

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Edgewater Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 1809 N Madison Ave Anderson, IN 46011	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents from misappropriation when residents' Institutional Special Needs Plan (ISNP) benefits were utilized by a staff member for purposes other than the individual resident's benefit for 3 of 3 residents reviewed for misappropriation of property (Resident D, Resident E, and Resident F). This deficient practice was corrected on 7/18/25, prior to the start of survey, and was therefore past noncompliance. Findings include: 1. Resident E's clinical record was reviewed on 8/28/25 at 11:21 a.m. Diagnoses included aphasia following cerebral infarction, cognitive communication deficit, and expressive language disorder. A quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated the resident was severely cognitively impaired. A progress note, dated 6/23/25 at 1:28 p.m., indicated the resident's representative was notified of a discrepancy with the resident's ISNP card and funds. The facility verified transactions and adjusted as needed for reconciliation. 2. Resident F's clinical record was reviewed on 8/28/25 at 1:39 p.m. Diagnoses included severe intellectual disabilities, unspecified dementia, cognitive communication deficit, other symptoms and signs involving cognitive functions and awareness, encephalopathy, and developmental disorder of speech and language. A quarterly MDS, dated [DATE], indicated the resident was severely cognitively impaired. A progress note, dated 6/23/25 at 1:30 p.m., indicated the resident's representative was notified of a discrepancy with the resident's ISNP card and funds. The facility verified transactions and adjusted as needed for reconciliation. 3. Resident D's clinical record was reviewed on 8/28/25 at 2:29 p.m. Diagnoses included metabolic encephalopathy. A quarterly MDS, dated [DATE], indicated the resident was moderately cognitively impaired. A progress note, dated 6/23/25 at 1:31 p.m., indicated the resident's guardian was notified of a discrepancy with the resident's ISNP card and funds. The facility verified transactions and adjusted as needed for reconciliation. During an interview, on 8/28/25 at 1:45 p.m., the Administrator indicated when the facility credit card was accessed to buy supplies for the activities department, it was noticed that several of the residents' ISNP accounts had zero balances, which was unusual. The Administrator was alerted and began an investigation. The Administrator discovered the Activities Director used multiple resident ISNP cards to purchase items for the activities program. She used the residents' individual ISNP benefits cards to purchase items for the facility. The Administrator indicated she believed the Activities Director did not think about what she was doing and had no intent to take anything from the residents' ISNP benefits. A review of the investigation file, provided by the Administrator on 8/28/25 at 2:26 p.m., indicated the following: According to the Timeline, the following occurred: On 6/17/25 at 1:30 p.m., the Business Office Manager informed the Administrator there was a concern with Resident D's ISNP benefits card. The transaction was identified that the Activities Director had gone to the grocery on that date to shop for the residents' needs. The Administrator spoke with the Activities Director about the expenses, asked her (Activities Director) to make a note of which resident to whom each item belonged and where the item was stored. The Activities Director indicated she had put all the items on one transaction and must have utilized the wrong residents' benefits cards for the items. She did not know why she had not done individual transactions for each resident. The Activities Director indicated the residents' items were labeled, then later indicated the items still needed to be labeled for the residents. The Activities Director indicated the items had been purchased for Residents D, H, J, and K. A discrepancy was found in what was purchased on the receipt versus what the residents received. The Business Office Manager and the Administrator searched the activity room and storage room for the missing items. On 6/18/25, the Administrator completed an audit of the items at the facility from the grocery store receipt. A facility interview, on 6/18/25 with Activity Assistant 4, indicated she had assisted the Activity Director remove groceries from the Activity Director's car on 6/10/25. Too much was in the car to tell if any groceries were left in the car. The Activity Director brought in five bags of groceries that she said were for her (Activity Director) dinner. Popsicles were in one of the bags; the Activity Director had indicated the popsicles were on sale. She saw the Activity Director drink a bottle of Dr Pepper. The Activity Director delivered some items to the residents and told Activity Assistant 4 the remaining items went towards Bingo prizes and some baking activities. On 6/18/25, the Activity Director told Activity Assistant 4 she was suspended, gave Activity Assistant 4 a black marker, and asked her to label some items in the supply room. She reviewed the items on the list that were purchased. She did not recall seeing the missing items on the activity cart on the day she unloaded the groceries. She recognized the missing popsicles and bottle of Dr Pepper as items that		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a resident's catheter was anchored according to the physician's orders for 1 of 3 residents reviewed for catheters. (Resident C) Findings include: Resident C's closed clinical record was reviewed on 8/27/25 at 3:36 p.m. Diagnoses included infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter, other obstructive and reflux uropathy, urinary tract infection, and benign prostatic hyperplasia with lower urinary tract symptoms. Physician orders included cefpodoxime (antibiotic) 200 milligrams (mg) every 12 hours for urinary tract infection (7/25/25 - 7/27/25), levofloxacin (antibiotic) 500 mg daily (7/30/25 - 8/5/25), tiroprium (for overactive bladder) 20 mg twice a day (7/24/25), Foley catheter: 16 French 5-10 milliliter (mL) bulb (7/25/24 - 7/30/25), Foley catheter: 18 French 10 mL bulb (7/30/25), If resident does not void in six hours anchor foley catheter (7/29/25 - 7/30/25), and May use 18 French catheter to re-anchor until a 16 French 10 mL is available (7/29/25). An admission Minimum Data Set (MDS) assessment, dated 7/30/25, indicated the resident was cognitively intact. He required substantial/maximal staff assistance with toileting and showering hygiene. He required partial/moderate staff assistance with transferring to the toilet and the tub. He had an indwelling catheter and was frequently incontinent of bowels. His primary medical condition was infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter. A care plan for urinary tract infection (UTI) (created and last reviewed/revised 7/24/25) had a goal that the resident will be free from symptoms of UTI. Approaches included administering antibiotic as ordered, assisting with incontinence care, and observing for continued or worsening symptoms of UTI such as acute dysuria (painful urination), fever, costovertebral angle pain or tenderness, suprapubic pain, hematuria, worsening incontinence, urgency, and frequency. A care plan for UTI prophylaxis related to foley removal (created and last reviewed/revised 7/30/25) had a goal that the resident will be free from symptoms of UTI. Approaches included administering antibiotic as ordered, assisting with incontinence care, and observing for continued or worsening symptoms of UTI such as acute dysuria (painful urination), fever, costovertebral angle pain or tenderness, suprapubic pain, hematuria, worsening incontinence, urgency, and frequency. A care plan for the resident required an indwelling catheter related to other obstructive and reflux uropathy (created and last reviewed/revised 8/5/25) had a goal that resident will have catheter care managed appropriately as evidenced by; Not exhibiting signs of urinary tract infection or urethral trauma. Approaches included avoid obstructions in the drainage, change catheter per physician order, provide assistance for catheter care, and use 18 French 10 mL foley catheter per physician order. A urology procedure visit report, dated 7/29/25, signed by the urologist on 7/29/25 at 11:26 a.m., indicated the resident's catheter was removed. A nursing progress note, dated 7/29/25 at 12:42 p.m., indicated the resident had been seen by the urologist that morning and returned with new orders. The staff nurse had the packet from the urologist. Family was aware of the appointment and the new orders sent back with the resident. A nursing progress note, dated 7/29/25 at 2:07 p.m., indicated the resident was seen by the urologist and returned with new orders. A nursing progress note, dated 7/29/25 at 5:06 p.m., indicated the resident had not voided. The resident requested the catheter to be re-anchored after supper. A grievance report, dated 7/29/25 at 8:25 p.m., indicated the resident representative emailed the Administrator regarding concern that the resident's catheter had not been re-anchored. The Administrator called the charge nurse at 8:32 p.m. on 7/29/25. The charge nurse indicated the resident had refused to have the catheter re-anchored earlier and wanted to wait until after dinner. The ordered catheter size was not available, and she had to wait to get an order from the nurse practitioner. The new order was received, and the catheter was placed at approximately 8:45 p.m. A nursing progress note, recorded on 7/30/25 at 3:04 a.m., dated 7/29/25 at 8:44 p.m., indicated the nurse went to see if the resident was ready to have his catheter anchored. He did not have any urinary output. An order for a 16 French 10 mL bulb catheter was ordered which was not available. The nurse practitioner was notified and gave an order for the resident to use an 18 French 10 mL bulb coude (type of catheter). The catheter was anchored with an immediate return of urine. The resident received an as needed pain medication at 8:12 p.m. prior to catheterization, had a fentanyl patch in place, and received routine acetaminophen to manage pain. The resident voiced no concerns. The physician's report, signed at 11:26 a.m., indicated the catheter was removed. The late entry nursing progress note, on 7/30/25 at 3:04 a.m., and the grievance report, on 7/29/25 at 8:25 a.m., indicated the catheter was re-anchored at approximately 8:45 a.m. The physician's order indicated to anchor a foley catheter if the resident did not void in six hours. The time between urinary catheter removal and re-anchoring of the urinary catheter was over		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide physician ordered pain medication in a timely manner for 1 of 3 residents reviewed for admission. (Resident C) Finding includes: Resident C's closed clinical record was reviewed on 8/27/25 at 3:26 p.m. Diagnoses included rheumatoid arthritis, polyneuropathy, post-laminectomy syndrome (syndrome after spinal surgery characterized by persistent or worsening pain, numbness, tingling, and weakness in the legs or back), and chronic pain due to trauma. Physician orders included fentanyl (opiate pain medication) patch 75 mcg (micrograms)/hour every other day (7/25/25), hydromorphone (opiate pain medication) 4 milligrams (mg) every four hours as needed (PRN) for moderate pain (7/24/25), ibuprofen (anti-inflammatory medication) 600 mg three times a day (7/25/25), acetaminophen (Tylenol) 650 mg every four hours PRN (as needed) for mild pain (7/24/25), and acetaminophen every four hours (7/24/25). An admission Minimum Data Set (MDS) assessment, dated 7/30/25, indicated the resident was cognitively intact. He received a scheduled pain medication and a PRN pain medication. He complained of frequent moderate pain that frequently affected his therapy, sleep, and day-to-day activities. A care plan for pain (created and last reviewed/revised on 7/29/25) had a goal that the resident will be free from adverse effects of pain. The approaches included administering medications as ordered, documenting effectiveness of medications, and notifying the physician if pain is unrelieved and/or worsening. A hospital discharge summary which included medications administered, dated 7/23/25, indicated the resident had last received a PRN hydromorphone on 7/23/25 at 12:05 p.m. The resident face sheet indicated he was admitted on [DATE] at 6:57 p.m. A nursing progress note, dated 7/23/25 at 6:57 p.m., edited by the nurse on 7/24/25 at 10:10 a.m. because more data was available, (recorded on 7/24/25 at 10:08 a.m.), indicated the resident arrived at the facility. The resident complained of pain and discomfort that shift and had an order for hydromorphone and a fentanyl patch. Placement of the patch on the resident's left arm was verified by two nurses. The resident complained of pain, but the medications had not yet been delivered. The nurse notified the pharmacy and confirmed orders. The pharmacy indicated the orders were sent out and should be there soon. Resident was made aware. Acetaminophen was offered and administered. The resident was told when the pharmacy arrived with the medications, the nurse would check on the resident to see if he needed stronger pain medications. The resident voiced understanding and voiced no other concerns. A nursing progress note, dated 7/24/25 at 12:50 a.m. (recorded as late entry on 7/25/25 at 12:14 p.m.), indicated the pharmacy delivered stat medications at that time. A nursing progress note, dated 7/24/25 at 2:30 a.m. (recorded as late entry on 7/25/25 at 12:21 p.m.), indicated the resident pressed his call light at that time and a PRN medication was administered with no concerns voiced. The nurse told the resident when the medication arrived the staff had checked on the resident, and the resident appeared to be resting peacefully. She waited until he woke up and pressed the call light for the PRN pain medication. The resident replied he had taken a little nap. A nursing progress note, dated 7/24/25 at 6:57 a.m., indicated the resident arrived at the facility. The resident complained of pain and discomfort that shift and had an order for hydromorphone and a fentanyl patch. Placement of the patch on the resident's left arm was verified by two nurses. The residents complained of pain, but the medications had not yet been delivered. The nurse notified the pharmacy and confirmed orders. The pharmacy indicated the orders were sent out and should be there soon. The resident was made aware. Acetaminophen was offered and administered. The resident was told when the pharmacy arrived with the medications, the nurse would check on the resident to see if he needed stronger pain medications. The resident voiced understanding and voiced no other concerns. The medication administration record for 7/2025 was reviewed. The PRN (as needed) medications given as mentioned in the 7/23/25 note on the resident's admittance were not documented. The first documented given dose of PRN hydromorphone indicated the resident took the medication at 6:53 a.m. with a pain rating of 8 on a 1 to 10 scale. A narcotic count sheet indicated the hydromorphone was received on 7/24/25 at 12:50 a.m. and given at 2:30 a.m. The resident routinely took between four and six PRN hydromorphone daily to manage pain from 7/24/25 through 7/29/25. During a phone interview, on 8/28/25 at 11:09 AM, Resident C's representative indicated the resident had called the resident representative on the night he was admitted. The resident indicated he was in pain. He told the resident representative the facility did not have his medications, and no one would help him. He asked the resident representative to help him and bring his medications from home. During an interview, on 8/29/25 at 11:19 a.m. LPN 7 indicated when a resident was		