the secured memory unit of the facility. On 8/19/25, the resident was transferred to an unsecured unit.A progress note, dated 8/16/24 at 1:50 p.m., indicated Resident 53 was arguing with another resident, became agitated, and lunged at the other resident. Resident 53 was offered a snack and an activity, but the agitation continued. The psychiatric nurse practitioner was notified and gave an order for valproic acid (a seizure drug used off-label to treat bipolar disorder)125 mg to be given three times daily.A progress note, dated 8/18/24 at 4:26 p.m., indicated Resident 53 saw a female resident attempt to take a ball from another male resident. Resident 53 shoved the (other) male resident to the ground and caused the other resident to hit his hip on the way to the floor. The men were immediately separated. Resident 53 appeared to forget the incident and returned to his previous activities.A progress note, dated 8/29/24 at 5:46 a.m., indicated Resident 53 was combative with staff and raised his fists to them.A progress note, dated 10/6/24 at 9:55 p.m., indicated Resident 53 was combative with certified nurse aids (CNA), used foul language, and pushed one of the CNAs against the wall. Prior to the incident, the resident walked around the hallways and did not want to get ready for bed. His brief was soiled, and he walked into the hallway half naked. The CNAs tried to calm him down, reassured him, explained why his brief needed to be changed, and eventually was able to get the brief changed. He would not allow his clothing to be changed.A social service progress note, dated 10/11/24 at 9:46 p.m., indicated the resident refused care and was combative when staff tried to assist him. Several attempts of personalized interventions did not work. He was left alone and reapproached later.A progress note, dated 11/8/24 at 8:53 p.m., indicated the resident became agitated during a clothing change. Resident 53 attempted to choke the CNA providing care, but the CNA was able to get away before the resident caused harm.During an observation, on 7/25/25 at 2:31 p.m., Resident 53 wandered up and down the Center hallway, turned right at the nurse's station and walked to the exit door at the end of the South hallway. He turned around, walked back towards the nurse's station, looked in several rooms as he passed them, and headed down the North hallway. At 2:37 p.m., the resident stood at the exit door of the North hallway, then turned left into a hallway leading to the memory unit. Resident 53 was not visible to staff at that point. At 2:43 p.m., he wandered back into the North hallway and made his way to the lounge area next to the nurse's station. No staff approached Resident 53 or offered a snack, activity, or diversion.During an interview with LPN 8, on 7/25/25 at 2:35 p.m., she indicated Stop Sign Banners were secured across the doorways of residents who have complained about Resident 53 entering their rooms unannounced and/or uninvited. She thought the banners helped to keep Resident 53 out of other residents' rooms, but not always. Resident 53 would often stand in doorways and stare at the other residents. He would sometimes go in, uninvited, and the other residents would turn on their call lights for assistance. CNAs and/or nurses would retrieve Resident 53 and try to redirect him.During an interview with CNA 9, on 7/25/25 at 2:42 p.m., she indicated the banners across the doorways were to help keep Resident 53 out of other residents' rooms. Resident 53 would sometimes pull the banner away, go into a room, and lay down on a bed. The other residents would turn on their call lights for assistance and some would yell at him to get out. Yelling at him did not deter him and he would just stare at the other residents. Nurses or CNAs would remove him from the rooms. He could become aggressive and push others. During an interview with LPN 10, on 7/25/25 at 2:46 p.m., she indicated the banners were used to keep wanderers out of other residents' rooms. There were a few wanderers, but Resident 53 was the primary one. Sometimes he would pull the banner(s) off the doors and go inside. He was more likely to go into a room without the banner than one with the banner. He could become combative with staff, especially during personal care or toileting. He would sometimes participate in activities, but most times would not.During an observation, on 7/25/25 at 2:50 p.m., Resident 53 was leaning on the medication cart at the nurse's station. He listened to others talking and looked around aimlessly. At 2:55 p.m., he remained at the nurse's station. No staff made eye contact with or talked to him.During an observation, on 7/28/25 at 1:41 p.m., Resident 53 was at the (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exit door of the South hallway. He moved from the South exit door, past the nurse's station, and down to the exit door of the North hallway. He placed his hands on the handle of the door but did not push to open it. He moved into the hallway leading to the memory unit and was not visible for four minutes. At 1:45 p.m., he returned to the North hallway exit door. As he walked down the hallway, he stopped at the doors and peered inside. A CNA passed him but did not make eye contact. He smiled at two staff members, but neither responded to him. He continued down the South hallway, went into the physical therapy room, came back out, and crossed the hallway into another resident's room at 1:49 p.m. He wandered around the room, picked up a bag of potato chips, looked at them, and sat them back down. At 1:50 p.m., he straightened the sheets on the other resident's bed, sat down, put his feet up, and settled into the bed. A physical therapy assistant (PTA) returned an item to the therapy room and on her way out noticed Resident 53 in the bed. She addressed him by name and made several attempts to get Resident 53 out of bed. She offered her hand, but he would not comply. She eventually offered him a cookie which resulted in him getting out of bed. He accompanied her to the hallway where she replaced the banner across the door. He tried to pull the banner away again. At approximately 2:00 p.m., the resident went with the PTA down the hall towards the nurse's station.During an interview with the DON, on 7/28/25 at 2:22 p.m., she indicated approximately one year ago, Resident 53 was the only male on the memory unit. He was very protective of the women on the unit, particularly one woman. When another male was admitted to the memory unit, Resident 53 got aggressive with him. An incident occurred involving the female resident(s) and a ball. Resident 53 shoved the other male resident, causing the other male to fall and hit his hip on the way down to the floor. When another incident almost occurred, the facility decided to place Resident 53 on the unsecured unit. Some residents complained about Resident 53 entering their rooms unannounced and uninvited, but he was harmless.During an interview with the DON, on 7/28/25 at 2:25 p.m., she indicated the facility did not have a policy specifically addressing wandering.3.1-37(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to implement pharmacy recommendations and follow physician orders to discontinue medications for 1 of 5 residents reviewed for pharmacy recommendations. (Resident 24)Finding includes: Resident 24's clinical record was reviewed on 7/23/25 at 9:38 a.m. Diagnoses included major depressive disorder, dementia, and hypertension (high blood pressure). Current orders included ondansetron HCL (for nausea) 4 milligram every six hours as needed for nausea or vomiting.A quarterly Minimum Data Set (MDS) assessment, dated 5/27/25, indicated Resident 24's cognitive status was severely impaired.A pharmacy medication regimen review, dated 1/1/25, indicated the provider agreed to discontinue Resident 24's PRN ondansetron and PRN Imodium (for diarrhea).The clinical record indicated Resident 24's ondansetron was not discontinued.During an interview, on 7/28/25 at 1:48 p.m., the ADON indicated Resident 24's ondansetron had never been discontinued.During an interview, on 7/28/25 at 2:03 p.m., the DON indicated based on the 1/1/25 pharmacy recommendation, Resident 24's ondansetron and Imodium order should have been discontinued. Upon receiving pharmacy recommendations, they were given to the provider to review and sign, and then the provider returned the signed recommendation to the ADON or DON. The ADON reviewed the recommendations and changed orders accordingly.3.1-25(b)3.1-25(o)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure a resident did not receive an excessive dosage than ordered of an antidepressant when physician orders were not followed for a gradual dose reduction for 1 of 5 residents reviewed for unnecessary medications. (Resident 24)Finding includes: Resident 24's clinical record was reviewed on 7/23/25 at 9:38 a.m. Diagnoses included major depressive disorder, dementia, and hypertension (high blood pressure). Current orders included escitalopram oxalate (for depression) 5 milligram daily.A quarterly Minimum Data Set (MDS) assessment, dated 5/27/25, indicated Resident 24's cognitive status was severely impaired.A pharmacy medication regimen review, dated 5/7/25, indicated Resident 24 had a gradual dose reduction approved for escitalopram to go from 10 milligrams to 5 milligrams daily. The 5-milligram order was added but the 10-milligram order did not get discontinued. Recommendation was to discontinue the 10-milligram order to comply with the gradual dose reduction.The clinical record indicated an escitalopram 5 milligram order was entered by the ADON on 5/1/25 to start on 5/2/25. The DON acknowledged the order on 5/13/25 The 10-milligram order did not get discontinued until 5/12/25 at 2:38 p.m. by the ADON. The DON acknowledged the order on 5/13/25 at 8:38 a.m. This resulted in the orders for both 5 mg and 10 mg to be active at the same time. The electronic medication administration record (EMAR) indicated that escitalopram 5 milligram and escitalopram 10 milligram were both administered on 5/2/25 through 5/12/25.During an interview, on 7/28/25 at 2:03 p.m., the DON indicated the escitalopram dose was discussed at the 5/1/25 behavior meeting and it was determined to decrease the dosage to 5 milligrams. Orders were usually entered during the behavior meeting by the ADON. Upon receiving pharmacy recommendations, they were given to the provider to review and sign, and then the provider returned the signed recommendation to the ADON or DON. The ADON reviewed the recommendations and changed orders accordingly.During an interview, on 7/28/2025 at 2:31 p.m., the DON indicated that Resident 24's EMAR indicated an escitalopram 5 milligram tablet, and an escitalopram 10 milligram table was administered daily from 5/2/25 through 5/12/25. She was made aware of the error after the pharmacy notified her of the duplicate medication administration. The 10-milligram tablet was discontinued at that time.3.1-48(a)(1)3.1-48(b)(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. A. Based on observation and interview, the facility failed to ensure narcotic medication was appropriately identified, labeled and stored. This deficient practice had the potential to affect 1 of 58 residents who resided in the facility.B. Based on observation, record review, and interview, the facility failed to ensure medications were labeled for 1 of 2 medication carts observed. This deficient practice had the potential to affect 15 of 15 residents who received medications from the secured unit medication cart Findings include:A. During a medication storage observation of the South medication cart, on 7/22/25 at 11:35 a.m., accompanied by QMA 7, the following was observed: Four white pills were in a plastic medication sleeve labeled with Resident 32's name, a.m. and p.m. The pills were oblong; the medication was scored and had markings M365. The name of the medication was not marked on the plastic sleeve. QMA 7 indicated Resident 32 had gone out for a leave of absence (LOA) with her representative. The facility dispensed 10 hydrocodone-acetaminophen (opiate pain medication) 5/325 milligram pills into the plastic mediation sleeve for her to take during her LOA. On 7/22/25 at 12:20 p.m., the DON indicated Resident 32 went on a LOA for five days accompanied by her representative. When Resident 32 returned from her leave, there were four pills remining in the plastic sleeve. The facility accepted the remaining pills, filled out a Controlled Substance Record report and placed the medications into the narcotic lock box. The Controlled Substance Record report was missing the resident identification. The DON indicated the paper should have been filled out accurately with the resident's name on the form and the medication should have been destroyed. On 7/23/25 at 2:18 p.m., LPN 8 indicated she did not place a resident identifier on the Controlled Substance Report form. She did not verify the medication before accepting the medication and placing it in the narcotic lock box. When loose medication were brought back into the facility, they should be destroyed. B. During an observation, on 7/25/25 at 9:38 a.m., the medication cart on the secured unit contained two unlabeled medications in Resident 27's section in the second drawer. The medications were a bottle of extra strength acetaminophen (Tylenol) tablets and a bottle of acidophilus probiotic tablets. Resident 43's section contained an unlabeled bottle with Vitamin D3 2000 IU (50 mcg). An opened bottle of nystatin (antifungal) powder approximately one half full without a resident identifier was in the treatment drawer. During an interview, at the same time of the observation, QMA 17 indicated the bottles should be labeled with the resident's name, an expiration date, and when opened. She did not know to whom the bottle of nystatin belonged. Resident 27's clinical record was reviewed on 7/28/25 at 2:38 p.m. The current orders included acetaminophen 325 mg – two tablets every day (5/30/25). The record lacked an order for an acidophilus probiotic. Resident 43's clinical record was reviewed on 7/28/25 at 2:39 p.m. The current orders included cholecalciferol 50 mcg daily (7/11/25). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 7/28/25 at 9:44 a.m., LPN 6 indicated medications should be labeled with the resident's name, the physician, the name of the medication, the open date, and the directions (order). During an interview, on 7/28/25 at 9:48 a.m., the ADON indicated medications should be labeled with the resident's name, the physician's name, the date opened, the actual order and if the medication is an as needed medication (PRN). A current facility policy, titled Medication Storage in The Facility, provided by the DON, on 7/22/25 at 3:31 p.m., indicated the following: .Policy: Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. A current facility policy, dated 3/2023, provided by the DON on 7/23/25 at 2:16 p.m., titled 1.10:NONCONTRACTED PHARMACY FACILITY AGREEMENT, indicated the following: .Nonprescription medications without a prescription label are in the manufacturer's original container and labeled with the resident's name. 3.1-25(j) 3.1-25(k)